

EXHIBIT A – Continuation

ADDITIONAL PLAN INFORMATION

Certificate of Coverages

(Please contact the City Secretary's office to obtain this
Exhibit)

(956) 565-3114 ex. 138 or 161 or by email to:
jcastillo@cityofmercedes.com



Thank you for choosing Continental American Insurance Company

1.800.433.3036

www.aflacgroupinsurance.com

Your Group Policy Number is: CTR0015283525
Product: Accident
Your Policy is Effective : 01/01/2024
Your State of Issue is: Texas


CITY OF MERCEDES
400 S OHIO AVE
MERCEDES TX 78570-3120



March 14, 2024

CITY OF MERCEDES
400 S OHIO AVE
MERCEDES TX 78570-3120

**Re: Your CITY OF MERCEDES Group Accident Coverage
Policy No.: CTR0015283525**

Welcome to the Aflac family!

Thank you so much for adding Aflac coverage in your employee benefits offering. We take commitments to our accounts very seriously and promise to be there when you and your employees need us. Enclosed, you'll find:

A Master Policy packet for the Aflac group plan you've chosen to make available to your employees. Each packet includes:

- A master policy, which indicates your group coverage effective date and other coverage details,
- A copy of your master application, **and**
- A copy of your employees' coverage certificate. **(We'll let employees know they can request copies of their certificates from you, so please be sure to make the coverage documents available. Of course, employees are also welcome to call us directly to request copies of their certificates.)**

If you have any questions about your group plan or your employees' coverage, please reach out to your account manager, or give us a call at 1.866.319.8089 Monday through Friday, from 9 a.m. to 7 p.m. Eastern time.

Again, welcome to the Aflac family!

MPCOVLET_A

Continental American Insurance Company • Columbia, South Carolina • 1.800.433.3036 toll-free

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 New York, group coverage is underwritten by American Family Life Assurance Company of New York (22 Corporate Woods Boulevard, Suite 2, Albany, New York 12211), and customer service is administered by CAIC.

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Continental American Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: Continental American Insurance Company at 1-800-433-3036

Toll-free:

1-800-433-3036

Email: cscmail@aflac.com

Mail: Continental American Insurance Company
Post Office Box 427
Columbia, South Carolina 29202

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call: 1-800-252-3439

Online: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Continental American Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Continental American Insurance Company al 1-800-433-3036

Teléfono gratuito:

1-800-433-3036

Correo electrónico: cscmail@aflac.com

Dirección postal: Continental American Insurance Company
Post Office Box 427
Columbia, South Carolina 29202

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame: 1-800-252-3439

En línea: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
 - o Up to \$500,000 for health benefit plans, with some exceptions.
 - o Up to \$300,000 for disability income benefits.
 - o Up to \$300,000 for long-term care insurance benefits.
 - o Up to \$200,000 for all other types of health insurance.
- **Life insurance:**
 - o Up to \$100,000 in net cash surrender or withdrawal value.
 - o Up to \$300,000 in death benefits.
- **Individual annuities:** Up to \$250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to \$300,000 per person, regardless of the number of policies or contracts. A limit of \$500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

<p>To learn more about the Association and your protections, contact:</p> <p>Texas Life and Health Insurance Guaranty Association 1601 Congress Avenue Austin, TX 78701 1-800-982-6362 or www.txlifega.org</p>	<p>For questions about insurance, contact:</p> <p>Texas Department of Insurance P.O. Box 149104 Austin, TX 78714-9104 1-800-252-3439 or www.tdi.texas.gov</p>
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Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.



CONTINENTAL AMERICAN INSURANCE COMPANY
Columbia, South Carolina
800.433.3036

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

Continuation of Coverage Endorsement

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

EFFECTIVE DATE

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

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

CONTINUATION OF COVERAGE

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

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

To keep your Certificate in force, you must:

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

PREMIUMS

Initial premium rates will be based on the rates in effect at the time you apply to continue your coverage. Premium rates can be changed by the Company at any time upon 60 days written notice to you. Any such change will be applied to all Certificates in your class and will not be based on your or your Spouse and Dependent Children's health or other individual factors.

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

TERMINATION

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

- 31 days after the date you fail to pay any required premium.

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

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

CONTRACT

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

- The Certificate terminates, or
- Premiums are no longer paid for this Endorsement.

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

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

Group Accidental Injury Insurance Policy

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

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

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

The Policyholder as shown on the Policy Schedule applied for coverage under this Group Accidental Injury Insurance Policy (the "Plan"). This Plan is issued by Continental American Insurance Company (the "Company," "CAIC," "we," "us," or "our"). Based on the Master Application and the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. (Please note that male pronouns--such as "he," "him," and "his"--are used for both males and females, unless the context clearly shows otherwise.) The Policyholder may add new Insureds from time to time, according to the Plan's terms.

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

This Plan is a legal contract between the Company and the Policyholder. All matter printed or written by the Company on the following pages is part of this Plan. This Plan is delivered in and is governed by the laws of the jurisdiction shown on the Policy Schedule.

In witness whereof, the Company executes this Plan at its home office in Columbia, South Carolina, on the Effective Date.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

Group Accidental Injury Insurance Non-Participating

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

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SECTION I - ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

PRIMARY INSURED

Eligibility

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

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

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

Employees should refer to *Type of Coverage* in their Certificate Schedule to determine who is covered under the Certificate.

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

Effective Date

The Plan's Effective Date is shown on the Policy Schedule. This Plan becomes effective on the Policy Effective Date at 12:01 a.m., as determined by the Policyholder's address.

An eligible Employee must enroll in this Plan and agree to pay the required premiums for coverage to become effective. He must enroll within 31 days of the date he first becomes eligible for coverage. *The first premium must have been paid for coverage to become effective.*

The Employee's Effective Date is the date his insurance takes effect. After we receive and approve the Application, that date is either:

- The date shown on the Certificate Schedule if the Employee is Actively at Work on that date, or
- The date the Employee returns to an Actively-at-Work status if he was not Actively at Work on the date shown on the Certificate Schedule.

Termination of an Employee's Insurance

An Employee's insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date (the last day of the Grace Period), if the premium has not been paid.

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

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DEPENDENT COVERAGE

Eligibility

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

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

Children Placed for Adoption are children for whom the Employee has entered a decree of adoption, has initiated adoption proceedings, or is a party to a suit in which the Employee seeks to adopt the child. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. The Employee must continue to have custody pursuant to the decree of the court.

Effective Date

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

Termination of Dependent Insurance

Dependent coverage will terminate on the earliest of the following:

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

Plan Termination

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

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

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

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

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

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

Continuation Privilege

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

To keep his coverage in force, the Employee must:

- Notify the Company within 31 days after the date his coverage would otherwise terminate. He may notify us by sending written notice to P.O. Box 84079, Columbus, GA 31993-9101 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly to the Company no later than 31 days after the date his coverage would otherwise terminate and on each premium due date thereafter.

The Employee's ported coverage will end on the earliest of the following dates:

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

If the Employee qualifies for this Continuation Privilege, then the Company will apply the same Benefits and Plan Provisions as shown in his previously-issued Certificate. Notification of any changes in the Plan will be provided directly by the Company.

SECTION II - PREMIUM PROVISIONS

Premium Payments

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

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

Premium Changes

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

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

We will provide the Policyholder a 60-day advance written notice of any change in premiums.

Grace Period

This Plan has a 31-day Grace Period. If a 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. If the Plan is discontinued, the Plan's termination date will be the latest date for which premium has been paid.

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SECTION III - DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- An assisted living facility.

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

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

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

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

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

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

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

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

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

Spouse is an Employee's legal wife or husband, including a legally-recognized same-sex Spouse, or a person of either gender who is in a legally recognized and registered domestic partnership, civil union, reciprocal beneficiary relationship, or similar relationship with the Employee.

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

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

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SECTION IV - BENEFIT PROVISIONS

Initial Treatment Category

Initial Treatment Benefit

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

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

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

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

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

Ambulance Benefit

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

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

Ambulance service includes air ambulance service.

Major Diagnostic Testing Benefit

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

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

These exams must be performed in a Hospital, a Doctor's office, a Medical Diagnostic Imaging Center, or an Ambulatory Surgical Center. The exam must be performed within 6 Months after the accident for a benefit to be payable.

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

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

Emergency Room Observation Benefit

The daily benefit amount shown in the Benefit Schedule is payable for each 24-hour period of observation that, because of a Covered Accidental Injury, an Insured:

- Receives Treatment in a Hospital emergency room, and
- Is held in a Hospital for observation without being admitted as an inpatient, and
- Receives initial Treatment within 168 hours after the accident.

For periods of observation lasting fewer than 24 hours but more than 4 hours, a limited benefit amount as shown in the Benefit Schedule is payable.

Prescriptions Benefit

We will pay the amount shown in the Benefit Schedule for a prescription filled. The prescription must meet three criteria: (1) be ordered by a Doctor due to a Covered Accidental Injury; (2) be dispensed by a licensed pharmacist; and (3) be medically necessary for the care and Treatment of the Insured due to a Covered Accidental Injury. The prescription must be received within 6 months after the accident for a benefit to be payable.

This benefit does not include benefits for: (a) therapeutic devices or appliances; (b) experimental drugs; (c) drugs, medicines or insulin used by or administered to a person while he is confined to a Hospital, rest home, extended-care facility, convalescent home, nursing home or similar institution; or (d) immunization agents, biological sera, blood or blood plasma.

This benefit is not payable for pain management techniques for which a benefit is paid under the Pain Management Benefit (if available).

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

Pain Management Benefit

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

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

The benefit is only payable for pain management techniques (as shown above) that are administered in a Hospital or Doctor's office, and are due to a Covered Accidental Injury. For a benefit to be payable, the pain management technique must be administered within 6 months after the Covered Accident. This benefit is not payable for an epidural administered during a surgical procedure.

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

Blood/Plasma/Platelets Benefit

We will pay the amount shown in the Benefit Schedule for each day that an Insured receives blood, plasma, or platelets due to a Covered Accidental Injury. The Insured must receive the blood, plasma, or platelets within 6 months after the accident for a benefit to be payable.

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

Concussion Benefit

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

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

Traumatic Brain Injury Benefit

We will pay the amount shown in the Benefit Schedule if the Insured is diagnosed by a neurologist with Traumatic Brain Injury (TBI) due to a Covered Accident. *Traumatic Brain Injury (TBI)* is an injury that is caused by a traumatic blow to the head, neck, or shoulders; and results in neurological deficit. To qualify as TBI, the neurological deficit must require:

- Treatment by a neurologist, and
- Prescribed course of physical, speech, and/or occupational therapy under the direction of a neurologist.

The diagnosis must be made within 6 Months after the accident for a benefit to be payable.

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

Burns Benefit

We will pay the amount shown in the Benefit Schedule if the Insured has burns in a Covered Accident. We will pay the Burns Benefit according to the percentage of body surface burned. The Insured must be treated for burns by a Doctor within 6 Months after the accident for a benefit to be payable. First-degree burns are not covered.

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

Emergency Dental Work Benefit

We will pay the amount shown in the Benefit Schedule if the Insured has an Accidental Injury to natural teeth as the result of a Covered Accident. We will pay for extraction or repair with a crown as shown in the Benefit Schedule. The dental work must be performed within 6 Months of the accident for a benefit to be payable.

Eye Injuries Benefit

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

Dislocation Benefit

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

If the dislocation requires open reduction, we will pay 200.00% of the amount shown in the Benefit Schedule.

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

Multiple dislocations refer to more than one dislocation requiring either open or closed reduction in any one Covered Accident. For each covered dislocation, we will pay the amounts shown in the Benefit Schedule. However, we will pay no more than 200.00% 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 25.00% of the amount shown in the Benefit Schedule for the affected joint. (*Partial dislocation* includes subluxation.)

Laceration Benefit

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

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

If the Insured suffers multiple lacerations in a Covered Accident, and the lacerations are repaired with stitches by a Doctor within 168 Hours after the accident, we will pay this benefit based on the largest single laceration that requires stitches, as shown in the Benefit Schedule. However, we will pay no more than 200.00% of the benefit amount for the laceration that has the higher dollar amount.

Fracture Benefit

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

If the fracture requires open reduction, we will pay 200.00% 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 200.00% of the benefit amount for the bone fractured that has the highest dollar amount.

Chip fracture refers to a piece of bone that is completely broken off near a joint. If a Doctor diagnoses the fracture as a chip fracture, we will pay 25.00% of the amount shown in the Benefit Schedule for the affected bone.

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

Outpatient Surgery and Anesthesia Benefit

We will pay the daily benefit amount shown in the Benefit Schedule when, due to a Covered Accidental Injury, an Insured has an outpatient surgical procedure performed by a Doctor. "Surgical procedure" does not include laceration repair. If an outpatient surgical procedure is covered under another benefit in this Plan, we will pay the **higher** of that benefit amount **or** the Outpatient Surgery and Anesthesia Benefit. For a benefit to be payable, the surgery must be performed within 1 year after the Covered Accident.

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

The surgery can be performed:

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

Facilities Fee for Outpatient Surgery Benefit

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

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

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

Inpatient Surgery and Anesthesia Benefit

We will pay the daily benefit amount shown in the Benefit Schedule when, due to a Covered Accidental Injury, an Insured has an inpatient surgical procedure performed by a Doctor. The surgery must be performed while the Insured is confined to a Hospital as an inpatient. If an inpatient surgical procedure is covered under another benefit in this Plan, we will pay the **higher** of that benefit amount **or** the Inpatient Surgery and Anesthesia Benefit. For a benefit to be payable, the surgery must be performed within 1 year after the Covered Accident.

Transportation Benefit

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

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

Use of such transportation must begin within 6 Months after the Covered Accident date. The distance to the Hospital Treatment or diagnostic study must be greater than 100 miles from the Insured's residence.

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

Coma Benefit

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

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

Hospitalization Category

Hospital Admission Benefit

We will pay this benefit when an Insured is admitted to a Hospital and confined as an inpatient because of a Covered Accidental Injury. To be eligible to receive this benefit, an Insured must be admitted to a Hospital within 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 pay this benefit once per period of Hospital Confinement.

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

Hospital Confinement Benefit

We will pay the amount shown in the Benefit Schedule for each day that an Insured is confined to a Hospital as an inpatient as the result of a Covered Accidental Injury. To be eligible to receive this benefit, the Insured must be confined to a Hospital within 6 Months of the date of the Covered Accident.

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

If we pay benefits for confinement and the Insured becomes confined again within 6 Months because of the same Accidental Injury, we will treat this confinement as the same period of confinement.

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

Hospital Intensive Care Benefit

If an Insured is confined in a Hospital Intensive Care Unit because of a Covered Accidental Injury, we will pay the daily benefit amount shown in the Benefit Schedule. To be eligible to receive this benefit an Insured must be admitted to a Hospital Intensive Care Unit within 6 Months of the date of the Covered Accident.

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

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

If we pay benefits for confinement in a Hospital Intensive Care Unit and an Insured becomes confined to a Hospital Intensive Care Unit again within 6 Months because of the same Accidental Injury, we will treat this confinement as the same period of confinement.

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

Intermediate Intensive Care Step-Down Unit Benefit

If an Insured is confined in an Intermediate Intensive Care Step-Down Unit because of a Covered Accidental Injury, we will pay the daily benefit amount shown on the Benefit Schedule. The Insured must be admitted to an Intermediate Intensive Care Step-Down Unit within 6 Months of the date of the Covered Accident.

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

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

If we pay benefits for confinement in a Hospital's Intermediate Intensive Care Step-Down Unit and the Insured becomes confined to a Hospital's Intermediate Intensive Care Step-Down Unit again within 6 Months because of the same condition, we will treat this confinement as the same period of confinement.

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

Family Member Lodging Benefit

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

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

The Treatment must take place within 6 Months after the Covered Accident for a benefit to be payable.

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After Care Category

Appliances Benefit

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

For a benefit to be payable, the Doctor's advice to use a medical appliance must be within 6 months after the Covered Accident.

Accident Follow-Up Treatment Benefit

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

- The Insured receives initial Treatment within 168 hours after the Covered Accident.
- The Insured receives Doctor-prescribed follow-up Treatment.
- The follow-up Treatment begins within 6 Months after the Covered Accident or discharge from the Hospital.

Chiropractic procedures are not considered Follow-up Treatment.

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

Post-Traumatic Stress Disorder Benefit

Post-Traumatic Stress Disorder (PTSD) is a mental health condition triggered by a Covered Accident. We will pay the amount shown in the Benefit Schedule if the Insured is diagnosed with Post-traumatic Stress Disorder. An Insured must meet the diagnostic criteria for PTSD, stipulated in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV-TR), and be under the active care of either a Psychiatrist or Ph.D.-level Psychologist. The diagnosis must take place within 6 months after the Covered Accident for a benefit to be payable.

For the purposes of this benefit:

- **Psychiatrist** is a Doctor of medicine who specializes in the diagnosis and Treatment of mental disorders.
- **Psychologist** is a clinical, mental health professional who works with patients. A Psychologist is not a Doctor of medicine who typically provides medical interventions and drug therapies, but provides analysis and counseling.

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

Rehabilitation Unit Benefit

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

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

Therapy Benefit

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

- The Insured receives initial Treatment within 168 hours after the Covered Accident.
- The Insured receives Doctor-prescribed therapy Treatment in one of the following categories: physical therapy provided by a licensed physical therapist, occupational

therapy provided by a licensed occupational therapist, or speech therapy provided by a licensed speech therapist.

- The therapy Treatment begins within 90 days after the Covered Accident or discharge from the Hospital.

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

Chiropractic or Alternative Therapy Benefit

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

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

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

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Life Change Events Category

Dismemberment Benefit

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

- Is injured, and
- Loses a hand, a foot, or sight within 6 Months after the accident as a result of the Injury.

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

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

If the Dismemberment Benefit is paid and the Insured later dies as a result of the same Covered Accident, we will pay the appropriate death benefit (if available), less any amounts paid under this benefit.

Paralysis Benefit

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

- The Insured is injured,
- The Accidental Injury causes paralysis which lasts more than 90 days, and
- The paralysis is diagnosed by a Doctor within 6 Months after the accident.

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

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

Prosthesis Benefit

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

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

This benefit is not payable for:

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

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

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

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

Residence/Vehicle Modification Benefit

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

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

The modification must occur within one year after the accident.

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

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SECTION V - EXCLUSIONS

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

- **War** – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the Insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion, or civil state of belligerence. War does not include acts of 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:
 - Allergic reactions
 - Any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings
 - An error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure for any sickness
 - Any related medical/surgical Treatment or diagnostic procedures for such illness
- **Self-Inflicted Injuries** - injuring or attempting to injure oneself intentionally.
- **Racing** - riding in or driving any motor-driven vehicle in a race, stunt show, or speed test in a professional or semi-professional capacity.
- **Illegal Occupation** - voluntarily participating in, committing, or attempting to commit a felony or illegal act or activity, or voluntarily working at, or being engaged in, an illegal occupation or job.
- **Sports** - participating in any organized sport in a professional or semi-professional capacity for pay or profit.
- **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.
- **Driving** – driving any taxi or intrastate or interstate long-distance vehicle for wage, compensation, or profit.

For **24-Hour Coverage**, the following exclusions will not apply:

- An Injury arising from any employment.
- An Injury or sickness covered by Worker's Compensation.

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SECTION VI - CLAIM PROVISIONS

Notice of Claim

The Insured must give written notice of claim:

- No later than 20th day after a Covered Accidental Injury, or
- As soon as reasonably possible.

When we receive written Notice of Claim, we will send a claim form. If the Claimant does not receive the claim form within 15 days after the notice is sent, written Proof of Loss can be sent to us without waiting for the form. Notice must include the Employee's name and the Certificate number. Notice can be mailed to the Company at the following address:

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

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. It can include a statement by the treating Doctor.) Proof of Loss establishes the nature and extent of the loss, the Company's obligation to pay the claim, and the Claimant's right to receive payment.

The Claimant must provide Proof of Loss to the Company at the following address:

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

Proof of Loss must be given to us within 90 days of the Covered Accidental Injury. Failure to give Proof of Loss within such time shall not invalidate or reduce any claim if such Proof of Loss is given as soon as reasonably possible. The Company will not accept Proof of Loss any later than one year and three months after the Covered Accidental Injury, except in the absence of the Claimant's legal mental capacity.

The Claimant will be responsible for the cost of obtaining a completed claim form. We may request additional Proof of Loss, such as records from Hospitals or Doctors. The Claimant will be responsible for the cost of obtaining these records.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

When we receive the claim and due Proof of Loss, we will review the Proof of Loss. If we approve the claim, we will pay the benefits subject to the terms of the Certificate.

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 exams and/or autopsy.

Time of Payment of Claims

For benefits other than for loss of time, the Company will, once we receive the required Proof of Loss, pay, deny, or settle each submitted claim no later than the 60th day after the date Proof of Loss is received. Subject to written Proof of Loss, all accrued benefits payable under the Policy for loss of time will be paid at least monthly during the period for which the Company is liable. Any balance remaining unpaid at the end of that time will be paid as soon as possible after Proof of Loss is received.

Payment of Claims

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

- To the beneficiary designated by the Insured or the beneficiary's assignee,
- To the Insured's surviving Spouse,
- To the Insured's estate.

Unpaid Premium

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

Changing of Beneficiary

A change in beneficiary must be submitted in writing to our Home Office and signed by the Employee. Unless otherwise specified by the Employee, a change in beneficiary will take effect on the date the notice of change is signed. We will not be liable for any action taken before notice is received and recorded at the Home Office.

Claim Review

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

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

Appeals Procedure

Before filing any lawsuit-and no later than 60 days after notice of denial of a claim-the Employee, the Claimant, or an authorized representative of either must appeal any denial of benefits under the Plan by sending a written request for review of the denial to our Home Office.

Legal Action

The Employee may not take Legal Action against us for benefits under this Plan:

- Within 60 days after he has sent us written Proof of Loss, or
- More than three years from the time written proof is required to be given.

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SECTION VII - GENERAL PROVISIONS

Entire Contract Changes

This insurance is provided under a contract of Group Accidental Injury Insurance with the Policyholder. The Entire Contract of Insurance is made up of:

- The Policy;
- The Certificates of Insurance;
- The Application of the Policyholder, a copy of which is attached to and made part of the Policy when issued; and
- Any Riders, Endorsements, or Amendments to the Policy or Certificate.

In the absence of fraud, a statement made by the Policyholder or an Insured is considered a representation and not a warranty. A statement made by the Policyholder or an Insured will not be used in any contest under the Plan, unless a copy of the written instrument containing the statement is or has been provided to:

- The person making the statement; or
- If the statement was made by the Insured, and the Insured has died or become incapacitated, the Insured's beneficiary or personal representative.

Changes to the 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 or producer (nor can an agent or producer waive any Plan provisions).

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.

Successor Insured

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

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

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

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

Time Limit on Certain Defenses

After two years from the Employee's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of intentional misstatements, of a material fact, made on the Employee's 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 Certificates

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

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

Required Information

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

Conformity with State Statutes

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

POLICY SCHEDULE

Group Policyholder: CITY OF MERCEDES
Group Policy Number: CTR0015283525
Group Policy Effective Date: January 1, 2024
Group Policy Anniversary Date: January 1, 2025
Jurisdiction: Texas

24-Hour Coverage

*Initial premium includes the premium for any Riders purchased at the same time as the coverage provided by an Employee's Certificate.

This Plan is delivered in and governed by the laws of the jurisdiction shown above.

BENEFIT SCHEDULE

Initial Treatment Category - High

	Primary Insured	Spouse	Child
Initial Treatment Benefit			
<i>Hospital emergency room with X-Ray</i>	\$250.00	\$250.00	\$250.00
<i>Hospital emergency room without X-Ray</i>	\$200.00	\$200.00	\$200.00
<i>Urgent Care facility with X-Ray</i>	\$250.00	\$250.00	\$250.00
<i>Urgent Care facility without X-Ray</i>	\$200.00	\$200.00	\$200.00
<i>Office or facility (other than a Hospital emergency room or Urgent Care) with X-Ray</i>	\$150.00	\$150.00	\$150.00
<i>Office or facility (other than a Hospital emergency room or Urgent Care) without X-Ray</i>	\$100.00	\$100.00	\$100.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Ambulance Benefit			
	\$400.00	\$400.00	\$400.00
Air Ambulance Benefit			
	\$1,200.00	\$1,200.00	\$1,200.00
Major Diagnostic Testing Benefit			
	\$200.00	\$200.00	\$200.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Emergency Room Observation Benefit			
<i>Per each 24 hour period of observation</i>	\$100.00	\$100.00	\$100.00
<i>Period of observation at least 4 hours and up to 24 hours</i>	\$50.00	\$50.00	\$50.00
Prescriptions Benefit			
	\$5.00	\$5.00	\$5.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	2	2	2
Pain Management Benefit			
	\$100.00	\$100.00	\$100.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Blood/Plasma/Platelets Benefit			
	\$200.00	\$200.00	\$200.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	3	3	3
Concussion Benefit			
	\$500.00	\$500.00	\$500.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Traumatic Brain Injury Benefit			
	\$5,000.00	\$5,000.00	\$5,000.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Burns Benefit			
<i>Second Degree</i>			
Less than 10%	\$100.00	\$100.00	\$100.00
At least 10% but less than 25%	\$200.00	\$200.00	\$200.00
At least 25% but less than 35%	\$500.00	\$500.00	\$500.00
35% or more	\$1,000.00	\$1,000.00	\$1,000.00
<i>Third Degree</i>			
Less than 10%	\$1,000.00	\$1,000.00	\$1,000.00
At least 10% but less than 25%	\$5,000.00	\$5,000.00	\$5,000.00
At least 25% but less than 35%	\$10,000.00	\$10,000.00	\$10,000.00
35% or more	\$20,000.00	\$20,000.00	\$20,000.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Emergency Dental Work Benefit			
Repair with crown	\$200.00	\$200.00	\$200.00
Extraction	\$50.00	\$50.00	\$50.00
Eye Injuries Benefit			
	\$250.00	\$250.00	\$250.00

Dislocation Benefit			
Hip	\$3,000.00	\$3,000.00	\$3,000.00
Knee (not knee cap)	\$1,950.00	\$1,950.00	\$1,950.00
Shoulder	\$1,500.00	\$1,500.00	\$1,500.00
Foot/ankle	\$1,200.00	\$1,200.00	\$1,200.00
Hand	\$1,050.00	\$1,050.00	\$1,050.00
Lower jaw	\$900.00	\$900.00	\$900.00
Wrist	\$750.00	\$750.00	\$750.00
Elbow	\$600.00	\$600.00	\$600.00
Finger/toe	\$240.00	\$240.00	\$240.00
Laceration Benefit			
Over 15 centimeters	\$800.00	\$800.00	\$800.00
5 to 15 centimeters	\$400.00	\$400.00	\$400.00
Under 5 centimeters	\$100.00	\$100.00	\$100.00
Lacerations not requiring stitches	\$50.00	\$50.00	\$50.00
Fracture Benefit			
Hip/thigh	\$4,000.00	\$4,000.00	\$4,000.00
Vertebrae	\$3,600.00	\$3,600.00	\$3,600.00
Pelvis	\$3,200.00	\$3,200.00	\$3,200.00
Skull (depressed)	\$3,000.00	\$3,000.00	\$3,000.00
Skull (simple)	\$1,400.00	\$1,400.00	\$1,400.00
Leg	\$2,400.00	\$2,400.00	\$2,400.00
Foot/ankle/knee cap	\$2,000.00	\$2,000.00	\$2,000.00
Forearm/hand/wrist	\$2,000.00	\$2,000.00	\$2,000.00
Lower jaw	\$1,600.00	\$1,600.00	\$1,600.00
Shoulder blade/collar bone	\$1,600.00	\$1,600.00	\$1,600.00
Upper arm/upper jaw	\$1,400.00	\$1,400.00	\$1,400.00
Facial bones (except teeth)	\$1,200.00	\$1,200.00	\$1,200.00
Vertebral processes	\$800.00	\$800.00	\$800.00
Coccyx/rib/finger/toe	\$320.00	\$320.00	\$320.00
Sternum	\$3,600.00	\$3,600.00	\$3,600.00
Sacral/Sacrum	\$800.00	\$800.00	\$800.00
Outpatient Surgery and Anesthesia Benefit			
<i>Hospital Outpatient or Ambulatory Surgical Center</i>	\$400.00/day	\$400.00/day	\$400.00/day
<i>Doctor's Office or Emergency Room</i>	\$50.00/day	\$50.00/day	\$50.00/day
<i>(Maximum is applicable only to Doctor's office or Emergency Room)</i>			
<i>Maximum number of payments per Covered Accident, per Insured</i>	2	2	2
Facilities Fee for Outpatient Surgery Benefit	\$100.00	\$100.00	\$100.00
<i>Payable once per each eligible Outpatient Surgery and Anesthesia Benefit</i>			
Inpatient Surgery and Anesthesia Benefit	\$1,000.00/day	\$1,000.00/day	\$1,000.00/day
Transportation Benefit			
Plane	\$500.00	\$500.00	\$500.00
Any Ground Transportation	\$200.00	\$200.00	\$200.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	3	3	3
Coma Benefit	\$10,000.00	\$10,000.00	\$10,000.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Hospitalization Category - High	Primary Insured	Spouse	Child
Hospital Admission Benefit	\$1,250.00	\$1,250.00	\$1,250.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Hospital Confinement Benefit	\$300.00/day	\$300.00/day	\$300.00/day
<i>Maximum Benefit Period: 365 days</i>			
Hospital Intensive Care Benefit	\$400.00/day	\$400.00/day	\$400.00/day
<i>Maximum Benefit Period: 30 days</i>			
Intermediate Intensive Care Step-Down Unit Benefit	\$200.00/day	\$200.00/day	\$200.00/day
<i>Maximum Benefit Period: 30 days</i>			
Family Member Lodging Benefit	\$200.00/day	\$200.00/day	\$200.00/day
<i>Maximum Benefit Period: 30 days</i>			

After Care Category - High	Primary Insured	Spouse	Child
Appliances Benefit			
<i>Cane</i>	\$40.00	\$40.00	\$40.00
<i>Ankle Brace</i>	\$40.00	\$40.00	\$40.00
<i>Walking Boot</i>	\$100.00	\$100.00	\$100.00
<i>Walker</i>	\$100.00	\$100.00	\$100.00
<i>Crutches</i>	\$100.00	\$100.00	\$100.00
<i>Leg Brace</i>	\$100.00	\$100.00	\$100.00
<i>Wheelchair</i>	\$400.00	\$400.00	\$400.00
<i>Knee Scooter</i>	\$400.00	\$400.00	\$400.00
<i>Body Jacket</i>	\$400.00	\$400.00	\$400.00
<i>Back Brace</i>	\$400.00	\$400.00	\$400.00
<i>Cervical Collar</i>	\$100.00	\$100.00	\$100.00
Accident Follow-Up Treatment Benefit			
<i>Maximum number of payments per Covered Accident, per Insured</i>	\$50.00	\$50.00	\$50.00
	6	6	6
Post-Traumatic Stress Disorder Benefit			
<i>Maximum number of payments per Covered Accident, per Insured</i>	\$200.00	\$200.00	\$200.00
	1	1	1
Rehabilitation Unit Benefit			
<i>Maximum Benefit Period per Hospital confinement</i>	\$100.00/day	\$100.00/day	\$100.00/day
<i>Calendar Year Maximum</i>	31 days	31 days	31 days
	62 days	62 days	62 days
Therapy Benefit			
<i>Maximum number of payments per Covered Accident, per Insured</i>	\$50.00	\$50.00	\$50.00
	10	10	10
Chiropractic or Alternative Therapy Benefit			
<i>Maximum number of payments per Covered Accident, per Insured</i>	\$30.00	\$30.00	\$30.00
	6	6	6
Life Change Events Category - High			
	Primary Insured	Spouse	Child
Dismemberment Benefit			
<i>Loss of hand, foot, or sight</i>			
Single loss	\$12,500.00	\$5,000.00	\$2,500.00
Double loss	\$25,000.00	\$10,000.00	\$5,000.00
Loss of one or more fingers or toes	\$1,250.00	\$500.00	\$250.00
Partial amputation of finger or toe	\$125.00	\$125.00	\$125.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Paralysis			
Four limbs (quadriplegia)	\$10,000.00	\$10,000.00	\$10,000.00
Two limbs (paraplegia)	\$5,000.00	\$5,000.00	\$5,000.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Prosthesis Benefit			
Single	\$3,000.00	\$3,000.00	\$3,000.00
Multiple	\$6,000.00	\$6,000.00	\$6,000.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Residence/Vehicle Modification Benefit			
<i>Maximum number of payments per Covered Accident, per Insured</i>	\$2,000.00	\$2,000.00	\$2,000.00
	1	1	1

INCORPORATION OF RIDER PROVISIONS

The attached listed Riders are made a part of this Plan.

Rider Name

Wellness Rider
Accidental Death Rider

Form Number

C70301TX
C70305TX

SCHEDULE OF PREMIUMS

RATES TABLE FOR: CITY OF MERCEDES / ACCIDENT

DEDUCTION FREQUENCY	:	Monthly (12pp / yr)
EMPLOYEE COST	:	\$17.48



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

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

Amendment to Policy and Certificate of Insurance for Group Accidental Injury

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

EFFECTIVE DATE

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

The Termination of Your Insurance provision is deleted and replaced with the following:

Termination of Your Insurance

Your insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date (the last day of the Grace Period), if the premium has not been paid.

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

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

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

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

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

CONTRACT

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

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

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

Amendment to Worker's Compensation Disclosure

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

EFFECTIVE DATE

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

The Worker's Compensation Disclosure on the Face Page of the Policy and Certificate is deleted and replaced with the following:

THIS IS NOT A WORKERS' COMPENSATION INSURANCE POLICY. THE EMPLOYER DOES NOT OBTAIN WORKERS' COMPENSATION INSURANCE COVERAGE BY PURCHASING THIS POLICY, AND IF THE EMPLOYER HAS NOT ELECTED TO OBTAIN WORKERS' COMPENSATION INSURANCE COVERAGE, THE EMPLOYER DOES NOT OBTAIN THOSE BENEFITS THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS IN THIS STATE. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAWS IN THIS STATE AS THEY PERTAIN TO EMPLOYERS THAT ELECT NOT TO MAINTAIN WORKERS' COMPENSATION INSURANCE COVERAGE AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

CONTRACT

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

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY
 Columbia, South Carolina
 800.433.3036

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

Wellness Rider
To Certificate of Insurance for Group Accidental Injury Insurance Policy

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

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

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

EFFECTIVE DATE

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

WELLNESS BENEFIT

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

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

The amount paid will be based on when the Wellness Test was performed. See the Benefit Schedule for details.

This benefit is limited to the maximum number of payments shown in the Benefit Schedule.

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 intentional misstatements, of a material fact, made on the Application. This does not apply to fraudulent misstatements.

CONTRACT

This Rider is part of the Group Accidental Injury Insurance Policy. It will terminate when:

- The Certificate terminates, or
- Premiums are no longer paid for this Rider.

Signed for the Company at its Home Office,

Virgil R. Miller

Virgil R. Miller, President

J. Matthew Loudermilk

J. Matthew Loudermilk, Secretary

WELLNESS RIDER BENEFITS SCHEDULE

	Primary Insured	Spouse	Child
Wellness tests performed during the first Calendar Year	\$25.00	\$25.00	\$25.00
Wellness tests performed during the second and third Calendar Year	\$50.00	\$50.00	\$50.00
Wellness tests performed after the fourth Calendar Year	\$75.00	\$75.00	\$75.00
Maximum number of payments per Calendar Year, per Insured	1	1	1



CONTINENTAL AMERICAN INSURANCE COMPANY
Columbia, South Carolina
800.433.3036

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

Accidental Death Rider
To Certificate of Insurance for Group Accidental Injury Insurance Policy

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

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

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

EFFECTIVE DATE

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

DEFINITIONS

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

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.

BENEFITS

Accidental Death Benefit

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

- The Insured is injured, and
- The Injury causes the Insured 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 Rider Schedule if the Insured:

- Is a fare-paying passenger on a Common Carrier,
- Is injured in a Covered Accident, and
- Dies within 90 days after the Covered Accident.

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

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 intentional misstatements, of a material fact, made on the Application. This does not apply to fraudulent misstatements.

CONTRACT

This Rider is part of the Group Accidental Injury Insurance Policy. It will terminate when:

- The Certificate terminates, or
- Premiums are no longer paid for this Rider.

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary

ACCIDENTAL DEATH RIDER BENEFITS SCHEDULE

	Primary Insured	Spouse	Child
Accidental Death	\$50,000.00	\$25,000.00	\$10,000.00
Accidental Common-Carrier Death	\$100,000.00	\$50,000.00	\$20,000.00



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

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

Certificate of Insurance For Group Accidental Injury Insurance Policy

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

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

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

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

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

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

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

The Certificate Effective Date is shown in the Certificate Schedule. The Certificate will terminate as provided in the provision entitled, "Termination of Your Insurance" in Section I. 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.

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SECTION I - ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

PRIMARY INSURED

Eligibility

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

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

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

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

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

Effective Date

Your Employee Effective Date is shown on the Certificate Schedule.

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

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

Termination of Your Insurance

Your insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date (the last day of the Grace Period), if the premium has not been paid.

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

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DEPENDENT COVERAGE

Eligibility

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

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

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

Effective Date

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

Termination of Dependent Insurance

Dependent coverage will terminate on the earliest of the following:

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

Plan Termination

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

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

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

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

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

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

Continuation Privilege

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

To keep your coverage in force, you must:

- Notify the Company within 31 days after the date your coverage would otherwise terminate. You may notify us by sending written notice to P.O. Box 84079, Columbus, GA 31993-9101 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly to the Company no later than 31 days after the date your coverage would otherwise terminate and on each premium due date thereafter.

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

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

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

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SECTION II - PREMIUM PROVISIONS

Premium Payments

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

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

Premium Changes

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

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

We will provide the Policyholder a 60-day advance written notice of any change in premiums.

Grace Period

This Plan has a 31-day Grace Period. If a 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. If the Plan is discontinued, the Plan's termination date will be the latest date for which premium has been paid.

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SECTION III - DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Spouse is an Employee's legal wife or husband, including a legally-recognized same-sex Spouse, or a person of either gender who is in a legally recognized and registered domestic partnership, civil union, reciprocal beneficiary relationship, or similar relationship with the Employee.

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

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

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SECTION IV - BENEFIT PROVISIONS

Initial Treatment Category

Initial Treatment Benefit

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

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

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

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

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

Ambulance Benefit

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

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

Ambulance service includes air ambulance service.

Major Diagnostic Testing Benefit

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

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

These exams must be performed in a Hospital, a Doctor's office, a Medical Diagnostic Imaging Center, or an Ambulatory Surgical Center. The exam must be performed within 6 Months after the accident for a benefit to be payable.

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

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

Emergency Room Observation Benefit

The daily benefit amount shown in the Benefit Schedule is payable for each 24-hour period of observation that, because of a Covered Accidental Injury, an Insured:

- Receives Treatment in a Hospital emergency room, and
- Is held in a Hospital for observation without being admitted as an inpatient, and
- Receives initial Treatment within 168 Hours after the accident.

For periods of observation lasting fewer than 24 hours but more than 4 hours, a limited benefit amount as shown in the Benefit Schedule is payable.

Prescriptions Benefit

We will pay the amount shown in the Benefit Schedule for a prescription filled. The prescription must meet three criteria: (1) be ordered by a Doctor due to a Covered Accidental Injury; (2) be dispensed by a licensed pharmacist; and (3) be medically necessary for the care and Treatment of the Insured due to a Covered Accidental Injury. The prescription must be received within 6 months after the accident for a benefit to be payable.

This benefit does not include benefits for: (a) therapeutic devices or appliances; (b) experimental drugs; (c) drugs, medicines or insulin used by or administered to a person while he is confined to a Hospital, rest home, extended-care facility, convalescent home, nursing home or similar institution; or (d) immunization agents, biological sera, blood or blood plasma.

This benefit is not payable for pain management techniques for which a benefit is paid under the Pain Management Benefit (if available).

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

Pain Management Benefit

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

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

The benefit is only payable for pain management techniques (as shown above) that are administered in a Hospital or Doctor's office, and are due to a Covered Accidental Injury. For a benefit to be payable, the pain management technique must be administered within 6 months after the Covered Accident. This benefit is not payable for an epidural administered during a surgical procedure.

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

Blood/Plasma/Platelets Benefit

We will pay the amount shown in the Benefit Schedule for each day that an Insured receives blood, plasma, or platelets due to a Covered Accidental Injury. The Insured must receive the blood, plasma, or platelets within 6 months after the accident for a benefit to be payable.

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

Concussion Benefit

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

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

Traumatic Brain Injury Benefit

We will pay the amount shown in the Benefit Schedule if the Insured is diagnosed by a neurologist with Traumatic Brain Injury (TBI) due to a Covered Accident. *Traumatic Brain Injury (TBI)* is an injury that is caused by a traumatic blow to the head, neck, or shoulders; and that results in neurological deficit. To qualify as TBI, the neurological deficit must require:

- Treatment by a neurologist, and
- Prescribed course of physical, speech, and/or occupational therapy under the direction of a neurologist.

The diagnosis must be made within 6 Months after the accident for a benefit to be payable.

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

Burns Benefit

We will pay the amount shown in the Benefit Schedule if the Insured has burns in a Covered Accident. We will pay the Burns Benefit according to the percentage of body surface burned. The Insured must be treated for burns by a Doctor within 6 Months after the accident for a benefit to be payable. First-degree burns are not covered.

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

Emergency Dental Work Benefit

We will pay the amount shown in the Benefit Schedule if the Insured has an Accidental Injury to natural teeth as the result of a Covered Accident. We will pay for extraction or repair with a crown as shown in the Benefit Schedule. The dental work must be performed within 6 Months of the accident for a benefit to be payable.

Eye Injuries Benefit

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

Dislocation Benefit

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

If the dislocation requires open reduction, we will pay 200.00% of the amount shown in the Benefit Schedule.

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

Multiple dislocations refer to more than one dislocation requiring either open or closed reduction in any one Covered Accident. For each covered dislocation, we will pay the amounts shown in the Benefit Schedule. However, we will pay no more than 200.00% 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 25.00% of the amount shown in the Benefit Schedule for the affected joint. (*Partial dislocation* includes subluxation.)

Laceration Benefit

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

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

If the Insured suffers multiple lacerations in a Covered Accident, and the lacerations are repaired with stitches by a Doctor within 168 Hours after the accident, we will pay this benefit based on the largest single laceration that requires stitches, as shown in the Benefit Schedule. However, we will pay no more than 200.00% of the benefit amount for the laceration that has the higher dollar amount.

Fracture Benefit

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

If the fracture requires open reduction, we will pay 200.00% 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 200.00% of the benefit amount for the bone fractured that has the highest dollar amount.

Chip fracture refers to a piece of bone that is completely broken off near a joint. If a Doctor diagnoses the fracture as a chip fracture, we will pay 25.00% of the amount shown in the Benefit Schedule for the affected bone.

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

Outpatient Surgery and Anesthesia Benefit

We will pay the daily benefit amount shown in the Benefit Schedule when, due to a Covered Accidental Injury, an Insured has an outpatient surgical procedure performed by a Doctor. "Surgical procedure" does not include laceration repair. If an outpatient surgical procedure is covered under another benefit in this Plan, we will pay the **higher** of that benefit amount **or** the Outpatient Surgery and Anesthesia Benefit. For a benefit to be payable, the surgery must be performed within 1 year after the Covered Accident.

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

The surgery can be performed:

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

Facilities Fee for Outpatient Surgery Benefit

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

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

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

Inpatient Surgery and Anesthesia Benefit

We will pay the daily benefit amount shown in the Benefit Schedule when, due to a Covered Accidental Injury, an Insured has an inpatient surgical procedure performed by a Doctor. The surgery must be performed while the Insured is confined to a Hospital as an inpatient. If an inpatient surgical procedure is covered under another benefit in this Plan, we will pay the **higher** of that benefit amount **or** the Inpatient Surgery and Anesthesia Benefit. For a benefit to be payable, the surgery must be performed within 1 year after the Covered Accident.

Transportation Benefit

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

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

Use of such transportation must begin within 6 Months after the Covered Accident date. The distance to the Hospital Treatment or diagnostic study must be greater than 100 miles from the Insured's residence.

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

Coma Benefit

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

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

Hospitalization Category

Hospital Admission Benefit

We will pay this benefit when an Insured is admitted to a Hospital and confined as an inpatient because of a Covered Accidental Injury. To be eligible to receive this benefit, an Insured must be admitted to a Hospital within 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 pay this benefit once per period of Hospital Confinement.

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

Hospital Confinement Benefit

We will pay the amount shown in the Benefit Schedule for each day that an Insured is confined to a Hospital as an inpatient as the result of a Covered Accidental Injury. To be eligible to receive this benefit, the Insured must be confined to a Hospital within 6 Months of the date of the Covered Accident.

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

If we pay benefits for confinement and the Insured becomes confined again within 6 Months because of the same Accidental Injury, we will treat this confinement as the same period of confinement.

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

Hospital Intensive Care Benefit

If an Insured is confined in a Hospital Intensive Care Unit because of a Covered Accidental Injury, we will pay the daily benefit amount shown in the Benefit Schedule. To be eligible to receive this benefit an Insured must be admitted to a Hospital Intensive Care Unit within 6 Months of the date of the Covered Accident.

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

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

If we pay benefits for confinement in a Hospital Intensive Care Unit and an Insured becomes confined to a Hospital Intensive Care Unit again within 6 Months because of the same Accidental Injury, we will treat this confinement as the same period of confinement.

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

Intermediate Intensive Care Step-Down Unit Benefit

If an Insured is confined in an Intermediate Intensive Care Step-Down Unit because of a Covered Accidental Injury, we will pay the daily benefit amount shown on the Benefit Schedule. The Insured must be admitted to an Intermediate Intensive Care Step-Down Unit within 6 Months of the date of the Covered Accident.

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

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

If we pay benefits for confinement in a Hospital's Intermediate Intensive Care Step-Down Unit and the Insured becomes confined to a Hospital's Intermediate Intensive Care Step-Down Unit again within 6 Months because of the same condition, we will treat this confinement as the same period of confinement.

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

Family Member Lodging Benefit

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

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

The Treatment must take place within 6 Months after the Covered Accident for a benefit to be payable.

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After Care Category

Appliances Benefit

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

For a benefit to be payable, the Doctor's advice to use a medical appliance must be within 6 months after the Covered Accident.

Accident Follow-Up Treatment Benefit

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

- The Insured receives initial Treatment within 168 hours after the Covered Accident.
- The Insured receives Doctor-prescribed follow-up Treatment.
- The follow-up Treatment begins within 6 Months after the Covered Accident or discharge from the Hospital.

Chiropractic procedures are not considered Follow-up Treatment.

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

Post-Traumatic Stress Disorder Benefit

Post-Traumatic Stress Disorder (PTSD) is a mental health condition triggered by a Covered Accident. We will pay the amount shown in the Benefit Schedule if the Insured is diagnosed with Post-traumatic Stress Disorder. An Insured must meet the diagnostic criteria for PTSD, stipulated in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV-TR), and be under the active care of either a Psychiatrist or Ph.D.-level Psychologist. The diagnosis must take place within 6 months after the Covered Accident for a benefit to be payable.

For the purposes of this benefit:

- **Psychiatrist** is a Doctor of medicine who specializes in the diagnosis and Treatment of mental disorders.
- **Psychologist** is a clinical, mental health professional who works with patients. A Psychologist is not a Doctor of medicine who typically provides medical interventions and drug therapies, but provides analysis and counseling.

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

Rehabilitation Unit Benefit

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

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

Therapy Benefit

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

- The Insured receives initial Treatment within 168 hours after the Covered Accident.
- The Insured receives Doctor-prescribed therapy Treatment in one of the following categories: physical therapy provided by a licensed physical therapist, occupational

therapy provided by a licensed occupational therapist, or speech therapy provided by a licensed speech therapist.

- The therapy Treatment begins within 90 days after the Covered Accident or discharge from the Hospital.

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

Chiropractic or Alternative Therapy Benefit

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

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

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

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Life Change Events Category

Dismemberment Benefit

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

- Is injured, and
- Loses a hand, a foot, or sight within 6 Months after the accident as a result of the Injury.

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

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

If the Dismemberment Benefit is paid and the Insured later dies as a result of the same Covered Accident, we will pay the appropriate death benefit (if available), less any amounts paid under this benefit.

Paralysis Benefit

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

- The Insured is injured,
- The Accidental Injury causes paralysis which lasts more than 90 days, and
- The paralysis is diagnosed by a Doctor within 6 Months after the accident.

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

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

Prosthesis Benefit

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

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

This benefit is not payable for:

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

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

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

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

Residence/Vehicle Modification Benefit

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

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

The modification must occur within one year after the accident.

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

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SECTION V - EXCLUSIONS

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

- **War** – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the Insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion, or civil state of belligerence. War does not include acts of 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:
 - o Allergic reactions
 - o Any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings
 - o An error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure for any sickness
 - o Any related medical/surgical Treatment or diagnostic procedures for such illness
- **Self-Inflicted Injuries** - injuring or attempting to injure oneself intentionally.
- **Racing** - riding in or driving any motor-driven vehicle in a race, stunt show, or speed test in a professional or semi-professional capacity.
- **Illegal Occupation** - voluntarily participating in, committing, or attempting to commit a felony or illegal act or activity, or voluntarily working at, or being engaged in, an illegal occupation or job.
- **Sports** - participating in any organized sport in a professional or semi-professional capacity for pay or profit.
- **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.
- **Driving** – driving any taxi or intrastate or interstate long-distance vehicle for wage, compensation, or profit.

For **24-Hour Coverage**, the following exclusions will not apply:

- An Injury arising from any employment.
- An Injury or sickness covered by Worker's Compensation.

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SECTION VI - CLAIM PROVISIONS

Notice of Claim

The Insured must give written notice of claim:

- No later than the 20th day after a Covered Accidental Injury, or
- As soon as reasonably possible.

When we receive written Notice of Claim, we will send a claim form. If the Claimant does not receive the claim form within 15 days after the notice is sent, written Proof of Loss can be sent to us without waiting for the form. Notice must include the Employee's name and the Certificate number. Notice can be mailed to the Company at the following address:

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

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

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. It can include a statement by the treating Doctor.) Proof of Loss establishes the nature and extent of the loss, the Company's obligation to pay the claim, and the Claimant's right to receive payment.

The Claimant must provide Proof of Loss to the Company at the following address:

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

Proof of Loss must be given to us within 90 days of the Covered Accidental Injury. Failure to give Proof of Loss within such time shall not invalidate or reduce any claim if such Proof of Loss is given as soon as reasonably possible. The Company will not accept Proof of Loss any later than one year and three months after the Covered Accidental Injury, except in the absence of the Claimant's legal mental capacity.

The Claimant will be responsible for the cost of obtaining a completed claim form. We may request additional Proof of Loss, such as records from Hospitals or Doctors. The Claimant will be responsible for the cost of obtaining these records.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

When we receive the claim and due Proof of Loss, we will review the Proof of Loss. If we approve the claim, we will pay the benefits subject to the terms of the Certificate.

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 exams and/or autopsy.

Time of Payment of Claims

For benefits other than for loss of time, the Company will, once we receive the required Proof of Loss, pay, deny, or settle each submitted claim no later than the 60th day after the date Proof of Loss is received. Subject to written Proof of Loss, all accrued benefits payable under the Policy for loss of time will be paid at least monthly during the period for which the Company is liable. Any balance remaining unpaid at the end of that time will be paid as soon as possible after the Proof of Loss is received.

Payment of Claims

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

- To the beneficiary designated by the Insured or the beneficiary's assignee,
- To the Insured's surviving Spouse,
- To the Insured's estate.

Unpaid Premium

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

Changing of Beneficiary

A change in beneficiary must be submitted in writing to our Home Office and signed by the Employee. Unless otherwise specified by the Employee, a change in beneficiary will take effect on the date the notice of change is signed. We will not be liable for any action taken before notice is received and recorded at the Home Office.

Claim Review

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

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

Appeals Procedure

Before filing any lawsuit - and no later than 60 days after notice of denial of a claim--the Employee, the Claimant, or an authorized representative of either must appeal any denial of benefits under the Plan by sending a written request for review of the denial to our Home Office.

Legal Action

The Employee may not take Legal Action against us for benefits under this Plan:

- Within 60 days after he has sent us written Proof of Loss, or
- More than three years from the time written proof is required to be given.

(This space left intentionally blank.)

SECTION VII - GENERAL PROVISIONS

Entire Contract Changes

This insurance is provided under a contract of Group Accidental Injury Insurance with the Policyholder. The Entire Contract of Insurance is made up of:

- The Policy;
- The Certificates of Insurance;
- The Application of the Policyholder, a copy of which is attached to and made part of the Policy when issued; and
- Any Riders, Endorsements, or Amendments to the Policy or Certificate.

In the absence of fraud, a statement made by the Policyholder or an Insured is considered a representation and not a warranty. A statement made by the Policyholder or an Insured will not be used in any contest under the Plan, unless a copy of the written instrument containing the statement is or has been provided to:

- The person making the statement; or
- If the statement was made by the Insured, and the Insured has died or become incapacitated, the Insured's beneficiary or personal representative.

Changes to the 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, and
- May not be made by any agent or producer (nor can an agent or producer waive any Plan provisions).

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.

Successor Insured

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

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

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

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

Time Limit on Certain Defenses

After two years from the Employee's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of intentional misstatements, of a material fact, made on the Employee's 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 Certificates

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

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

Required Information

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

Conformity with State Statutes

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

BENEFIT SCHEDULE

Initial Treatment Category - High	Primary Insured	Spouse	Child
Initial Treatment Benefit			
Hospital emergency room with X-Ray	\$250.00	\$250.00	\$250.00
Hospital emergency room without X-Ray	\$200.00	\$200.00	\$200.00
Urgent Care facility with X-Ray	\$250.00	\$250.00	\$250.00
Urgent Care facility without X-Ray	\$200.00	\$200.00	\$200.00
Office or facility (other than a Hospital emergency room or Urgent Care) with X-Ray	\$150.00	\$150.00	\$150.00
Office or facility (other than a Hospital emergency room or Urgent Care) without X-Ray	\$100.00	\$100.00	\$100.00
Maximum number of payments per Covered Accident, per Insured	1	1	1
Ambulance Benefit			
	\$400.00	\$400.00	\$400.00
Air Ambulance Benefit			
	\$1,200.00	\$1,200.00	\$1,200.00
Major Diagnostic Testing Benefit			
	\$200.00	\$200.00	\$200.00
Maximum number of payments per Covered Accident, per Insured	1	1	1
Emergency Room Observation Benefit			
Per each 24 hour period of observation	\$100.00	\$100.00	\$100.00
Period of observation at least 4 hours and up to 24 hours	\$50.00	\$50.00	\$50.00
Prescriptions Benefit			
	\$5.00	\$5.00	\$5.00
Maximum number of payments per Covered Accident, per Insured	2	2	2
Pain Management Benefit			
	\$100.00	\$100.00	\$100.00
Maximum number of payments per Covered Accident, per Insured	1	1	1
Blood/Plasma/Platelets Benefit			
	\$200.00	\$200.00	\$200.00
Maximum number of payments per Covered Accident, per Insured	3	3	3
Concussion Benefit			
	\$500.00	\$500.00	\$500.00
Maximum number of payments per Covered Accident, per Insured	1	1	1
Traumatic Brain Injury Benefit			
	\$5,000.00	\$5,000.00	\$5,000.00
Maximum number of payments per Covered Accident, per Insured	1	1	1
Burns Benefit			
<i>Second Degree</i>			
Less than 10%	\$100.00	\$100.00	\$100.00
At least 10% but less than 25%	\$200.00	\$200.00	\$200.00
At least 25% but less than 35%	\$500.00	\$500.00	\$500.00
35% or more	\$1,000.00	\$1,000.00	\$1,000.00
<i>Third Degree</i>			
Less than 10%	\$1,000.00	\$1,000.00	\$1,000.00
At least 10% but less than 25%	\$5,000.00	\$5,000.00	\$5,000.00
At least 25% but less than 35%	\$10,000.00	\$10,000.00	\$10,000.00
35% or more	\$20,000.00	\$20,000.00	\$20,000.00
Maximum number of payments per Covered Accident, per Insured	1	1	1
Emergency Dental Work Benefit			
Repair with crown	\$200.00	\$200.00	\$200.00
Extraction	\$50.00	\$50.00	\$50.00
Eye Injuries Benefit			
	\$250.00	\$250.00	\$250.00
Dislocation Benefit			
Hip	\$3,000.00	\$3,000.00	\$3,000.00
Knee (not knee cap)	\$1,950.00	\$1,950.00	\$1,950.00
Shoulder	\$1,500.00	\$1,500.00	\$1,500.00
Foot/ankle	\$1,200.00	\$1,200.00	\$1,200.00
Hand	\$1,050.00	\$1,050.00	\$1,050.00
Lower jaw	\$900.00	\$900.00	\$900.00
Wrist	\$750.00	\$750.00	\$750.00
Elbow	\$600.00	\$600.00	\$600.00
Finger/toe	\$240.00	\$240.00	\$240.00

Laceration Benefit			
Over 15 centimeters	\$800.00	\$800.00	\$800.00
5 to 15 centimeters	\$400.00	\$400.00	\$400.00
Under 5 centimeters	\$100.00	\$100.00	\$100.00
Lacerations not requiring stitches	\$50.00	\$50.00	\$50.00
Fracture Benefit			
Hip/thigh	\$4,000.00	\$4,000.00	\$4,000.00
Vertebrae	\$3,600.00	\$3,600.00	\$3,600.00
Pelvis	\$3,200.00	\$3,200.00	\$3,200.00
Skull (depressed)	\$3,000.00	\$3,000.00	\$3,000.00
Skull (simple)	\$1,400.00	\$1,400.00	\$1,400.00
Leg	\$2,400.00	\$2,400.00	\$2,400.00
Foot/ankle/knee cap	\$2,000.00	\$2,000.00	\$2,000.00
Forearm/hand/wrist	\$2,000.00	\$2,000.00	\$2,000.00
Lower jaw	\$1,600.00	\$1,600.00	\$1,600.00
Shoulder blade/collar bone	\$1,600.00	\$1,600.00	\$1,600.00
Upper arm/upper jaw	\$1,400.00	\$1,400.00	\$1,400.00
Facial bones (except teeth)	\$1,200.00	\$1,200.00	\$1,200.00
Vertebral processes	\$800.00	\$800.00	\$800.00
Coccyx/rib/finger/toe	\$320.00	\$320.00	\$320.00
Sternum	\$3,600.00	\$3,600.00	\$3,600.00
Sacral/Sacrum	\$800.00	\$800.00	\$800.00
Outpatient Surgery and Anesthesia Benefit			
<i>Hospital Outpatient or Ambulatory Surgical Center</i>	\$400.00/day	\$400.00/day	\$400.00/day
<i>Doctor's Office or Emergency Room</i>	\$50.00/day	\$50.00/day	\$50.00/day
<i>(Maximum is applicable only to Doctor's office or Emergency Room)</i>			
<i>Maximum number of payments per Covered Accident, per Insured</i>	2	2	2
Facilities Fee for Outpatient Surgery Benefit	\$100.00	\$100.00	\$100.00
<i>Payable once per each eligible Outpatient Surgery and Anesthesia Benefit</i>			
Inpatient Surgery and Anesthesia Benefit	\$1,000.00/day	\$1,000.00/day	\$1,000.00/day
Transportation Benefit			
Plane	\$500.00	\$500.00	\$500.00
Any Ground Transportation	\$200.00	\$200.00	\$200.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	3	3	3
Coma Benefit	\$10,000.00	\$10,000.00	\$10,000.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Hospitalization Category - High	Primary Insured	Spouse	Child
Hospital Admission Benefit	\$1,250.00	\$1,250.00	\$1,250.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Hospital Confinement Benefit	\$300.00/day	\$300.00/day	\$300.00/day
<i>Maximum Benefit Period: 365 days</i>			
Hospital Intensive Care Benefit	\$400.00/day	\$400.00/day	\$400.00/day
<i>Maximum Benefit Period: 30 days</i>			
Intermediate Intensive Care Step-Down Unit Benefit	\$200.00/day	\$200.00/day	\$200.00/day
<i>Maximum Benefit Period: 30 days</i>			
Family Member Lodging Benefit	\$200.00/day	\$200.00/day	\$200.00/day
<i>Maximum Benefit Period: 30 days</i>			
After Care Category - High	Primary Insured	Spouse	Child
Appliances Benefit			
Cane	\$40.00	\$40.00	\$40.00
Ankle Brace	\$40.00	\$40.00	\$40.00
Walking Boot	\$100.00	\$100.00	\$100.00
Walker	\$100.00	\$100.00	\$100.00
Crutches	\$100.00	\$100.00	\$100.00
Leg Brace	\$100.00	\$100.00	\$100.00
Wheelchair	\$400.00	\$400.00	\$400.00
	\$400.00	\$400.00	\$400.00

<i>Knee Scooter</i>	\$400.00	\$400.00	\$400.00
<i>Body Jacket</i>	\$400.00	\$400.00	\$400.00
<i>Back Brace</i>	\$100.00	\$100.00	\$100.00
<i>Cervical Collar</i>			
Accident Follow-Up Treatment Benefit	\$50.00	\$50.00	\$50.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	6	6	6
Post-Traumatic Stress Disorder Benefit	\$200.00	\$200.00	\$200.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Rehabilitation Unit Benefit	\$100.00/day	\$100.00/day	\$100.00/day
<i>Maximum Benefit Period per Hospital confinement</i>	31 days	31 days	31 days
<i>Calendar Year Maximum</i>	62 days	62 days	62 days
Therapy Benefit	\$50.00	\$50.00	\$50.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	10	10	10
Chiropractic or Alternative Therapy Benefit	\$30.00	\$30.00	\$30.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	6	6	6

Life Change Events Category - High

	Primary Insured	Spouse	Child
Dismemberment Benefit			
<i>Loss of hand, foot, or sight</i>			
Single loss	\$12,500.00	\$5,000.00	\$2,500.00
Double loss	\$25,000.00	\$10,000.00	\$5,000.00
Loss of one or more fingers or toes	\$1,250.00	\$500.00	\$250.00
Partial amputation of finger or toe	\$125.00	\$125.00	\$125.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Paralysis			
Four limbs (quadriplegia)	\$10,000.00	\$10,000.00	\$10,000.00
Two limbs (paraplegia)	\$5,000.00	\$5,000.00	\$5,000.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Prosthesis Benefit			
Single	\$3,000.00	\$3,000.00	\$3,000.00
Multiple	\$6,000.00	\$6,000.00	\$6,000.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Residence/Vehicle Modification Benefit	\$2,000.00	\$2,000.00	\$2,000.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

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

Amendment to Policy and Certificate of Insurance for Group Accidental Injury

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

EFFECTIVE DATE

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

The Termination of Your Insurance provision is deleted and replaced with the following:

Termination of Your Insurance

Your insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date (the last day of the Grace Period), if the premium has not been paid.

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

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

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

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

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

CONTRACT

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

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

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

Amendment to Worker's Compensation Disclosure

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

EFFECTIVE DATE

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

The Worker's Compensation Disclosure on the Face Page of the Policy and Certificate is deleted and replaced with the following:

THIS IS NOT A WORKERS' COMPENSATION INSURANCE POLICY. THE EMPLOYER DOES NOT OBTAIN WORKERS' COMPENSATION INSURANCE COVERAGE BY PURCHASING THIS POLICY, AND IF THE EMPLOYER HAS NOT ELECTED TO OBTAIN WORKERS' COMPENSATION INSURANCE COVERAGE, THE EMPLOYER DOES NOT OBTAIN THOSE BENEFITS THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS IN THIS STATE. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAWS IN THIS STATE AS THEY PERTAIN TO EMPLOYERS THAT ELECT NOT TO MAINTAIN WORKERS' COMPENSATION INSURANCE COVERAGE AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

CONTRACT

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

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

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Thank you for choosing Continental American Insurance Company

1.800.433.3036

www.aflacgroupinsurance.com

Your Group Policy Number is:

CTR0015283525

Product:

Accident

Your Policy is Effective :

01/01/2024

Your State of Issue is:

Texas



CITY OF MERCEDES
400 S OHIO AVE
MERCEDES TX 78570-3120



March 14, 2024

CITY OF MERCEDES
400 S OHIO AVE
MERCEDES TX 78570-3120

**Re: Your CITY OF MERCEDES Group Accident Coverage
Policy No.: CTR0015283525**

Welcome to the Aflac family!

Thank you so much for adding Aflac coverage in your employee benefits offering. We take commitments to our accounts very seriously and promise to be there when you and your employees need us. Enclosed, you'll find:

A Master Policy packet for the Aflac group plan you've chosen to make available to your employees. Each packet includes:

- A master policy, which indicates your group coverage effective date and other coverage details,
- A copy of your master application, **and**
- A copy of your employees' coverage certificate. **(We'll let employees know they can request copies of their certificates from you, so please be sure to make the coverage documents available. Of course, employees are also welcome to call us directly to request copies of their certificates.)**

If you have any questions about your group plan or your employees' coverage, please reach out to your account manager, or give us a call at 1.866.319.8089 Monday through Friday, from 9 a.m. to 7 p.m. Eastern time.

Again, welcome to the Aflac family!

MPCOVLET_A

Continental American Insurance Company • Columbia, South Carolina • 1.800.433.3036 toll-free

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 New York, group coverage is underwritten by American Family Life Assurance Company of New York (22 Corporate Woods Boulevard, Suite 2, Albany, New York 12211), and customer service is administered by CAIC.

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Continental American Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: Continental American Insurance Company at 1-800-433-3036

Toll-free:

1-800-433-3036

Email: cscmail@aflac.com

Mail: Continental American Insurance Company
Post Office Box 427
Columbia, South Carolina 29202

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call: 1-800-252-3439

Online: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Continental American Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Continental American Insurance Company al 1-800-433-3036

Teléfono gratuito:

1-800-433-3036

Correo electrónico: cscmail@aflac.com

Dirección postal: Continental American Insurance Company
Post Office Box 427
Columbia, South Carolina 29202

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame: 1-800-252-3439

En línea: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
 - o Up to \$500,000 for health benefit plans, with some exceptions.
 - o Up to \$300,000 for disability income benefits.
 - o Up to \$300,000 for long-term care insurance benefits.
 - o Up to \$200,000 for all other types of health insurance.
- **Life insurance:**
 - o Up to \$100,000 in net cash surrender or withdrawal value.
 - o Up to \$300,000 in death benefits.
- **Individual annuities:** Up to \$250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to \$300,000 per person, regardless of the number of policies or contracts. A limit of \$500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

<p>To learn more about the Association and your protections, contact:</p> <p>Texas Life and Health Insurance Guaranty Association 1601 Congress Avenue Austin, TX 78701 1-800-982-6362 or www.txlifega.org</p>	<p>For questions about insurance, contact:</p> <p>Texas Department of Insurance P.O. Box 149104 Austin, TX 78714-9104 1-800-252-3439 or www.tdi.texas.gov</p>
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Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.



CONTINENTAL AMERICAN INSURANCE COMPANY
Columbia, South Carolina
800.433.3036

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

Continuation of Coverage Endorsement

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

EFFECTIVE DATE

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

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

CONTINUATION OF COVERAGE

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

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

To keep your Certificate in force, you must:

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

PREMIUMS

Initial premium rates will be based on the rates in effect at the time you apply to continue your coverage. Premium rates can be changed by the Company at any time upon 60 days written notice to you. Any such change will be applied to all Certificates in your class and will not be based on your or your Spouse and Dependent Children's health or other individual factors.

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

TERMINATION

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

- 31 days after the date you fail to pay any required premium.

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

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

CONTRACT

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

- The Certificate terminates, or
- Premiums are no longer paid for this Endorsement.

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

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

Group Accidental Injury Insurance Policy

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

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

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

The Policyholder as shown on the Policy Schedule applied for coverage under this Group Accidental Injury Insurance Policy (the "Plan"). This Plan is issued by Continental American Insurance Company (the "Company," "CAIC," "we," "us," or "our"). Based on the Master Application and the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. (Please note that male pronouns--such as "he," "him," and "his"--are used for both males and females, unless the context clearly shows otherwise.) The Policyholder may add new Insureds from time to time, according to the Plan's terms.

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

This Plan is a legal contract between the Company and the Policyholder. All matter printed or written by the Company on the following pages is part of this Plan. This Plan is delivered in and is governed by the laws of the jurisdiction shown on the Policy Schedule.

In witness whereof, the Company executes this Plan at its home office in Columbia, South Carolina, on the Effective Date.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

Group Accidental Injury Insurance Non-Participating

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

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SECTION I - ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

PRIMARY INSURED

Eligibility

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

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

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

Employees should refer to *Type of Coverage* in their Certificate Schedule to determine who is covered under the Certificate.

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

Effective Date

The Plan's Effective Date is shown on the Policy Schedule. This Plan becomes effective on the Policy Effective Date at 12:01 a.m., as determined by the Policyholder's address.

An eligible Employee must enroll in this Plan and agree to pay the required premiums for coverage to become effective. He must enroll within 31 days of the date he first becomes eligible for coverage. *The first premium must have been paid for coverage to become effective.*

The Employee's Effective Date is the date his insurance takes effect. After we receive and approve the Application, that date is either:

- The date shown on the Certificate Schedule if the Employee is Actively at Work on that date, or
- The date the Employee returns to an Actively-at-Work status if he was not Actively at Work on the date shown on the Certificate Schedule.

Termination of an Employee's Insurance

An Employee's insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date (the last day of the Grace Period), if the premium has not been paid.

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

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DEPENDENT COVERAGE

Eligibility

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

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

Children Placed for Adoption are children for whom the Employee has entered a decree of adoption, has initiated adoption proceedings, or is a party to a suit in which the Employee seeks to adopt the child. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. The Employee must continue to have custody pursuant to the decree of the court.

Effective Date

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

Termination of Dependent Insurance

Dependent coverage will terminate on the earliest of the following:

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

Plan Termination

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

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

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

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

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

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

Continuation Privilege

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

To keep his coverage in force, the Employee must:

- Notify the Company within 31 days after the date his coverage would otherwise terminate. He may notify us by sending written notice to P.O. Box 84079, Columbus, GA 31993-9101 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly to the Company no later than 31 days after the date his coverage would otherwise terminate and on each premium due date thereafter.

The Employee's ported coverage will end on the earliest of the following dates:

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

If the Employee qualifies for this Continuation Privilege, then the Company will apply the same Benefits and Plan Provisions as shown in his previously-issued Certificate. Notification of any changes in the Plan will be provided directly by the Company.

SECTION II - PREMIUM PROVISIONS

Premium Payments

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

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

Premium Changes

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

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

We will provide the Policyholder a 60-day advance written notice of any change in premiums.

Grace Period

This Plan has a 31-day Grace Period. If a 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. If the Plan is discontinued, the Plan's termination date will be the latest date for which premium has been paid.

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SECTION III - DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- An assisted living facility.

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

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

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

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

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

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

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

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

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

Spouse is an Employee's legal wife or husband, including a legally-recognized same-sex Spouse, or a person of either gender who is in a legally recognized and registered domestic partnership, civil union, reciprocal beneficiary relationship, or similar relationship with the Employee.

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

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

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SECTION IV - BENEFIT PROVISIONS

Initial Treatment Category

Initial Treatment Benefit

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

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

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

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

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

Ambulance Benefit

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

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

Ambulance service includes air ambulance service.

Major Diagnostic Testing Benefit

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

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

These exams must be performed in a Hospital, a Doctor's office, a Medical Diagnostic Imaging Center, or an Ambulatory Surgical Center. The exam must be performed within 6 Months after the accident for a benefit to be payable.

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

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

Emergency Room Observation Benefit

The daily benefit amount shown in the Benefit Schedule is payable for each 24-hour period of observation that, because of a Covered Accidental Injury, an Insured:

- Receives Treatment in a Hospital emergency room, and
- Is held in a Hospital for observation without being admitted as an inpatient, and
- Receives initial Treatment within 168 hours after the accident.

For periods of observation lasting fewer than 24 hours but more than 4 hours, a limited benefit amount as shown in the Benefit Schedule is payable.

Prescriptions Benefit

We will pay the amount shown in the Benefit Schedule for a prescription filled. The prescription must meet three criteria: (1) be ordered by a Doctor due to a Covered Accidental Injury; (2) be dispensed by a licensed pharmacist; and (3) be medically necessary for the care and Treatment of the Insured due to a Covered Accidental Injury. The prescription must be received within 6 months after the accident for a benefit to be payable.

This benefit does not include benefits for: (a) therapeutic devices or appliances; (b) experimental drugs; (c) drugs, medicines or insulin used by or administered to a person while he is confined to a Hospital, rest home, extended-care facility, convalescent home, nursing home or similar institution; or (d) immunization agents, biological sera, blood or blood plasma.

This benefit is not payable for pain management techniques for which a benefit is paid under the Pain Management Benefit (if available).

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

Pain Management Benefit

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

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

The benefit is only payable for pain management techniques (as shown above) that are administered in a Hospital or Doctor's office, and are due to a Covered Accidental Injury. For a benefit to be payable, the pain management technique must be administered within 6 months after the Covered Accident. This benefit is not payable for an epidural administered during a surgical procedure.

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

Blood/Plasma/Platelets Benefit

We will pay the amount shown in the Benefit Schedule for each day that an Insured receives blood, plasma, or platelets due to a Covered Accidental Injury. The Insured must receive the blood, plasma, or platelets within 6 months after the accident for a benefit to be payable.

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

Concussion Benefit

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

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

Traumatic Brain Injury Benefit

We will pay the amount shown in the Benefit Schedule if the Insured is diagnosed by a neurologist with Traumatic Brain Injury (TBI) due to a Covered Accident. *Traumatic Brain Injury (TBI)* is an injury that is caused by a traumatic blow to the head, neck, or shoulders; and results in neurological deficit. To qualify as TBI, the neurological deficit must require:

- Treatment by a neurologist, and
- Prescribed course of physical, speech, and/or occupational therapy under the direction of a neurologist.

The diagnosis must be made within 6 Months after the accident for a benefit to be payable.

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

Burns Benefit

We will pay the amount shown in the Benefit Schedule if the Insured has burns in a Covered Accident. We will pay the Burns Benefit according to the percentage of body surface burned. The Insured must be treated for burns by a Doctor within 6 Months after the accident for a benefit to be payable. First-degree burns are not covered.

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

Emergency Dental Work Benefit

We will pay the amount shown in the Benefit Schedule if the Insured has an Accidental Injury to natural teeth as the result of a Covered Accident. We will pay for extraction or repair with a crown as shown in the Benefit Schedule. The dental work must be performed within 6 Months of the accident for a benefit to be payable.

Eye Injuries Benefit

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

Dislocation Benefit

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

If the dislocation requires open reduction, we will pay 200.00% of the amount shown in the Benefit Schedule.

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

Multiple dislocations refer to more than one dislocation requiring either open or closed reduction in any one Covered Accident. For each covered dislocation, we will pay the amounts shown in the Benefit Schedule. However, we will pay no more than 200.00% 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 25.00% of the amount shown in the Benefit Schedule for the affected joint. (*Partial dislocation* includes subluxation.)

Laceration Benefit

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

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

If the Insured suffers multiple lacerations in a Covered Accident, and the lacerations are repaired with stitches by a Doctor within 168 Hours after the accident, we will pay this benefit based on the largest single laceration that requires stitches, as shown in the Benefit Schedule. However, we will pay no more than 200.00% of the benefit amount for the laceration that has the higher dollar amount.

Fracture Benefit

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

If the fracture requires open reduction, we will pay 200.00% 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 200.00% of the benefit amount for the bone fractured that has the highest dollar amount.

Chip fracture refers to a piece of bone that is completely broken off near a joint. If a Doctor diagnoses the fracture as a chip fracture, we will pay 25.00% of the amount shown in the Benefit Schedule for the affected bone.

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

Outpatient Surgery and Anesthesia Benefit

We will pay the daily benefit amount shown in the Benefit Schedule when, due to a Covered Accidental Injury, an Insured has an outpatient surgical procedure performed by a Doctor. "Surgical procedure" does not include laceration repair. If an outpatient surgical procedure is covered under another benefit in this Plan, we will pay the **higher** of that benefit amount **or** the Outpatient Surgery and Anesthesia Benefit. For a benefit to be payable, the surgery must be performed within 1 year after the Covered Accident.

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

The surgery can be performed:

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

Facilities Fee for Outpatient Surgery Benefit

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

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

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

Inpatient Surgery and Anesthesia Benefit

We will pay the daily benefit amount shown in the Benefit Schedule when, due to a Covered Accidental Injury, an Insured has an inpatient surgical procedure performed by a Doctor. The surgery must be performed while the Insured is confined to a Hospital as an inpatient. If an inpatient surgical procedure is covered under another benefit in this Plan, we will pay the **higher** of that benefit amount **or** the Inpatient Surgery and Anesthesia Benefit. For a benefit to be payable, the surgery must be performed within 1 year after the Covered Accident.

Transportation Benefit

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

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

Use of such transportation must begin within 6 Months after the Covered Accident date. The distance to the Hospital Treatment or diagnostic study must be greater than 100 miles from the Insured's residence.

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

Coma Benefit

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

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

Hospitalization Category

Hospital Admission Benefit

We will pay this benefit when an Insured is admitted to a Hospital and confined as an inpatient because of a Covered Accidental Injury. To be eligible to receive this benefit, an Insured must be admitted to a Hospital within 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 pay this benefit once per period of Hospital Confinement.

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

Hospital Confinement Benefit

We will pay the amount shown in the Benefit Schedule for each day that an Insured is confined to a Hospital as an inpatient as the result of a Covered Accidental Injury. To be eligible to receive this benefit, the Insured must be confined to a Hospital within 6 Months of the date of the Covered Accident.

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

If we pay benefits for confinement and the Insured becomes confined again within 6 Months because of the same Accidental Injury, we will treat this confinement as the same period of confinement.

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

Hospital Intensive Care Benefit

If an Insured is confined in a Hospital Intensive Care Unit because of a Covered Accidental Injury, we will pay the daily benefit amount shown in the Benefit Schedule. To be eligible to receive this benefit an Insured must be admitted to a Hospital Intensive Care Unit within 6 Months of the date of the Covered Accident.

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

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

If we pay benefits for confinement in a Hospital Intensive Care Unit and an Insured becomes confined to a Hospital Intensive Care Unit again within 6 Months because of the same Accidental Injury, we will treat this confinement as the same period of confinement.

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

Intermediate Intensive Care Step-Down Unit Benefit

If an Insured is confined in an Intermediate Intensive Care Step-Down Unit because of a Covered Accidental Injury, we will pay the daily benefit amount shown on the Benefit Schedule. The Insured must be admitted to an Intermediate Intensive Care Step-Down Unit within 6 Months of the date of the Covered Accident.

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

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

If we pay benefits for confinement in a Hospital's Intermediate Intensive Care Step-Down Unit and the Insured becomes confined to a Hospital's Intermediate Intensive Care Step-Down Unit again within 6 Months because of the same condition, we will treat this confinement as the same period of confinement.

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

Family Member Lodging Benefit

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

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

The Treatment must take place within 6 Months after the Covered Accident for a benefit to be payable.

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After Care Category

Appliances Benefit

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

For a benefit to be payable, the Doctor's advice to use a medical appliance must be within 6 months after the Covered Accident.

Accident Follow-Up Treatment Benefit

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

- The Insured receives initial Treatment within 168 hours after the Covered Accident.
- The Insured receives Doctor-prescribed follow-up Treatment.
- The follow-up Treatment begins within 6 Months after the Covered Accident or discharge from the Hospital.

Chiropractic procedures are not considered Follow-up Treatment.

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

Post-Traumatic Stress Disorder Benefit

Post-Traumatic Stress Disorder (PTSD) is a mental health condition triggered by a Covered Accident. We will pay the amount shown in the Benefit Schedule if the Insured is diagnosed with Post-traumatic Stress Disorder. An Insured must meet the diagnostic criteria for PTSD, stipulated in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV-TR), and be under the active care of either a Psychiatrist or Ph.D.-level Psychologist. The diagnosis must take place within 6 months after the Covered Accident for a benefit to be payable.

For the purposes of this benefit:

- **Psychiatrist** is a Doctor of medicine who specializes in the diagnosis and Treatment of mental disorders.
- **Psychologist** is a clinical, mental health professional who works with patients. A Psychologist is not a Doctor of medicine who typically provides medical interventions and drug therapies, but provides analysis and counseling.

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

Rehabilitation Unit Benefit

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

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

Therapy Benefit

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

- The Insured receives initial Treatment within 168 hours after the Covered Accident.
- The Insured receives Doctor-prescribed therapy Treatment in one of the following categories: physical therapy provided by a licensed physical therapist, occupational

therapy provided by a licensed occupational therapist, or speech therapy provided by a licensed speech therapist.

- The therapy Treatment begins within 90 days after the Covered Accident or discharge from the Hospital.

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

Chiropractic or Alternative Therapy Benefit

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

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

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

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Life Change Events Category

Dismemberment Benefit

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

- Is injured, and
- Loses a hand, a foot, or sight within 6 Months after the accident as a result of the Injury.

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

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

If the Dismemberment Benefit is paid and the Insured later dies as a result of the same Covered Accident, we will pay the appropriate death benefit (if available), less any amounts paid under this benefit.

Paralysis Benefit

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

- The Insured is injured,
- The Accidental Injury causes paralysis which lasts more than 90 days, and
- The paralysis is diagnosed by a Doctor within 6 Months after the accident.

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

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

Prosthesis Benefit

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

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

This benefit is not payable for:

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

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

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

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

Residence/Vehicle Modification Benefit

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

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

The modification must occur within one year after the accident.

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

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SECTION V - EXCLUSIONS

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

- **War** – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the Insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion, or civil state of belligerence. War does not include acts of 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:
 - o Allergic reactions
 - o Any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings
 - o An error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure for any sickness
 - o Any related medical/surgical Treatment or diagnostic procedures for such illness
- **Self-Inflicted Injuries** - injuring or attempting to injure oneself intentionally.
- **Racing** - riding in or driving any motor-driven vehicle in a race, stunt show, or speed test in a professional or semi-professional capacity.
- **Illegal Occupation** - voluntarily participating in, committing, or attempting to commit a felony or illegal act or activity, or voluntarily working at, or being engaged in, an illegal occupation or job.
- **Sports** - participating in any organized sport in a professional or semi-professional capacity for pay or profit.
- **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.
- **Driving** – driving any taxi or intrastate or interstate long-distance vehicle for wage, compensation, or profit.

For **24-Hour Coverage**, the following exclusions will not apply:

- An Injury arising from any employment.
- An Injury or sickness covered by Worker's Compensation.

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SECTION VI - CLAIM PROVISIONS

Notice of Claim

The Insured must give written notice of claim:

- No later than 20th day after a Covered Accidental Injury, or
- As soon as reasonably possible.

When we receive written Notice of Claim, we will send a claim form. If the Claimant does not receive the claim form within 15 days after the notice is sent, written Proof of Loss can be sent to us without waiting for the form. Notice must include the Employee's name and the Certificate number. Notice can be mailed to the Company at the following address:

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

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. It can include a statement by the treating Doctor.) Proof of Loss establishes the nature and extent of the loss, the Company's obligation to pay the claim, and the Claimant's right to receive payment.

The Claimant must provide Proof of Loss to the Company at the following address:

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

Proof of Loss must be given to us within 90 days of the Covered Accidental Injury. Failure to give Proof of Loss within such time shall not invalidate or reduce any claim if such Proof of Loss is given as soon as reasonably possible. The Company will not accept Proof of Loss any later than one year and three months after the Covered Accidental Injury, except in the absence of the Claimant's legal mental capacity.

The Claimant will be responsible for the cost of obtaining a completed claim form. We may request additional Proof of Loss, such as records from Hospitals or Doctors. The Claimant will be responsible for the cost of obtaining these records.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

When we receive the claim and due Proof of Loss, we will review the Proof of Loss. If we approve the claim, we will pay the benefits subject to the terms of the Certificate.

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 exams and/or autopsy.

Time of Payment of Claims

For benefits other than for loss of time, the Company will, once we receive the required Proof of Loss, pay, deny, or settle each submitted claim no later than the 60th day after the date Proof of Loss is received. Subject to written Proof of Loss, all accrued benefits payable under the Policy for loss of time will be paid at least monthly during the period for which the Company is liable. Any balance remaining unpaid at the end of that time will be paid as soon as possible after Proof of Loss is received.

Payment of Claims

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

- To the beneficiary designated by the Insured or the beneficiary's assignee,
- To the Insured's surviving Spouse,
- To the Insured's estate.

Unpaid Premium

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

Changing of Beneficiary

A change in beneficiary must be submitted in writing to our Home Office and signed by the Employee. Unless otherwise specified by the Employee, a change in beneficiary will take effect on the date the notice of change is signed. We will not be liable for any action taken before notice is received and recorded at the Home Office.

Claim Review

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

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

Appeals Procedure

Before filing any lawsuit-and no later than 60 days after notice of denial of a claim-the Employee, the Claimant, or an authorized representative of either must appeal any denial of benefits under the Plan by sending a written request for review of the denial to our Home Office.

Legal Action

The Employee may not take Legal Action against us for benefits under this Plan:

- Within 60 days after he has sent us written Proof of Loss, or
- More than three years from the time written proof is required to be given.

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SECTION VII - GENERAL PROVISIONS

Entire Contract Changes

This insurance is provided under a contract of Group Accidental Injury Insurance with the Policyholder. The Entire Contract of Insurance is made up of:

- The Policy;
- The Certificates of Insurance;
- The Application of the Policyholder, a copy of which is attached to and made part of the Policy when issued; and
- Any Riders, Endorsements, or Amendments to the Policy or Certificate.

In the absence of fraud, a statement made by the Policyholder or an Insured is considered a representation and not a warranty. A statement made by the Policyholder or an Insured will not be used in any contest under the Plan, unless a copy of the written instrument containing the statement is or has been provided to:

- The person making the statement; or
- If the statement was made by the Insured, and the Insured has died or become incapacitated, the Insured's beneficiary or personal representative.

Changes to the 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 or producer (nor can an agent or producer waive any Plan provisions).

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.

Successor Insured

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

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

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

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

Time Limit on Certain Defenses

After two years from the Employee's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of intentional misstatements, of a material fact, made on the Employee's 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 Certificates

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

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

Required Information

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

Conformity with State Statutes

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

POLICY SCHEDULE

Group Policyholder: CITY OF MERCEDES
Group Policy Number: CTR0015283525
Group Policy Effective Date: January 1, 2024
Group Policy Anniversary Date: January 1, 2025
Jurisdiction: Texas

24-Hour Coverage

*Initial premium includes the premium for any Riders purchased at the same time as the coverage provided by an Employee's Certificate.

This Plan is delivered in and governed by the laws of the jurisdiction shown above.

BENEFIT SCHEDULE

Initial Treatment Category - Low

	Primary Insured	Spouse	Child
Initial Treatment Benefit			
<i>Hospital emergency room with X-Ray</i>	\$125.00	\$125.00	\$125.00
<i>Hospital emergency room without X-Ray</i>	\$100.00	\$100.00	\$100.00
<i>Urgent Care facility with X-Ray</i>	\$125.00	\$125.00	\$125.00
<i>Urgent Care facility without X-Ray</i>	\$100.00	\$100.00	\$100.00
<i>Office or facility (other than a Hospital emergency room or Urgent Care) with X-Ray</i>	\$75.00	\$75.00	\$75.00
<i>Office or facility (other than a Hospital emergency room or Urgent Care) without X-Ray</i>	\$50.00	\$50.00	\$50.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Ambulance Benefit			
	\$200.00	\$200.00	\$200.00
Air Ambulance Benefit			
	\$600.00	\$600.00	\$600.00
Major Diagnostic Testing Benefit			
	\$100.00	\$100.00	\$100.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Emergency Room Observation Benefit			
<i>Per each 24 hour period of observation</i>	\$50.00	\$50.00	\$50.00
<i>Period of observation at least 4 hours and up to 24 hours</i>	\$25.00	\$25.00	\$25.00
Prescriptions Benefit			
	\$5.00	\$5.00	\$5.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	2	2	2
Pain Management Benefit			
	\$50.00	\$50.00	\$50.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Blood/Plasma/Platelets Benefit			
	\$100.00	\$100.00	\$100.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	3	3	3
Concussion Benefit			
	\$250.00	\$250.00	\$250.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Traumatic Brain Injury Benefit			
	\$2,500.00	\$2,500.00	\$2,500.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Burns Benefit			
<i>Second Degree</i>			
Less than 10%	\$50.00	\$50.00	\$50.00
At least 10% but less than 25%	\$100.00	\$100.00	\$100.00
At least 25% but less than 35%	\$250.00	\$250.00	\$250.00
35% or more	\$500.00	\$500.00	\$500.00
<i>Third Degree</i>			
Less than 10%	\$500.00	\$500.00	\$500.00
At least 10% but less than 25%	\$2,500.00	\$2,500.00	\$2,500.00
At least 25% but less than 35%	\$5,000.00	\$5,000.00	\$5,000.00
35% or more	\$10,000.00	\$10,000.00	\$10,000.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Emergency Dental Work Benefit			
Repair with crown	\$100.00	\$100.00	\$100.00
Extraction	\$25.00	\$25.00	\$25.00
Eye Injuries Benefit			
	\$125.00	\$125.00	\$125.00

Dislocation Benefit			
Hip	\$1,500.00	\$1,500.00	\$1,500.00
Knee (not knee cap)	\$975.00	\$975.00	\$975.00
Shoulder	\$750.00	\$750.00	\$750.00
Foot/ankle	\$600.00	\$600.00	\$600.00
Hand	\$525.00	\$525.00	\$525.00
Lower jaw	\$450.00	\$450.00	\$450.00
Wrist	\$375.00	\$375.00	\$375.00
Elbow	\$300.00	\$300.00	\$300.00
Finger/toe	\$120.00	\$120.00	\$120.00
Laceration Benefit			
Over 15 centimeters	\$400.00	\$400.00	\$400.00
5 to 15 centimeters	\$200.00	\$200.00	\$200.00
Under 5 centimeters	\$50.00	\$50.00	\$50.00
Lacerations not requiring stitches	\$25.00	\$25.00	\$25.00
Fracture Benefit			
Hip/thigh	\$2,000.00	\$2,000.00	\$2,000.00
Vertebrae	\$1,800.00	\$1,800.00	\$1,800.00
Pelvis	\$1,600.00	\$1,600.00	\$1,600.00
Skull (depressed)	\$1,500.00	\$1,500.00	\$1,500.00
Skull (simple)	\$700.00	\$700.00	\$700.00
Leg	\$1,200.00	\$1,200.00	\$1,200.00
Foot/ankle/knee cap	\$1,000.00	\$1,000.00	\$1,000.00
Forearm/hand/wrist	\$1,000.00	\$1,000.00	\$1,000.00
Lower jaw	\$800.00	\$800.00	\$800.00
Shoulder blade/collar bone	\$800.00	\$800.00	\$800.00
Upper arm/upper jaw	\$700.00	\$700.00	\$700.00
Facial bones (except teeth)	\$600.00	\$600.00	\$600.00
Vertebral processes	\$400.00	\$400.00	\$400.00
Coccyx/rib/finger/toe	\$160.00	\$160.00	\$160.00
Sternum	\$1,800.00	\$1,800.00	\$1,800.00
Sacral/Sacrum	\$400.00	\$400.00	\$400.00
Outpatient Surgery and Anesthesia Benefit			
<i>Hospital Outpatient or Ambulatory Surgical Center</i>	\$200.00/day	\$200.00/day	\$200.00/day
<i>Doctor's Office or Emergency Room</i>	\$25.00/day	\$25.00/day	\$25.00/day
<i>(Maximum is applicable only to Doctor's office or Emergency Room)</i>			
<i>Maximum number of payments per Covered Accident, per Insured</i>	2	2	2
Facilities Fee for Outpatient Surgery Benefit	\$50.00	\$50.00	\$50.00
<i>Payable once per each eligible Outpatient Surgery and Anesthesia Benefit</i>			
Inpatient Surgery and Anesthesia Benefit	\$500.00/day	\$500.00/day	\$500.00/day
Transportation Benefit			
Plane	\$250.00	\$250.00	\$250.00
Any Ground Transportation	\$100.00	\$100.00	\$100.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	3	3	3
Coma Benefit	\$5,000.00	\$5,000.00	\$5,000.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Hospitalization Category - Low	Primary Insured	Spouse	Child
Hospital Admission Benefit	\$625.00	\$625.00	\$625.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Hospital Confinement Benefit	\$150.00/day	\$150.00/day	\$150.00/day
<i>Maximum Benefit Period: 365 days</i>			
Hospital Intensive Care Benefit	\$200.00/day	\$200.00/day	\$200.00/day
<i>Maximum Benefit Period: 30 days</i>			
Intermediate Intensive Care Step-Down Unit Benefit	\$100.00/day	\$100.00/day	\$100.00/day
<i>Maximum Benefit Period: 30 days</i>			
Family Member Lodging Benefit	\$100.00/day	\$100.00/day	\$100.00/day
<i>Maximum Benefit Period: 30 days</i>			

After Care Category - Low

	Primary Insured	Spouse	Child
Appliances Benefit			
<i>Cane</i>	\$20.00	\$20.00	\$20.00
<i>Ankle Brace</i>	\$20.00	\$20.00	\$20.00
<i>Walking Boot</i>	\$50.00	\$50.00	\$50.00
<i>Walker</i>	\$50.00	\$50.00	\$50.00
<i>Crutches</i>	\$50.00	\$50.00	\$50.00
<i>Leg Brace</i>	\$50.00	\$50.00	\$50.00
<i>Wheelchair</i>	\$200.00	\$200.00	\$200.00
<i>Knee Scooter</i>	\$200.00	\$200.00	\$200.00
<i>Body Jacket</i>	\$200.00	\$200.00	\$200.00
<i>Back Brace</i>	\$200.00	\$200.00	\$200.00
<i>Cervical Collar</i>	\$50.00	\$50.00	\$50.00
Accident Follow-Up Treatment Benefit			
<i>Maximum number of payments per Covered Accident, per Insured</i>	\$25.00	\$25.00	\$25.00
	6	6	6
Post-Traumatic Stress Disorder Benefit			
<i>Maximum number of payments per Covered Accident, per Insured</i>	\$100.00	\$100.00	\$100.00
	1	1	1
Rehabilitation Unit Benefit			
<i>Maximum Benefit Period per Hospital confinement</i>	\$50.00/day	\$50.00/day	\$50.00/day
<i>Calendar Year Maximum</i>	31 days	31 days	31 days
	62 days	62 days	62 days
Therapy Benefit			
<i>Maximum number of payments per Covered Accident, per Insured</i>	\$25.00	\$25.00	\$25.00
	10	10	10
Chiropractic or Alternative Therapy Benefit			
<i>Maximum number of payments per Covered Accident, per Insured</i>	\$15.00	\$15.00	\$15.00
	6	6	6

Life Change Events Category - Low

	Primary Insured	Spouse	Child
Dismemberment Benefit			
<i>Loss of hand, foot, or sight</i>			
Single loss	\$6,250.00	\$2,500.00	\$1,250.00
Double loss	\$12,500.00	\$5,000.00	\$2,500.00
Loss of one or more fingers or toes	\$625.00	\$250.00	\$125.00
Partial amputation of finger or toe	\$62.50	\$62.50	\$62.50
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Paralysis			
Four limbs (quadriplegia)	\$5,000.00	\$5,000.00	\$5,000.00
Two limbs (paraplegia)	\$2,500.00	\$2,500.00	\$2,500.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Prosthesis Benefit			
Single	\$1,500.00	\$1,500.00	\$1,500.00
Multiple	\$3,000.00	\$3,000.00	\$3,000.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Residence/Vehicle Modification Benefit			
<i>Maximum number of payments per Covered Accident, per Insured</i>	\$1,000.00	\$1,000.00	\$1,000.00
	1	1	1

INCORPORATION OF RIDER PROVISIONS

The attached listed Riders are made a part of this Plan.

Rider Name

Wellness Rider
Accidental Death Rider

Form Number

C70301TX
C70305TX

SCHEDULE OF PREMIUMS

RATES TABLE FOR: CITY OF MERCEDES / ACCIDENT

DEDUCTION FREQUENCY	:	Monthly (12pp / yr)
EMPLOYEE COST	:	\$3.50



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

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

Amendment to Policy and Certificate of Insurance for Group Accidental Injury

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

EFFECTIVE DATE

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

The Termination of Your Insurance provision is deleted and replaced with the following:

Termination of Your Insurance

Your insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date (the last day of the Grace Period), if the premium has not been paid.

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

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

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

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

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

CONTRACT

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

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

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

Amendment to Worker's Compensation Disclosure

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

EFFECTIVE DATE

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

The Worker's Compensation Disclosure on the Face Page of the Policy and Certificate is deleted and replaced with the following:

THIS IS NOT A WORKERS' COMPENSATION INSURANCE POLICY. THE EMPLOYER DOES NOT OBTAIN WORKERS' COMPENSATION INSURANCE COVERAGE BY PURCHASING THIS POLICY, AND IF THE EMPLOYER HAS NOT ELECTED TO OBTAIN WORKERS' COMPENSATION INSURANCE COVERAGE, THE EMPLOYER DOES NOT OBTAIN THOSE BENEFITS THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS IN THIS STATE. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAWS IN THIS STATE AS THEY PERTAIN TO EMPLOYERS THAT ELECT NOT TO MAINTAIN WORKERS' COMPENSATION INSURANCE COVERAGE AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

CONTRACT

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

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY
Columbia, South Carolina
800.433.3036

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

Wellness Rider
To Certificate of Insurance for Group Accidental Injury Insurance Policy

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

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

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

EFFECTIVE DATE

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

WELLNESS BENEFIT

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

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

The amount paid will be based on when the Wellness Test was performed. See the Benefit Schedule for details.

This benefit is limited to the maximum number of payments shown in the Benefit Schedule.

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 intentional misstatements, of a material fact, made on the Application. This does not apply to fraudulent misstatements.

CONTRACT

This Rider is part of the Group Accidental Injury Insurance Policy. It will terminate when:

- The Certificate terminates, or
- Premiums are no longer paid for this Rider.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

WELLNESS RIDER BENEFITS SCHEDULE

	Primary Insured	Spouse	Child
Wellness tests performed during the first Calendar Year	\$15.00	\$15.00	\$15.00
Wellness tests performed during the second and third Calendar Year	\$30.00	\$30.00	\$30.00
Wellness tests performed after the fourth Calendar Year	\$60.00	\$60.00	\$60.00
Maximum number of payments per Calendar Year, per Insured	1	1	1



CONTINENTAL AMERICAN INSURANCE COMPANY
Columbia, South Carolina
800.433.3036

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

Accidental Death Rider
To Certificate of Insurance for Group Accidental Injury Insurance Policy

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

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

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

EFFECTIVE DATE

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

DEFINITIONS

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

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.

BENEFITS

Accidental Death Benefit

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

- The Insured is injured, and
- The Injury causes the Insured 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 Rider Schedule if the Insured:

- Is a fare-paying passenger on a Common Carrier,
- Is injured in a Covered Accident, and
- Dies within 90 days after the Covered Accident.

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

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 intentional misstatements, of a material fact, made on the Application. This does not apply to fraudulent misstatements.

CONTRACT

This Rider is part of the Group Accidental Injury Insurance Policy. It will terminate when:

- The Certificate terminates, or
- Premiums are no longer paid for this Rider.

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary

ACCIDENTAL DEATH RIDER BENEFITS SCHEDULE

	Primary Insured	Spouse	Child
Accidental Death	\$50,000.00	\$25,000.00	\$10,000.00
Accidental Common-Carrier Death	\$100,000.00	\$50,000.00	\$20,000.00



CONTINENTAL AMERICAN INSURANCE COMPANY
Columbia, South Carolina

800.433.3036

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

**Certificate of Insurance For
Group Accidental Injury Insurance Policy**

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

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

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

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

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

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

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

The Certificate Effective Date is shown in the Certificate Schedule. The Certificate will terminate as provided in the provision entitled, "Termination of Your Insurance" in Section I. 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.

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SECTION I - ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

PRIMARY INSURED

Eligibility

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

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

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

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

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

Effective Date

Your Employee Effective Date is shown on the Certificate Schedule.

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

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

Termination of Your Insurance

Your insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date (the last day of the Grace Period), if the premium has not been paid.

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

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DEPENDENT COVERAGE

Eligibility

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

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

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

Effective Date

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

Termination of Dependent Insurance

Dependent coverage will terminate on the earliest of the following:

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

Plan Termination

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

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

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

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

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

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

Continuation Privilege

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

To keep your coverage in force, you must:

- Notify the Company within 31 days after the date your coverage would otherwise terminate. You may notify us by sending written notice to P.O. Box 84079, Columbus, GA 31993-9101 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly to the Company no later than 31 days after the date your coverage would otherwise terminate and on each premium due date thereafter.

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

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

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

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SECTION II - PREMIUM PROVISIONS

Premium Payments

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

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

Premium Changes

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

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

We will provide the Policyholder a 60-day advance written notice of any change in premiums.

Grace Period

This Plan has a 31-day Grace Period. If a 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. If the Plan is discontinued, the Plan's termination date will be the latest date for which premium has been paid.

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SECTION III - DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Spouse is an Employee's legal wife or husband, including a legally-recognized same-sex Spouse, or a person of either gender who is in a legally recognized and registered domestic partnership, civil union, reciprocal beneficiary relationship, or similar relationship with the Employee.

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

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

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SECTION IV - BENEFIT PROVISIONS

Initial Treatment Category

Initial Treatment Benefit

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

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

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

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

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

Ambulance Benefit

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

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

Ambulance service includes air ambulance service.

Major Diagnostic Testing Benefit

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

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

These exams must be performed in a Hospital, a Doctor's office, a Medical Diagnostic Imaging Center, or an Ambulatory Surgical Center. The exam must be performed within 6 Months after the accident for a benefit to be payable.

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

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

Emergency Room Observation Benefit

The daily benefit amount shown in the Benefit Schedule is payable for each 24-hour period of observation that, because of a Covered Accidental Injury, an Insured:

- Receives Treatment in a Hospital emergency room, and
- Is held in a Hospital for observation without being admitted as an inpatient, and
- Receives initial Treatment within 168 Hours after the accident.

For periods of observation lasting fewer than 24 hours but more than 4 hours, a limited benefit amount as shown in the Benefit Schedule is payable.

Prescriptions Benefit

We will pay the amount shown in the Benefit Schedule for a prescription filled. The prescription must meet three criteria: (1) be ordered by a Doctor due to a Covered Accidental Injury; (2) be dispensed by a licensed pharmacist; and (3) be medically necessary for the care and Treatment of the Insured due to a Covered Accidental Injury. The prescription must be received within 6 months after the accident for a benefit to be payable.

This benefit does not include benefits for: (a) therapeutic devices or appliances; (b) experimental drugs; (c) drugs, medicines or insulin used by or administered to a person while he is confined to a Hospital, rest home, extended-care facility, convalescent home, nursing home or similar institution; or (d) immunization agents, biological sera, blood or blood plasma.

This benefit is not payable for pain management techniques for which a benefit is paid under the Pain Management Benefit (if available).

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

Pain Management Benefit

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

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

The benefit is only payable for pain management techniques (as shown above) that are administered in a Hospital or Doctor's office, and are due to a Covered Accidental Injury. For a benefit to be payable, the pain management technique must be administered within 6 months after the Covered Accident. This benefit is not payable for an epidural administered during a surgical procedure.

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

Blood/Plasma/Platelets Benefit

We will pay the amount shown in the Benefit Schedule for each day that an Insured receives blood, plasma, or platelets due to a Covered Accidental Injury. The Insured must receive the blood, plasma, or platelets within 6 months after the accident for a benefit to be payable.

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

Concussion Benefit

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

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

Traumatic Brain Injury Benefit

We will pay the amount shown in the Benefit Schedule if the Insured is diagnosed by a neurologist with Traumatic Brain Injury (TBI) due to a Covered Accident. *Traumatic Brain Injury (TBI)* is an injury that is caused by a traumatic blow to the head, neck, or shoulders; and that results in neurological deficit. To qualify as TBI, the neurological deficit must require:

- Treatment by a neurologist, and
- Prescribed course of physical, speech, and/or occupational therapy under the direction of a neurologist.

The diagnosis must be made within 6 Months after the accident for a benefit to be payable.

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

Burns Benefit

We will pay the amount shown in the Benefit Schedule if the Insured has burns in a Covered Accident. We will pay the Burns Benefit according to the percentage of body surface burned. The Insured must be treated for burns by a Doctor within 6 Months after the accident for a benefit to be payable. First-degree burns are not covered.

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

Emergency Dental Work Benefit

We will pay the amount shown in the Benefit Schedule if the Insured has an Accidental Injury to natural teeth as the result of a Covered Accident. We will pay for extraction or repair with a crown as shown in the Benefit Schedule. The dental work must be performed within 6 Months of the accident for a benefit to be payable.

Eye Injuries Benefit

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

Dislocation Benefit

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

If the dislocation requires open reduction, we will pay 200.00% of the amount shown in the Benefit Schedule.

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

Multiple dislocations refer to more than one dislocation requiring either open or closed reduction in any one Covered Accident. For each covered dislocation, we will pay the amounts shown in the Benefit Schedule. However, we will pay no more than 200.00% 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 25.00% of the amount shown in the Benefit Schedule for the affected joint. (*Partial dislocation* includes subluxation.)

Laceration Benefit

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

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

If the Insured suffers multiple lacerations in a Covered Accident, and the lacerations are repaired with stitches by a Doctor within 168 Hours after the accident, we will pay this benefit based on the largest single laceration that requires stitches, as shown in the Benefit Schedule. However, we will pay no more than 200.00% of the benefit amount for the laceration that has the higher dollar amount.

Fracture Benefit

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

If the fracture requires open reduction, we will pay 200.00% 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 200.00% of the benefit amount for the bone fractured that has the highest dollar amount.

Chip fracture refers to a piece of bone that is completely broken off near a joint. If a Doctor diagnoses the fracture as a chip fracture, we will pay 25.00% of the amount shown in the Benefit Schedule for the affected bone.

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

Outpatient Surgery and Anesthesia Benefit

We will pay the daily benefit amount shown in the Benefit Schedule when, due to a Covered Accidental Injury, an Insured has an outpatient surgical procedure performed by a Doctor. "Surgical procedure" does not include laceration repair. If an outpatient surgical procedure is covered under another benefit in this Plan, we will pay the **higher** of that benefit amount **or** the Outpatient Surgery and Anesthesia Benefit. For a benefit to be payable, the surgery must be performed within 1 year after the Covered Accident.

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

The surgery can be performed:

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

Facilities Fee for Outpatient Surgery Benefit

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

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

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

Inpatient Surgery and Anesthesia Benefit

We will pay the daily benefit amount shown in the Benefit Schedule when, due to a Covered Accidental Injury, an Insured has an inpatient surgical procedure performed by a Doctor. The surgery must be performed while the Insured is confined to a Hospital as an inpatient. If an inpatient surgical procedure is covered under another benefit in this Plan, we will pay the **higher** of that benefit amount **or** the Inpatient Surgery and Anesthesia Benefit. For a benefit to be payable, the surgery must be performed within 1 year after the Covered Accident.

Transportation Benefit

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

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

Use of such transportation must begin within 6 Months after the Covered Accident date. The distance to the Hospital Treatment or diagnostic study must be greater than 100 miles from the Insured's residence.

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

Coma Benefit

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

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

Hospitalization Category

Hospital Admission Benefit

We will pay this benefit when an Insured is admitted to a Hospital and confined as an inpatient because of a Covered Accidental Injury. To be eligible to receive this benefit, an Insured must be admitted to a Hospital within 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 pay this benefit once per period of Hospital Confinement.

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

Hospital Confinement Benefit

We will pay the amount shown in the Benefit Schedule for each day that an Insured is confined to a Hospital as an inpatient as the result of a Covered Accidental Injury. To be eligible to receive this benefit, the Insured must be confined to a Hospital within 6 Months of the date of the Covered Accident.

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

If we pay benefits for confinement and the Insured becomes confined again within 6 Months because of the same Accidental Injury, we will treat this confinement as the same period of confinement.

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

Hospital Intensive Care Benefit

If an Insured is confined in a Hospital Intensive Care Unit because of a Covered Accidental Injury, we will pay the daily benefit amount shown in the Benefit Schedule. To be eligible to receive this benefit an Insured must be admitted to a Hospital Intensive Care Unit within 6 Months of the date of the Covered Accident.

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

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

If we pay benefits for confinement in a Hospital Intensive Care Unit and an Insured becomes confined to a Hospital Intensive Care Unit again within 6 Months because of the same Accidental Injury, we will treat this confinement as the same period of confinement.

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

Intermediate Intensive Care Step-Down Unit Benefit

If an Insured is confined in an Intermediate Intensive Care Step-Down Unit because of a Covered Accidental Injury, we will pay the daily benefit amount shown on the Benefit Schedule. The Insured must be admitted to an Intermediate Intensive Care Step-Down Unit within 6 Months of the date of the Covered Accident.

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

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

If we pay benefits for confinement in a Hospital's Intermediate Intensive Care Step-Down Unit and the Insured becomes confined to a Hospital's Intermediate Intensive Care Step-Down Unit again within 6 Months because of the same condition, we will treat this confinement as the same period of confinement.

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

Family Member Lodging Benefit

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

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

The Treatment must take place within 6 Months after the Covered Accident for a benefit to be payable.

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After Care Category

Appliances Benefit

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

For a benefit to be payable, the Doctor's advice to use a medical appliance must be within 6 months after the Covered Accident.

Accident Follow-Up Treatment Benefit

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

- The Insured receives initial Treatment within 168 hours after the Covered Accident.
- The Insured receives Doctor-prescribed follow-up Treatment.
- The follow-up Treatment begins within 6 Months after the Covered Accident or discharge from the Hospital.

Chiropractic procedures are not considered Follow-up Treatment.

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

Post-Traumatic Stress Disorder Benefit

Post-Traumatic Stress Disorder (PTSD) is a mental health condition triggered by a Covered Accident. We will pay the amount shown in the Benefit Schedule if the Insured is diagnosed with Post-traumatic Stress Disorder. An Insured must meet the diagnostic criteria for PTSD, stipulated in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV-TR), and be under the active care of either a Psychiatrist or Ph.D.-level Psychologist. The diagnosis must take place within 6 months after the Covered Accident for a benefit to be payable.

For the purposes of this benefit:

- **Psychiatrist** is a Doctor of medicine who specializes in the diagnosis and Treatment of mental disorders.
- **Psychologist** is a clinical, mental health professional who works with patients. A Psychologist is not a Doctor of medicine who typically provides medical interventions and drug therapies, but provides analysis and counseling.

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

Rehabilitation Unit Benefit

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

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

Therapy Benefit

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

- The Insured receives initial Treatment within 168 hours after the Covered Accident.
- The Insured receives Doctor-prescribed therapy Treatment in one of the following categories: physical therapy provided by a licensed physical therapist, occupational

therapy provided by a licensed occupational therapist, or speech therapy provided by a licensed speech therapist.

- The therapy Treatment begins within 90 days after the Covered Accident or discharge from the Hospital.

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

Chiropractic or Alternative Therapy Benefit

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

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

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

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Life Change Events Category

Dismemberment Benefit

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

- Is injured, and
- Loses a hand, a foot, or sight within 6 Months after the accident as a result of the Injury.

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

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

If the Dismemberment Benefit is paid and the Insured later dies as a result of the same Covered Accident, we will pay the appropriate death benefit (if available), less any amounts paid under this benefit.

Paralysis Benefit

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

- The Insured is injured,
- The Accidental Injury causes paralysis which lasts more than 90 days, and
- The paralysis is diagnosed by a Doctor within 6 Months after the accident.

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

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

Prosthesis Benefit

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

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

This benefit is not payable for:

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

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

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

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

Residence/Vehicle Modification Benefit

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

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

The modification must occur within one year after the accident.

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

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SECTION V - EXCLUSIONS

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

- **War** – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the Insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion, or civil state of belligerence. War does not include acts of 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:
 - o Allergic reactions
 - o Any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings
 - o An error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure for any sickness
 - o Any related medical/surgical Treatment or diagnostic procedures for such illness
- **Self-Inflicted Injuries** - injuring or attempting to injure oneself intentionally.
- **Racing** - riding in or driving any motor-driven vehicle in a race, stunt show, or speed test in a professional or semi-professional capacity.
- **Illegal Occupation** - voluntarily participating in, committing, or attempting to commit a felony or illegal act or activity, or voluntarily working at, or being engaged in, an illegal occupation or job.
- **Sports** - participating in any organized sport in a professional or semi-professional capacity for pay or profit.
- **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.
- **Driving** – driving any taxi or intrastate or interstate long-distance vehicle for wage, compensation, or profit.

For **24-Hour Coverage**, the following exclusions will not apply:

- An Injury arising from any employment.
- An Injury or sickness covered by Worker's Compensation.

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SECTION VI - CLAIM PROVISIONS

Notice of Claim

The Insured must give written notice of claim:

- No later than the 20th day after a Covered Accidental Injury, or
- As soon as reasonably possible.

When we receive written Notice of Claim, we will send a claim form. If the Claimant does not receive the claim form within 15 days after the notice is sent, written Proof of Loss can be sent to us without waiting for the form. Notice must include the Employee's name and the Certificate number. Notice can be mailed to the Company at the following address:

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

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

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. It can include a statement by the treating Doctor.) Proof of Loss establishes the nature and extent of the loss, the Company's obligation to pay the claim, and the Claimant's right to receive payment.

The Claimant must provide Proof of Loss to the Company at the following address:

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

Proof of Loss must be given to us within 90 days of the Covered Accidental Injury. Failure to give Proof of Loss within such time shall not invalidate or reduce any claim if such Proof of Loss is given as soon as reasonably possible. The Company will not accept Proof of Loss any later than one year and three months after the Covered Accidental Injury, except in the absence of the Claimant's legal mental capacity.

The Claimant will be responsible for the cost of obtaining a completed claim form. We may request additional Proof of Loss, such as records from Hospitals or Doctors. The Claimant will be responsible for the cost of obtaining these records.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

When we receive the claim and due Proof of Loss, we will review the Proof of Loss. If we approve the claim, we will pay the benefits subject to the terms of the Certificate.

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 exams and/or autopsy.

Time of Payment of Claims

For benefits other than for loss of time, the Company will, once we receive the required Proof of Loss, pay, deny, or settle each submitted claim no later than the 60th day after the date Proof of Loss is received. Subject to written Proof of Loss, all accrued benefits payable under the Policy for loss of time will be paid at least monthly during the period for which the Company is liable. Any balance remaining unpaid at the end of that time will be paid as soon as possible after the Proof of Loss is received.

Payment of Claims

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

- To the beneficiary designated by the Insured or the beneficiary's assignee,
- To the Insured's surviving Spouse,
- To the Insured's estate.

Unpaid Premium

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

Changing of Beneficiary

A change in beneficiary must be submitted in writing to our Home Office and signed by the Employee. Unless otherwise specified by the Employee, a change in beneficiary will take effect on the date the notice of change is signed. We will not be liable for any action taken before notice is received and recorded at the Home Office.

Claim Review

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

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

Appeals Procedure

Before filing any lawsuit - and no later than 60 days after notice of denial of a claim--the Employee, the Claimant, or an authorized representative of either must appeal any denial of benefits under the Plan by sending a written request for review of the denial to our Home Office.

Legal Action

The Employee may not take Legal Action against us for benefits under this Plan:

- Within 60 days after he has sent us written Proof of Loss, or
- More than three years from the time written proof is required to be given.

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SECTION VII - GENERAL PROVISIONS

Entire Contract Changes

This insurance is provided under a contract of Group Accidental Injury Insurance with the Policyholder. The Entire Contract of Insurance is made up of:

- The Policy;
- The Certificates of Insurance;
- The Application of the Policyholder, a copy of which is attached to and made part of the Policy when issued; and
- Any Riders, Endorsements, or Amendments to the Policy or Certificate.

In the absence of fraud, a statement made by the Policyholder or an Insured is considered a representation and not a warranty. A statement made by the Policyholder or an Insured will not be used in any contest under the Plan, unless a copy of the written instrument containing the statement is or has been provided to:

- The person making the statement; or
- If the statement was made by the Insured, and the Insured has died or become incapacitated, the Insured's beneficiary or personal representative.

Changes to the 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, and
- May not be made by any agent or producer (nor can an agent or producer waive any Plan provisions).

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.

Successor Insured

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

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

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

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

Time Limit on Certain Defenses

After two years from the Employee's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of intentional misstatements, of a material fact, made on the Employee's 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 Certificates

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

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

Required Information

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

Conformity with State Statutes

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

BENEFIT SCHEDULE

Initial Treatment Category - Low

	Primary Insured	Spouse	Child
Initial Treatment Benefit			
<i>Hospital emergency room with X-Ray</i>	\$125.00	\$125.00	\$125.00
<i>Hospital emergency room without X-Ray</i>	\$100.00	\$100.00	\$100.00
<i>Urgent Care facility with X-Ray</i>	\$125.00	\$125.00	\$125.00
<i>Urgent Care facility without X-Ray</i>	\$100.00	\$100.00	\$100.00
<i>Office or facility (other than a Hospital emergency room or Urgent Care) with X-Ray</i>	\$75.00	\$75.00	\$75.00
<i>Office or facility (other than a Hospital emergency room or Urgent Care) without X-Ray</i>	\$50.00	\$50.00	\$50.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Ambulance Benefit	\$200.00	\$200.00	\$200.00
Air Ambulance Benefit	\$600.00	\$600.00	\$600.00
Major Diagnostic Testing Benefit	\$100.00	\$100.00	\$100.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Emergency Room Observation Benefit			
<i>Per each 24 hour period of observation</i>	\$50.00	\$50.00	\$50.00
<i>Period of observation at least 4 hours and up to 24 hours</i>	\$25.00	\$25.00	\$25.00
Prescriptions Benefit	\$5.00	\$5.00	\$5.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	2	2	2
Pain Management Benefit	\$50.00	\$50.00	\$50.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Blood/Plasma/Platelets Benefit	\$100.00	\$100.00	\$100.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	3	3	3
Concussion Benefit	\$250.00	\$250.00	\$250.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Traumatic Brain Injury Benefit	\$2,500.00	\$2,500.00	\$2,500.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Burns Benefit			
<i>Second Degree</i>			
Less than 10%	\$50.00	\$50.00	\$50.00
At least 10% but less than 25%	\$100.00	\$100.00	\$100.00
At least 25% but less than 35%	\$250.00	\$250.00	\$250.00
35% or more	\$500.00	\$500.00	\$500.00
<i>Third Degree</i>			
Less than 10%	\$500.00	\$500.00	\$500.00
At least 10% but less than 25%	\$2,500.00	\$2,500.00	\$2,500.00
At least 25% but less than 35%	\$5,000.00	\$5,000.00	\$5,000.00
35% or more	\$10,000.00	\$10,000.00	\$10,000.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Emergency Dental Work Benefit			
Repair with crown	\$100.00	\$100.00	\$100.00
Extraction	\$25.00	\$25.00	\$25.00
Eye Injuries Benefit	\$125.00	\$125.00	\$125.00
Dislocation Benefit			
Hip	\$1,500.00	\$1,500.00	\$1,500.00
Knee (not knee cap)	\$975.00	\$975.00	\$975.00
Shoulder	\$750.00	\$750.00	\$750.00
Foot/ankle	\$600.00	\$600.00	\$600.00
Hand	\$525.00	\$525.00	\$525.00
Lower jaw	\$450.00	\$450.00	\$450.00
Wrist	\$375.00	\$375.00	\$375.00
Elbow	\$300.00	\$300.00	\$300.00
Finger/toe	\$120.00	\$120.00	\$120.00

Laceration Benefit			
Over 15 centimeters	\$400.00	\$400.00	\$400.00
5 to 15 centimeters	\$200.00	\$200.00	\$200.00
Under 5 centimeters	\$50.00	\$50.00	\$50.00
Lacerations not requiring stitches	\$25.00	\$25.00	\$25.00
Fracture Benefit			
Hip/thigh	\$2,000.00	\$2,000.00	\$2,000.00
Vertebrae	\$1,800.00	\$1,800.00	\$1,800.00
Pelvis	\$1,600.00	\$1,600.00	\$1,600.00
Skull (depressed)	\$1,500.00	\$1,500.00	\$1,500.00
Skull (simple)	\$700.00	\$700.00	\$700.00
Leg	\$1,200.00	\$1,200.00	\$1,200.00
Foot/ankle/knee cap	\$1,000.00	\$1,000.00	\$1,000.00
Forearm/hand/wrist	\$1,000.00	\$1,000.00	\$1,000.00
Lower jaw	\$800.00	\$800.00	\$800.00
Shoulder blade/collar bone	\$800.00	\$800.00	\$800.00
Upper arm/upper jaw	\$700.00	\$700.00	\$700.00
Facial bones (except teeth)	\$600.00	\$600.00	\$600.00
Vertebral processes	\$400.00	\$400.00	\$400.00
Coccyx/rib/finger/toe	\$160.00	\$160.00	\$160.00
Sternum	\$1,800.00	\$1,800.00	\$1,800.00
Sacral/Sacrum	\$400.00	\$400.00	\$400.00
Outpatient Surgery and Anesthesia Benefit			
<i>Hospital Outpatient or Ambulatory Surgical Center</i>	\$200.00/day	\$200.00/day	\$200.00/day
<i>Doctor's Office or Emergency Room</i>	\$25.00/day	\$25.00/day	\$25.00/day
<i>(Maximum is applicable only to Doctor's office or Emergency Room)</i>			
<i>Maximum number of payments per Covered Accident, per Insured</i>	2	2	2
Facilities Fee for Outpatient Surgery Benefit	\$50.00	\$50.00	\$50.00
<i>Payable once per each eligible Outpatient Surgery and Anesthesia Benefit</i>			
Inpatient Surgery and Anesthesia Benefit	\$500.00/day	\$500.00/day	\$500.00/day
Transportation Benefit			
Plane	\$250.00	\$250.00	\$250.00
Any Ground Transportation	\$100.00	\$100.00	\$100.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	3	3	3
Coma Benefit	\$5,000.00	\$5,000.00	\$5,000.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Hospitalization Category - Low	Primary Insured	Spouse	Child
Hospital Admission Benefit	\$625.00	\$625.00	\$625.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Hospital Confinement Benefit	\$150.00/day	\$150.00/day	\$150.00/day
<i>Maximum Benefit Period: 365 days</i>			
Hospital Intensive Care Benefit	\$200.00/day	\$200.00/day	\$200.00/day
<i>Maximum Benefit Period: 30 days</i>			
Intermediate Intensive Care Step-Down Unit Benefit	\$100.00/day	\$100.00/day	\$100.00/day
<i>Maximum Benefit Period: 30 days</i>			
Family Member Lodging Benefit	\$100.00/day	\$100.00/day	\$100.00/day
<i>Maximum Benefit Period: 30 days</i>			
After Care Category - Low	Primary Insured	Spouse	Child
Appliances Benefit			
Cane	\$20.00	\$20.00	\$20.00
Ankle Brace	\$20.00	\$20.00	\$20.00
Walking Boot	\$50.00	\$50.00	\$50.00
Walker	\$50.00	\$50.00	\$50.00
Crutches	\$50.00	\$50.00	\$50.00
Leg Brace	\$50.00	\$50.00	\$50.00
Wheelchair	\$200.00	\$200.00	\$200.00
	\$200.00	\$200.00	\$200.00

<i>Knee Scooter</i>	\$200.00	\$200.00	\$200.00
<i>Body Jacket</i>	\$200.00	\$200.00	\$200.00
<i>Back Brace</i>	\$50.00	\$50.00	\$50.00
<i>Cervical Collar</i>			
Accident Follow-Up Treatment Benefit	\$25.00	\$25.00	\$25.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	6	6	6
Post-Traumatic Stress Disorder Benefit	\$100.00	\$100.00	\$100.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Rehabilitation Unit Benefit	\$50.00/day	\$50.00/day	\$50.00/day
<i>Maximum Benefit Period per Hospital confinement</i>	31 days	31 days	31 days
<i>Calendar Year Maximum</i>	62 days	62 days	62 days
Therapy Benefit	\$25.00	\$25.00	\$25.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	10	10	10
Chiropractic or Alternative Therapy Benefit	\$15.00	\$15.00	\$15.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	6	6	6

Life Change Events Category - Low

	Primary Insured	Spouse	Child
Dismemberment Benefit			
<i>Loss of hand, foot, or sight</i>			
Single loss	\$6,250.00	\$2,500.00	\$1,250.00
Double loss	\$12,500.00	\$5,000.00	\$2,500.00
Loss of one or more fingers or toes	\$625.00	\$250.00	\$125.00
Partial amputation of finger or toe	\$62.50	\$62.50	\$62.50
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Paralysis			
Four limbs (quadriplegia)	\$5,000.00	\$5,000.00	\$5,000.00
Two limbs (paraplegia)	\$2,500.00	\$2,500.00	\$2,500.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Prosthesis Benefit			
Single	\$1,500.00	\$1,500.00	\$1,500.00
Multiple	\$3,000.00	\$3,000.00	\$3,000.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Residence/Vehicle Modification Benefit	\$1,000.00	\$1,000.00	\$1,000.00
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

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

Amendment to Policy and Certificate of Insurance for Group Accidental Injury

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

EFFECTIVE DATE

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

The Termination of Your Insurance provision is deleted and replaced with the following:

Termination of Your Insurance

Your insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date (the last day of the Grace Period), if the premium has not been paid.

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

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

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

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

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

CONTRACT

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

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

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

Amendment to Worker's Compensation Disclosure

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

EFFECTIVE DATE

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

The Worker's Compensation Disclosure on the Face Page of the Policy and Certificate is deleted and replaced with the following:

THIS IS NOT A WORKERS' COMPENSATION INSURANCE POLICY. THE EMPLOYER DOES NOT OBTAIN WORKERS' COMPENSATION INSURANCE COVERAGE BY PURCHASING THIS POLICY, AND IF THE EMPLOYER HAS NOT ELECTED TO OBTAIN WORKERS' COMPENSATION INSURANCE COVERAGE, THE EMPLOYER DOES NOT OBTAIN THOSE BENEFITS THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS IN THIS STATE. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAWS IN THIS STATE AS THEY PERTAIN TO EMPLOYERS THAT ELECT NOT TO MAINTAIN WORKERS' COMPENSATION INSURANCE COVERAGE AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

CONTRACT

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

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary



Thank you for choosing Continental American Insurance Company

1.800.433.3036

www.aflacgroupinsurance.com

Your Group Policy Number is:

CTR0015283525

Product:

Critical Illness

Your Policy is Effective :

01/01/2024

Your State of Issue is:

Texas



CITY OF MERCEDES
400 S OHIO AVE
MERCEDES TX 78570-3120



March 14, 2024

CITY OF MERCEDES
400 S OHIO AVE
MERCEDES TX 78570-3120

**Re: Your CITY OF MERCEDES Group Critical Illness Coverage
Policy No.: CTR0015283525**

Welcome to the Aflac family!

Thank you so much for adding Aflac coverage in your employee benefits offering. We take commitments to our accounts very seriously and promise to be there when you and your employees need us. Enclosed, you'll find:

A Master Policy packet for the Aflac group plan you've chosen to make available to your employees. Each packet includes:

- A master policy, which indicates your group coverage effective date and other coverage details,
- A copy of your master application, **and**
- A copy of your employees' coverage certificate. **(We'll let employees know they can request copies of their certificates from you, so please be sure to make the coverage documents available. Of course, employees are also welcome to call us directly to request copies of their certificates.)**

If you have any questions about your group plan or your employees' coverage, please reach out to your account manager, or give us a call at 1.866.319.8089 Monday through Friday, from 9 a.m. to 7 p.m. Eastern time.

Again, welcome to the Aflac family!

MPCOVLET_A

Continental American Insurance Company • Columbia, South Carolina • 1.800.433.3036 toll-free

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 New York, group coverage is underwritten by American Family Life Assurance Company of New York (22 Corporate Woods Boulevard, Suite 2, Albany, New York 12211), and customer service is administered by CAIC.

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Continental American Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: Continental American Insurance Company at 1-800-433-3036

Toll-free:

1-800-433-3036

Email: cscmail@aflac.com

Mail: Continental American Insurance Company
Post Office Box 427
Columbia, South Carolina 29202

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call: 1-800-252-3439

Online: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Continental American Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Continental American Insurance Company al 1-800-433-3036

Teléfono gratuito:

1-800-433-3036

Correo electrónico: cscmail@aflac.com

Dirección postal: Continental American Insurance Company
Post Office Box 427
Columbia, South Carolina 29202

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame: 1-800-252-3439

En línea: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
 - o Up to \$500,000 for health benefit plans, with some exceptions.
 - o Up to \$300,000 for disability income benefits.
 - o Up to \$300,000 for long-term care insurance benefits.
 - o Up to \$200,000 for all other types of health insurance.
- **Life insurance:**
 - o Up to \$100,000 in net cash surrender or withdrawal value.
 - o Up to \$300,000 in death benefits.
- **Individual annuities:** Up to \$250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to \$300,000 per person, regardless of the number of policies or contracts. A limit of \$500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

<p>To learn more about the Association and your protections, contact:</p> <p>Texas Life and Health Insurance Guaranty Association 1601 Congress Avenue Austin, TX 78701 1-800-982-6362 or www.txlifega.org</p>	<p>For questions about insurance, contact:</p> <p>Texas Department of Insurance P.O. Box 149104 Austin, TX 78714-9104 1-800-252-3439 or www.tdi.texas.gov</p>
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Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.



CONTINENTAL AMERICAN INSURANCE COMPANY
Columbia, South Carolina
800.433.3036

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

Continuation of Coverage Endorsement

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

EFFECTIVE DATE

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

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

CONTINUATION OF COVERAGE

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

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

To keep your Certificate in force, you must:

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

PREMIUMS

Initial premium rates will be based on the rates in effect at the time you apply to continue your coverage. Premium rates can be changed by the Company at any time upon 60 days written notice to you. Any such change will be applied to all Certificates in your class and will not be based on your or your Spouse and Dependent Children's health or other individual factors.

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

TERMINATION

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

- 31 days after the date you fail to pay any required premium.

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

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

CONTRACT

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

- The Certificate terminates, or
- Premiums are no longer paid for this Endorsement.

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY
Columbia, South Carolina
800.433.3036

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

Group Critical Illness Insurance Policy

Policyholder Name:	CITY OF MERCEDES	Jurisdiction	Texas
Group Policy Number	CTR0015283525	Non-Participating	
Effective Date	January 1, 2024	Anniversary Date	January 1, 2025

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

This Plan provides benefits for the Critical Illnesses listed in the Policy Schedule.

Please read it carefully.

This policy is not a Medicare supplement policy.

NOTICE: This Policy may be subject to an increase in premium at time of renewal.

This is not a policy of workers' compensation insurance. The employer does not become a subscriber to the workers' compensation system by purchasing this policy, and if the employer is a non-subscriber, the employer loses those benefits which would otherwise accrue under the workers' compensation laws. The employer must comply with the workers' compensation law as it pertains to non-subscribers and the required notifications that must be filed and posted.

The Policyholder as shown on the Policy Schedule applied for coverage under this Group Critical Illness Insurance Policy (the "Plan"). This Plan is issued by Continental American Insurance Company (the "Company," "CAIC," "we," "us," or "our"). Based on the Master Application and the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages.

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

This Plan is a legal contract between the Company and the Policyholder. All material printed by the Company on the following pages is part of the Plan. This Plan is delivered in and governed by the laws of the jurisdiction shown on the Policy Schedule.

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.

In witness whereof, the Company executes this Plan at its home office in Columbia, South Carolina, on the Effective Date.

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary

**Group Critical Illness Insurance
Non-Participating**

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Section I	-	Eligibility, Effective Date, and Termination
Section II	-	Premium Provisions
Section III	-	Definitions
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Section V	-	Exclusions
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Section VII	-	General Provisions
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		Schedule of Premiums

SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

PRIMARY INSURED

Eligibility

An Employee is eligible to be covered under this Plan if they are Actively at Work for their employer and included in the class that is eligible for coverage, as shown on the Master Application.

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

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

Employees should refer to *Type of Coverage* in their Certificate Schedule to determine who is covered under the Certificate.

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

Effective Date

The Plan's Effective Date is shown on the Policy Schedule. This Plan becomes effective on the Policy Effective Date at 12:01 a.m., as determined by the Policyholder's address.

An eligible Employee must enroll in this Plan and agree to pay the required premiums for coverage to become effective. An Employee must enroll within 31 days of the date they first become eligible for coverage. *The first premium must have been paid for coverage to become effective.*

We may require evidence of insurability satisfactory to us if the amount of coverage applied for exceeds the guaranteed-issue amount, if any, or if we do not receive the Application within 31 days after the Employee was first eligible for coverage. Evidence of insurability may also be required based on an agreement between the Policyholder and us.

The Employee's Effective Date is the date their insurance takes effect. After we receive and approve the Application, that date is either:

- The date shown on the Certificate Schedule if the Employee is Actively at Work on that date, or
- The date the Employee returns to an Actively-at-Work status if they were not Actively at Work on the date shown on the Certificate Schedule.

Termination of an Employee's Insurance

An Employee's insurance will terminate on whichever occurs first:

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

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

DEPENDENT COVERAGE

Eligibility

Dependents may be eligible for coverage under this Plan. **Employees should refer to the Type of Coverage on their Certificate Schedule to determine Dependent eligibility.** A **Dependent** is the Spouse of an Employee or the Dependent Child of an Employee (details included in the **Definitions** section). An eligible Spouse must not currently be disabled or unable to work and be at least 18 years of age.

Effective Date

The Effective Date for a Spouse is:

- The date shown on the Certificate Schedule if that Spouse is not confined to a hospital and is eligible for coverage on that date, or
- The first day of the month following the date the Spouse is no longer confined to a hospital (if that Spouse was confined to a hospital on the Certificate Schedule date) and is eligible for coverage on that date.

A Spouse may be added to the Plan after the Employee's Effective Date within 31 days after a Life Event or during an approved enrollment period. To be added, the Employee must complete an Application to add their Spouse to the Plan. The Company will assign the Effective Date for a Spouse's coverage after approving the application. For Spouse coverage to become effective, the Spouse must be included in the premium payment.

The Effective Date for a Dependent Child is:

- The Employee Effective Date, or
- The moment of birth for a newborn child, the date the petition is filed for adoption for adopted children, or the date of the Employee's marriage for step-children.

Termination of Dependent Insurance

Dependent Coverage will terminate on the earliest of the following:

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

Plan Termination

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

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

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

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

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

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

Portability Privilege

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

To keep their coverage in force, the Employee must:

- Notify the Company in writing within 31 days after the date their coverage would otherwise terminate. They may notify us by sending written notice to P.O. Box 84079, Columbus, GA 31993-9101 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly to the Company no later than 31 days after the date their coverage would otherwise terminate and on each premium due date thereafter.

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

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

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

Extension of Benefits

If coverage under the Policy or any Riders that are in force ends while an Insured is confined in a Hospital for a covered Critical Illness, the Company will continue to pay benefits for confinement that become payable after the date coverage under the Policy or any Riders ends if the Insured meets the following requirements:

- The confinement must be continuous after the date of termination; and
- Coverage must not have ended as a result of the Insured's or, in the case of a Dependent Child or Spouse, the Primary Insured's voluntary termination of coverage.

This Extension of Benefits terminates upon the earliest of the following:

- The date the Insured is no longer confined to a Hospital;
- The date the Insured receives the maximum benefit for being confined to a Hospital; or
- 90 days after the date coverage would otherwise terminate.

Hospital means a place that meets all of the following criteria: Is legally licensed and operated as a hospital, provides overnight care of injured and sick people, is supervised by a Doctor, has full-time nurses supervised by a registered nurse, and has on-site use of X-ray equipment, laboratory, and surgical facilities.

The term Hospital specifically excludes any facility not meeting the definition of Hospital as defined in this Plan, including but not limited to: A nursing home, an extended-care facility, a skilled nursing facility, a rest home or home for the aged, a rehabilitation facility, a facility for the Treatment of alcoholism or drug addiction, or an assisted living facility.

SECTION II – PREMIUM PROVISIONS

Premium Payments

Premiums should be paid to the Company at P.O. Box 84069, Columbus, Georgia, 31908-4069.

The first premiums are 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.

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

Premium Changes

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

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

We will provide the Policyholder a 60-day advance written notice of any change to a premium.

Premiums on the Group Policy Anniversary Date are determined by the Attained Age of each Employee. The Attained Age rates are shown in the Schedule of Premiums.

Grace Period

This Plan has a 31-day Grace Period. If a 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. If the Plan is discontinued, the Plan's termination date will be the latest date for which premium has been paid.

SECTION III - DEFINITIONS

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

Actively at Work (Active Work) refers to an Employee's ability to perform their regular employment duties for a full normal workday. The Employee may perform these activities either at their employer's regular place of business or at a location where they are required to travel to perform the regular duties of their employment.

Acute Coronary Syndrome is an obstruction of the coronary arteries that occurs as a result of Myocardial Infarction with or without ST elevation. This is determined by an electrocardiogram (ECG). Acute Coronary Syndrome includes unstable angina but does not include stable angina.

Arteriosclerosis means a disease of the arteries characterized by plaque deposits on the arteries' inner walls, resulting in their abnormal thickening and loss of elasticity.

Arteriovenous Malformation means a congenital disease of the blood vessels in the brain, brain stem, or spinal cord that is characterized by a complex, tangled web of abnormal arteries and veins and may be connected by one or more fistulas.

Atherosclerosis means a disease in which plaque builds up inside a person's arteries.

Attained Age means the Employee's age on their Certificate Effective Date and on each Group Policy Anniversary Date thereafter.

Bone Marrow Transplant (Stem Cell Transplant) means a procedure to replace damaged or destroyed bone marrow with healthy bone marrow stem cells. For a benefit to be payable, a Bone Marrow Transplant (Stem Cell Transplant) must be caused by at least one of the following diseases:

- Aplastic anemia
- Congenital neutropenia
- Severe immunodeficiency syndromes
- Sickle cell anemia
- Thalassemia
- Fanconi anemia
- Leukemia
- Lymphoma
- Multiple myeloma

The Bone Marrow Transplant (Stem Cell Transplant) benefit is not payable if the Transplant results from a covered Critical Illness for which a benefit has been paid under this Plan.

Brain Aneurysm is a weak area in the wall of a blood vessel of the brain that causes the blood vessel to bulge, balloon out, or rupture.

Cancer (internal or invasive) is a disease that meets either of the following definitions:

- A malignant tumor characterized by:
 - The uncontrolled growth and spread of malignant cells, and
 - The invasion of distant tissue.
- A disease meeting the diagnostic criteria of malignancy, as established by the American Board of Pathology. A Pathologist must have examined and provided a report on the histocytologic architecture or pattern of the tumor, tissue, or specimen.

Cancer (internal or invasive) also includes:

- Melanoma that is Clark's Level III or higher **or** Breslow depth equal to or greater than 0.77mm,
- Myelodysplastic syndrome - RCMD (refractory cytopenia with multilineage dysplasia),
- Myelodysplastic syndrome - RAEB (refractory anemia with excess blasts),
- Myelodysplastic syndrome - RAEB-T (refractory anemia with excess blasts in transformation), or
- Myelodysplastic syndrome - CMML (chronic myelomonocytic leukemia).

The following are **not** considered internal or invasive Cancers:

- Pre-malignant tumors or polyps
- Carcinomas in Situ
- Any superficial, non-invasive Skin Cancers including basal cell and squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is Diagnosed as
 - Clark's Level I or II,
 - Breslow depth less than 0.77mm, **or**
 - Stage 1A melanomas under TNM Staging
- Metastatic Cancer

Carcinoma in Situ is Non-Invasive Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

Melanoma in Situ means melanoma cells that occur only on the outer layer of the skin (the epidermis), where there is no invasion of the deeper layer (the dermis).

Non-Invasive Cancer is a Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

For the purposes of this Plan, a Non-Invasive Cancer is:

- Internal Carcinoma in Situ
- Myelodysplastic Syndrome - RA (refractory anemia)
- Myelodysplastic Syndrome - RARS (refractory anemia with ring sideroblasts)
- Myeloproliferative Blood Disorder

Premalignant conditions or conditions with malignant potential, other than those specifically named above, are **not** considered Non-Invasive Cancer.

Skin Cancer, as defined in this Plan, is **not** considered Non-Invasive Cancer and therefore is not payable under the Non-Invasive Cancer benefit.

Skin Cancer is a Cancer that forms in the tissues of the skin.

The following are considered Skin Cancers:

- Basal cell carcinoma
- Squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is Diagnosed as:
 - Clark's Level I or II,
 - Breslow depth less than 0.77mm, or

- o Stage 1A melanomas under TNM Staging

These conditions are not payable under the Cancer (internal or invasive) benefit.

Cancer, Non-Invasive Cancer, Metastatic Cancer or Skin Cancer must be Diagnosed in one of two ways:

1. **Pathological Diagnosis** is a Diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This Diagnosis must be made by a certified Pathologist and conform to the American Board of Pathology standards.
2. **Clinical Diagnosis** is based only on the study of symptoms. The Company will accept a Clinical Diagnosis only if:
 - A Doctor cannot make a Pathological Diagnosis because it is medically inappropriate or life-threatening,
 - Medical evidence exists to support the Diagnosis, and
 - A Doctor is treating the Insured for Cancer or Carcinoma in Situ.

Cardiomyopathy means a disease with measurable deterioration of the function of the myocardium, and is typically characterized by breathlessness and swelling of the legs.

Chronic Kidney Disease means a disease characterized by the gradual loss in renal function over time due to diabetes mellitus, Hypertension, glomerulonephritis, polycystic kidney disease, autoimmune disease, or genetic disease.

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

Complete Remission is defined as having no Symptoms and no Signs that can be identified to indicate the presence of Cancer.

Coronary Artery Bypass Surgery means open heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts and where such narrowing or blockage is attributed to Coronary Artery Disease or Acute Coronary Syndrome. This excludes any non-surgical procedure, such as, but not limited to, balloon angioplasty, laser relief, or stents.

Coronary Artery Disease occurs when the coronary arteries become damaged due to acute coronary occlusion, coronary atherosclerosis, aneurysm and/or dissection of the coronary arteries, or coronary atherosclerosis due to lipid rich plaque.

Critical Illness is a disease or a sickness as defined in the Plan that first manifests while your coverage is in force.

Any loss due to Critical Illness must begin while your coverage is in force. Critical Illness includes only the following, provided such Critical Illness meets all applicable definitions contained in the Plan and, where indicated, is caused by an underlying condition:

- Bone Marrow Transplant (Stem Cell Transplant)
- Cancer (internal or invasive)
- Coronary Artery Bypass Surgery
- Heart Attack (Myocardial Infarction)
- Kidney Failure (End-Stage Renal Failure)
- Major Organ Transplant
- Non-Invasive Cancer
- Stroke
- Sudden Cardiac Arrest
- Type I Diabetes
- Metastatic Cancer

Date of Diagnosis is defined as follows:

- **Bone Marrow Transplant (Stem Cell Transplant):** The date the surgery occurs.
- **Cancer:** The day tissue specimens, blood samples, or titer(s) are taken (Diagnosis of Cancer and/or Carcinoma in Situ is based on such specimens).
- **Coronary Artery Bypass Surgery:** The date the surgery occurs.

- **Heart Attack (Myocardial Infarction):** The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the Heart Attack (Myocardial Infarction) definition.
- **Kidney Failure (End-Stage Renal Failure):** The date a Doctor recommends that an Insured begin renal dialysis.
- **Major Organ Transplant:** The date the surgery occurs.
- **Metastatic Cancer:** The date a Doctor determines Cancer has metastasized to other parts of the body from the original site.
- **Non-Invasive Cancer:** The day tissue specimens, blood samples, or titer(s) are taken (Diagnosis of Cancer and/or Carcinoma in Situ is based on such specimens).
- **Skin Cancer:** The date the skin biopsy samples are taken for microscopic examination.
- **Stroke:** The date the Stroke occurs (based on documented neurological deficits and neuroimaging studies).
- **Sudden Cardiac Arrest:** The date the pumping action of the heart fails (based on the Sudden Cardiac Arrest definition).
- **Type I Diabetes:** The date a Doctor Diagnoses an Insured as having Type I Diabetes based on clinical and/or laboratory findings as supported by medical records.

Dependent Children are an Employee's or an Employee's Spouse's natural children, step-children, grandchildren who are the Employee's dependents for federal income tax purposes at the time the application for coverage of the grandchild is made, foster children, children subject to legal guardianship, adopted children, children for whom the Employee is required to provide medical support, or Children Placed for Adoption, who are younger than age 26. However, we will continue coverage for Dependent Children insured under the Plan after the age of 26 if they are incapable of self-sustaining employment due to mental or physical disability, and are chiefly dependent on a parent for support and maintenance. The Employee or the Employee's Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday.

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

Children Placed for Adoption are Children for whom the Employee has entered a decree of adoption, Employee has initiated adoption proceedings, or is party to a suit in which the Employee seeks to adopt the child. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court.

Diagnosis (Diagnosed) refers to the definitive and certain identification of an illness or disease that:

- Is made by a Doctor and
- Is based on clinical or laboratory investigations, as supported by the Insured's medical records.

The illness must meet the requirements outlined in this Plan for the particular Critical Illness being Diagnosed.

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

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

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

Family Member includes the Employee's Spouse as well as the following members of the Employee's immediate family:

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

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

Heart Attack (Myocardial Infarction) is the death of a portion of the heart muscle (myocardium) caused by a blockage of one or more coronary arteries due to Coronary Artery Disease or Acute Coronary Syndrome.

Heart Attack (Myocardial Infarction) does not include:

- Any other disease or injury involving the cardiovascular system.
- Cardiac Arrest not caused by a Heart Attack (Myocardial Infarction).

Diagnosis of a Heart Attack (Myocardial Infarction) must include the following:

- New and serial electrocardiographic (ECG) findings consistent with Heart Attack (Myocardial Infarction), and
- Elevation of cardiac enzymes above generally accepted laboratory levels of normal. (In the case of creatine phosphokinase (CPK) a CPK-MB measurement must be used.)

Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms may also be used.

Hypertension means a disease that is characterized by elevated blood pressure in the arteries with a systolic reading of at least 140 mmHg and a diastolic reading of at least 90 mmHg.

Kidney Failure (End-Stage Renal Failure) means end-stage renal failure caused by End-Stage Renal Disease, which results in the chronic, irreversible failure of both kidneys to function.

Kidney Failure (End-Stage Renal Failure) is covered only under the following conditions:

- A Doctor advises that regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) is necessary to treat the Kidney Failure (End-Stage Renal Failure); or
- The Kidney Failure (End-Stage Renal Failure) results in kidney transplantation.

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

Maintenance Drug Therapy is a course of systemic medication given to a patient after a Cancer goes into Complete Remission because of primary Treatment. Maintenance Drug Therapy includes ongoing hormonal therapy, immunotherapy, or chemo-prevention therapy. Maintenance Drug Therapy is meant to decrease the risk of Cancer recurrence; it is not meant to treat a Cancer that is still present.

Major Organ Transplant means undergoing surgery as a recipient of a covered transplant of a human heart, lung, liver, kidney, or pancreas. A transplant must be caused by one or more of the following diseases:

- Bronchiectasis, which is a lung disease state defined by localized, irreversible dilation of the bronchial tree caused by destruction of the muscle and elastic tissue.
- Cardiomyopathy, which is a heart disease characterized by the measurable deterioration of the function of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid.
- Cirrhosis, which is a liver disease characterized by replacement of liver tissue by fibrosis, scar tissue, and regenerative nodules, leading to loss of liver function.
- Chronic obstructive pulmonary disease, which is a lung disease characterized by persistently poor airflow as a result of breakdown of lung tissue and dysfunction of the small airways.
- Congenital Heart Disease, which is heart disease characterized by abnormalities in cardiovascular structures that occur before birth.
- Coronary Artery Disease
- Cystic fibrosis, which is a hereditary disease of the exocrine glands affecting the pancreas, respiratory system, and sweat glands. It is characterized by the production of abnormally viscous mucus by the affected glands.

- Hepatitis, which is a disease caused by the hepatitis A, B, or C virus and is characterized by the inflammation of the liver.
- Interstitial lung disease, which is a lung disease that affects the interstitium of the lungs.
- Lymphangioleiomyomatosis, which is a lung disease characterized by an indolent, progressive growth of smooth muscles cells throughout the lungs, pulmonary blood vessels, lymphatics, and pleurae.
- Polycystic liver disease, which is characterized by multiple variable-sized cysts lined by cuboidal epithelium.
- Pulmonary fibrosis, which is a lung disease where the lung tissue becomes thickened, stiff, and scarred due to chronic inflammation.
- Pulmonary hypertension, which is a disease characterized by increased pressure in the pulmonary artery and results in the thickening of the pulmonary arteries and the narrowing of these blood vessels, which causes the right side of the heart to become enlarged.
- Sarcoidosis, which is a disease characterized by the growth of granulomatous lesions that appear in the body.
- Valvular heart disease, which is a disease of the heart valves.

If, while the Certificate in force, the Insured is placed on a transplant list for a Major Organ Transplant due to one of the above-identified diseases, we will pay 25% of the Critical Illness benefit. The remainder of the Critical Illness benefit will become payable on the date the surgery occurs. A Major Organ Transplant benefit is not payable if the Major Organ Transplant results from a covered Critical Illness for which a benefit has been paid.

Malignant Hypertension is blood pressure that is so high that it actually causes damage to organs, particularly in the nervous system, the cardiovascular system, and/or the kidneys. One type of such damage is called papilledema, a condition in which the optic nerve leading to the eye becomes dangerously swollen, threatening vision.

Metastatic Cancer means a Cancer (internal or invasive) that has spread from the part of the body where it was first formed to other parts of the body. This occurs when cancer cells break away from the original tumor, travel through the blood or lymph system, and form new tumors in other organs or tissues of the body. When this occurs, the new metastatic tumor is the same type of Cancer as the original tumor even though located in a different area of the body.

Pathologist is a Doctor who is:

- Licensed to practice medicine, and
- Licensed by the American Board of Pathology to practice pathologic anatomy.

A Pathologist also includes an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Signs and/or Symptoms are the evidence of disease or physical disturbance observed by a Doctor or other medical professional. The Doctor (or other medical professional) must observe these Signs while acting within the scope of their license.

Spouse is your legal wife or husband who is listed on your Application.

Stroke means apoplexy due to rupture or acute occlusion of a cerebral artery. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. Stroke must be either:

- **Ischemic:** Due to advanced Arteriosclerosis or Arteriosclerosis of the arteries of the neck or brain, or vascular embolism, or
- **Hemorrhagic:** Due to uncontrolled Hypertension, Malignant Hypertension, Brain Aneurysm, or Arteriovenous Malformation.

The Stroke must be positively Diagnosed by a Doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

Stroke does not include:

- Transient Ischemic Attacks (TIAs)

- Head injury
- Chronic cerebrovascular insufficiency
- Reversible ischemic neurological deficits unless brain tissue damage is confirmed by neurological imaging

Stroke will be covered only if the Insured submits evidence of the neurological damage by providing:

- Computed Axial Tomography (CAT scan) images, or
- Magnetic Resonance Imaging (MRI).

Sudden Cardiac Arrest is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to Coronary Artery Disease, Cardiomyopathy, or Hypertension.

Sudden Cardiac Arrest is not a Heart Attack (Myocardial Infarction). A Sudden Cardiac Arrest benefit is not payable if the Sudden Cardiac Arrest is caused by or contributed to by a Heart Attack (Myocardial Infarction).

Transient Ischemic Attack (TIA) occurs when blood flow to part of the brain is temporarily blocked or reduced. For a benefit to be payable, the TIA must be caused by one or more of the following diseases:

- Advanced Arteriosclerosis
- Arteriosclerosis of the arteries of the neck or brain
- Vascular embolism
- Hypertension
- Malignant Hypertension
- Brain Aneurysm
- Arteriovenous Malformation.

The TIA must be positively Diagnosed by a Doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

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.

Treatment-Free From Cancer refers to the period of time without the consultation, care, or services provided by a Doctor. This includes receiving diagnostic measures and taking prescribed drugs and medicines. Treatment does not include Maintenance Drug Therapy or routine follow-up visits to verify whether Cancer or Carcinoma in Situ has returned.

Type I Diabetes means a form of diabetes mellitus causing total insulin deficiency of an Insured along with continuous dependence on exogenous insulin in order to maintain life. Type I Diabetes excludes Gestational Diabetes and Prediabetes.

SECTION IV - BENEFIT PROVISIONS

The benefit amounts payable under this section are shown in the Policy Schedule. The Company will pay benefits for a Critical Illness in the order the events occur.

Critical Illness Benefit

Initial Diagnosis Benefit

We will pay the Critical Illness benefit when an Insured is Diagnosed with one of the Critical Illnesses shown in the Benefit Schedule, and when such Diagnosis is caused by or solely attributed to an underlying disease as identified herein. We will pay this benefit if:

- The initial Date of Diagnosis is while the Insured's coverage is in force, and
- The Certificate does not exclude the illness or condition by name or by specific description.

Benefits will be based on the Face Amount in effect on the Critical Illness Date of Diagnosis.

Additional Diagnosis Benefit

Once benefits have been paid for a Critical Illness, the Company will pay benefits for each different Critical Illness when the Date of Diagnosis for the new Critical Illness is separated from the prior, different Critical Illness by at least 6 consecutive months and the new Critical Illness is not caused or contributed by a Critical Illness for which benefits have been paid.

Reoccurrence Benefit

Once benefits have been paid for a Critical Illness, benefits are payable for that same Critical Illness when the Date of Diagnosis for the Reoccurrence of that Critical Illness is separated from the prior occurrence of that Critical Illness by at least 6 consecutive months and the Critical Illness is not caused or contributed by a Critical Illness for which benefits have been paid.

Non-Invasive Cancer Benefit

We will pay the amount shown in the Policy Schedule for the Diagnosis of a Non-Invasive Cancer. This benefit is payable in addition to all other applicable benefits.

Metastatic Cancer Benefit

We will pay the amount shown in the Policy Schedule for the Diagnosis of a Metastatic Cancer.

Additional Benefits

Additional Benefits are payable if the Date of Diagnosis is while the Insured's coverage is in force, and the Certificate does not exclude the illness or condition by name or by specific description.

Skin Cancer Benefit

We will pay the amount shown in the Policy Schedule for the Diagnosis of Skin Cancer. This benefit is payable 1 per calendar year.

Health Screening Benefit

We will pay the amount shown in the Policy Schedule for Health Screening Tests performed while an Insured's coverage is in force. This benefit is payable 1 per calendar year, per Insured up to the maximum shown on the Certificate Schedule. Benefits are payable for Covered Dependent Children at 50.00% of the Employee benefit amount.

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

Health Screening Tests include, but are not limited to, the following:

- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Non-diagnostic vascular screening
- DNA stool analysis
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test to determine level of HDL and LDL
- Serum protein electrophoresis (blood test for myeloma)
- Spiral CT screening for lung cancer
- Stress test on a bicycle or treadmill
- Thermography
- HIV test performed via nucleic acid test (NAT)
- HPV test performed via Pap smear
- Biopsies
- Genetic Screening Test performed in a medical facility
- Human Coronavirus test
- Dental Exams
- Vision Exams
- Immunizations
- Mental Health Screening

Waiver of Premium Benefit

If an Employee becomes Totally Disabled as defined in this Plan due to a covered Critical Illness, we will waive premiums for the Employee and any currently covered Dependents (this includes any Riders that are in force).

Total Disability or **Totally Disabled** means the Employee is completely unable to perform all of the substantial and material duties and functions of their occupation and any other gainful occupation in which the Employee earns substantially the same compensation earned before the disability.

After 90 days of Total Disability, all Plan premiums will be waived if:

- The Employee's Total Disability began before the age of 65;
- The Employee's Total Disability has continued without interruption for at least 90 days, during which time the Employee and/or the Policyholder have paid premiums; and
- The Employee provides proof of Total Disability as required by us. Satisfactory Proof of Loss for Total Disability must be provided at least once every 12 months.

Pending our approval of a claim for the Waiver of Premium Benefit, premiums should be paid as they are due. Premiums that were paid for the first 90 days of Total Disability will be refunded after the claim for this benefit is approved.

Waiver of Premium will continue until the earliest of the following:

- The premium due date following the Employee's 65th birthday,
- The date the Company has waived premiums for a total of 24 months of Total Disability,
- The date the Employee refuses to provide proof of continuing Total Disability,
- The date the Employee's Total Disability ends, or
- The date coverage ends according to the Termination provisions in **Section I – Eligibility, Effective Date, and Termination.**

If the Employee is still eligible for coverage when they return to Active Work, coverage for any Insured may be continued if premium payments are resumed.

SECTION V – EXCLUSIONS

Exclusions

We will not pay for loss due to any of the following:

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured
- **Suicide** – committing or attempting to commit suicide, while sane or insane
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job

- **Participation in Aggressive Conflict** of any kind, including:
 - o War (declared or undeclared) or military conflicts
 - o Insurrection or riot
 - o Civil commotion or civil state of belligerence
- **Illegal substance abuse, which includes the following:**
 - o Abuse of legally-obtained prescription medication
 - o Illegal use of non-prescription drugs
- An error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure
- Diagnosis of a Critical Illness made by a Family Member.

SECTION VI – CLAIM PROVISIONS

Notice of Claim

Written notice of claim must be given to us:

- Within 60 days after the Date of Diagnosis, or
- As soon as reasonably possible.

When we receive written Notice of Claim, we will send a claim form. If the Claimant does not receive the claim form within 15 days after the notice is sent, written Proof of Loss can be sent to us without waiting for the form. Notice must include the Employee's name and the Certificate number. Notice can be mailed to the Company at:

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

Failure to give notice within the time prescribed does not invalidate or reduce any claim if it was not reasonably possible to give the notice within that time and notice was given as soon as was reasonably possible.

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. It includes a statement by the treating Doctor.) Proof of Loss establishes the nature and extent of the loss, the Company's obligation to pay the claim, and the Claimant's right to receive payment.

The Claimant must provide Proof of Loss to the Company at:

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

Proof of Loss must be given to us within 90 days of the Date of Diagnosis. Failure to give Proof of Loss within such time shall not invalidate or reduce any claim if such Proof of Loss is given as soon as reasonably possible. The Company will not accept Proof of Loss any later than one year and three months after the Date of Diagnosis, except in the absence of the Claimant's legal mental capacity.

The Claimant will be responsible for the cost of obtaining a completed claim form. We may request additional Proof of Loss, such as records from hospitals or Doctors. The Claimant will be responsible for the cost of obtaining these records.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

When we receive the claim and due Proof of Loss, we will review the Proof of Loss. If we approve the claim, we will pay the benefits subject to the terms of the Certificate.

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 exams or autopsy.

Prompt Payment of Benefits

For benefits other than for loss of time, the Company will, once we receive the required Proof of Loss, pay, deny, or settle each submitted claim not later than the 60th day after the date Proof of Loss is received. Subject to written Proof of Loss, all accrued benefits payable under the policy for loss of time will be paid at least monthly during the period for which the insurer is liable. Any balance remaining unpaid at the end of that time will be paid as soon as possible after the Proof of Loss is received.

Payment of Claims

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

- To the Employee's beneficiary or the beneficiary's assignee,
- To the Employee's surviving Spouse,
- To the Employee's estate.

Special Rules for the Payment of Claims for Dependent Children

When required by law, We will provide for benefits payable for a Dependent Child to be paid to the Texas Health and Human Services Commission if such agency paid, through medical assistance, for the treatment received by the Dependent Child for a Covered Condition.

When required by law, We will provide for benefits payable for a Dependent Child to be paid to the Dependent Child's possessory or managing conservator if that individual:

1. provides a written notice that the individual is a possessory or managing conservator of the Dependent Child on whose behalf the claim is made; and
2. provides a certified copy of a court order designating the individual as possessory or managing conservator of the Dependent Child or other relevant evidence.

Unpaid Premium

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

Changing of Beneficiary

A change in beneficiary must be submitted in writing to our Home Office in a form acceptable to us and signed by the Employee. Unless otherwise specified by the Employee, a change in beneficiary will take effect on the date the notice of change is signed. We will not be liable for any action taken before notice is received and recorded at the Home Office.

Claim Review

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

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

Appeals Procedure

Before filing any lawsuit—and no later than 60 days after notice of denial of a claim—the Employee, the Claimant, or an authorized representative of either must appeal any denial of benefits under the Plan by sending a written request for review of the denial to our Home Office.

Legal Action

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

- Within 60 days after the Employee has sent us written Proof of Loss, or
- More than three years from the time written proof is required to be given.

SECTION VII – GENERAL PROVISIONS

Entire Contract Changes

This insurance is provided under a contract of Group Critical Illness insurance with the Policyholder. The entire Contract of Insurance is made up of:

- The Policy;
- The Certificates of insurance;
- The Application of the Policyholder, a copy of which is attached to and made part of the Policy when issued; and

- Any Riders, Endorsements, or Amendments to the Policy or Certificate.

In the absence of fraud, a statement made by the Policyholder or an Insured is considered a representation and not a warranty. A statement made by the Policyholder or an Insured may not be used in any contest under the Plan, unless a copy of the written instrument containing the statement is or has been provided to:

- The person making the statement; or
- If the statement was made by the Insured and the Insured has died or become incapacitated, the Insured's beneficiary or personal representative.

Changes to this Plan:

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

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.

Successor Insured

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

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

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

If the Certificate does not cover a surviving Spouse, the Certificate will terminate from the date of the Employee's death. All unearned premium from the date of the Employee's death will be refunded.

Time Limit on Certain Defenses

After two years from the Employee's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Employee's 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 Certificates

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

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

Required Information

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

Conformity with State Statutes

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

SECTION VIII – INCORPORATION OF RIDER PROVISIONS

The attached listed Certificate Riders are made a part of this Plan.

Rider Name
Specified Disease Rider

Form Number
C22306TX

POLICY SCHEDULE

Group Policyholder:	CITY OF MERCEDES
Group Policy Number:	CTR0015283525
Group Policy Effective Date:	January 1, 2024
Group Policy Anniversary Date:	January 1, 2025
Jurisdiction:	Texas
Face Amount:	See Certificates
Spouse Amount:	See Certificates
Covered Dependent Children:	50.00% of applicable Face Amount
Benefit Percentages:	
Bone Marrow Transplant (Stem Cell Transplant)	100.00% of applicable Face Amount
Cancer (internal or invasive)	100.00% of applicable Face Amount
Coronary Artery Bypass Surgery	100.00% of applicable Face Amount
Heart Attack (Myocardial Infarction)	100.00% of applicable Face Amount
Kidney Failure (End-Stage Renal Failure)	100.00% of applicable Face Amount
Major Organ Transplant	100.00% of applicable Face Amount
Stroke	100.00% of applicable Face Amount
Sudden Cardiac Arrest	100.00% of applicable Face Amount
Type I Diabetes	100.00% of applicable Face Amount
Metastatic Cancer	25.00% of applicable Face Amount
Non-Invasive Cancer	25.00% of applicable Face Amount
Maximum Payable for Additional Diagnosis Benefit:	1 per 6 months
Maximum Payable for Reoccurrence Benefit:	1 per 6 months
Additional Benefits:	
Health Screening Benefit Amount:	\$50.00 per Insured
Maximum per Insured:	1 per Calendar Year
Health Screening Benefit for Covered Dependent Children:	50.00% of Health Screening Benefit Amount
Maximum:	1 per Calendar Year
Skin Cancer:	\$1,000.00
Skin Cancer for Covered Dependent Children:	50.00% of Skin Cancer Benefit Amount
Maximum per Covered Person:	1 per Calendar Year
Waiver of Premium:	Yes

This Plan is delivered in and governed by the laws of the jurisdiction shown above.

This Plan is age-banded. That means Employees' rates may increase on the Group Policy Anniversary Date. Premiums at the Policy Anniversary Date are determined by the Employee's Attained Age rate, as shown in the Policy Schedule of Premiums.

BENEFIT SCHEDULE

Critical Illness Benefits

The applicable benefit amount is payable for the following Critical Illnesses, provided such Critical Illness meets all applicable definitions contained in the Plan and is caused by an underlying disease as set forth herein:

- Bone Marrow Transplant (Stem Cell Transplant)
- Cancer (internal or invasive)
- Coronary Artery Bypass Surgery
- Heart Attack (Myocardial Infarction)
- Kidney Failure (End-Stage Renal Failure)
- Major Organ Transplant
- Non-Invasive Cancer
- Stroke
- Sudden Cardiac Arrest
- Type I Diabetes
- Metastatic Cancer

Additional Benefits

Health Screening Benefit
Skin Cancer Benefit
Waiver of Premium Benefit

Schedule of Premiums

CITY OF MERCEDES - Monthly

Uni Tobacco-Employee				
Issue Age	\$5,000	\$10,000	\$15,000	\$20,000
18- 25	1.97	3.94	5.91	7.88
26 - 30	2.70	5.40	8.11	10.81
31 - 35	3.51	7.02	10.52	14.03
36 - 40	4.60	9.20	13.80	18.40
41 - 45	6.06	12.13	18.19	24.25
46 - 50	8.02	16.04	24.06	32.08
51 - 55	12.50	25.00	37.50	50.00
56 - 60	15.14	30.28	45.42	60.56
61 - 65	24.58	49.17	73.75	98.33
66 +	39.16	78.33	117.49	156.66

Uni Tobacco-Spouse			
Issue Age	\$5,000	\$7,500	\$10,000
18- 25	1.97	2.96	3.94
26 - 30	2.70	4.05	5.40
31 - 35	3.51	5.26	7.02
36 - 40	4.60	6.90	9.20
41 - 45	6.06	9.09	12.13
46 - 50	8.02	12.03	16.04
51 - 55	12.50	18.75	25.00
56 - 60	15.14	22.71	30.28
61 - 65	24.58	36.87	49.17
66 +	39.16	58.75	78.33



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

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

Specified Disease Rider To Certificate of Insurance for Group Critical Illness

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

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

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

The benefits are available to those Insureds designated in the Certificate Schedule. Diagnosis must occur while this Rider is in force.

EFFECTIVE DATE

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

DEFINITIONS

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

Date of Diagnosis is defined for each Specified Disease as follows:

- **Adrenal Hypofunction (Addison's Disease):** The date a Doctor Diagnoses an Insured as having Adrenal Hypofunction and where such Diagnosis is supported by medical records.
- **Cerebrospinal Meningitis:** The date a Doctor Diagnoses an Insured as having Cerebrospinal Meningitis and where such Diagnosis is supported by medical records.
- **Diphtheria:** The date a Doctor Diagnoses an Insured as having Diphtheria based on clinical and/or laboratory findings as supported by medical records.
- **Encephalitis:** The date a Doctor Diagnoses an Insured as having Encephalitis and where such Diagnosis is supported by medical records.
- **Human Coronavirus:** The date a Doctor Diagnoses an Insured as having Human Coronavirus based on laboratory findings as supported by viral testing or a blood test.
- **Huntington's Chorea:** The date a Doctor Diagnoses an Insured as having Huntington's Chorea based on clinical findings as supported by medical records.
- **Legionnaire's Disease:** The date a Doctor Diagnoses an Insured as having Legionnaire's Disease by finding *Legionella* bacteria in a clinical specimen taken from the Insured.
- **Lyme Disease:** The date a Doctor Diagnoses an Insured as having Lyme Disease and where such Diagnosis is supported by medical records.
- **Malaria:** The date a Doctor Diagnoses an Insured as having Malaria and where such Diagnosis is supported by medical records.
- **Muscular Dystrophy:** The date a Doctor Diagnoses an Insured as having Muscular Dystrophy and where such Diagnosis is supported by medical records.
- **Myasthenia Gravis:** The date a Doctor Diagnoses an Insured as having Myasthenia Gravis and where such Diagnosis is supported by medical records.
- **Necrotizing Fasciitis:** The date a Doctor Diagnoses an Insured as having Necrotizing Fasciitis and where such Diagnosis is supported by medical records.
- **Osteomyelitis:** The date a Doctor Diagnoses an Insured as having Osteomyelitis and where such Diagnosis is supported by medical records.
- **Poliomyelitis:** The date a Doctor Diagnoses an Insured as having Poliomyelitis and where such Diagnosis is supported by medical records.

- **Rabies:** The date a Doctor Diagnoses an Insured as having Rabies and where such Diagnosis is supported by medical records.
- **Sickle Cell Anemia:** The date a Doctor Diagnoses an Insured as having Sickle Cell Anemia and where such Diagnosis is supported by medical records.
- **Systemic Lupus:** The date a Doctor Diagnoses an Insured as having Systemic Lupus and where such Diagnosis is supported by medical records.
- **Systemic Sclerosis (Scleroderma):** The date a Doctor Diagnoses an Insured as having Systemic Sclerosis and where such Diagnosis is supported by medical records.
- **Tetanus:** The date a Doctor Diagnoses an Insured as having Tetanus by finding Clostridium tetani bacteria in a clinical specimen taken from the Insured.
- **Tuberculosis:** The date a Doctor Diagnoses an Insured as having Tuberculosis by finding Mycobacterium tuberculosis bacteria in a clinical specimen taken from the Insured.

Adrenal Hypofunction (Addison's Disease) means a disease occurring when the body's adrenal glands do not produce sufficient steroid hormones.

Adrenal Hypofunction does not include secondary and tertiary adrenal insufficiency.

Cerebrospinal Meningitis means a disease resulting in the inflammation of the meninges of both the brain and spinal cord caused by infection from viruses, bacteria, or other microorganisms or from Cancer.

Diphtheria means an infectious disease caused by the bacterium *Corynebacterium diphtheriae* and characterized by the production of a systemic toxin and the formation of a false membrane lining of the mucous membrane of the throat and other respiratory passages, causing difficulty in breathing, high fever, and/or weakness.

Diphtheria can be Diagnosed either through laboratory tests that confirm Diphtheria through a culture obtained from the infected area or through clinical observation of visible symptoms.

Encephalitis means an inflammation of the brain, usually caused by a direct viral infection or a hyper-sensitivity reaction to a virus or foreign protein.

Human Coronavirus means a severe type of virus having a lipid envelope studded with club-shaped spike proteins that infects humans, leading to an upper respiratory infection or Pneumonia, and spread through the air by coughing, sneezing, close personal contact, or touching a contaminated object or surface. This does not include the following Human Coronaviruses: 229E, NL63, OC43, and HKU1.

Huntington's Chorea means a hereditary disease characterized by gradual loss of brain function and voluntary movement due to degenerative changes in the cerebral cortex and basal ganglia.

Legionnaire's Disease means an infectious lung disease caused by species of the aerobic bacteria belonging to the genus *Legionella*.

Lyme Disease means an inflammatory disease caused by bacteria that are transmitted by ticks that is characterized initially by a rash, headache, fever, and chills, and later by possible arthritis and neurological and cardiac disorders.

Malaria means an infectious disease characterized by cycles of chills, fever, and sweating, caused by the bite of an anopheles mosquito infected with a protozoan of the genus *Plasmodium*.

Muscular Dystrophy means a genetic disease that causes progressive weakness and degeneration in the musculoskeletal system and where such muscles are replaced by scar tissue and fat. Muscular Dystrophy is characterized by progressive skeletal muscle weakness, defects in muscle proteins, and the death of muscle cells and tissues.

Myasthenia Gravis means a disease characterized by progressive weakness and exhaustibility of voluntary muscles without atrophy or sensory disturbance and caused by an autoimmune attack on acetylcholine receptors at the neuromuscular junction.

Necrotizing Fasciitis means a severe soft tissue infection by bacteria that is marked by edema and necrosis of subcutaneous tissues with involvement of adjacent fascia and by painful red swollen skin over the affected areas.

Osteomyelitis means an infectious inflammatory disease of the bone that typically results from a bacterial infection and may result in the death of bone tissue.

Poliomyelitis (Polio) means an acute infectious disease caused by the poliovirus and characterized by fever, motor paralysis, and atrophy of skeletal muscles. It often results in permanent disability and deformity, and marked by inflammation of nerve cells in the anterior gray matter in each lateral half of the spinal cord.

Rabies means an acute viral disease of the nervous system caused by a rhabdovirus, which is usually transmitted through the bite of a rabid animal. It is typically characterized by increased salivation, abnormal behavior, and eventual paralysis.

Sickle Cell Anemia means a hereditary disease caused by a genetic blood disorder. It is characterized by red blood cells that assume an abnormal, rigid, sickle shape due to a mutation on the hemoglobin gene.

Systemic Lupus means an autoimmune disease where the body's immune system attacks healthy tissue, leading to long-term inflammation. This disease is primarily characterized by joint pain and swelling.

Systemic Sclerosis (Scleroderma) means a progressive autoimmune disease characterized by the hardening and tightening of the skin and connective tissues.

Tetanus means a disease marked by rigidity and spasms of the voluntary muscles, caused by the bacterium *Clostridium tetani*.

Tuberculosis means an infectious disease caused by *Mycobacterium tuberculosis* bacteria. It is characterized by the growth of nodules in the bodily tissues, as well as by fever, cough, difficulty breathing, caseation, pleural effusions, and fibrosis.

BENEFIT PROVISIONS

Tier I – Specified Disease Benefit: We will pay the Benefit shown on the Rider Schedule if an Insured is Diagnosed with one of the Tier I Specified Diseases listed below, and if the Date of Diagnosis is while this Rider is in force:

- Adrenal Hypofunction
- Cerebrospinal Meningitis
- Diphtheria
- Encephalitis
- Huntington's Chorea
- Legionnaire's Disease
- Lyme Disease
- Malaria
- Muscular Dystrophy
- Myasthenia Gravis
- Necrotizing Fasciitis
- Osteomyelitis
- Poliomyelitis
- Rabies
- Sickle Cell Anemia
- Systemic Lupus
- Systemic Sclerosis (Scleroderma)
- Tetanus
- Tuberculosis

For any subsequent Tier I Specified Disease to be covered, the Date of Diagnosis of the subsequent Tier I Specified Disease must be 6 Months or more after the date the Insured first qualified for any previously paid Tier I Specified Disease Benefit.

Tier II – Specified Disease Benefit: We will pay the Benefit shown on the Rider Schedule if an Insured is Diagnosed with one of the Tier II Specified Diseases listed below. Furthermore, the Date of Diagnosis must be while this Rider is in force.

In order to receive a Tier II Specified Disease Benefit the Insured must be as a direct result of a Tier II Specified Disease. In addition, the Insured must be receiving Treatment for the Tier II Specified Disease for the minimum number of days shown in the Rider Schedule. Only the highest eligible benefit amount shown on the Rider Schedule will be payable under these benefits. In the event a lower benefit amount was previously paid under these benefits for any period of Hospital confinement and that confinement is extended or the Insured is moved to an Intensive Care Unit triggering a higher payment, the difference between the previous paid benefit amount and the new benefit amount will be provided:

- Human Coronavirus

For any subsequent Tier II Specified Disease to be covered, the Date of Diagnosis of the subsequent Tier II Specified Disease must be 6 Months or more after the date the Insured first qualified for any previously paid Tier II Specified Disease Benefit.

This benefit is limited to the maximum shown in the Rider Schedule.

GENERAL PROVISIONS

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.

CONTRACT

This Rider is part of the Critical Illness Certificate. It will terminate when:

- That Certificate terminates, or
- Premiums are no longer paid for this Rider, subject to the Grace Period.

This Rider is subject to all of the terms of the Critical Illness Certificate to which it is attached unless those terms are inconsistent with this Rider.

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary

Benefits

Tier I Specified Disease Benefit:

Adrenal Hypofunction (Addison's Disease)	25.00% of applicable Face Amount
Cerebrospinal Meningitis	25.00% of applicable Face Amount
Diphtheria	25.00% of applicable Face Amount
Encephalitis	25.00% of applicable Face Amount
Huntington's Chorea	25.00% of applicable Face Amount
Legionnaire's Disease	25.00% of applicable Face Amount
Lyme Disease	25.00% of applicable Face Amount
Malaria	25.00% of applicable Face Amount
Muscular Dystrophy	25.00% of applicable Face Amount
Myasthenia Gravis	25.00% of applicable Face Amount
Necrotizing Fasciitis	25.00% of applicable Face Amount
Osteomyelitis	25.00% of applicable Face Amount
Poliomyelitis (Polio)	25.00% of applicable Face Amount
Rabies	25.00% of applicable Face Amount
Sickle Cell Anemia	25.00% of applicable Face Amount
Systemic Lupus	25.00% of applicable Face Amount
Systemic Sclerosis (Scleroderma)	25.00% of applicable Face Amount
Tetanus	25.00% of applicable Face Amount
Tuberculosis	25.00% of applicable Face Amount

Tier II Specified Disease Benefit:

Human Coronavirus	10.00% of applicable Face Amount
Maximum per Insured per Lifetime	1 time



CONTINENTAL AMERICAN INSURANCE COMPANY
Columbia, South Carolina
800.433.3036

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

**Certificate of Insurance For
Group Critical Illness Insurance Policy**

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

This Plan provides benefits for the Critical Illnesses listed in the Benefit Schedule.

Please read it carefully.

This certificate is not a Medicare supplement policy.

NOTICE: This Certificate may be subject to an increase in premium at time of renewal.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

Your Employer (the "Policyholder") applied for coverage under this Group Critical Illness Insurance Policy (the "Plan"). This Plan is issued by Continental American Insurance Company (the "Company," "CAIC," "we," "us," or "our"). For the purposes of this Plan, "you" (including "your" and "yours") refers to you. Based on the application process and the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages.

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

We certify that you are insured under the Group Critical Illness Policy (the "Plan"). The Plan was issued to the Policyholder. This coverage provides benefits for loss resulting from Critical Illness. 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. The Certificate will terminate as provided in the provision titled "Termination of Your Insurance" in Section I. 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, when it becomes effective, automatically replaces any Certificate or Certificates previously issued to you under the Plan.

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

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SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

PRIMARY INSURED

Eligibility

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

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

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

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

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

Effective Date

Your Employee Effective Date is shown on the Certificate Schedule.

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

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

Termination of Your Insurance

Your insurance will terminate on whichever occurs first:

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

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

DEPENDENT COVERAGE

Eligibility

Dependents may be eligible for coverage under this Plan. **You should refer to the Type of Coverage on the Certificate Schedule to determine Dependent eligibility.** A **Dependent** is your Spouse or your Dependent Child (details included in the **Definitions** section). An eligible Spouse must not currently be disabled or unable to work and be at least 18 years of age.

Effective Date

The Effective Date for a Spouse is:

- The date shown on the Certificate Schedule if that Spouse is not confined to a hospital and is eligible for coverage on that date, or
- The first day of the month following the date the Spouse is no longer confined to a hospital (if that Spouse was confined to a hospital on the Certificate Schedule date) and is eligible for coverage on that date.

A Spouse may be added to the Plan after the Employee's Effective Date within 31 days after a Life Event or during an approved enrollment period. To be added, the Employee must complete an Application to add their Spouse to the Plan. The Company will assign the Effective Date for a Spouse's coverage after approving the application. For Spouse coverage to become effective, the Spouse must be included in the premium payment.

The Effective Date for a Dependent Child is:

- The Employee Effective Date, or
- The moment of birth for a newborn child, the date the petition is filed for adoption for adopted children, or the date of the Employee's marriage for step-children.

A day begins at 12:01 a.m. standard time at the Employee's, Spouse's, or Dependent Child's place of residence.

Termination of Dependent Insurance

Dependent Coverage will terminate on the earliest of the following:

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

Plan Termination

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

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

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

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

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

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

Portability Privilege

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

To keep your coverage in force, you must:

- Notify the Company in writing within 31 days after the date your coverage would otherwise terminate. You may notify us by sending written notice to P.O. Box 84079, Columbus, GA 31993-9101 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly to the Company no later than 31 days after the date your coverage would otherwise terminate and on each premium due date thereafter.

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

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

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

Extension of Benefits

If coverage under the Certificate or any Riders that are in force ends while an Insured is confined in a Hospital for a covered Critical Illness, the Company will continue to pay benefits for confinement that become payable after the date coverage under the Certificate or any Riders ends if the Insured meets the following requirements:

- The confinement must be continuous after the date of termination; and
- Coverage must not have ended as a result of the Insured's or, in the case of a Dependent Child or Spouse, the Primary Insured's voluntary termination of coverage.

This Extension of Benefits terminates upon the earliest of the following:

- The date the Insured is no longer confined to a Hospital;
- The date the Insured receives the maximum benefit for being confined to a Hospital; or
- 90 days after the date coverage would otherwise terminate.

Hospital means a place that meets all of the following criteria: Is legally licensed and operated as a hospital, provides overnight care of injured and sick people, is supervised by a Doctor, has full-time nurses supervised by a registered nurse, and has on-site use of X-ray equipment, laboratory, and surgical facilities.

The term Hospital specifically excludes any facility not meeting the definition of Hospital as defined in this Plan, including but not limited to: A nursing home, an extended-care facility, a skilled nursing facility, a rest home or home for the aged, a rehabilitation facility, a facility for the Treatment of alcoholism or drug addiction, or an assisted living facility.

SECTION II – PREMIUM PROVISIONS

Premium Payments

Premiums should be paid to the Company at P.O. Box 84069, Columbus, Georgia, 31908-4069.

The first premiums are 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.

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

Premium Changes

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

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

We will provide the Policyholder a 60-day advance written notice of any change to a premium.

Premiums on the Group Policy Anniversary Date are determined by your Attained Age. The Attained Age rates are shown in the Schedule of Premiums.

Grace Period

This Plan has a 31-day Grace Period. If a 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. If the Plan is discontinued, the Plan's termination date will be the latest date for which premium has been paid.

SECTION III - DEFINITIONS

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

Actively at Work (Active Work) refers to your ability to perform your regular employment duties for a full normal workday. You may perform these activities either at your employer's regular place of business or at a location where you are required to travel to perform the regular duties of your employment.

Acute Coronary Syndrome is an obstruction of the coronary arteries that occurs as a result of Myocardial Infarction with or without ST elevation. This is determined by an electrocardiogram (ECG). Acute Coronary Syndrome includes unstable angina but does not include stable angina.

Arteriosclerosis means a disease of the arteries characterized by plaque deposits on the arteries' inner walls, resulting in their abnormal thickening and loss of elasticity.

Arteriovenous Malformation means a congenital disease of the blood vessels in the brain, brain stem, or spinal cord that is characterized by a complex, tangled web of abnormal arteries and veins and may be connected by one or more fistulas.

Atherosclerosis means a disease in which plaque builds up inside a person's arteries.

Attained Age means your age on your Certificate Effective Date and on each Group Policy Anniversary Date thereafter.

Bone Marrow Transplant (Stem Cell Transplant) means a procedure to replace damaged or destroyed bone marrow with healthy bone marrow stem cells. For a benefit to be payable, a Bone Marrow Transplant (Stem Cell Transplant) must be caused by at least one of the following diseases:

- Aplastic anemia
- Congenital neutropenia
- Severe immunodeficiency syndromes
- Sickle cell anemia
- Thalassemia
- Fanconi anemia
- Leukemia
- Lymphoma
- Multiple myeloma

The Bone Marrow Transplant (Stem Cell Transplant) benefit is not payable if the Transplant results from a covered Critical Illness for which a benefit has been paid under this Plan.

Brain Aneurysm is a weak area in the wall of a blood vessel of the brain that causes the blood vessel to bulge, balloon out, or rupture.

Cancer (internal or invasive) is a disease that meets either of the following definitions:

- A malignant tumor characterized by:
 - The uncontrolled growth and spread of malignant cells, and
 - The invasion of distant tissue.
- A disease meeting the diagnostic criteria of malignancy, as established by the American Board of Pathology. A Pathologist must have examined and provided a report on the histocytologic architecture or pattern of the tumor, tissue, or specimen.

Cancer (internal or invasive) also includes:

- Melanoma that is Clark's Level III or higher **or** Breslow depth equal to or greater than 0.77mm,
- Myelodysplastic syndrome - RCMD (refractory cytopenia with multilineage dysplasia),
- Myelodysplastic syndrome - RAEB (refractory anemia with excess blasts),
- Myelodysplastic syndrome - RAEB-T (refractory anemia with excess blasts in transformation), or
- Myelodysplastic syndrome - CMML (chronic myelomonocytic leukemia).

The following are **not** considered internal or invasive Cancers:

- Pre-malignant tumors or polyps
- Carcinomas in Situ
- Any superficial, non-invasive Skin Cancers including basal cell and squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is Diagnosed as
 - Clark's Level I or II,
 - Breslow depth less than 0.77mm, **or**
 - Stage 1A melanomas under TNM Staging
- Metastatic Cancer

Carcinoma in Situ is Non-Invasive Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

Melanoma in Situ means melanoma cells that occur only on the outer layer of the skin (the epidermis), where there is no invasion of the deeper layer (the dermis).

Non-Invasive Cancer is a Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

For the purposes of this Plan, a Non-Invasive Cancer is:

- Internal Carcinoma in Situ
- Myelodysplastic Syndrome - RA (refractory anemia)
- Myelodysplastic Syndrome - RARS (refractory anemia with ring sideroblasts)
- Myeloproliferative Blood Disorder

Premalignant conditions or conditions with malignant potential, other than those specifically named above, are **not** considered Non-Invasive Cancer.

Skin Cancer, as defined in this Plan, is **not** considered Non-Invasive Cancer and is therefore not payable under the Non-Invasive Cancer benefit.

Skin Cancer is a Cancer that forms in the tissues of the skin.

The following are considered Skin Cancers:

- Basal cell carcinoma
- Squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is Diagnosed as
 - Clark's Level I or II,
 - Breslow depth less than 0.77mm, or

- o Stage 1A melanomas under TNM Staging

These conditions are not payable under the Cancer (internal or invasive) benefit.

Cancer, Non-Invasive Cancer, Metastatic Cancer or Skin Cancer must be Diagnosed in one of two ways:

1. **Pathological Diagnosis** is a Diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This Diagnosis must be made by a certified Pathologist and conform to the American Board of Pathology standards.
2. **Clinical Diagnosis** is based only on the study of symptoms. The Company will accept a Clinical Diagnosis only if:
 - A Doctor cannot make a Pathological Diagnosis because it is medically inappropriate or life-threatening,
 - Medical evidence exists to support the Diagnosis, and
 - A Doctor is treating the Insured for Cancer or Carcinoma in Situ.

Cardiomyopathy means a disease with measurable deterioration of the function of the myocardium, and is typically characterized by breathlessness and swelling of the legs.

Chronic Kidney Disease means a disease characterized by the gradual loss in renal function over time due to diabetes mellitus, Hypertension, glomerulonephritis, polycystic kidney disease, autoimmune disease, or genetic disease.

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

Complete Remission is defined as having no Symptoms and no Signs that can be identified to indicate the presence of Cancer.

Coronary Artery Bypass Surgery means open heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts and where such narrowing or blockage is attributed to Coronary Artery Disease or Acute Coronary Syndrome. This excludes any non-surgical procedure, such as, but not limited to, balloon angioplasty, laser relief, or stents.

Coronary Artery Disease occurs when the coronary arteries become damaged due to acute coronary occlusion, coronary atherosclerosis, aneurysm and/or dissection of the coronary arteries, or coronary atherosclerosis due to lipid rich plaque.

Critical Illness is a disease or a sickness as defined in the Plan that first manifests while your coverage is in force.

Any loss due to Critical Illness must begin while your coverage is in force. Critical Illness includes only the following, provided such Critical Illness meets all applicable definitions contained in the Plan and, where indicated, is caused by an underlying condition:

- Bone Marrow Transplant (Stem Cell Transplant)
- Cancer (internal or invasive)
- Coronary Artery Bypass Surgery
- Heart Attack (Myocardial Infarction)
- Kidney Failure (End-Stage Renal Failure)
- Major Organ Transplant
- Non-Invasive Cancer
- Stroke
- Sudden Cardiac Arrest
- Type I Diabetes
- Metastatic Cancer

Date of Diagnosis is defined as follows:

- **Bone Marrow Transplant (Stem Cell Transplant):** The date the surgery occurs.
- **Cancer:** The day tissue specimens, blood samples, or titer(s) are taken (Diagnosis of Cancer and/or Carcinoma in Situ is based on such specimens).
- **Coronary Artery Bypass Surgery:** The date the surgery occurs.

- **Heart Attack (Myocardial Infarction):** The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the Heart Attack (Myocardial Infarction) definition.
- **Kidney Failure (End-Stage Renal Failure):** The date a Doctor recommends that an Insured begin renal dialysis.
- **Major Organ Transplant:** The date the surgery occurs.
- **Metastatic Cancer:** The date a Doctor determines Cancer has metastasized to other parts of the body from the original site.
- **Non-Invasive Cancer:** The day tissue specimens, blood samples, or titer(s) are taken (Diagnosis of Cancer and/or Carcinoma in Situ is based on such specimens).
- **Skin Cancer:** The date the skin biopsy samples are taken for microscopic examination.
- **Stroke:** The date the Stroke occurs (based on documented neurological deficits and neuroimaging studies).
- **Sudden Cardiac Arrest:** The date the pumping action of the heart fails (based on the Sudden Cardiac Arrest definition).
- **Type I Diabetes:** The date a Doctor Diagnoses an Insured as having Type I Diabetes based on clinical and/or laboratory findings as supported by medical records.

Dependent Children are your or your Spouse's natural children, step-children, grandchildren who are your dependents for federal income tax purposes at the time the application for coverage of the grandchild is made, foster children, children subject to legal guardianship, adopted children, children for whom you are required to provide medical support, or Children Placed for Adoption, who are younger than age 26. However, we will continue coverage for Dependent Children insured under the Plan after the age of 26 if they are incapable of self-sustaining employment due to mental or physical disability, and are chiefly dependent on a parent for support and maintenance. You or your Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday.

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

Children Placed for Adoption are Children for whom you have entered a decree of adoption, have initiated adoption proceedings, or are party to a suit in which you seek to adopt the child. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court.

Diagnosis (Diagnosed) refers to the definitive and certain identification of an illness or disease that:

- Is made by a Doctor and
- Is based on clinical or laboratory investigations, as supported by your medical records.

The illness must meet the requirements outlined in this Plan for the particular Critical Illness being Diagnosed.

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

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

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

Family Member includes your Spouse as well as the following members of your immediate family:

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

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

Heart Attack (Myocardial Infarction) is the death of a portion of the heart muscle (myocardium) caused by a blockage of one or more coronary arteries due to Coronary Artery Disease or Acute Coronary Syndrome.

Heart Attack (Myocardial Infarction) does not include:

- Any other disease or injury involving the cardiovascular system.
- Cardiac Arrest not caused by a Heart Attack (Myocardial Infarction).

Diagnosis of a Heart Attack (Myocardial Infarction) must include the following:

- New and serial electrocardiographic (ECG) findings consistent with Heart Attack (Myocardial Infarction), and
- Elevation of cardiac enzymes above generally accepted laboratory levels of normal. (In the case of creatine phosphokinase (CPK) a CPK-MB measurement must be used.)

Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms may also be used.

Hypertension means a disease that is characterized by elevated blood pressure in the arteries with a systolic reading of at least 140 mmHg and a diastolic reading of at least 90 mmHg.

Kidney Failure (End-Stage Renal Failure) means end-stage renal failure caused by End-Stage Renal Disease, which results in the chronic, irreversible failure of both kidneys to function.

Kidney Failure (End-Stage Renal Failure) is covered only under the following conditions:

- A Doctor advises that regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) is necessary to treat the Kidney Failure (End-Stage Renal Failure); or
- The Kidney Failure (End-Stage Renal Failure) results in kidney transplantation.

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

Maintenance Drug Therapy is a course of systemic medication given to a patient after a Cancer goes into Complete Remission because of primary Treatment. Maintenance Drug Therapy includes ongoing hormonal therapy, immunotherapy, or chemo-prevention therapy. Maintenance Drug Therapy is meant to decrease the risk of Cancer recurrence; it is not meant to treat a Cancer that is still present.

Major Organ Transplant means undergoing surgery as a recipient of a covered transplant of a human heart, lung, liver, kidney, or pancreas. A transplant must be caused by one or more of the following diseases:

- Bronchiectasis, which is a lung disease state defined by localized, irreversible dilation of the bronchial tree caused by destruction of the muscle and elastic tissue.
- Cardiomyopathy, which is a heart disease characterized by the measurable deterioration of the function of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid.
- Cirrhosis, which is a liver disease characterized by replacement of liver tissue by fibrosis, scar tissue, and regenerative nodules, leading to loss of liver function.
- Chronic obstructive pulmonary disease, which is a lung disease characterized by persistently poor airflow as a result of breakdown of lung tissue and dysfunction of the small airways.
- Congenital Heart Disease, which is heart disease characterized by abnormalities in cardiovascular structures that occur before birth.
- Coronary Artery Disease
- Cystic fibrosis, which is a hereditary disease of the exocrine glands affecting the pancreas, respiratory system, and sweat glands. It is characterized by the production of abnormally viscous mucus by the affected glands.
- Hepatitis, which is a disease caused by the hepatitis A, B, or C virus and is characterized by the inflammation of the liver.

- Interstitial lung disease, which is a lung disease that affects the interstitium of the lungs.
- Lymphangiomyomatosis, which is a lung disease characterized by an indolent, progressive growth of smooth muscle cells throughout the lungs, pulmonary blood vessels, lymphatics, and pleurae.
- Polycystic liver disease, which is characterized by multiple variable-sized cysts lined by cuboidal epithelium.
- Pulmonary fibrosis, which is a lung disease where the lung tissue becomes thickened, stiff, and scarred due to chronic inflammation.
- Pulmonary hypertension, which is a disease characterized by increased pressure in the pulmonary artery and results in the thickening of the pulmonary arteries and the narrowing of these blood vessels, which causes the right side of the heart to become enlarged.
- Sarcoidosis, which is a disease characterized by the growth of granulomatous lesions that appear in the body.
- Valvular heart disease, which is a disease of the heart valves.

If, while the Certificate in force, the Insured is placed on a transplant list for a Major Organ Transplant due to one of the above-identified diseases, we will pay 25% of the Critical Illness benefit. The remainder of the Critical Illness benefit will become payable on the date the surgery occurs. A Major Organ Transplant benefit is not payable if the Major Organ Transplant results from a covered Critical Illness for which a benefit has been paid.

Malignant Hypertension is blood pressure that is so high that it actually causes damage to organs, particularly in the nervous system, the cardiovascular system, and/or the kidneys. One type of such damage is called papilledema, a condition in which the optic nerve leading to the eye becomes dangerously swollen, threatening vision.

Metastatic Cancer means a Cancer (internal or invasive) that has spread from the part of the body where it was first formed to other parts of the body. This occurs when cancer cells break away from the original tumor, travel through the blood or lymph system, and form new tumors in other organs or tissues of the body. When this occurs, the new metastatic tumor is the same type of Cancer as the original tumor even though located in a different area of the body.

Pathologist is a Doctor who is:

- Licensed to practice medicine, and
- Licensed by the American Board of Pathology to practice pathologic anatomy.

A Pathologist also includes an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Signs and/or Symptoms are the evidence of disease or physical disturbance observed by a Doctor or other medical professional. The Doctor (or other medical professional) must observe these Signs while acting within the scope of their license.

Spouse is your legal wife or husband who is listed on your Application.

Stroke means apoplexy due to rupture or acute occlusion of a cerebral artery. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. Stroke must be either:

- **Ischemic:** Due to advanced Arteriosclerosis or Arteriosclerosis of the arteries of the neck or brain, or vascular embolism, or
- **Hemorrhagic:** Due to uncontrolled Hypertension, Malignant Hypertension, Brain Aneurysm, or Arteriovenous Malformation.

The Stroke must be positively Diagnosed by a Doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

Stroke does not include:

- Transient Ischemic Attacks (TIAs)
- Head injury
- Chronic cerebrovascular insufficiency

- Reversible ischemic neurological deficits unless brain tissue damage is confirmed by neurological imaging

Stroke will be covered only if the Insured submits evidence of the neurological damage by providing:

- Computed Axial Tomography (CAT scan) images, or
- Magnetic Resonance Imaging (MRI).

Sudden Cardiac Arrest is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to Coronary Artery Disease, Cardiomyopathy, or Hypertension.

Sudden Cardiac Arrest is not a Heart Attack (Myocardial Infarction). A Sudden Cardiac Arrest benefit is not payable if the Sudden Cardiac Arrest is caused by or contributed to by a Heart Attack (Myocardial Infarction).

Transient Ischemic Attack (TIA) occurs when blood flow to part of the brain is temporarily blocked or reduced. For a benefit to be payable, the TIA must be caused by one or more of the following diseases:

- Advanced Arteriosclerosis
- Arteriosclerosis of the arteries of the neck or brain
- Vascular embolism
- Hypertension
- Malignant Hypertension
- Brain Aneurysm
- Arteriovenous Malformation.

The TIA must be positively Diagnosed by a Doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

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.

Treatment-Free From Cancer refers to the period of time without the consultation, care, or services provided by a Doctor. This includes receiving diagnostic measures and taking prescribed drugs and medicines. Treatment does not include Maintenance Drug Therapy or routine follow-up visits to verify whether Cancer or Carcinoma in Situ has returned.

Type I Diabetes means a form of diabetes mellitus causing total insulin deficiency of an Insured along with continuous dependence on exogenous insulin in order to maintain life. Type I Diabetes excludes Gestational Diabetes and Prediabetes.

SECTION IV - BENEFIT PROVISIONS

The benefit amounts payable under this section are shown in the Certificate Schedule. The Company will pay benefits for a Critical Illness in the order the events occur.

Critical Illness Benefit

Initial Diagnosis Benefit

We will pay the Critical Illness benefit when an Insured is Diagnosed with one of the Critical Illnesses shown in the Benefit Schedule, and when such Diagnosis is caused by or solely attributed to an underlying disease as identified herein. We will pay this benefit if:

- The initial Date of Diagnosis is while the Insured's coverage is in force, and
- The Certificate does not exclude the illness or condition by name or by specific description.

Employee

Benefits will be based on the Face Amount in effect on the Critical Illness Date of Diagnosis.

Additional Diagnosis Benefit

Once benefits have been paid for a Critical Illness, the Company will pay benefits for each different Critical Illness when the Date of Diagnosis for the new Critical Illness is separated from the prior, different Critical Illness by at least 6 consecutive months and the new Critical Illness is not caused or contributed by a Critical Illness for which benefits have been paid.

Reoccurrence Benefit

Once benefits have been paid for a Critical Illness, benefits are payable for that same Critical Illness when the Date of Diagnosis for the Reoccurrence of that Critical Illness is separated from the prior occurrence of that Critical Illness by at least 6 consecutive months and the Critical Illness is not caused or contributed by a Critical Illness for which benefits have been paid.

Non-Invasive Cancer Benefit

We will pay the amount shown in the Certificate Schedule for the Diagnosis of a Non-Invasive Cancer. This benefit is payable in addition to all other applicable benefits.

Metastatic Cancer Benefit

We will pay the amount shown in the Policy Schedule for the Diagnosis of a Metastatic Cancer.

Additional Benefits

Additional Benefits are payable if the Date of Diagnosis is while the Insured's coverage is in force, and the Certificate does not exclude the illness or condition by name or by specific description.

Skin Cancer Benefit

We will pay the amount shown in the Certificate Schedule for the Diagnosis of Skin Cancer. This benefit is payable 1 per calendar year.

Health Screening Benefit

We will pay the amount shown in the Certificate Schedule for Health Screening Tests performed while an Insured's coverage is in force. This benefit is payable 1 per calendar year, per Insured up to the maximum shown on the Certificate Schedule. Benefits are payable for Covered Dependent Children at 50.00% of the Employee benefit amount.

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

Health Screening Tests include, but are not limited to, the following:

- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Non-diagnostic vascular screening
- DNA stool analysis
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test to determine level of HDL and LDL
- Serum protein electrophoresis (blood test for myeloma)
- Spiral CT screening for lung cancer
- Stress test on a bicycle or treadmill
- Thermography
- HIV test performed via nucleic acid test (NAT)
- HPV test performed via Pap smear
- Biopsies
- Genetic Screening Test performed in a medical facility
- Human Coronavirus test
- Dental Exams
- Vision Exams
- Immunizations
- Mental Health Screening

Waiver of Premium Benefit

If you become Totally Disabled as defined in this Plan due to a covered Critical Illness, we will waive premiums for you and any currently covered Dependents (this includes any Riders that are in force).

Total Disability or **Totally Disabled** means you are completely unable to perform all the substantial and material duties and functions of your occupation and any other gainful occupation in which you earn substantially the same compensation earned before the disability.

After 90 days of Total Disability, all Plan premiums will be waived if:

- Your Total Disability began before your age of 65;
- Your Total Disability has continued without interruption for at least 90 days, during which time you and/or the Policyholder have paid premiums; and
- You provide proof of Total Disability as required by us. Satisfactory Proof of Loss for Total Disability must be provided at least once every 12 months.

Pending our approval of a claim for the Waiver of Premium Benefit, premiums should be paid as they are due. Premiums that were paid for the first 90 days of Total Disability will be refunded after your claim for this benefit is approved.

Waiver of Premium will continue until the earliest of the following:

- The premium due date following your 65th birthday,
- The date the Company has waived premiums for a total of 24 months of Total Disability,
- The date you refuse to provide proof of continuing Total Disability,
- The date your Total Disability ends, or
- The date coverage ends according to the Termination provisions in **Section I – Eligibility, Effective Date, and Termination.**

If you are still eligible for coverage when you return to Active Work, coverage for any Insured may be continued if premium payments are resumed.

SECTION V – EXCLUSIONS

Exclusions

We will not pay for loss due to any of the following:

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured
- **Suicide** – committing or attempting to commit suicide, while sane or insane
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job

- **Participation in Aggressive Conflict** of any kind, including:
 - o War (declared or undeclared) or military conflicts
 - o Insurrection or riot
 - o Civil commotion or civil state of belligerence
- **Illegal substance abuse, which includes the following:**
 - o Abuse of legally-obtained prescription medication
 - o Illegal use of non-prescription drugs
- An error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure
- Diagnosis of a Critical Illness made by a Family Member.

SECTION VI – CLAIM PROVISIONS

Notice of Claim

Written notice of claim must be given to us:

- Within 60 days after the Date of Diagnosis, or
- As soon as reasonably possible.

When we receive written Notice of Claim, we will send a claim form. If the Claimant does not receive the claim form within 15 days after the notice is sent, written Proof of Loss can be sent to us without waiting for the form. Notice must include your name and Certificate number. Notice can be mailed to the Company at:

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

Failure to give notice within the time prescribed does not invalidate or reduce any claim if it was not reasonably possible to give the notice within that time and notice was given as soon as was reasonably possible.

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. It includes a statement by the treating Doctor.) Proof of Loss establishes the nature and extent of the loss, the Company's obligation to pay the claim, and the Claimant's right to receive payment.

The Claimant must provide Proof of Loss to the Company at:

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

Proof of Loss must be given to us within 90 days of the Date of Diagnosis. Failure to give Proof of Loss within such time shall not invalidate or reduce any claim if such Proof of Loss is given as soon as reasonably possible. The Company will not accept Proof of Loss any later than one year and three months after the Date of Diagnosis, except in the absence of the Claimant's legal mental capacity.

The Claimant will be responsible for the cost of obtaining a completed claim form. We may request additional Proof of Loss, such as records from hospitals or Doctors. The Claimant will be responsible for the cost of obtaining these records.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

When we receive the claim and due Proof of Loss, we will review the Proof of Loss. If we approve the claim, we will pay the benefits subject to the terms of the Certificate.

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 exams or autopsy.

Prompt Payment of Benefits

For benefits other than for loss of time, the Company will, once we receive the required Proof of Loss, pay, deny, or settle each submitted claim not later than the 60th day after the date Proof of Loss is received. Subject to written Proof of Loss, all accrued benefits payable under the policy for loss of time will be paid at least monthly during the period for which the insurer is liable. Any balance remaining unpaid at the end of that time will be paid as soon as possible after the Proof of Loss is received.

Payment of Claims

We will pay all benefits to you unless otherwise assigned. For any benefits that remain unpaid at the time of death, we will pay those benefits in the following order:

- To your beneficiary or the beneficiary's assignee,
- To your surviving Spouse,
- To your estate.

Special Rules for the Payment of Claims for Dependent Children

When required by law, We will provide for benefits payable for a Dependent Child to be paid to the Texas Health and Human Services Commission if such agency paid, through medical assistance, for the treatment received by the Dependent Child for a Covered Condition.

When required by law, We will provide for benefits payable for a Dependent Child to be paid to the Dependent Child's possessory or managing conservator if that individual:

1. provides a written notice that the individual is a possessory or managing conservator of the Dependent Child on whose behalf the claim is made; and
2. provides a certified copy of a court order designating the individual as possessory or managing conservator of the Dependent Child or other relevant evidence.

Unpaid Premium

When a claim is paid, we may deduct any premium due and unpaid from the claim payment.

Changing of Beneficiary

A change in beneficiary must be submitted in writing to our Home Office in a form acceptable to us and signed by you. Unless otherwise specified by you, a change in beneficiary will take effect on the date the notice of change is signed. We will not be liable for any action taken before notice is received and recorded at the Home Office.

Claim Review

If a claim is denied, you will be given written notice of:

- The reason for the denial,
- The Plan provision that supports the denial, and
- Your right to ask for a review of the claim.

Appeals Procedure

Before filing any lawsuit—and no later than 60 days after notice of denial of a claim—you, the Claimant, or an authorized representative of either must appeal any denial of benefits under the Plan by sending a written request for review of the denial to our Home Office.

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 three years from the time written proof is required to be given.

SECTION VII – GENERAL PROVISIONS

Entire Contract Changes

Your insurance is provided under a contract of Group Critical Illness insurance with the Policyholder. The entire Contract of Insurance is made up of:

- The Policy;
- The Certificate of insurance;
- The Application of the Policyholder, a copy of which is attached to and made part of the Policy when issued; and

- Any Riders, Endorsements, or Amendments to the Policy or Certificate.

In the absence of fraud, a statement made by the Policyholder or an Insured is considered a representation and not a warranty. A statement made by the Policyholder or an Insured may not be used in any contest under the Plan, unless a copy of the written instrument containing the statement is or has been provided to:

- The person making the statement; or
- If the statement was made by the Insured and the Insured has died or become incapacitated, the Insured's beneficiary or personal representative.

Changes to this Plan:

- Will not be valid unless approved in writing by an officer of the Company,
- Must be noted on or attached to the Contract, and
- May not be made by any insurance agent (nor can an agent waive any Plan provisions).

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.

Successor Insured

If you die while covered under this Certificate and your Spouse is also insured under this Plan at the time of your death, then your surviving Spouse may elect to become the Primary Insured at the current Spouse Face Amount. This would include continuation of any Dependent Child coverage that is in force at that time.

To become the Primary Insured and keep coverage in force, your surviving Spouse must:

- Notify the Company in writing within 31 days after the date of your death; and
- Pay the required premium to the Company no later than 31 days after the date of your death, and on each premium due date thereafter.

If the Certificate does not cover a surviving Spouse, the Certificate will terminate from the date of your death. All unearned premium from the date of your death will be refunded.

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 Certificates

The Company will give the Policyholder a Certificate for each Employee. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, and
- The rights and privileges under the Plan.

Required Information

The Policyholder will be responsible for furnishing all information and proofs that the Company may reasonably require with regard to the Plan.

Conformity with State Statutes

This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes.

BENEFITS SCHEDULE

Critical Illness Benefits

The applicable benefit amount is payable for the following Critical Illnesses, provided such Critical Illness meets all applicable definitions contained in the Plan and is caused by an underlying disease as set forth herein:

- Bone Marrow Transplant (Stem Cell Transplant)
- Cancer (internal or invasive)
- Coronary Artery Bypass Surgery
- Heart Attack (Myocardial Infarction)
- Kidney Failure (End-Stage Renal Failure)
- Major Organ Transplant
- Non-Invasive Cancer
- Stroke
- Sudden Cardiac Arrest
- Type I Diabetes
- Metastatic Cancer

Additional Benefits

Health Screening Benefit
Skin Cancer Benefit
Waiver of Premium Benefit



Thank you for choosing Continental American Insurance Company

1.800.433.3036

www.aflacgroupinsurance.com

Your Group Policy Number is:

CTR0015283525

Product:

Disability Insurance

Your Policy is Effective :

01/01/2024

Your State of Issue is:

Texas


CITY OF MERCEDES
400 S OHIO AVE
MERCEDES TX 78570-3120

MPMAIL



March 14, 2024

CITY OF MERCEDES
400 S OHIO AVE
MERCEDES TX 78570-3120

**Re: Your CITY OF MERCEDES Group Disability Insurance Coverage
Policy No.: CTR0015283525**

Welcome to the Aflac family!

Thank you so much for adding Aflac coverage in your employee benefits offering. We take commitments to our accounts very seriously and promise to be there when you and your employees need us. Enclosed, you'll find:

A Master Policy packet for the Aflac group plan you've chosen to make available to your employees. Each packet includes:

- A master policy, which indicates your group coverage effective date and other coverage details,
- A copy of your master application, **and**
- A copy of your employees' coverage certificate. **(We'll let employees know they can request copies of their certificates from you, so please be sure to make the coverage documents available. Of course, employees are also welcome to call us directly to request copies of their certificates.)**

If you have any questions about your group plan or your employees' coverage, please reach out to your account manager, or give us a call at 1.866.319.8089 Monday through Friday, from 9 a.m. to 7 p.m. Eastern time.

Again, welcome to the Aflac family!

MPCOVLET_A

Continental American Insurance Company • Columbia, South Carolina • 1.800.433.3036 toll-free

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 New York, group coverage is underwritten by American Family Life Assurance Company of New York (22 Corporate Woods Boulevard, Suite 2, Albany, New York 12211), and customer service is administered by CAIC.

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
 - o Up to \$500,000 for health benefit plans, with some exceptions.
 - o Up to \$300,000 for disability income benefits.
 - o Up to \$300,000 for long-term care insurance benefits.
 - o Up to \$200,000 for all other types of health insurance.
- **Life insurance:**
 - o Up to \$100,000 in net cash surrender or withdrawal value.
 - o Up to \$300,000 in death benefits.
- **Individual annuities:** Up to \$250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to \$300,000 per person, regardless of the number of policies or contracts. A limit of \$500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

<p>To learn more about the Association and your protections, contact:</p> <p>Texas Life and Health Insurance Guaranty Association 1601 Congress Avenue Austin, TX 78701 1-800-982-6362 or www.txlifega.org</p>	<p>For questions about insurance, contact:</p> <p>Texas Department of Insurance P.O. Box 149104 Austin, TX 78714-9104 1-800-252-3439 or www.tdi.texas.gov</p>
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Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
1.800.433.3036

GROUP SHORT-TERM DISABILITY INSURANCE POLICY

This coverage only pays benefits for short-term Disability as listed in the Benefit Schedule of this Policy. Benefits are paid for short-term Disability caused by Sickness or Off-the-Job Injury. This Policy does not provide benefits for any other Sickness or condition.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

IF THE INSURED HAS ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

CITY OF MERCEDES (the "Policyholder") applied for coverage under this Group Short-Term Disability 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. (Please note that male pronouns--such as *he*, *him*, and *his*--are used for both males and females, unless the context clearly shows otherwise.)

You will notice that certain words and phrases (including some medical terms and the names of Plan documents) in this document are capitalized. These refer to terms with very specific definitions as they apply to this insurance Plan.

**This is a limited Plan. Please read it carefully.
This policy is not a Medicare supplement policy.**

This Plan becomes effective on the Effective Date at 12:01 a.m., as determined by the Policyholder's address. Plan Termination is governed by Section I. The Plan continues to be effective while premiums are paid, as provided in Section II.

The Plan's first Anniversary Date appears below. Subsequent anniversaries will be the same date each following year.

The Policyholder may add new Employees from time to time, according to the Plan's terms.

This Plan is a legal contract between the Company and the Policyholder. All material printed by the Company on the following pages is part of the Plan. This Plan is delivered in and governed by the laws of the jurisdiction shown below.

In witness whereof, the Company executes this Plan at its home office in Columbia, South Carolina, on the Effective Date.

Signed for the Company at its Home Office.



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary

Group Policy Number CTR0015283525
Effective Date January 1, 2024
Jurisdiction Texas

Anniversary Date January 1, 2025
Non-Participating

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Section I - Eligibility, Effective Date, Termination, and Continuation Privilege

Eligibility

A person is an eligible Employee under this Plan if he meets **all** the following requirements:

- He is an Employee of the Policyholder's.
- He is engaged in full or part-time work.
- He is included in the class of Employees eligible for coverage, as shown on the Application.

Effective Date

The Plan's Effective Date is shown on Page 1.

An Employee's Effective Date is the date his insurance takes effect. That date is **one of** the two following dates:

- The date that is shown on the Certificate Schedule if the Employee is Actively at Work on that date.
- The date the Employee returns to an Actively-at-Work status if he is not Actively at Work on the date that is 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 Policy year. To do this, the Company must give 31 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 Employees of the Plan's termination. If the Plan terminates, it—and all Certificates 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 ends, we will provide coverage for claims arising from Disabilities that were first diagnosed while the Plan was in force.

Termination of an Employee's Insurance

An Employee's 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 he no longer meets the Plan's definition of an Employee.
- The date he no longer belongs to an eligible class.

If an Insured's coverage ends, we will provide coverage for claims arising from short-term Disability that was first diagnosed while his coverage was in force.

Continuation Privilege

When an Employee ends employment with the Policyholder and his coverage would otherwise end, that Employee may choose to continue his coverage under this Plan. The Employee may continue the coverage that he had on the date his employment ended.

To keep his Certificate in force, the Employee must meet the following three requirements:

- He must apply to the Company in writing within 31 days after the date his insurance would otherwise terminate.
- He must pay the required premium — the premium in effect at the time of port — to the Company no later than 31 days after the date the Certificate would otherwise terminate and on each premium due date thereafter.
- He must be engaged in full or part-time work.

Coverage will end:

- 31 days after the date the Employee fails to pay any required premium, **or**
- The date this Group Plan is terminated, whichever occurs first.

If an Employee qualifies for this Continuation Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate as shown in his previously issued Certificate.

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 each year. The Company will give the Policyholder written notice 60 days before any change in rates becomes effective.

Premium Payments

The first premiums are 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:

Actively at Work refers to an Insured's ability to perform his regular employment duties for a full normal workday. The Insured may perform these activities either at his employer's regular place of business or at a location where the Insured may be required to travel to perform the regular duties of his employment.

Base Annual Pay is the Employee's annual income from his Job with the Policyholder. This pay excludes overtime pay, bonuses, or any other special pay.

Benefit Period is the maximum number of days *after* the Elimination Period, if any, for which the Insured can be paid benefits for any Period of Disability. Each new Benefit Period is subject to a new Elimination Period. See the Benefit Schedule for the Benefit Period.

For the purposes of this calculation, a "month" is defined as 30 days for which benefits are paid.

Complications of Pregnancy refers to:

- Conditions requiring Medical Treatment that comes before or comes after the termination of a pregnancy. The diagnoses for this Medical Treatment must be distinct from pregnancy but either adversely affected by pregnancy or caused by pregnancy. For a condition to be a Complication of Pregnancy, it must constitute a classifiably distinct pregnancy complication. Examples of such Complications of Pregnancy are:
 - o Acute nephritis,
 - o Nephrosis,
 - o Cardiac decompensation,
 - o Missed abortion,
 - o Disease of the vascular, hemopoietic, nervous, or endocrine systems, and
 - o Similar medical and surgical conditions of comparable severity.
- Further Complications of Pregnancy include:
 - o Hyperemesis gravidarum and pre-eclampsia requiring hospital confinement,
 - o Ectopic pregnancy that is terminated, and
 - o Spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy *do not include* the following conditions:

- multiple gestation pregnancy.
- false labor.
- occasional spotting.
- morning sickness.

Complications of Pregnancy do not include other similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

Elective cesarean deliveries are not considered Complications of Pregnancy.

Daily Disability Benefit is one-thirtieth of the applicable monthly Disability benefit shown on the Benefit Schedule.

Disability

- **Total Disability** refers to the Insured's being under the care and attendance of a Doctor due to a condition that causes his inability to perform the material and substantial duties of his Job with the employer. To qualify as Total Disability, the Insured may not be working at any job.
- **Partial Disability** refers to the Insured's being under the care and attendance of a Doctor due to a condition that causes his inability to perform the material and substantial duties of his Job. To qualify as Partial Disability, the Insured is able to work at any job earning less than **80.00%** of the Base Annual Pay of his Job at the time he became disabled.

Doctor is defined as a person who meets **all** the following criteria:

- A person who is legally qualified to practice medicine.
- A person who is licensed as a physician by the state where Treatment is received.

A Doctor does **not** include the Insured or the Insured's Family Member.

Elimination Period is the number of continuous days at the beginning of the Insured's Period of Disability for which no benefits are payable. See the Benefit Schedule for the Elimination Period. Each new Benefit Period is subject to a new Elimination Period.

Employee is a person who meets eligibility requirements under **Section I – Eligibility**, and who is covered under this Plan. The Employee is the Insured under this Plan.

Family Member includes anyone related to the Insured in the following manner: spouse, brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren, father- or mother-in-law, as applicable.

Full-Time Job refers to a job at which the Insured works, performing his occupational duties for pay or benefits, for the required number of hours per week. This requirement appears under the Eligibility section of the Benefit Schedule.

Injury refers to an Off-the-Job bodily injury not otherwise excluded. An Injury meets **all** the following criteria:

- It is directly caused by a covered accident.
- It is not caused by Sickness, disease, bodily infirmity, or any other cause.
- It occurs on or after the Effective Date of coverage and while coverage is in force.

Insured means the eligible person whose coverage under the Certificate becomes effective. The Insured is named on his Certificate Schedule. The Insured is always the covered eligible Employee under an employer group Policy.

Medically Necessary refers to Treatment, services, or supplies that are necessary and appropriate for the diagnosis or Treatment of a Sickness or an Injury based upon generally accepted medical practice.

Mental Illness is defined as a Total Disability resulting from psychiatric or psychological conditions, regardless of cause. Mental Illness includes but is not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, post-partum depression, personality disorders and adjustment disorders. It also includes any other condition usually treated by a Doctor, mental health provider, or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the above conditions.

Off-the-Job Injury means an Injury that occurs while the Insured is not working at any job for pay or benefits.

On-the-Job Injury means an Injury that occurs while the Insured is working at any job for pay or benefits.

Period of Disability means the length of time the Insured is either Totally Disabled or Partially Disabled from one or more causes. It starts the first full day of Total Disability or Partial Disability after the Insured ceases to be Actively at Work for the Policyholder. It ends on the **earlier** of the following two dates:

- The date the Insured ceases to be Totally Disabled or Partially Disabled.
- The date the Insured returns to an Actively at Work status for any employer.

Sickness refers to a covered illness, disease, infection, or any other abnormal physical condition. Sickness must meet **all** the following criteria:

- It must not be caused by an Injury.
- It occurs while coverage is in force.

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.

Section IV – Benefit Provisions

The benefit amounts payable under this section are shown in the Benefit Schedule.

We will pay the following benefits, as applicable, if the Insured’s Disability is caused by a covered Sickness or covered Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other Policy terms.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with the Insured while a claim is pending, or to use an independent consultant and Doctor’s statement to determine whether the Insured is qualified to receive Disability benefits.**

The Insured must be under the care and attendance of a Doctor for these benefits to be payable. Benefits will cease on the date of the Insured’s death.

Separate Periods of Disability

SAME OR RELATED CONDITION

Separate Periods of Disability resulting from the **same condition or a related condition** are considered a continuation of the prior Disability if they are not separated by 180 days or more.

Once the maximum *Total Disability Benefit Period* or maximum *Partial Disability Benefit Period* has been paid, the Insured will not be eligible for a new *Total Disability Benefit Period* or for a new *Partial Disability Benefit Period* for Disability due to the **same condition or a related condition**, until **180** days after **all** the following conditions are met:

- He has been released by a Doctor from the prior Disability.
- He is no longer disabled.
- He is no longer qualified to receive any Disability benefits under this Policy.

After his Disability Benefit Period, the Insured may continue his coverage if **all** the following conditions are met:

- He returns to work within 90 days after his Benefit Period ends.
- Premium payments for his coverage resumes upon his return to work.
- The group Policy is still in force upon his return to work.

UNRELATED CAUSES

Separate Periods of Disability resulting from **unrelated causes** are considered a continuation of the prior Disability if they are not separated by the Insured’s returning to work at a Job for 30 consecutive days, during which he is performing the material and substantial duties of that job.

Once the maximum *Total Disability Benefit Period* or maximum *Partial Disability Benefit Period* has been paid, the Insured will not be eligible for a new *Total Disability Benefit Period* or for a new *Partial Disability Benefit Period* for Disability due to an **unrelated cause**, until 30 consecutive days after **all** the following conditions are met:

- He has been released by a Doctor from a prior Disability.
- He is no longer disabled.
- He is no longer qualified to receive any Disability benefits under this Policy.

After his Disability Benefit Period, the Insured may continue his coverage if **all** the following conditions are met:

- He returns to work within 90 days after his Benefit Period ends.
- Premium payments for his coverage resumes upon his return to work.
- The group Policy is still in force upon his return to work.

Periods of Disability meeting either of these separation requirements will begin a new *Total Disability Benefit Period* or a new *Partial Disability Benefit Period* (a maximum of 3 months), subject to a new Elimination Period.

The Partial Disability Benefit has its own Benefit Period; it is not subject to the Total Disability Benefit Period. An insured may be eligible for the Partial Disability Benefit even if he had not received the Total Disability Benefit.

TOTAL DISABILITY BENEFIT: SICKNESS or OFF-THE-JOB INJURY

If the Insured has a Job at the time of his Sickness or Off-the-Job Injury, we will insure him as follows while coverage is in force:

If the Insured's covered Sickness or covered Off-the-Job Injury causes his Total Disability within **90** days of his last Treatment for his covered Sickness or covered Off-the-Job Injury, we will pay him the Daily Disability Benefit for each day of his Total Disability. This benefit is payable up to the Total Disability Benefit Period and is subject to the Elimination Period shown in the Benefit Schedule. The Total Disability Benefit Period begins after the Elimination Period has been satisfied. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

The Insured will no longer be qualified to receive this benefit upon the earlier of his: (1) being released by his Doctor to perform the material and substantial duties of his Job, or (2) working at any job earning 80.00% or more of his pre-Disability Base Annual Pay.

PARTIAL DISABILITY BENEFIT: SICKNESS or OFF-THE-JOB INJURY

If the Insured has a Job at the time of his Sickness or Off-the-Job Injury, we will insure him as follows while coverage is in force:

If the Insured's covered Sickness or covered Off-the-Job Injury causes his Partial Disability within **90** days of his last Treatment for his covered Sickness or covered Off-the-Job Injury, we will pay **50.00%** of the Daily Disability Benefit for each day of his Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of 3 months) and is subject to the Elimination Period. The Partial Disability Benefit Period and the Elimination Period appear in the Benefit Schedule. The Partial Disability Benefit Period begins after the Elimination Period has been satisfied and after the Insured returns to work earning less than **80.00%** of the Base Annual Pay of his job.

The Insured will no longer be qualified to receive this benefit upon the earlier of his: (1) being released by his Doctor to perform the material and substantial duties of his Job, or (2) working at any job earning 80.00% or more of his pre-Disability Annual Income.

Section V – Limitations & Exclusions Provisions

Pre-Existing Conditions Limitation

Pre-existing Condition is an illness, disease, infection, disorder, pregnancy, or injury that existed within the 12-month period before the Insured's Effective Date. For a condition to have been Pre-existing:

- a Doctor must have advised, diagnosed, or treated the Insured, or
- it must be a condition that would ordinarily cause a prudent person to seek medical advice or treatment.

We will **not** pay benefits for any Disability resulting from or affected by a Pre-existing Condition if the Disability began within the 12-month period after the Insured's Effective Date.

This limitation does not apply to a loss incurred or a Disability beginning after the end of 12 consecutive months, beginning on the Insured's Effective Date of coverage, during which the Insured has not received medical advice or treatment in connection with the Pre-Existing Condition.

Pregnancy Limitation

Within the first nine months of the Effective Date of coverage, we will *not* pay benefits for a Disability that is caused by, or occurs as a result of, the Insured's Pregnancy or childbirth. Disability due to Complications of Pregnancy will be covered to the same extent as a covered Sickness.

After this coverage has been in force for nine months from the Effective Date of coverage, Disability benefits for childbirth *will be* payable. The maximum Period of Disability allowed for Disability due to childbirth is **six weeks for noncesarean delivery** and **eight weeks for cesarean delivery**, less the Elimination Period, unless the Insured furnishes proof that her Disability continues beyond these time frames due to Complications of Pregnancy.

Replacement

If this Plan replaces another carrier's Short Term Disability plan, we will provide coverage for individuals who were covered under the preceding plan provided that:

- They are a member of a class eligible for coverage under this Plan;
- They satisfy this Plan's Actively at Work and non-confinement requirements; and
- They elect to be covered under this Plan.

If an individual who would otherwise be covered under this Plan does not satisfy this Plan's Actively at Work and non-confinement requirements, that individual may be covered under this Plan when he satisfies those requirements.

Limitations and Exclusions

A. We will not pay benefits whenever coverage provided by this Policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

B. We will not pay benefits whenever fraud is committed in making a claim under this coverage.

C. We will not pay benefits for a Disability that is caused by or occurs as a result of:

1. Any act of war, declared or undeclared; insurrection; rebellion; or act of participation in a riot.
2. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve.
3. An intentionally self-inflicted Injury.
4. A commission of a crime for which the Insured has been convicted; we will not pay a benefit for any Period of Disability during which the Insured is incarcerated.
5. Travel in, or jumping or descent from any aircraft, except when a fare-paying passenger in a licensed passenger aircraft.
6. Mental Illness as defined in **Section III – Definitions**.
7. Alcoholism or drug addiction.
8. An Injury arising from any employment.
9. Injury or Sickness covered by Worker's Compensation.
10. Sickness or Injury for which the Employee is eligible to receive benefits under any sick leave (sick days) plan.
11. Loss of a professional license, occupational license, or certification.
12. Having cosmetic surgery or other elective procedures that are not Medically Necessary.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury.

Section VI – Claim Provisions

Notice of Claim

The Insured must give written notice of claim:

- Not later than the 20th day after a diagnosis of Disability **or**

- As soon as reasonably possible.

Notice must include the Insured's name and the Certificate number. Notice can be mailed to the Company at:

P.O. Box 84075, Columbus, GA 31993-9103.

Claim Forms

When the Company receives notice of a claim, we will send the Insured forms so that he can file Proof of Loss (details included in the **Proof of Loss** section below).

If the Company does not provide the forms before the 16th day after the date we received notice of claim, the Insured can meet Proof of Loss requirements by providing a written statement about the nature and extent of the loss. The Insured will also need to provide a statement by the treating Doctor. The Insured must provide this information within the time limit stated in the **Proof of Loss** section.

Proof of Loss

Proof of Loss refers to all documentation that supports a claim (this information is often found in standardized medical documents, such as hospital bills and operative reports). The Insured must provide Proof of Loss to the Company at:

P.O. Box 84075, Columbus, GA 31993-9103.

The Insured must provide Proof of Loss documentation not later than the 90th day after the beginning of the period for which the insurer is liable. However, the Company will not invalidate or reduce any claim if it was not reasonably possible for the Insured to provide this proof within the required time.

The Insured must provide the proof as soon as reasonably possible. The Company will not accept proof any later than one year and three months after diagnosis of the Disability, except in the absence of the Insured's legal mental capacity.

Prompt Payment of Benefits

For benefits other than for loss of time, the Company will, once we receive the required Proof of Loss, pay, deny, or settle each submitted claim not later than the 60th day after the date proof of loss is received. Subject to written Proof of Loss, all accrued benefits payable under the policy for loss of time will be paid at least monthly during the period for which the insurer is liable. Any balance remaining unpaid at the end of that time will be paid as soon as possible after the proof of loss is received.

Payment of Claims

We will pay all benefits to the Insured 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 the beneficiary designated by the Insured or the beneficiary's assignee.
2. To the Insured's surviving spouse.
3. To the Insured's estate.

Changing of Beneficiary

The Insured can ask us to change his beneficiary at any time. The request must be in writing and it will go into effect the day the Insured signs 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 exams or autopsy.

Legal Action

The Insured cannot take legal action against us for benefits under this Plan:

- Within 60 days after he has sent us written Proof of Loss; **or**
- More than 3 years from the time written proof is required to be given.

Notice of Acceptance or Denial of Claim

CAIC will notify the Insured in writing of the acceptance or denial of a claim no later than the fifteenth business day after the date we receive all items, statements, and forms we require to secure final proof of loss. However, if we are unable to accept or deny the claim within that time period, we will, within the same period, notify the Insured of the reasons we need additional time. CAIC shall accept or deny the claim not later than the 45th day after the date we notify the Insured of the need for additional time.

If CAIC denies a claim, the reason for the denial will appear in the denial notification.

Section VII – General Provisions

Assignment

We will not assume responsibility for determining the validity of an assignment of the Insured's benefits to a provider of services. No such assignment of benefits will be recognized until we receive notice that the Insured has specifically assigned the benefits of his Group Short-Term Disability Insurance Certificate.

Other Insurance With Continental American Insurance Company

If the Insured is covered under more than one Continental American Insurance Certificate with Disability benefits, only one Disability benefit chosen by the Insured or the Insured's estate, as the case may be, will be effective. We will return all premiums paid for the canceled benefits from the date of duplication, less any benefits paid under these policies from such date.

Entire Contract Changes

The *Entire Contract of Insurance* is made up of:

- this Policy
- the Master Application
- Certificates
- endorsements
- benefit agreements **and**
- riders (if any).

All statements (excluding fraudulent ones) that the Policyholder or an Insured has made in the Application will be considered representations, **not** warranties. A statement made by the Policyholder or an Insured may not be used in any contest under the Plan, unless a copy of the written instrument containing the statement is or has been provided to:

- The person making the statement; or
- If the statement was made by the Insured and the Insured has died or become incapacitated, the Insured's beneficiary or personal representative.

This will ensure that Policyholders or Insureds 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.

Time Limit on Certain Defenses

After two years from the Effective Date of the Insured's coverage, no misstatements, except fraudulent misstatements, made by the Insured in the Application shall be used to void his coverage or to deny a claim for Disability commencing after the expiration of such two-year period.

No claim for loss incurred or Disability commencing after 12 months from the Effective Date of coverage shall be reduced on the grounds that a Sickness or physical condition, not excluded from coverage by name or specific description, had existed before the Effective Date of coverage. Coverage for Pre-existing Conditions will not be reduced or denied after the Insured's coverage has been in force 12 months.

Misstatement of Age

If the Insured's age has been misstated on the Application, the benefits will be those the premium paid would have purchased at the correct age. We will refund all unearned premiums paid, less any benefits paid, if the Insured's misstated age at the time of Application was outside the age limits for his coverage.

Misstatement of Occupation or Income

If the Insured's occupation has been misstated, the benefits will be those that the premiums paid would have purchased for his correct occupation. If his income has been misstated, the benefit payable will be that which would have been allowed for his true income level, and any overpayment of premium will be refunded.

Clerical Error

Clerical error by the Policyholder will not end coverage or continue terminated coverage. In the event of a clerical error, we will make a premium adjustment.

Individual Certificates

We 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 we may reasonably require with regard to the Plan.

Conformity With State Statutes

This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes.

Section VIII - Benefit Schedule

ELIGIBILITY

All Employees working at least 30 hours or more weekly, who are Actively at Work, and have completed at least 1 months of continuous employment with the Policyholder's group.

BENEFIT PERIOD

Benefit	Benefit Period
Total Disability (non-Occupational)	3 Months
Partial Disability	3 Months

ELIMINATION PERIOD

Total and/or Partial Disability	Elimination Period
Injury	0 Days
Sickness	7 Days

Section IX - Schedule of Premiums

The Monthly Benefit Amount for Total Disability issued is subject to 60.00% of the eligible Employee's Base Annual Pay.*

BENEFIT AMOUNTS

Minimum	3 units (\$300/Month)
Maximum	60 units (\$6,000/Month)
The percentage of income replacement may vary for state-sponsored disability programs for Employees who reside in: California, Hawaii, New Jersey, New York, Puerto Rico, Rhode Island	

***Base Annual Pay** is the Employee's annual income from his Job with his employer. This pay excludes overtime pay, bonuses, or any other special pay.

Any increase in the Monthly Disability Benefit due to an increase in earnings is subject to written Application to and acceptance by Continental American Insurance Company. Evidence of insurability may be required.

PREMIUMS

The table below shows the premiums applicable to the Plan on the Effective Date. The rates shown are for each \$100.00 of monthly benefit amount and include the rate for Partial Disability Benefits. Rates can be changed annually.

Ages	Units	Monthly Rate per \$100 of Monthly Benefit
18- 49	\$100	\$2.55375
50-64	\$100	\$2.73616
65-74	\$100	\$3.24241

Income Replacement: 60%				
Annual Salary Range	Monthly Benefit	AGE 18-49	AGE 50-64	AGE 65-74
\$9,000.00 to \$9,000.00	\$300	\$7.66	\$8.21	\$9.73
\$9,000.00 to \$9,999.00	\$400	\$10.22	\$10.94	\$12.97
\$10,000.00 to \$11,999.00	\$500	\$12.77	\$13.68	\$16.21
\$12,000.00 to \$13,999.00	\$600	\$15.32	\$16.42	\$19.45
\$14,000.00 to \$15,999.00	\$700	\$17.88	\$19.15	\$22.70
\$16,000.00 to \$17,999.00	\$800	\$20.43	\$21.89	\$25.94
\$18,000.00 to \$19,999.00	\$900	\$22.98	\$24.63	\$29.18
\$20,000.00 to \$21,999.00	\$1,000	\$25.54	\$27.36	\$32.42
\$22,000.00 to \$23,999.00	\$1,100	\$28.09	\$30.10	\$35.67
\$24,000.00 to \$25,999.00	\$1,200	\$30.65	\$32.83	\$38.91
\$26,000.00 to \$27,999.00	\$1,300	\$33.20	\$35.57	\$42.15
\$28,000.00 to \$29,999.00	\$1,400	\$35.75	\$38.31	\$45.39
\$30,000.00 to \$31,999.00	\$1,500	\$38.31	\$41.04	\$48.64
\$32,000.00 to \$33,999.00	\$1,600	\$40.86	\$43.78	\$51.88
\$34,000.00 to \$35,999.00	\$1,700	\$43.41	\$46.51	\$55.12
\$36,000.00 to \$37,999.00	\$1,800	\$45.97	\$49.25	\$58.36
\$38,000.00 to \$39,999.00	\$1,900	\$48.52	\$51.99	\$61.61
\$40,000.00 to \$41,999.00	\$2,000	\$51.08	\$54.72	\$64.85
\$42,000.00 to \$43,999.00	\$2,100	\$53.63	\$57.46	\$68.09
\$44,000.00 to \$45,999.00	\$2,200	\$56.18	\$60.20	\$71.33
\$46,000.00 to \$47,999.00	\$2,300	\$58.74	\$62.93	\$74.58
\$48,000.00 to \$49,999.00	\$2,400	\$61.29	\$65.67	\$77.82
\$50,000.00 to \$51,999.00	\$2,500	\$63.84	\$68.40	\$81.06
\$52,000.00 to \$53,999.00	\$2,600	\$66.40	\$71.14	\$84.30
\$54,000.00 to \$55,999.00	\$2,700	\$68.95	\$73.88	\$87.55
\$56,000.00 to \$57,999.00	\$2,800	\$71.51	\$76.61	\$90.79
\$58,000.00 to \$59,999.00	\$2,900	\$74.06	\$79.35	\$94.03
Over \$60,000.00	\$3,000	\$76.61	\$82.08	\$97.27

Income Replacement: 40%

Annual Salary Range	Monthly Benefit	AGE 18-49	AGE 50-64	AGE 65-74
\$9,000.00 to \$11,999.00	\$300	\$7.66	\$8.21	\$9.73
\$12,000.00 to \$14,999.00	\$400	\$10.22	\$10.94	\$12.97
\$15,000.00 to \$17,999.00	\$500	\$12.77	\$13.68	\$16.21
\$18,000.00 to \$20,999.00	\$600	\$15.32	\$16.42	\$19.45
\$21,000.00 to \$23,999.00	\$700	\$17.88	\$19.15	\$22.70
\$24,000.00 to \$26,999.00	\$800	\$20.43	\$21.89	\$25.94
\$27,000.00 to \$29,999.00	\$900	\$22.98	\$24.63	\$29.18
\$30,000.00 to \$32,999.00	\$1,000	\$25.54	\$27.36	\$32.42
\$33,000.00 to \$35,999.00	\$1,100	\$28.09	\$30.10	\$35.67
\$36,000.00 to \$38,999.00	\$1,200	\$30.65	\$32.83	\$38.91
\$39,000.00 to \$41,999.00	\$1,300	\$33.20	\$35.57	\$42.15
\$42,000.00 to \$44,999.00	\$1,400	\$35.75	\$38.31	\$45.39
\$45,000.00 to \$47,999.00	\$1,500	\$38.31	\$41.04	\$48.64
\$48,000.00 to \$50,999.00	\$1,600	\$40.86	\$43.78	\$51.88
\$51,000.00 to \$53,999.00	\$1,700	\$43.41	\$46.51	\$55.12
\$54,000.00 to \$56,999.00	\$1,800	\$45.97	\$49.25	\$58.36
\$57,000.00 to \$59,999.00	\$1,900	\$48.52	\$51.99	\$61.61
\$60,000.00 to \$62,999.00	\$2,000	\$51.08	\$54.72	\$64.85
\$63,000.00 to \$65,999.00	\$2,100	\$53.63	\$57.46	\$68.09
\$66,000.00 to \$68,999.00	\$2,200	\$56.18	\$60.20	\$71.33
\$69,000.00 to \$71,999.00	\$2,300	\$58.74	\$62.93	\$74.58
\$72,000.00 to \$74,999.00	\$2,400	\$61.29	\$65.67	\$77.82
\$75,000.00 to \$77,999.00	\$2,500	\$63.84	\$68.40	\$81.06
\$78,000.00 to \$80,999.00	\$2,600	\$66.40	\$71.14	\$84.30
\$81,000.00 to \$83,999.00	\$2,700	\$68.95	\$73.88	\$87.55
\$84,000.00 to \$86,999.00	\$2,800	\$71.51	\$76.61	\$90.79
\$87,000.00 to \$89,999.00	\$2,900	\$74.06	\$79.35	\$94.03
Over \$90,000.00	\$3,000	\$76.61	\$82.08	\$97.27



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Amendment to Worker's Compensation Disclosure

This Amendment is part of the Policy and Certificate to which it is attached. This Amendment is subject to all the definitions, terms, and other provisions of the Policy and Certificate to which it is attached, unless those terms are inconsistent with this Amendment.

EFFECTIVE DATE

If issued at the same time as the Certificate, this Amendment becomes effective when the Certificate becomes effective. If issued after the Certificate, this Amendment will have a later Effective Date.

The Worker's Compensation Disclosure on the Face Page of the Policy and Certificate is deleted and replaced with the following:

THIS IS NOT A WORKERS' COMPENSATION INSURANCE POLICY. THE EMPLOYER DOES NOT OBTAIN WORKERS' COMPENSATION INSURANCE COVERAGE BY PURCHASING THIS POLICY, AND IF THE EMPLOYER HAS NOT ELECTED TO OBTAIN WORKERS' COMPENSATION INSURANCE COVERAGE, THE EMPLOYER DOES NOT OBTAIN THOSE BENEFITS THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS IN THIS STATE. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAWS IN THIS STATE AS THEY PERTAIN TO EMPLOYERS THAT ELECT NOT TO MAINTAIN WORKERS' COMPENSATION INSURANCE COVERAGE AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

CONTRACT

This Amendment is part of the Policy and Certificate and will terminate when the Policy or Certificate terminates.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
1.800.433.3036

GROUP SHORT-TERM DISABILITY INSURANCE CERTIFICATE

This coverage only pays benefits for short-term Disability as listed in the Benefit Schedule of this Certificate. Benefits are paid for short-term Disability that is caused by Sickness or Off-the-Job Injury. This Certificate does not provide benefits for any other Sickness or condition.

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

CITY OF MERCEDES ("the Policyholder") applied for coverage under this Group Short-Term Disability Insurance Policy (the "Plan"). This Plan is issued by Continental American Insurance Company (the "Company," "we," "us," or "our"). For the purpose of this Plan, "you" (including "your" and "yours") refers to you. 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 file and made part of this Certificate. (Please note that male pronouns--such as *you*, *you*, and *your*--are used for both males and females, unless the context clearly shows otherwise.)

You will notice that certain words and phrases (including some medical terms and the names of Plan documents) in this document are capitalized. These refer to terms with very specific definitions as they apply to this insurance Plan.

**Please read your Certificate carefully.
This certificate is not a Medicare supplement policy.**

We certify that you are insured under the Group Short-Term Disability Insurance Policy (the "Plan"). The Plan was issued to your Employer, the Policyholder. This coverage provides benefits for loss resulting from short-term disability. 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. The Certificate will terminate as provided in the provision titled "Termination of an Employee's Insurance" in Section I. 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.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

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Section I - Eligibility, Effective Date, Termination, and Continuation Privilege

Eligibility

You are an eligible Employee under this Plan if you meet **all** the following requirements:

- You are an Employee of the Policyholder.
- You are engaged in full or part-time work.
- You are included in the class of Employees that are eligible for coverage, as shown on the Application.

Effective Date

The Effective Date of the Plan is shown on Page 1.

Your Certificate Effective Date is the date your insurance takes effect. That date is **one of** the two following dates:

- The date that is shown on the Certificate Schedule if you are Actively at Work on that date.
- The date you return to an Actively-at-Work status if you are not Actively at Work on the date that is 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 Policy year. To do this, the Company must give 31 days' written notice.
- The number of participating Employees is less than the number that was agreed upon by the Company and the Policyholder in the signed Master Application.

The Policyholder has the sole responsibility to notify you of the termination of the Plan. If the Plan terminates, it — as well as all Certificates and Riders issued under the Plan — will end on the stated termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

If the Plan ends, we will provide coverage for claims arising from Disabilities that were first Diagnosed 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 your coverage ends, we will provide coverage for claims that arise from short-term Disability that was first Diagnosed while your coverage was in force.

Continuation Privilege

When you end employment with the Policyholder and your coverage would otherwise end, you may choose to continue your coverage under this Plan. You may continue the coverage that you had on the date your employment ended.

To keep your Certificate in force, you must meet the following three requirements:

- You must apply to the Company in writing within 31 days after the date your insurance would otherwise terminate.
- You must pay the required premium — the premium in effect at the time of port — to the Company no later than 31 days after the date the Certificate would otherwise terminate and on each premium due date thereafter.
- You must be engaged in full or Part-time work.

Coverage will end:

- 31 days after the date you fail to pay any required premium, or
- The date this Group Plan is terminated, whichever occurs first.

If you qualify for this Continuation Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate that are shown in your previously issued Certificate.

Section II – Premium Provisions

Premium Calculations

The Schedule of Premiums determines the premium amount that is payable on any premium due date. The rates that are shown in this Schedule can be changed each year. The Company will give the Policyholder written notice 60 days before any change in rates becomes effective.

Premium Payments

The first premiums are 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:

Actively at Work refers to 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.

Base Annual Pay is the annual income from your Job with your employer. This pay excludes overtime pay, bonuses, or any other special pay.

Benefit Period is the maximum number of days *after* the Elimination Period, if any, for which you can be paid benefits for any Period of Disability. Each new Benefit Period is subject to a new Elimination Period. See the Benefit Schedule for the Benefit Period.

For the purposes of this calculation, a "month" is defined as 30 days for which benefits are paid.

Complications of Pregnancy refers to:

- Conditions that require Medical Treatment that comes before or comes after the termination of a pregnancy. The diagnoses for this Medical Treatment must be distinct from pregnancy but either adversely affected by pregnancy or caused by pregnancy. For a condition to be a Complication of Pregnancy, it must constitute a classifiably distinct pregnancy complication. Examples of such Complications of Pregnancy are:
 - o Acute nephritis,
 - o Nephrosis,
 - o Cardiac decompensation,
 - o Missed abortion,
 - o Disease of the vascular, hemopoietic, nervous, or endocrine systems, and
 - o Similar medical and surgical conditions of comparable severity.
- Further Complications of Pregnancy include:
 - o Hyperemesis gravidarum and pre-eclampsia requiring hospital confinement,
 - o Ectopic pregnancy that is terminated, and
 - o Spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy *do not include* the following conditions:

- Multiple gestation pregnancy.
- False labor.
- Occasional spotting.
- Morning sickness.

Complications of Pregnancy do not include other similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

Elective cesarean deliveries are not considered Complications of Pregnancy.

Daily Disability Benefit is one-thirtieth of the applicable monthly Disability benefit that is shown on the Benefit Schedule.

Disability

- **Total Disability** refers to your being under the care and attendance of a Doctor due to a condition that causes your inability to perform the material and substantial duties of your Job. To qualify as Total Disability, you may not be working at any job.
- **Partial Disability** refers to your being under the care and attendance of a Doctor due to a condition that causes your inability to perform the material and substantial duties of your Job. To qualify as Partial Disability, you are able to work at any job earning less than 80.00% of the Annual Income of your Job at the time you became disabled.

Doctor is defined as a person who meets **all** the following criteria:

- A person who is legally qualified to practice medicine.
- A person who is licensed as a physician by the state where Treatment is received.

A Doctor does **not** include you or your Family Member.

Elimination Period is the number of continuous days at the beginning of your Period of Disability for which there are no benefits payable. See the Benefit Schedule for the Elimination Period. Each new Benefit Period is subject to a new Elimination Period.

Employee is a person who meets the eligibility requirements that are under Section I – Eligibility, and who is covered under this Plan. The Employee under this Plan is you.

Family Member includes anyone related to you in the following manner: spouse, brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren, father- or mother-in-law, as applicable.

Full-Time Job refers to a job at which you work, performing your job-related duties for pay or benefits, for the required number of hours per week. This requirement appears under the Eligibility section of the Benefit Schedule.

Injury refers to an Off-the-Job bodily injury that is not otherwise excluded. An Injury meets **all** the following criteria:

- It is directly caused by a covered accident.
- It is not caused by Sickness, disease, bodily infirmity, or any other cause.
- It occurs on or after the Effective Date of coverage and while coverage is in force.

Insured means the eligible person whose coverage under the Certificate becomes effective.

Medically Necessary refers to Treatment, services, or supplies that are necessary and appropriate for the diagnosis or Treatment of a Sickness or an Injury based upon generally accepted medical practice.

Mental Illness is defined as a Total Disability resulting from psychiatric or psychological conditions, regardless of the cause. Mental Illness includes but is not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, post-partum depression, personality disorders as well as adjustment disorders. It also includes any other condition that is usually treated by a Doctor, mental health provider, or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the conditions stated above.

Off-the-Job Injury means an Injury that occurs while you are not working at any job for pay or benefits.

On-the-Job Injury means an Injury that occurs while you are working at any job for pay or benefits.

Period of Disability means the length of time that you are either Totally Disabled or Partially Disabled from one or more causes. It starts the first full day of Total Disability or Partial Disability after you cease to be Actively at Work for the Policyholder. It ends on the **earlier** of the following two dates:

- The date you cease to be Totally Disabled, or Partially Disabled.
- The date you return to an Actively at Work status for any employer.

Sickness refers to a covered illness, disease, infection, or any other abnormal physical condition.

Sickness must meet **all** the following criteria:

- It must not be caused by an Injury.
- It occurs while coverage is in force.

Treatment or Medical Treatment is the consultation, care, or services that are provided by a Doctor. This includes receiving any diagnostic measures as well as taking prescribed drugs and medicines.

Section IV – Benefit Provisions

The benefit amounts payable that are under this section are shown in the Benefit Schedule.

We will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Injury and if it occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other Policy terms.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you while a claim is pending, or to use an independent consultant and Doctor's statement to determine whether you are qualified to receive Disability benefits.**

You must be under the care and attendance of a Doctor for these benefits to be payable. Benefits will cease on the date of your death.

Separate Periods of Disability

SAME OR RELATED CONDITION

Separate Periods of Disability resulting from the **same condition or a related condition** are considered a continuation of the prior Disability if they are not separated by 180 days or more.

Once the maximum *Total Disability Benefit Period* or maximum *Partial Disability Benefit Period* has been paid, you will not be eligible for a new *Total Disability Benefit Period* or for a new *Partial Disability Benefit Period* for Disability due to the **same condition or a Related condition**, until 180 days after **all** the following conditions are met:

- You have been released by a Doctor from the prior Disability.
- You are no longer disabled.
- You are no longer qualified to receive any Disability benefits under this Certificate.

After your Disability Benefit Period, you may continue your coverage if **all** the following conditions are met:

- You return to work within 90 days after your Benefit Period ends.
- Premium payments for your coverage resume upon your return to work.
- The group Policy is still in force upon your return to work.

UNRELATED CAUSES

Separate Periods of Disability resulting from unrelated causes are considered a continuation of the prior Disability if they are not separated by your returning to work at a Job for 30 consecutive days, during which you are performing the material and substantial duties of that job.

Once the maximum *Total Disability Benefit Period* or maximum *Partial Disability Benefit Period* has been paid, you will not be eligible for a new *Total Disability Benefit Period* or for a new *Partial Disability Benefit Period* for Disability due to an **unrelated cause**, until 30 consecutive days after **all** the following conditions are met:

- You have been released by a Doctor from a prior Disability.
- You are no longer disabled.
- You are no longer qualified to receive any Disability benefits under this Certificate.

After your Disability Benefit Period, you may continue your coverage if **all** the following conditions are met:

- You return to work within 90 days after your Benefit Period ends.
- Premium payments for your coverage resume upon your return to work.
- The group Policy is still in force upon your return to work.

Periods of Disability meeting either of these separation requirements will begin a new *Total Disability Benefit Period* or a new *Partial Disability Benefit Period* (a maximum of 3 months), subject to a new Elimination Period.

The Partial Disability Benefit has its own Benefit Period; it isn't subject to the Total Disability Benefit Period. You may be eligible for the Partial Disability Benefit even if you have not received the Total Disability Benefit.

TOTAL DISABILITY BENEFIT: SICKNESS or OFF-THE-JOB INJURY

If you have a Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last Treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Total Disability. This benefit is payable up to the Total Disability Benefit Period. It is subject to the Elimination Period shown in the Benefit Schedule. The Total Disability Benefit Period begins after the Elimination Period has been satisfied.

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Doctor to perform the material and substantial duties of your Job, or (2) working at any job earning 80.00% or more of your pre-Disability Annual Income.

PARTIAL DISABILITY BENEFIT: SICKNESS or OFF-THE-JOB INJURY

If you have a Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last Treatment for your covered Sickness or covered Off-the-Job Injury, we will pay 50.00% of the Daily Disability Benefit for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of 3 months). It is subject to the Elimination Period. The Partial Disability Benefit Period and the Elimination Period both appear in the Benefit Schedule. The Partial Disability Benefit Period begins after the Elimination Period has been satisfied and after you return to work earning less than 80.00% of the Base Annual Pay of your job.

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Doctor to perform the material and substantial duties of your Job, or (2) working at any job earning 80.00% or more of your pre-Disability Annual Income.

Section V – Limitations & Exclusions Provisions

Pre-Existing Conditions Limitation

Pre-existing Condition is an illness, disease, infection, disorder, pregnancy, or injury that existed within the 12-month period before your Effective Date. For a condition to have been Pre-existing:

- a Doctor must have advised, diagnosed, or treated you, **or**
- it must be a condition that would ordinarily cause a prudent person to seek medical advice or treatment.

We will **not** pay benefits for any Disability resulting from or affected by a Pre-existing Condition if the Disability began within the 12-month period after your Effective Date.

This limitation does **not** apply to a loss incurred or a Disability beginning **after** the end of 12 consecutive months, beginning on the Insured's Effective Date of coverage, during which the Insured has not received medical advice or treatment in connection with the Pre-Existing Condition.

Pregnancy Limitation

Within the first nine months of the Effective Date of coverage, we will not pay benefits for a Disability that is caused by, or occurs as a result of, your Pregnancy or childbirth. Disability due to Complications of Pregnancy will be covered to the same extent as a covered Sickness.

After this coverage has been in force for nine months from the Effective Date of coverage, Disability benefits for childbirth *will be* payable. The maximum Period of Disability allowed for Disability due to childbirth is **six weeks for noncesarean delivery** and **eight weeks for cesarean delivery**, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames due to Complications of Pregnancy.

Replacement

If this Plan replaces another carrier's Short Term Disability plan, we will provide coverage for individuals who were covered under the preceding plan provided that:

- They are a member of a class eligible for coverage under this Plan;
- They satisfy this Plan's Actively at Work and non-confinement requirements; and
- They elect to be covered under this Plan.

If an individual who would otherwise be covered under this Plan does not satisfy this Plan's Actively at Work and non-confinement requirements, that individual may be covered under this Plan when he satisfies those requirements.

If this Plan replaces another carrier's Short-Term Disability plan, we will provide the lesser of:

- Extended benefit coverage that the previous carrier would have been required to provide under Texas law;
- Extended benefit coverage that we are required to provide under Texas law.

The extended benefit coverage may be reduced by any benefits actually payable under the previous carrier's health benefit plan.

Limitations and Exclusions

- A.** We will not pay benefits whenever coverage provided by this Policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.
- B.** We will not pay benefits whenever fraud is committed in making a claim under this coverage.
- C.** We will not pay benefits for a Disability that is caused by or occurs as a result of:
1. Any act of war, declared or undeclared; insurrection; rebellion; or act of participation in a riot.
 2. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve.
 3. An intentionally self-inflicted Injury.
 4. A commission of a crime for which the Insured has been convicted; we will not pay a benefit for any Period of Disability during which the Insured is incarcerated.
 5. Travel in, or jumping or descent from any aircraft, except when a fare-paying passenger in a licensed passenger aircraft.
 6. Mental Illness as defined in **Section III – Definitions**.
 7. Alcoholism or drug addiction.
 8. An Injury arising from any employment.
 9. Injury or Sickness covered by Worker's Compensation.
 10. Sickness or Injury for which the Employee is eligible to receive benefits under any sick leave (sick days) plan.
 11. Loss of a professional license, occupational license, or certification.
 12. Having cosmetic surgery or other elective procedures that are not Medically Necessary.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury.

Section VI – Claim Provisions

Notice of Claim

You must give written notice of claim:

- Not later than the 20th day after a diagnosis of Disability **or**
- As soon as is reasonably possible.

Notice must include your name and your Certificate number. Notice can be mailed to the Company at:
P.O. Box 84075, Columbus, GA 31993-9103.

Claim Forms

When the Company receives notice of a claim, we will send forms to you so that you can file Proof of Loss. (Details are included in the **Proof of Loss** section below.)

If the Company does not provide the forms before the 16th day after the date we received notice of claim, 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 all 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 84075, Columbus, GA 31993-9103.

You must provide Proof of Loss documentation not later than the 90th day after the beginning of the period for which the insurer is liable. 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 is reasonably possible. The Company will not accept proof any later than one year and three months after diagnosis of the Disability, except in the absence of your legal mental capacity.

Prompt Payment of Benefits

For benefits other than for loss of time, the Company will, once we receive the required Proof of Loss, pay, deny, or settle each submitted claim not later than the 60th day after the date proof of loss is received. Subject to written Proof of Loss, all accrued benefits payable under the policy for loss of time will be paid at least monthly during the period for which the insurer is liable. Any balance remaining unpaid at the end of that time will be paid as soon as possible after the proof of loss is received.

Payment of Claims

We will pay all benefits to you unless otherwise assigned. For any benefits that remain unpaid at the time of your death, we will pay those benefits in the following order:

1. To the beneficiary designated by the Insured or the beneficiary's assignee.
2. To your surviving spouse.
3. To your estate.

Changing of Beneficiary

You can ask us to change your beneficiary at any time. The request must be in writing and 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 you 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 exams or for an 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.

Notice of Acceptance or Denial of Claim

CAIC will notify the Insured in writing of the acceptance or denial of a claim no later than the fifteenth business day after the date we receive all items, statements, and forms we require to secure final proof of loss. However, if we are unable to accept or deny the claim within that time period, we will, within the same period, notify the Insured of the reasons we need additional time. CAIC shall accept or deny the claim not later than the 45th day after the date we notify the Insured of the need for additional time.

If CAIC denies a claim, the reason for the denial will appear in the denial notification.

Section VII – General Provisions

Assignment

We will not assume responsibility for determining the validity of an assignment of your benefits to a provider of services. No such assignment of benefits will be recognized until we receive notice that you have specifically assigned the benefits of your Group Short-Term Disability Insurance Certificate.

Other Insurance With Continental American Insurance Company

If you are covered under more than one Continental American Insurance Certificate with Disability benefits, only one Disability benefit chosen by you or your estate, as the case may be, will be effective.

We will return all premiums paid for the canceled benefits from the date of duplication, less any benefits paid under these policies from such date.

Entire Contract Changes

The *Entire Contract of Insurance* is made up of:

- this Policy
- the Master Application
- Certificates
- endorsements
- benefit agreements **and**
- riders (if any).

All statements (excluding fraudulent ones) that you or the Policyholder have made in the Application will be considered representations, **not** warranties. A statement made by you or the Policyholder may not be used in any contest under the Plan, unless a copy of the written instrument containing the statement is or has been provided to:

- The person making the statement; or
- If the statement was made by you and you have died or become incapacitated, your beneficiary or personal representative.

This will ensure that Policyholders or Insureds 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 you to be valid.

Time Limit on Certain Defenses

After two years from the Effective Date of your coverage, no misstatements, except fraudulent misstatements, made by you in the Application shall be used to void your coverage or to deny a claim for Disability starting after the expiration of such two-year period.

No claim for loss incurred or Disability starting after 12 months from the Effective Date of coverage shall be reduced on the grounds that a Sickness or physical condition, not excluded from coverage by name or specific description, had existed before the Effective Date of coverage. Coverage for Pre-existing

Misstatement of Age

If your age has been misstated on the Application, the benefits will be those the premium paid would have purchased at the correct age. We will refund all unearned premiums paid, less any benefits paid, if your misstated age at the time of Application was outside the age limits for your coverage.

Misstatement of Occupation or Income

If your occupation has been misstated, the benefits will be those that the premiums paid would have purchased for your correct occupation. If your income has been misstated, the benefit payable will be that which would have been allowed for your true income level. Any overpayment of premium will be refunded.

Clerical Error

Clerical error by the Policyholder will not end coverage or continue terminated coverage. If a clerical error occurs, we will make a premium adjustment.

Individual Certificates

We 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 we may reasonably require with regard to the Plan.

Conformity With State Statutes

This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes.



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Amendment to Worker's Compensation Disclosure

This Amendment is part of the Policy and Certificate to which it is attached. This Amendment is subject to all the definitions, terms, and other provisions of the Policy and Certificate to which it is attached, unless those terms are inconsistent with this Amendment.

EFFECTIVE DATE

If issued at the same time as the Certificate, this Amendment becomes effective when the Certificate becomes effective. If issued after the Certificate, this Amendment will have a later Effective Date.

The Worker's Compensation Disclosure on the Face Page of the Policy and Certificate is deleted and replaced with the following:

THIS IS NOT A WORKERS' COMPENSATION INSURANCE POLICY. THE EMPLOYER DOES NOT OBTAIN WORKERS' COMPENSATION INSURANCE COVERAGE BY PURCHASING THIS POLICY, AND IF THE EMPLOYER HAS NOT ELECTED TO OBTAIN WORKERS' COMPENSATION INSURANCE COVERAGE, THE EMPLOYER DOES NOT OBTAIN THOSE BENEFITS THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS IN THIS STATE. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAWS IN THIS STATE AS THEY PERTAIN TO EMPLOYERS THAT ELECT NOT TO MAINTAIN WORKERS' COMPENSATION INSURANCE COVERAGE AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

CONTRACT

This Amendment is part of the Policy and Certificate and will terminate when the Policy or Certificate terminates.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary



Thank you for choosing Continental American Insurance Company

1.800.433.3036

www.aflacgroupinsurance.com

Your Group Policy Number is:

CTR0015283525

Product:

Disability Insurance

Your Policy is Effective :

01/01/2024

Your State of Issue is:

Texas


CITY OF MERCEDES
400 S OHIO AVE
MERCEDES TX 78570-3120

MPMAIL



March 14, 2024

CITY OF MERCEDES
400 S OHIO AVE
MERCEDES TX 78570-3120

**Re: Your CITY OF MERCEDES Group Disability Insurance Coverage
Policy No.: CTR0015283525**

Welcome to the Aflac family!

Thank you so much for adding Aflac coverage in your employee benefits offering. We take commitments to our accounts very seriously and promise to be there when you and your employees need us. Enclosed, you'll find:

A Master Policy packet for the Aflac group plan you've chosen to make available to your employees. Each packet includes:

- A master policy, which indicates your group coverage effective date and other coverage details,
- A copy of your master application, **and**
- A copy of your employees' coverage certificate. **(We'll let employees know they can request copies of their certificates from you, so please be sure to make the coverage documents available. Of course, employees are also welcome to call us directly to request copies of their certificates.)**

If you have any questions about your group plan or your employees' coverage, please reach out to your account manager, or give us a call at 1.866.319.8089 Monday through Friday, from 9 a.m. to 7 p.m. Eastern time.

Again, welcome to the Aflac family!

MPCOVLET_A

Continental American Insurance Company • Columbia, South Carolina • 1.800.433.3036 toll-free

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 New York, group coverage is underwritten by American Family Life Assurance Company of New York (22 Corporate Woods Boulevard, Suite 2, Albany, New York 12211), and customer service is administered by CAIC.

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
 - o Up to \$500,000 for health benefit plans, with some exceptions.
 - o Up to \$300,000 for disability income benefits.
 - o Up to \$300,000 for long-term care insurance benefits.
 - o Up to \$200,000 for all other types of health insurance.
- **Life insurance:**
 - o Up to \$100,000 in net cash surrender or withdrawal value.
 - o Up to \$300,000 in death benefits.
- **Individual annuities:** Up to \$250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to \$300,000 per person, regardless of the number of policies or contracts. A limit of \$500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

<p>To learn more about the Association and your protections, contact:</p> <p>Texas Life and Health Insurance Guaranty Association 1601 Congress Avenue Austin, TX 78701 1-800-982-6362 or www.txlifega.org</p>	<p>For questions about insurance, contact:</p> <p>Texas Department of Insurance P.O. Box 149104 Austin, TX 78714-9104 1-800-252-3439 or www.tdi.texas.gov</p>
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Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
1.800.433.3036

GROUP SHORT-TERM DISABILITY INSURANCE POLICY

This coverage only pays benefits for short-term Disability as listed in the Benefit Schedule of this Policy. Benefits are paid for short-term Disability caused by Sickness or Off-the-Job Injury. This Policy does not provide benefits for any other Sickness or condition.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

IF THE INSURED HAS ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

CITY OF MERCEDES (the "Policyholder") applied for coverage under this Group Short-Term Disability 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. (Please note that male pronouns--such as *he*, *him*, and *his*--are used for both males and females, unless the context clearly shows otherwise.)

You will notice that certain words and phrases (including some medical terms and the names of Plan documents) in this document are capitalized. These refer to terms with very specific definitions as they apply to this insurance Plan.

**This is a limited Plan. Please read it carefully.
This policy is not a Medicare supplement policy.**

This Plan becomes effective on the Effective Date at 12:01 a.m., as determined by the Policyholder's address. Plan Termination is governed by Section I. The Plan continues to be effective while premiums are paid, as provided in Section II.

The Plan's first Anniversary Date appears below. Subsequent anniversaries will be the same date each following year.

The Policyholder may add new Employees from time to time, according to the Plan's terms.

This Plan is a legal contract between the Company and the Policyholder. All material printed by the Company on the following pages is part of the Plan. This Plan is delivered in and governed by the laws of the jurisdiction shown below.

In witness whereof, the Company executes this Plan at its home office in Columbia, South Carolina, on the Effective Date.

Signed for the Company at its Home Office.



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary

Group Policy Number CTR0015283525
Effective Date January 1, 2024
Jurisdiction Texas

Anniversary Date January 1, 2025
Non-Participating

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Section I - Eligibility, Effective Date, Termination, and Continuation Privilege

Eligibility

A person is an eligible Employee under this Plan if he meets **all** the following requirements:

- He is an Employee of the Policyholder's.
- He is engaged in full or part-time work.
- He is included in the class of Employees eligible for coverage, as shown on the Application.

Effective Date

The Plan's Effective Date is shown on Page 1.

An Employee's Effective Date is the date his insurance takes effect. That date is **one of** the two following dates:

- The date that is shown on the Certificate Schedule if the Employee is Actively at Work on that date.
- The date the Employee returns to an Actively-at-Work status if he is not Actively at Work on the date that is 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 Policy year. To do this, the Company must give 31 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 Employees of the Plan's termination. If the Plan terminates, it—and all Certificates 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 ends, we will provide coverage for claims arising from Disabilities that were first diagnosed while the Plan was in force.

Termination of an Employee's Insurance

An Employee's 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 he no longer meets the Plan's definition of an Employee.
- The date he no longer belongs to an eligible class.

If an Insured's coverage ends, we will provide coverage for claims arising from short-term Disability that was first diagnosed while his coverage was in force.

Continuation Privilege

When an Employee ends employment with the Policyholder and his coverage would otherwise end, that Employee may choose to continue his coverage under this Plan. The Employee may continue the coverage that he had on the date his employment ended.

To keep his Certificate in force, the Employee must meet the following three requirements:

- He must apply to the Company in writing within 31 days after the date his insurance would otherwise terminate.
- He must pay the required premium — the premium in effect at the time of port — to the Company no later than 31 days after the date the Certificate would otherwise terminate and on each premium due date thereafter.
- He must be engaged in full or part-time work.

Coverage will end:

- 31 days after the date the Employee fails to pay any required premium, **or**
- The date this Group Plan is terminated, whichever occurs first.

If an Employee qualifies for this Continuation Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate as shown in his previously issued Certificate.

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 each year. The Company will give the Policyholder written notice 60 days before any change in rates becomes effective.

Premium Payments

The first premiums are 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:

Actively at Work refers to an Insured's ability to perform his regular employment duties for a full normal workday. The Insured may perform these activities either at his employer's regular place of business or at a location where the Insured may be required to travel to perform the regular duties of his employment.

Base Annual Pay is the Employee's annual income from his Job with the Policyholder. This pay excludes overtime pay, bonuses, or any other special pay.

Benefit Period is the maximum number of days *after* the Elimination Period, if any, for which the Insured can be paid benefits for any Period of Disability. Each new Benefit Period is subject to a new Elimination Period. See the Benefit Schedule for the Benefit Period.

For the purposes of this calculation, a "month" is defined as 30 days for which benefits are paid.

Complications of Pregnancy refers to:

- Conditions requiring Medical Treatment that comes before or comes after the termination of a pregnancy. The diagnoses for this Medical Treatment must be distinct from pregnancy but either adversely affected by pregnancy or caused by pregnancy. For a condition to be a Complication of Pregnancy, it must constitute a classifiably distinct pregnancy complication. Examples of such Complications of Pregnancy are:
 - o Acute nephritis,
 - o Nephrosis,
 - o Cardiac decompensation,
 - o Missed abortion,
 - o Disease of the vascular, hemopoietic, nervous, or endocrine systems, and
 - o Similar medical and surgical conditions of comparable severity.
- Further Complications of Pregnancy include:
 - o Hyperemesis gravidarum and pre-eclampsia requiring hospital confinement,
 - o Ectopic pregnancy that is terminated, and
 - o Spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy *do not include* the following conditions:

- multiple gestation pregnancy.
- false labor.
- occasional spotting.
- morning sickness.

Complications of Pregnancy do not include other similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

Elective cesarean deliveries are not considered Complications of Pregnancy.

Daily Disability Benefit is one-thirtieth of the applicable monthly Disability benefit shown on the Benefit Schedule.

Disability

- **Total Disability** refers to the Insured's being under the care and attendance of a Doctor due to a condition that causes his inability to perform the material and substantial duties of his Job with the employer. To qualify as Total Disability, the Insured may not be working at any job.
- **Partial Disability** refers to the Insured's being under the care and attendance of a Doctor due to a condition that causes his inability to perform the material and substantial duties of his Job. To qualify as Partial Disability, the Insured is able to work at any job earning less than **80.00%** of the Base Annual Pay of his Job at the time he became disabled.

Doctor is defined as a person who meets **all** the following criteria:

- A person who is legally qualified to practice medicine.
- A person who is licensed as a physician by the state where Treatment is received.

A Doctor does **not** include the Insured or the Insured's Family Member.

Elimination Period is the number of continuous days at the beginning of the Insured's Period of Disability for which no benefits are payable. See the Benefit Schedule for the Elimination Period. Each new Benefit Period is subject to a new Elimination Period.

Employee is a person who meets eligibility requirements under **Section I – Eligibility**, and who is covered under this Plan. The Employee is the Insured under this Plan.

Family Member includes anyone related to the Insured in the following manner: spouse, brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren, father- or mother-in-law, as applicable.

Full-Time Job refers to a job at which the Insured works, performing his occupational duties for pay or benefits, for the required number of hours per week. This requirement appears under the Eligibility section of the Benefit Schedule.

Injury refers to an Off-the-Job bodily injury not otherwise excluded. An Injury meets **all** the following criteria:

- It is directly caused by a covered accident.
- It is not caused by Sickness, disease, bodily infirmity, or any other cause.
- It occurs on or after the Effective Date of coverage and while coverage is in force.

Insured means the eligible person whose coverage under the Certificate becomes effective. The Insured is named on his Certificate Schedule. The Insured is always the covered eligible Employee under an employer group Policy.

Medically Necessary refers to Treatment, services, or supplies that are necessary and appropriate for the diagnosis or Treatment of a Sickness or an Injury based upon generally accepted medical practice.

Mental Illness is defined as a Total Disability resulting from psychiatric or psychological conditions, regardless of cause. Mental Illness includes but is not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, post-partum depression, personality disorders and adjustment disorders. It also includes any other condition usually treated by a Doctor, mental health provider, or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the above conditions.

Off-the-Job Injury means an Injury that occurs while the Insured is not working at any job for pay or benefits.

On-the-Job Injury means an Injury that occurs while the Insured is working at any job for pay or benefits.

Period of Disability means the length of time the Insured is either Totally Disabled or Partially Disabled from one or more causes. It starts the first full day of Total Disability or Partial Disability after the Insured ceases to be Actively at Work for the Policyholder. It ends on the **earlier** of the following two dates:

- The date the Insured ceases to be Totally Disabled or Partially Disabled.
- The date the Insured returns to an Actively at Work status for any employer.

Sickness refers to a covered illness, disease, infection, or any other abnormal physical condition. Sickness must meet **all** the following criteria:

- It must not be caused by an Injury.
- It occurs while coverage is in force.

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.

Section IV – Benefit Provisions

The benefit amounts payable under this section are shown in the Benefit Schedule.

We will pay the following benefits, as applicable, if the Insured’s Disability is caused by a covered Sickness or covered Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other Policy terms.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with the Insured while a claim is pending, or to use an independent consultant and Doctor’s statement to determine whether the Insured is qualified to receive Disability benefits.**

The Insured must be under the care and attendance of a Doctor for these benefits to be payable. Benefits will cease on the date of the Insured’s death.

Separate Periods of Disability

SAME OR RELATED CONDITION

Separate Periods of Disability resulting from the **same condition or a related condition** are considered a continuation of the prior Disability if they are not separated by 180 days or more.

Once the maximum *Total Disability Benefit Period* or maximum *Partial Disability Benefit Period* has been paid, the Insured will not be eligible for a new *Total Disability Benefit Period* or for a new *Partial Disability Benefit Period* for Disability due to the **same condition or a related condition**, until **180** days after **all** the following conditions are met:

- He has been released by a Doctor from the prior Disability.
- He is no longer disabled.
- He is no longer qualified to receive any Disability benefits under this Policy.

After his Disability Benefit Period, the Insured may continue his coverage if **all** the following conditions are met:

- He returns to work within 90 days after his Benefit Period ends.
- Premium payments for his coverage resumes upon his return to work.
- The group Policy is still in force upon his return to work.

UNRELATED CAUSES

Separate Periods of Disability resulting from **unrelated causes** are considered a continuation of the prior Disability if they are not separated by the Insured’s returning to work at a Job for 30 consecutive days, during which he is performing the material and substantial duties of that job.

Once the maximum *Total Disability Benefit Period* or maximum *Partial Disability Benefit Period* has been paid, the Insured will not be eligible for a new *Total Disability Benefit Period* or for a new *Partial Disability Benefit Period* for Disability due to an **unrelated cause**, until 30 consecutive days after **all** the following conditions are met:

- He has been released by a Doctor from a prior Disability.
- He is no longer disabled.
- He is no longer qualified to receive any Disability benefits under this Policy.

After his Disability Benefit Period, the Insured may continue his coverage if **all** the following conditions are met:

- He returns to work within 90 days after his Benefit Period ends.
- Premium payments for his coverage resumes upon his return to work.
- The group Policy is still in force upon his return to work.

Periods of Disability meeting either of these separation requirements will begin a new *Total Disability Benefit Period* or a new *Partial Disability Benefit Period* (a maximum of 3 months), subject to a new Elimination Period.

The Partial Disability Benefit has its own Benefit Period; it is not subject to the Total Disability Benefit Period. An insured may be eligible for the Partial Disability Benefit even if he had not received the Total Disability Benefit.

TOTAL DISABILITY BENEFIT: SICKNESS or OFF-THE-JOB INJURY

If the Insured has a Job at the time of his Sickness or Off-the-Job Injury, we will insure him as follows while coverage is in force:

If the Insured's covered Sickness or covered Off-the-Job Injury causes his Total Disability within **90** days of his last Treatment for his covered Sickness or covered Off-the-Job Injury, we will pay him the Daily Disability Benefit for each day of his Total Disability. This benefit is payable up to the Total Disability Benefit Period and is subject to the Elimination Period shown in the Benefit Schedule. The Total Disability Benefit Period begins after the Elimination Period has been satisfied. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

The Insured will no longer be qualified to receive this benefit upon the earlier of his: (1) being released by his Doctor to perform the material and substantial duties of his Job, or (2) working at any job earning 80.00% or more of his pre-Disability Base Annual Pay.

PARTIAL DISABILITY BENEFIT: SICKNESS or OFF-THE-JOB INJURY

If the Insured has a Job at the time of his Sickness or Off-the-Job Injury, we will insure him as follows while coverage is in force:

If the Insured's covered Sickness or covered Off-the-Job Injury causes his Partial Disability within **90** days of his last Treatment for his covered Sickness or covered Off-the-Job Injury, we will pay **50.00%** of the Daily Disability Benefit for each day of his Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of 3 months) and is subject to the Elimination Period. The Partial Disability Benefit Period and the Elimination Period appear in the Benefit Schedule. The Partial Disability Benefit Period begins after the Elimination Period has been satisfied and after the Insured returns to work earning less than **80.00%** of the Base Annual Pay of his job.

The Insured will no longer be qualified to receive this benefit upon the earlier of his: (1) being released by his Doctor to perform the material and substantial duties of his Job, or (2) working at any job earning 80.00% or more of his pre-Disability Annual Income.

WAIVER OF PREMIUM BENEFIT

If the Insured's covered Sickness or covered Off-the-Job Injury causes his Total Disability or Partial Disability for more than 90 consecutive days while this coverage is in force, we will waive, from month to month, the premium for the Certificate and any applicable rider(s) for as long as he remains disabled, up to the applicable Benefit Period shown in the Benefit Schedule.

For premiums to be waived, we will require an employer's statement and a Doctor's statement certifying the Insured's inability to perform his customary duties or activities, and may each month thereafter require a Doctor's statement that his inability to perform those duties or activities continues. We may

ask for and use an independent consultant to determine the Insured's Disability when this benefit is in force.

All premiums must be paid to keep an Insured's Certificate and any applicable rider(s) in force until we approve his claim for this Waiver of Premium Benefit. Premium payments for the Insured must resume the earlier of his returning to work or within 90 days after he no longer qualifies for Disability benefits.

EXTENSION OF BENEFITS

If your coverage ends, we will provide coverage for claims that arise from a short-term Disability that was first Diagnosed while your coverage was in force. If you are Totally Disabled on the date your coverage ends, we will provide benefits for at least the lesser of:

- 90 days; or
- The duration of the Total Disability.

Section V – Limitations & Exclusions Provisions

Pre-Existing Conditions Limitation

Pre-existing Condition is an illness, disease, infection, disorder, pregnancy, or injury that existed within the 12-month period before the Insured's Effective Date. For a condition to have been Pre-existing:

- a Doctor must have advised, diagnosed, or treated the Insured, or
- it must be a condition that would ordinarily cause a prudent person to seek medical advice or treatment.

We will **not** pay benefits for any Disability resulting from or affected by a Pre-existing Condition if the Disability began within the 12-month period after the Insured's Effective Date.

This limitation does not apply to a loss incurred or a Disability beginning after the end of 12 consecutive months, beginning on the Insured's Effective Date of coverage, during which the Insured has not received medical advice or treatment in connection with the Pre-Existing Condition.

Pregnancy Limitation

Within the first nine months of the Effective Date of coverage, we will *not* pay benefits for a Disability that is caused by, or occurs as a result of, the Insured's Pregnancy or childbirth. Disability due to Complications of Pregnancy will be covered to the same extent as a covered Sickness.

After this coverage has been in force for nine months from the Effective Date of coverage, Disability benefits for childbirth *will be* payable. The maximum Period of Disability allowed for Disability due to childbirth is **six weeks for noncesarean delivery** and **eight weeks for cesarean delivery**, less the Elimination Period, unless the Insured furnishes proof that her Disability continues beyond these time frames due to Complications of Pregnancy.

Replacement

If this Plan replaces another carrier's Short Term Disability plan, we will provide coverage for individuals who were covered under the preceding plan provided that:

- They are a member of a class eligible for coverage under this Plan;
- They satisfy this Plan's Actively at Work and non-confinement requirements; and
- They elect to be covered under this Plan.

If an individual who would otherwise be covered under this Plan does not satisfy this Plan's Actively at Work and non-confinement requirements, that individual may be covered under this Plan when he satisfies those requirements.

Limitations and Exclusions

A. We will not pay benefits whenever coverage provided by this Policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

B. We will not pay benefits whenever fraud is committed in making a claim under this coverage.

C. We will not pay benefits for a Disability that is caused by or occurs as a result of:

1. Any act of war, declared or undeclared; insurrection; rebellion; or act of participation in a riot.

2. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve.
3. An intentionally self-inflicted Injury.
4. A commission of a crime for which the Insured has been convicted; we will not pay a benefit for any Period of Disability during which the Insured is incarcerated.
5. Travel in, or jumping or descent from any aircraft, except when a fare-paying passenger in a licensed passenger aircraft.
6. Mental Illness as defined in **Section III – Definitions**.
7. Alcoholism or drug addiction.
8. An Injury arising from any employment.
9. Injury or Sickness covered by Worker's Compensation.
10. Sickness or Injury for which the Employee is eligible to receive benefits under any sick leave (sick days) plan.
11. Loss of a professional license, occupational license, or certification.
12. Having cosmetic surgery or other elective procedures that are not Medically Necessary.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury.

Section VI – Claim Provisions

Notice of Claim

The Insured must give written notice of claim:

- Not later than the 20th day after a diagnosis of Disability **or**
- As soon as reasonably possible.

Notice must include the Insured's name and the Certificate number. Notice can be mailed to the Company at:

P.O. Box 84075, Columbus, GA 31993-9103.

Claim Forms

When the Company receives notice of a claim, we will send the Insured forms so that he can file Proof of Loss (details included in the **Proof of Loss** section below).

If the Company does not provide the forms before the 16th day after the date we received notice of claim, the Insured can meet Proof of Loss requirements by providing a written statement about the nature and extent of the loss. The Insured will also need to provide a statement by the treating Doctor. The Insured must provide this information within the time limit stated in the **Proof of Loss** section.

Proof of Loss

Proof of Loss refers to all documentation that supports a claim (this information is often found in standardized medical documents, such as hospital bills and operative reports). The Insured must provide Proof of Loss to the Company at:

P.O. Box 84075, Columbus, GA 31993-9103.

The Insured must provide Proof of Loss documentation not later than the 90th day after the beginning of the period for which the insurer is liable. However, the Company will not invalidate or reduce any claim if it was not reasonably possible for the Insured to provide this proof within the required time.

The Insured must provide the proof as soon as reasonably possible. The Company will not accept proof any later than one year and three months after diagnosis of the Disability, except in the absence of the Insured's legal mental capacity.

Prompt Payment of Benefits

For benefits other than for loss of time, the Company will, once we receive the required Proof of Loss, pay, deny, or settle each submitted claim not later than the 60th day after the date proof of loss is received. Subject to written Proof of Loss, all accrued benefits payable under the policy for loss of time will be paid at least monthly during the period for which the insurer is liable. Any balance

remaining unpaid at the end of that time will be paid as soon as possible after the proof of loss is received.

Payment of Claims

We will pay all benefits to the Insured 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 the beneficiary designated by the Insured or the beneficiary's assignee.
2. To the Insured's surviving spouse.
3. To the Insured's estate.

Changing of Beneficiary

The Insured can ask us to change his beneficiary at any time. The request must be in writing and it will go into effect the day the Insured signs 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 exams or autopsy.

Legal Action

The Insured cannot take legal action against us for benefits under this Plan:

- Within 60 days after he has sent us written Proof of Loss; **or**
- More than 3 years from the time written proof is required to be given.

Notice of Acceptance or Denial of Claim

CAIC will notify the Insured in writing of the acceptance or denial of a claim no later than the fifteenth business day after the date we receive all items, statements, and forms we require to secure final proof of loss. However, if we are unable to accept or deny the claim within that time period, we will, within the same period, notify the Insured of the reasons we need additional time. CAIC shall accept or deny the claim not later than the 45th day after the date we notify the Insured of the need for additional time.

If CAIC denies a claim, the reason for the denial will appear in the denial notification.

Section VII – General Provisions

Assignment

We will not assume responsibility for determining the validity of an assignment of the Insured's benefits to a provider of services. No such assignment of benefits will be recognized until we receive notice that the Insured has specifically assigned the benefits of his Group Short-Term Disability Insurance Certificate.

Other Insurance With Continental American Insurance Company

If the Insured is covered under more than one Continental American Insurance Certificate with Disability benefits, only one Disability benefit chosen by the Insured or the Insured's estate, as the case may be, will be effective. We will return all premiums paid for the canceled benefits from the date of duplication, less any benefits paid under these policies from such date.

Entire Contract Changes

The *Entire Contract of Insurance* is made up of:

- this Policy
- the Master Application
- Certificates
- endorsements
- benefit agreements **and**
- riders (if any).

All statements (excluding fraudulent ones) that the Policyholder or an Insured has made in the Application will be considered representations, **not** warranties. A statement made by the Policyholder or an Insured may not be used in any contest under the Plan, unless a copy of the written instrument containing the statement is or has been provided to:

- The person making the statement; or
- If the statement was made by the Insured and the Insured has died or become incapacitated, the Insured's beneficiary or personal representative.

This will ensure that Policyholders or Insureds 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.

Time Limit on Certain Defenses

After two years from the Effective Date of the Insured's coverage, no misstatements, except fraudulent misstatements, made by the Insured in the Application shall be used to void his coverage or to deny a claim for Disability commencing after the expiration of such two-year period.

No claim for loss incurred or Disability commencing after 12 months from the Effective Date of coverage shall be reduced on the grounds that a Sickness or physical condition, not excluded from coverage by name or specific description, had existed before the Effective Date of coverage. Coverage for Pre-existing Conditions will not be reduced or denied after the Insured's coverage has been in force 12 months.

Misstatement of Age

If the Insured's age has been misstated on the Application, the benefits will be those the premium paid would have purchased at the correct age. We will refund all unearned premiums paid, less any benefits paid, if the Insured's misstated age at the time of Application was outside the age limits for his coverage.

Misstatement of Occupation or Income

If the Insured's occupation has been misstated, the benefits will be those that the premiums paid would have purchased for his correct occupation. If his income has been misstated, the benefit payable will be that which would have been allowed for his true income level, and any overpayment of premium will be refunded.

Clerical Error

Clerical error by the Policyholder will not end coverage or continue terminated coverage. In the event of a clerical error, we will make a premium adjustment.

Individual Certificates

We 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 we may reasonably require with regard to the Plan.

Conformity With State Statutes

This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes.

Section VIII - Benefit Schedule

ELIGIBILITY

All Employees working at least 30 hours or more weekly, who are Actively at Work, and have completed at least 1 months of continuous employment with the Policyholder's group.

BENEFIT PERIOD

Benefit	Benefit Period
Total Disability (non-Occupational)	6 Months
Partial Disability	3 Months

ELIMINATION PERIOD

Total and/or Partial Disability	Elimination Period
Injury	7 Days
Sickness	7 Days

Section IX - Schedule of Premiums

The Monthly Benefit Amount for Total Disability issued is subject to 60.00% of the eligible Employee's Base Annual Pay.*

BENEFIT AMOUNTS

Minimum	3 units (\$300/Month)
Maximum	60 units (\$6,000/Month)
The percentage of income replacement may vary for state-sponsored disability programs for Employees who reside in: California, Hawaii, New Jersey, New York, Puerto Rico, Rhode Island	

***Base Annual Pay** is the Employee's annual income from his Job with his employer. This pay excludes overtime pay, bonuses, or any other special pay.

Any increase in the Monthly Disability Benefit due to an increase in earnings is subject to written Application to and acceptance by Continental American Insurance Company. Evidence of insurability may be required.

PREMIUMS

The table below shows the premiums applicable to the Plan on the Effective Date. The rates shown are for each \$100.00 of monthly benefit amount and include the rate for Partial Disability Benefits. Rates can be changed annually.

Ages	Units	Monthly Rate per \$100 of Monthly Benefit
18- 49	\$100	\$3.3915
50-64	\$100	\$3.86729
65-74	\$100	\$4.89171

Income Replacement: 60%

Annual Salary Range	Monthly Benefit	AGE 18-49	AGE 50-64	AGE 65-74
\$9,000.00 to \$9,000.00	\$300	\$10.17	\$11.60	\$14.68
\$9,000.00 to \$9,999.00	\$400	\$13.57	\$15.47	\$19.57
\$10,000.00 to \$11,999.00	\$500	\$16.96	\$19.34	\$24.46
\$12,000.00 to \$13,999.00	\$600	\$20.35	\$23.20	\$29.35
\$14,000.00 to \$15,999.00	\$700	\$23.74	\$27.07	\$34.24
\$16,000.00 to \$17,999.00	\$800	\$27.13	\$30.94	\$39.13
\$18,000.00 to \$19,999.00	\$900	\$30.52	\$34.81	\$44.03
\$20,000.00 to \$21,999.00	\$1,000	\$33.92	\$38.67	\$48.92
\$22,000.00 to \$23,999.00	\$1,100	\$37.31	\$42.54	\$53.81
\$24,000.00 to \$25,999.00	\$1,200	\$40.70	\$46.41	\$58.70
\$26,000.00 to \$27,999.00	\$1,300	\$44.09	\$50.27	\$63.59
\$28,000.00 to \$29,999.00	\$1,400	\$47.48	\$54.14	\$68.48
\$30,000.00 to \$31,999.00	\$1,500	\$50.87	\$58.01	\$73.38
\$32,000.00 to \$33,999.00	\$1,600	\$54.26	\$61.88	\$78.27
\$34,000.00 to \$35,999.00	\$1,700	\$57.66	\$65.74	\$83.16
\$36,000.00 to \$37,999.00	\$1,800	\$61.05	\$69.61	\$88.05
\$38,000.00 to \$39,999.00	\$1,900	\$64.44	\$73.48	\$92.94
\$40,000.00 to \$41,999.00	\$2,000	\$67.83	\$77.35	\$97.83
\$42,000.00 to \$43,999.00	\$2,100	\$71.22	\$81.21	\$102.73
\$44,000.00 to \$45,999.00	\$2,200	\$74.61	\$85.08	\$107.62
\$46,000.00 to \$47,999.00	\$2,300	\$78.00	\$88.95	\$112.51
\$48,000.00 to \$49,999.00	\$2,400	\$81.40	\$92.81	\$117.40
\$50,000.00 to \$51,999.00	\$2,500	\$84.79	\$96.68	\$122.29
\$52,000.00 to \$53,999.00	\$2,600	\$88.18	\$100.55	\$127.18
\$54,000.00 to \$55,999.00	\$2,700	\$91.57	\$104.42	\$132.08
\$56,000.00 to \$57,999.00	\$2,800	\$94.96	\$108.28	\$136.97
\$58,000.00 to \$59,999.00	\$2,900	\$98.35	\$112.15	\$141.86
Over \$60,000.00	\$3,000	\$101.75	\$116.02	\$146.75

Income Replacement: 40%

Annual Salary Range	Monthly Benefit	AGE 18-49	AGE 50-64	AGE 65-74
\$9,000.00 to \$11,999.00	\$300	\$10.17	\$11.60	\$14.68
\$12,000.00 to \$14,999.00	\$400	\$13.57	\$15.47	\$19.57
\$15,000.00 to \$17,999.00	\$500	\$16.96	\$19.34	\$24.46
\$18,000.00 to \$20,999.00	\$600	\$20.35	\$23.20	\$29.35
\$21,000.00 to \$23,999.00	\$700	\$23.74	\$27.07	\$34.24
\$24,000.00 to \$26,999.00	\$800	\$27.13	\$30.94	\$39.13
\$27,000.00 to \$29,999.00	\$900	\$30.52	\$34.81	\$44.03
\$30,000.00 to \$32,999.00	\$1,000	\$33.92	\$38.67	\$48.92
\$33,000.00 to \$35,999.00	\$1,100	\$37.31	\$42.54	\$53.81
\$36,000.00 to \$38,999.00	\$1,200	\$40.70	\$46.41	\$58.70
\$39,000.00 to \$41,999.00	\$1,300	\$44.09	\$50.27	\$63.59
\$42,000.00 to \$44,999.00	\$1,400	\$47.48	\$54.14	\$68.48
\$45,000.00 to \$47,999.00	\$1,500	\$50.87	\$58.01	\$73.38
\$48,000.00 to \$50,999.00	\$1,600	\$54.26	\$61.88	\$78.27
\$51,000.00 to \$53,999.00	\$1,700	\$57.66	\$65.74	\$83.16
\$54,000.00 to \$56,999.00	\$1,800	\$61.05	\$69.61	\$88.05
\$57,000.00 to \$59,999.00	\$1,900	\$64.44	\$73.48	\$92.94
\$60,000.00 to \$62,999.00	\$2,000	\$67.83	\$77.35	\$97.83
\$63,000.00 to \$65,999.00	\$2,100	\$71.22	\$81.21	\$102.73
\$66,000.00 to \$68,999.00	\$2,200	\$74.61	\$85.08	\$107.62
\$69,000.00 to \$71,999.00	\$2,300	\$78.00	\$88.95	\$112.51
\$72,000.00 to \$74,999.00	\$2,400	\$81.40	\$92.81	\$117.40
\$75,000.00 to \$77,999.00	\$2,500	\$84.79	\$96.68	\$122.29
\$78,000.00 to \$80,999.00	\$2,600	\$88.18	\$100.55	\$127.18
\$81,000.00 to \$83,999.00	\$2,700	\$91.57	\$104.42	\$132.08
\$84,000.00 to \$86,999.00	\$2,800	\$94.96	\$108.28	\$136.97
\$87,000.00 to \$89,999.00	\$2,900	\$98.35	\$112.15	\$141.86
Over \$90,000.00	\$3,000	\$101.75	\$116.02	\$146.75



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Amendment to Worker's Compensation Disclosure

This Amendment is part of the Policy and Certificate to which it is attached. This Amendment is subject to all the definitions, terms, and other provisions of the Policy and Certificate to which it is attached, unless those terms are inconsistent with this Amendment.

EFFECTIVE DATE

If issued at the same time as the Certificate, this Amendment becomes effective when the Certificate becomes effective. If issued after the Certificate, this Amendment will have a later Effective Date.

The Worker's Compensation Disclosure on the Face Page of the Policy and Certificate is deleted and replaced with the following:

THIS IS NOT A WORKERS' COMPENSATION INSURANCE POLICY. THE EMPLOYER DOES NOT OBTAIN WORKERS' COMPENSATION INSURANCE COVERAGE BY PURCHASING THIS POLICY, AND IF THE EMPLOYER HAS NOT ELECTED TO OBTAIN WORKERS' COMPENSATION INSURANCE COVERAGE, THE EMPLOYER DOES NOT OBTAIN THOSE BENEFITS THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS IN THIS STATE. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAWS IN THIS STATE AS THEY PERTAIN TO EMPLOYERS THAT ELECT NOT TO MAINTAIN WORKERS' COMPENSATION INSURANCE COVERAGE AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

CONTRACT

This Amendment is part of the Policy and Certificate and will terminate when the Policy or Certificate terminates.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
1.800.433.3036

GROUP SHORT-TERM DISABILITY INSURANCE CERTIFICATE

This coverage only pays benefits for short-term Disability as listed in the Benefit Schedule of this Certificate. Benefits are paid for short-term Disability that is caused by Sickness or Off-the-Job Injury. This Certificate does not provide benefits for any other Sickness or condition.

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

CITY OF MERCEDES ("the Policyholder") applied for coverage under this Group Short-Term Disability Insurance Policy (the "Plan"). This Plan is issued by Continental American Insurance Company (the "Company," "we," "us," or "our"). For the purpose of this Plan, "you" (including "your" and "yours") refers to you. 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 file and made part of this Certificate. (Please note that male pronouns--such as *you*, *you*, and *your*--are used for both males and females, unless the context clearly shows otherwise.)

You will notice that certain words and phrases (including some medical terms and the names of Plan documents) in this document are capitalized. These refer to terms with very specific definitions as they apply to this insurance Plan.

**Please read your Certificate carefully.
This certificate is not a Medicare supplement policy.**

We certify that you are insured under the Group Short-Term Disability Insurance Policy (the "Plan"). The Plan was issued to your Employer, the Policyholder. This coverage provides benefits for loss resulting from short-term disability. 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. The Certificate will terminate as provided in the provision titled "Termination of an Employee's Insurance" in Section I. 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.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

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Section I - Eligibility, Effective Date, Termination, and Continuation Privilege

Eligibility

You are an eligible Employee under this Plan if you meet **all** the following requirements:

- You are an Employee of the Policyholder.
- You are engaged in full or part-time work.
- You are included in the class of Employees that are eligible for coverage, as shown on the Application.

Effective Date

The Effective Date of the Plan is shown on Page 1.

Your Certificate Effective Date is the date your insurance takes effect. That date is **one of** the two following dates:

- The date that is shown on the Certificate Schedule if you are Actively at Work on that date.
- The date you return to an Actively-at-Work status if you are not Actively at Work on the date that is 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 Policy year. To do this, the Company must give 31 days' written notice.
- The number of participating Employees is less than the number that was agreed upon by the Company and the Policyholder in the signed Master Application.

The Policyholder has the sole responsibility to notify you of the termination of the Plan. If the Plan terminates, it — as well as all Certificates and Riders issued under the Plan — will end on the stated termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

If the Plan ends, we will provide coverage for claims arising from Disabilities that were first Diagnosed 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 your coverage ends, we will provide coverage for claims that arise from short-term Disability that was first Diagnosed while your coverage was in force.

Continuation Privilege

When you end employment with the Policyholder and your coverage would otherwise end, you may choose to continue your coverage under this Plan. You may continue the coverage that you had on the date your employment ended.

To keep your Certificate in force, you must meet the following three requirements:

- You must apply to the Company in writing within 31 days after the date your insurance would otherwise terminate.
- You must pay the required premium — the premium in effect at the time of port — to the Company no later than 31 days after the date the Certificate would otherwise terminate and on each premium due date thereafter.
- You must be engaged in full or Part-time work.

Coverage will end:

- 31 days after the date you fail to pay any required premium, or
- The date this Group Plan is terminated, whichever occurs first.

If you qualify for this Continuation Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate that are shown in your previously issued Certificate.

Section II – Premium Provisions

Premium Calculations

The Schedule of Premiums determines the premium amount that is payable on any premium due date. The rates that are shown in this Schedule can be changed each year. The Company will give the Policyholder written notice 60 days before any change in rates becomes effective.

Premium Payments

The first premiums are 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:

Actively at Work refers to 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.

Base Annual Pay is the annual income from your Job with your employer. This pay excludes overtime pay, bonuses, or any other special pay.

Benefit Period is the maximum number of days *after* the Elimination Period, if any, for which you can be paid benefits for any Period of Disability. Each new Benefit Period is subject to a new Elimination Period. See the Benefit Schedule for the Benefit Period.

For the purposes of this calculation, a "month" is defined as 30 days for which benefits are paid.

Complications of Pregnancy refers to:

- Conditions that require Medical Treatment that comes before or comes after the termination of a pregnancy. The diagnoses for this Medical Treatment must be distinct from pregnancy but either adversely affected by pregnancy or caused by pregnancy. For a condition to be a Complication of Pregnancy, it must constitute a classifiably distinct pregnancy complication. Examples of such Complications of Pregnancy are:
 - o Acute nephritis,
 - o Nephrosis,
 - o Cardiac decompensation,
 - o Missed abortion,
 - o Disease of the vascular, hemopoietic, nervous, or endocrine systems, and
 - o Similar medical and surgical conditions of comparable severity.
- Further Complications of Pregnancy include:
 - o Hyperemesis gravidarum and pre-eclampsia requiring hospital confinement,
 - o Ectopic pregnancy that is terminated, and
 - o Spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy *do not include* the following conditions:

- Multiple gestation pregnancy.
- False labor.
- Occasional spotting.
- Morning sickness.

Complications of Pregnancy do not include other similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

Elective cesarean deliveries are not considered Complications of Pregnancy.

Daily Disability Benefit is one-thirtieth of the applicable monthly Disability benefit that is shown on the Benefit Schedule.

Disability

- **Total Disability** refers to your being under the care and attendance of a Doctor due to a condition that causes your inability to perform the material and substantial duties of your Job. To qualify as Total Disability, you may not be working at any job.
- **Partial Disability** refers to your being under the care and attendance of a Doctor due to a condition that causes your inability to perform the material and substantial duties of your Job. To qualify as Partial Disability, you are able to work at any job earning less than 80.00% of the Annual Income of your Job at the time you became disabled.

Doctor is defined as a person who meets **all** the following criteria:

- A person who is legally qualified to practice medicine.
- A person who is licensed as a physician by the state where Treatment is received.

A Doctor does **not** include you or your Family Member.

Elimination Period is the number of continuous days at the beginning of your Period of Disability for which there are no benefits payable. See the Benefit Schedule for the Elimination Period. Each new Benefit Period is subject to a new Elimination Period.

Employee is a person who meets the eligibility requirements that are under Section I – Eligibility, and who is covered under this Plan. The Employee under this Plan is you.

Family Member includes anyone related to you in the following manner: spouse, brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren, father- or mother-in-law, as applicable.

Full-Time Job refers to a job at which you work, performing your job-related duties for pay or benefits, for the required number of hours per week. This requirement appears under the Eligibility section of the Benefit Schedule.

Injury refers to an Off-the-Job bodily injury that is not otherwise excluded. An Injury meets **all** the following criteria:

- It is directly caused by a covered accident.
- It is not caused by Sickness, disease, bodily infirmity, or any other cause.
- It occurs on or after the Effective Date of coverage and while coverage is in force.

Insured means the eligible person whose coverage under the Certificate becomes effective.

Medically Necessary refers to Treatment, services, or supplies that are necessary and appropriate for the diagnosis or Treatment of a Sickness or an Injury based upon generally accepted medical practice.

Mental Illness is defined as a Total Disability resulting from psychiatric or psychological conditions, regardless of the cause. Mental Illness includes but is not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, post-partum depression, personality disorders as well as adjustment disorders. It also includes any other condition that is usually treated by a Doctor, mental health provider, or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the conditions stated above.

Off-the-Job Injury means an Injury that occurs while you are not working at any job for pay or benefits.

On-the-Job Injury means an Injury that occurs while you are working at any job for pay or benefits.

Period of Disability means the length of time that you are either Totally Disabled or Partially Disabled from one or more causes. It starts the first full day of Total Disability or Partial Disability after you cease to be Actively at Work for the Policyholder. It ends on the **earlier** of the following two dates:

- The date you cease to be Totally Disabled, or Partially Disabled.
- The date you return to an Actively at Work status for any employer.

Sickness refers to a covered illness, disease, infection, or any other abnormal physical condition.

Sickness must meet **all** the following criteria:

- It must not be caused by an Injury.
- It occurs while coverage is in force.

Treatment or Medical Treatment is the consultation, care, or services that are provided by a Doctor. This includes receiving any diagnostic measures as well as taking prescribed drugs and medicines.

Section IV – Benefit Provisions

The benefit amounts payable that are under this section are shown in the Benefit Schedule.

We will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Injury and if it occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other Policy terms.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you while a claim is pending, or to use an independent consultant and Doctor's statement to determine whether you are qualified to receive Disability benefits.**

You must be under the care and attendance of a Doctor for these benefits to be payable. Benefits will cease on the date of your death.

Separate Periods of Disability

SAME OR RELATED CONDITION

Separate Periods of Disability resulting from the **same condition or a related condition** are considered a continuation of the prior Disability if they are not separated by 180 days or more.

Once the maximum *Total Disability Benefit Period* or maximum *Partial Disability Benefit Period* has been paid, you will not be eligible for a new *Total Disability Benefit Period* or for a new *Partial Disability Benefit Period* for Disability due to the **same condition or a Related condition**, until 180 days after **all** the following conditions are met:

- You have been released by a Doctor from the prior Disability.
- You are no longer disabled.
- You are no longer qualified to receive any Disability benefits under this Certificate.

After your Disability Benefit Period, you may continue your coverage if **all** the following conditions are met:

- You return to work within 90 days after your Benefit Period ends.
- Premium payments for your coverage resume upon your return to work.
- The group Policy is still in force upon your return to work.

UNRELATED CAUSES

Separate Periods of Disability resulting from unrelated causes are considered a continuation of the prior Disability if they are not separated by your returning to work at a Job for 30 consecutive days, during which you are performing the material and substantial duties of that job.

Once the maximum *Total Disability Benefit Period* or maximum *Partial Disability Benefit Period* has been paid, you will not be eligible for a new *Total Disability Benefit Period* or for a new *Partial Disability Benefit Period* for Disability due to an **unrelated cause**, until 30 consecutive days after **all** the following conditions are met:

- You have been released by a Doctor from a prior Disability.
- You are no longer disabled.
- You are no longer qualified to receive any Disability benefits under this Certificate.

After your Disability Benefit Period, you may continue your coverage if **all** the following conditions are met:

- You return to work within 90 days after your Benefit Period ends.
- Premium payments for your coverage resume upon your return to work.
- The group Policy is still in force upon your return to work.

Periods of Disability meeting either of these separation requirements will begin a new *Total Disability Benefit Period* or a new *Partial Disability Benefit Period* (a maximum of 3 months), subject to a new Elimination Period.

The Partial Disability Benefit has its own Benefit Period; it isn't subject to the Total Disability Benefit Period. You may be eligible for the Partial Disability Benefit even if you have not received the Total Disability Benefit.

TOTAL DISABILITY BENEFIT: SICKNESS or OFF-THE-JOB INJURY

If you have a Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last Treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Total Disability. This benefit is payable up to the Total Disability Benefit Period. It is subject to the Elimination Period shown in the Benefit Schedule. The Total Disability Benefit Period begins after the Elimination Period has been satisfied.

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Doctor to perform the material and substantial duties of your Job, or (2) working at any job earning 80.00% or more of your pre-Disability Annual Income.

PARTIAL DISABILITY BENEFIT: SICKNESS or OFF-THE-JOB INJURY

If you have a Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last Treatment for your covered Sickness or covered Off-the-Job Injury, we will pay 50.00% of the Daily Disability Benefit for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of 3 months). It is subject to the Elimination Period. The Partial Disability Benefit Period and the Elimination Period both appear in the Benefit Schedule. The Partial Disability Benefit Period begins after the Elimination Period has been satisfied and after you return to work earning less than 80.00% of the Base Annual Pay of your job.

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Doctor to perform the material and substantial duties of your Job, or (2) working at any job earning 80.00% or more of your pre-Disability Annual Income.

WAIVER OF PREMIUM BENEFIT

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability or Partial Disability for more than 90 consecutive days while this coverage is in force, we will waive, from month to month, the premium for the Certificate and any applicable rider(s) for as long as you remain disabled, up to the applicable Benefit Period shown in the Benefit Schedule.

For premiums to be waived, we will require both the statement of an employer and the statement of a Doctor certifying that you are unable to perform your customary duties or activities. We may each month thereafter require a Doctor's statement that your inability to perform those duties or activities continues. We may ask for and use an independent consultant to determine your Disability when this benefit is in force.

All premiums must be paid to keep the Certificate and any applicable rider(s) in force until we approve your claim for this Waiver of Premium Benefit. Premium payments for your coverage must resume the earlier of your returning to work or within 90 days after you no longer qualify for Disability benefits.

EXTENSION OF BENEFITS

If your coverage ends, we will provide coverage for claims that arise from a short-term Disability that was first Diagnosed while your coverage was in force. If you are Totally Disabled on the date your coverage ends, we will provide benefits for at least the lesser of:

- 90 days; or
- The duration of the Total Disability.

Section V – Limitations & Exclusions Provisions

Pre-Existing Conditions Limitation

Pre-existing Condition is an illness, disease, infection, disorder, pregnancy, or injury that existed within the 12-month period before your Effective Date. For a condition to have been Pre-existing:

- a Doctor must have advised, diagnosed, or treated you, **or**
- it must be a condition that would ordinarily cause a prudent person to seek medical advice or treatment.

We will **not** pay benefits for any Disability resulting from or affected by a Pre-existing Condition if the Disability began within the 12-month period after your Effective Date.

This limitation does **not** apply to a loss incurred or a Disability beginning **after** the end of 12 consecutive months, beginning on the Insured's Effective Date of coverage, during which the Insured has not received medical advice or treatment in connection with the Pre-Existing Condition.

Pregnancy Limitation

Within the first nine months of the Effective Date of coverage, we will not pay benefits for a Disability that is caused by, or occurs as a result of, your Pregnancy or childbirth. Disability due to Complications of Pregnancy will be covered to the same extent as a covered Sickness.

After this coverage has been in force for nine months from the Effective Date of coverage, Disability benefits for childbirth *will be* payable. The maximum Period of Disability allowed for Disability due to childbirth is **six weeks for noncesarean delivery** and **eight weeks for cesarean delivery**, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames due to Complications of Pregnancy.

Replacement

If this Plan replaces another carrier's Short Term Disability plan, we will provide coverage for individuals who were covered under the preceding plan provided that:

- They are a member of a class eligible for coverage under this Plan;
- They satisfy this Plan's Actively at Work and non-confinement requirements; and
- They elect to be covered under this Plan.

If an individual who would otherwise be covered under this Plan does not satisfy this Plan's Actively at Work and non-confinement requirements, that individual may be covered under this Plan when he satisfies those requirements.

If this Plan replaces another carrier's Short-Term Disability plan, we will provide the lesser of:

- Extended benefit coverage that the previous carrier would have been required to provide under Texas law;
- Extended benefit coverage that we are required to provide under Texas law.

The extended benefit coverage may be reduced by any benefits actually payable under the previous carrier's health benefit plan.

Limitations and Exclusions

A. We will not pay benefits whenever coverage provided by this Policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

B. We will not pay benefits whenever fraud is committed in making a claim under this coverage.

C. We will not pay benefits for a Disability that is caused by or occurs as a result of:

1. Any act of war, declared or undeclared; insurrection; rebellion; or act of participation in a riot.
2. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve.
3. An intentionally self-inflicted Injury.
4. A commission of a crime for which the Insured has been convicted; we will not pay a benefit for any Period of Disability during which the Insured is incarcerated.

5. Travel in, or jumping or descent from any aircraft, except when a fare-paying passenger in a licensed passenger aircraft.
6. Mental Illness as defined in **Section III – Definitions**.
7. Alcoholism or drug addiction.
8. An Injury arising from any employment.
9. Injury or Sickness covered by Worker's Compensation.
10. Sickness or Injury for which the Employee is eligible to receive benefits under any sick leave (sick days) plan.
11. Loss of a professional license, occupational license, or certification.
12. Having cosmetic surgery or other elective procedures that are not Medically Necessary.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury.

Section VI – Claim Provisions

Notice of Claim

You must give written notice of claim:

- Not later than the 20th day after a diagnosis of Disability **or**
- As soon as is reasonably possible.

Notice must include your name and your Certificate number. Notice can be mailed to the Company at:
P.O. Box 84075, Columbus, GA 31993-9103.

Claim Forms

When the Company receives notice of a claim, we will send forms to you so that you can file Proof of Loss. (Details are included in the **Proof of Loss** section below.)

If the Company does not provide the forms before the 16th day after the date we received notice of claim, 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 all 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 84075, Columbus, GA 31993-9103.

You must provide Proof of Loss documentation not later than the 90th day after the beginning of the period for which the insurer is liable. 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 is reasonably possible. The Company will not accept proof any later than one year and three months after diagnosis of the Disability, except in the absence of your legal mental capacity.

Prompt Payment of Benefits

For benefits other than for loss of time, the Company will, once we receive the required Proof of Loss, pay, deny, or settle each submitted claim not later than the 60th day after the date proof of loss is received. Subject to written Proof of Loss, all accrued benefits payable under the policy for loss of time will be paid at least monthly during the period for which the insurer is liable. Any balance remaining unpaid at the end of that time will be paid as soon as possible after the proof of loss is received.

Payment of Claims

We will pay all benefits to you unless otherwise assigned. For any benefits that remain unpaid at the time of your death, we will pay those benefits in the following order:

1. To the beneficiary designated by the Insured or the beneficiary's assignee.

2. To your surviving spouse.
3. To your estate.

Changing of Beneficiary

You can ask us to change your beneficiary at any time. The request must be in writing and 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 you 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 exams or for an 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.

Notice of Acceptance or Denial of Claim

CAIC will notify the Insured in writing of the acceptance or denial of a claim no later than the fifteenth business day after the date we receive all items, statements, and forms we require to secure final proof of loss. However, if we are unable to accept or deny the claim within that time period, we will, within the same period, notify the Insured of the reasons we need additional time. CAIC shall accept or deny the claim not later than the 45th day after the date we notify the Insured of the need for additional time.

If CAIC denies a claim, the reason for the denial will appear in the denial notification.

Section VII – General Provisions

Assignment

We will not assume responsibility for determining the validity of an assignment of your benefits to a provider of services. No such assignment of benefits will be recognized until we receive notice that you have specifically assigned the benefits of your Group Short-Term Disability Insurance Certificate.

Other Insurance With Continental American Insurance Company

If you are covered under more than one Continental American Insurance Certificate with Disability benefits, only one Disability benefit chosen by you or your estate, as the case may be, will be effective.

We will return all premiums paid for the canceled benefits from the date of duplication, less any benefits paid under these policies from such date.

Entire Contract Changes

The *Entire Contract of Insurance* is made up of:

- this Policy
- the Master Application
- Certificates
- endorsements
- benefit agreements **and**
- riders (if any).

All statements (excluding fraudulent ones) that you or the Policyholder have made in the Application will be considered representations, **not** warranties. A statement made by you or the Policyholder may not be used in any contest under the Plan, unless a copy of the written instrument containing the statement is or has been provided to:

- The person making the statement; or
- If the statement was made by you and you have died or become incapacitated, your beneficiary or personal representative.

This will ensure that Policyholders or Insureds 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 you to be valid.

Time Limit on Certain Defenses

After two years from the Effective Date of your coverage, no misstatements, except fraudulent misstatements, made by you in the Application shall be used to void your coverage or to deny a claim for Disability starting after the expiration of such two-year period.

No claim for loss incurred or Disability starting after 12 months from the Effective Date of coverage shall be reduced on the grounds that a Sickness or physical condition, not excluded from coverage by name or specific description, had existed before the Effective Date of coverage. Coverage for Pre-existing

Misstatement of Age

If your age has been misstated on the Application, the benefits will be those the premium paid would have purchased at the correct age. We will refund all unearned premiums paid, less any benefits paid, if your misstated age at the time of Application was outside the age limits for your coverage.

Misstatement of Occupation or Income

If your occupation has been misstated, the benefits will be those that the premiums paid would have purchased for your correct occupation. If your income has been misstated, the benefit payable will be that which would have been allowed for your true income level. Any overpayment of premium will be refunded.

Clerical Error

Clerical error by the Policyholder will not end coverage or continue terminated coverage. If a clerical error occurs, we will make a premium adjustment.

Individual Certificates

We 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 we may reasonably require with regard to the Plan.

Conformity With State Statutes

This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes.



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Amendment to Worker's Compensation Disclosure

This Amendment is part of the Policy and Certificate to which it is attached. This Amendment is subject to all the definitions, terms, and other provisions of the Policy and Certificate to which it is attached, unless those terms are inconsistent with this Amendment.

EFFECTIVE DATE

If issued at the same time as the Certificate, this Amendment becomes effective when the Certificate becomes effective. If issued after the Certificate, this Amendment will have a later Effective Date.

The Worker's Compensation Disclosure on the Face Page of the Policy and Certificate is deleted and replaced with the following:

THIS IS NOT A WORKERS' COMPENSATION INSURANCE POLICY. THE EMPLOYER DOES NOT OBTAIN WORKERS' COMPENSATION INSURANCE COVERAGE BY PURCHASING THIS POLICY, AND IF THE EMPLOYER HAS NOT ELECTED TO OBTAIN WORKERS' COMPENSATION INSURANCE COVERAGE, THE EMPLOYER DOES NOT OBTAIN THOSE BENEFITS THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS IN THIS STATE. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAWS IN THIS STATE AS THEY PERTAIN TO EMPLOYERS THAT ELECT NOT TO MAINTAIN WORKERS' COMPENSATION INSURANCE COVERAGE AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

CONTRACT

This Amendment is part of the Policy and Certificate and will terminate when the Policy or Certificate terminates.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary



Thank you for choosing Continental American Insurance Company

1.800.433.3036

www.aflacgroupinsurance.com

Your Group Policy Number is:

CTR0015283525

Product:

Hospital Indemnity

Your Policy is Effective :

01/01/2024

Your State of Issue is:

Texas

|||
CITY OF MERCEDES
400 S OHIO AVE
MERCEDES TX 78570-3120



March 14, 2024

CITY OF MERCEDES
400 S OHIO AVE
MERCEDES TX 78570-3120

**Re: Your CITY OF MERCEDES Group Hospital Indemnity Coverage
Policy No.: CTR0015283525**

Welcome to the Aflac family!

Thank you so much for adding Aflac coverage in your employee benefits offering. We take commitments to our accounts very seriously and promise to be there when you and your employees need us. Enclosed, you'll find:

A Master Policy packet for the Aflac group plan you've chosen to make available to your employees. Each packet includes:

- A master policy, which indicates your group coverage effective date and other coverage details,
- A copy of your master application, **and**
- A copy of your employees' coverage certificate. **(We'll let employees know they can request copies of their certificates from you, so please be sure to make the coverage documents available. Of course, employees are also welcome to call us directly to request copies of their certificates.)**

If you have any questions about your group plan or your employees' coverage, please reach out to your account manager, or give us a call at 1.866.319.8089 Monday through Friday, from 9 a.m. to 7 p.m. Eastern time.

Again, welcome to the Aflac family!

MPCOVLET_A

Continental American Insurance Company • Columbia, South Carolina • 1.800.433.3036 toll-free

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 New York, group coverage is underwritten by American Family Life Assurance Company of New York (22 Corporate Woods Boulevard, Suite 2, Albany, New York 12211), and customer service is administered by CAIC.

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Continental American Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: Continental American Insurance Company at 1-800-433-3036

Toll-free:

1-800-433-3036

Email: cscmail@aflac.com

Mail: Continental American Insurance Company
Post Office Box 427
Columbia, South Carolina 29202

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call: 1-800-252-3439

Online: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Continental American Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Continental American Insurance Company al 1-800-433-3036

Teléfono gratuito:

1-800-433-3036

Correo electrónico: cscmail@aflac.com

Dirección postal: Continental American Insurance Company
Post Office Box 427
Columbia, South Carolina 29202

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame: 1-800-252-3439

En línea: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
 - o Up to \$500,000 for health benefit plans, with some exceptions.
 - o Up to \$300,000 for disability income benefits.
 - o Up to \$300,000 for long-term care insurance benefits.
 - o Up to \$200,000 for all other types of health insurance.
- **Life insurance:**
 - o Up to \$100,000 in net cash surrender or withdrawal value.
 - o Up to \$300,000 in death benefits.
- **Individual annuities:** Up to \$250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to \$300,000 per person, regardless of the number of policies or contracts. A limit of \$500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

<p>To learn more about the Association and your protections, contact:</p> <p>Texas Life and Health Insurance Guaranty Association 1601 Congress Avenue Austin, TX 78701 1-800-982-6362 or www.txlifega.org</p>	<p>For questions about insurance, contact:</p> <p>Texas Department of Insurance P.O. Box 149104 Austin, TX 78714-9104 1-800-252-3439 or www.tdi.texas.gov</p>
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Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.



CONTINENTAL AMERICAN INSURANCE COMPANY
Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Continuation of Coverage Endorsement

This Endorsement is part of the Policy and Certificate to which it is attached. This Endorsement is subject to all the definitions, terms, and other provisions of the Policy and Certificate to which it is attached, unless those terms are inconsistent with this Endorsement.

EFFECTIVE DATE

If issued at the same time as the Certificate, this Endorsement becomes effective when the Certificate becomes effective. If issued after the Certificate, this Endorsement will have a later Effective Date.

The following provisions are added after the Continuation Privilege provision in your Certificate:

CONTINUATION OF COVERAGE

If the Group Policy is terminated by the Policyholder and is not replaced with another group policy you may apply to continue the coverage you had on the Group Policy termination date. This includes any in-force Spouse or Dependent Child coverage. The Group Policy will be continued as if the Group Policy is in force for those who have applied to continue their coverage under this provision. The members will continue to have coverage, with their Certificates remaining in force.

The Company will apply the same benefits and plan provisions as shown in your Certificate on the date you are eligible to continue coverage under this provision. Your continued coverage is subject to all of the provisions, exclusions and limitations of the Group Policy.

To keep your Certificate in force, you must:

- Apply to the Company in writing under this Continuation of Coverage provision within 31 days after the date your Certificate would terminate, **and**
- Pay the required premium no later than 31 days after the date the Certificate would terminate and on each premium due date thereafter to the Company at our Customer Service Center in Columbus, Georgia.

PREMIUMS

Initial premium rates will be based on the rates in effect at the time you apply to continue your coverage. Premium rates can be changed by the Company at any time upon 60 days written notice to you. Any such change will be applied to all Certificates in your class and will not be based on your or your Spouse and Dependent Children's health or other individual factors.

You may decrease, but not increase, the amount of your coverage, and the amount of your Spouse's coverage, if any.

TERMINATION

Your continued coverage, including any in-force Spouse or Dependent Child coverage, will end:

- 31 days after the date you fail to pay any required premium.

- When coverage is terminated by the Company. We will provide you a 31-day advance written notice of any termination.
- On the date you die (unless your Spouse elects to become the Primary Insured under the Successor Insured provision, if applicable).

Once continued coverage is cancelled it cannot be reinstated. If your coverage terminates, we will provide benefits for valid claims that arose while your coverage was active.

CONTRACT

This Endorsement is part of the Certificate. It will terminate when:

- The Certificate terminates, or
- Premiums are no longer paid for this Endorsement.

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY
Columbia, South Carolina
800.433.3036

**Endorsement
to Policy and Certificate of Insurance**

This Endorsement alters the Policy and the Certificate to which it is attached. Unless specifically addressed by this Endorsement, all other Policy and Certificate provisions, definitions, and terms continue to apply.

Continental American Insurance Company's mailing addresses for claims and premium payments are changed as listed below.

Notice of Claim and Proof of Loss should be mailed to the Company at:

P.O. Box 84075, Columbus, Georgia, 31993-9103

Premium Payments should be mailed to the Company at:

P.O. Box 84069, Columbus, Georgia, 31908-4069

If applicable, references to 2801 Devine Street, Columbia, SC 29205 are deleted.

Signed for the Company at its Home Office,

A handwritten signature in black ink that reads "Virgil R. Miller".

Virgil R. Miller, President

A handwritten signature in black ink that reads "J. Matthew Loudermilk".

J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY
Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Group Supplemental Hospital Indemnity Policy

This limited Plan provides supplemental benefits only. It does not constitute comprehensive health insurance coverage and does not satisfy the requirement of Minimum Essential Coverage under the Affordable Care Act.

THIS PLAN IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

This Policy is not a Medicare Supplement Policy. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

This Plan provides the benefits listed in the Benefit Schedule. Please read it carefully.

The Policyholder as shown on the Policy Schedule applied for coverage under this Group Supplemental Hospital Indemnity Insurance Policy (the "Plan"). This Plan is issued by Continental American Insurance Company (the "Company," "CAIC," "we," "us," or "our"). Based on the Master Application and the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. (Please note that male pronouns—such as "he," "him," and "his"—are used for both males and females, unless the context clearly shows otherwise.) The Policyholder may add new Insureds from time to time, according to the Plan's terms.

You will notice that certain words and phrases (including some medical terms and the names of Plan documents) in this document are capitalized. The capitalized words refer to terms with very specific definitions as they apply to this insurance Plan.

This Plan is a legal contract between the Company and the Policyholder. All material printed by the Company on the following pages is part of the Plan. This Plan is delivered in and governed by the laws of the jurisdiction shown on the Policy Schedule.

In witness whereof, the Company executes this Plan at its home office in Columbia, South Carolina, on the Effective Date.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

**Group Supplemental Hospital Indemnity Insurance
Non-Participating**

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.

Notice of Non-Insurance Benefits

The Company may offer or provide goods and/or services that are not related to insurance. These goods and services, which could be offered or provided to some people who apply for Continental American Insurance Company (CAIC) coverage or become insured by CAIC, may include (but are not limited to) the following:

- Enrollment services
- Educational services
- Benefit statement services
- Payroll or plan administration services

The services listed above will fall under the same benefit plan that includes or is related to the applicable CAIC coverage, individual wellness programs, and related services.

In addition, CAIC may arrange for third-party service providers to provide discounted goods and services to people who apply for CAIC coverage or who become insured by CAIC.

Though CAIC has arranged these goods, services, and/or third-party provider discounts, the third-party providers—**not CAIC**—are liable to applicants/insureds for these goods and services. CAIC is not responsible for providing the goods and/or services, nor is CAIC liable to applicants/insureds for the negligent provision of these goods and/or services by third-party service providers.

For information about this notice, call 800.433.3036.

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SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

Eligibility

An Employee is eligible to be covered under this Plan if he is Actively at Work for the Policyholder and included in the class that is eligible for coverage, as shown on the Master Application.

Insureds are defined as those who might be eligible for coverage under this Plan in the following categories:

- **Employee Coverage** – We insure only the Employee.
- **Employee and Spouse Coverage** – We insure the Employee and spouse (as defined in the applicable rider).
- **Employee and Children Coverage** – We insure the Employee and any dependent children (as defined in the applicable rider).
- **Family Coverage** – We insure the Employee, spouse, and any dependent children (as defined in the applicable rider).

We will not insure anyone specifically excluded from coverage by Endorsement to the Certificate or by application, even if that person would otherwise be eligible for coverage.

Details for adding Insureds to Plan coverage are outlined in the Effective Date section.

Effective Date

The Plan's Effective Date is shown on the Policy Schedule. This Plan becomes effective on the Policy Effective Date at 12:01 a.m., as determined by the Policyholder's address.

An eligible Employee must enroll in this Plan and agree to pay the required premiums for coverage to become effective. He must enroll within 31 days of the date he first becomes eligible for coverage. *The first premium must have been paid for coverage to become effective.*

We may require evidence of insurability satisfactory to us if we do not receive the Application within 31 days after the Employee was first eligible for coverage. Evidence of insurability may also be required based on an agreement between the Policyholder and us.

An Employee's Effective Date is the date his insurance takes effect. After we receive and approve the Application, that date is either:

- The date shown on the Certificate Schedule if the Employee is Actively at Work on that date, or
- The date the Employee returns to an Actively-at-Work status if he was not Actively at Work on the date shown on the Certificate Schedule.

If Employee and Spouse, Employee and Children, or Family Coverage is offered:

- A Dependent may be added to the Plan after the Employee's Effective Date within 31 days of a Life Event or during an approved enrollment period.
- If Dependent Child Rider coverage **is already in force**, no additional notice or premium is required to add another dependent child.
- If Dependent Spouse Rider or Dependent Child Rider coverage is **not** in force, the Employee must complete an Application to add a Dependent to the Plan. The Company will assign a Dependent Rider Effective Date for a Dependent's coverage after approving the Application. For Dependent coverage to become effective, the premium for the Dependent must be included in the premium payment.
- If Dependent Child Rider coverage is not already in force, **newborn** children are automatically covered from the moment of birth for 60 days. **Newly adopted** children are automatically covered from the earlier of a) placement for adoption, b) the date of entry of an order granting custody of the child for the purposes of adoption, or c) the effective date of adoption, for 60 days. To extend coverage beyond 60 days with no gap in coverage, the Employee must contact the Company within the 60-day time period following the child's birth or adoption. No premium is due for the first 60 days of newborn/newly adopted coverage.

A day begins at 12:01 a.m. standard time at the Employee's place of residence.

Plan Termination

The **Company** has the right to cancel the Plan on any premium due date for the following reasons:

- The premium is not paid before the end of the Grace Period,
- The number of participating Employees is less than the number mutually agreed upon by the Company and the Policyholder,
- The number of participating Employees changes by 25% or more,
- The Policyholder fails to perform any of the obligations that relate to this policy or that are required by applicable law,
- The Policyholder no longer offers coverage to a particular class of Employees,
- The Policyholder no longer serves a class of Employees who reside in a particular geographical area, or
- The Policyholder does not provide timely information that is reasonably required.

The **Policyholder** has the right to cancel the Plan on any premium due date.

- To do this, the Policyholder must give the Company at least 31 days' written notice.
- The Plan will end on the date in the written notice or the date the Company receives the notice, whichever is later.

All outstanding premiums are due upon Plan termination. If the Company accepts premium payments after the Plan terminates, this will not reinstate the Plan; we will refund any excess premium.

The Policyholder has the sole responsibility of notifying Certificateholders in writing of the Plan's termination as soon as reasonably possible. If the Plan terminates, it—and all Certificates and Riders issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

Termination of an Employee's Insurance

An Employee's insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date (the last day of the Grace Period), if the premium has not been paid.
- The date he no longer belongs to an eligible class.

If an Insured's coverage terminates, we will provide benefits for valid claims that arose while his coverage was active.

Continuation Privilege

When an Employee is no longer a member of an eligible class and his coverage would otherwise end, he may elect to continue his coverage under this Plan. He may continue the coverage he had on the date his Certificate would otherwise terminate, including any in-force Dependent Spouse Rider or Dependent Child Rider coverage, without any additional underwriting requirements.

To keep his coverage in force, the Employee must:

- Notify the Company within 31 days after the date his coverage would otherwise terminate. He may notify us by sending written notice to P.O. Box 84079, Columbus, GA 31993-9101 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly to the Company no later than 31 days after the date his coverage would otherwise terminate and on each premium due date thereafter.

The Employee's ported coverage will end on the earliest of the following dates:

- 31 days after the premium due date (the last day of the Grace Period), if the premium has not been paid, or
- The date the Group Plan is terminated.

If the Employee qualifies for this Continuation Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate as shown in his previously-issued Certificate. Notification of any changes in the Plan will be provided directly by the Company.

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SECTION II – PREMIUM PROVISIONS

Premium Payments

Premiums should be paid to the Company at its Home Office in Columbia, South Carolina. The first premiums are due on the Plan's Effective Date. After that, premiums are due on the first day of each month that the Plan remains in effect.

Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period provision.

Premium Changes

Unless we have agreed in writing not to increase premiums, the premium may change:

- On the Group Policy Anniversary Date based on renewal underwriting. (The Group Policy Anniversary Date is shown on the Policy Schedule and falls on the same date each year thereafter.)
- Whenever the terms or conditions of the Plan are modified. The new premium rates will apply only to premiums due on or after the rate change takes effect.

We will provide the Policyholder a 31-day advance written notice of any change in premiums.

Grace Period

This Plan has a 31-day Grace Period. If a 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. If the Plan is discontinued, the Plan's termination date will be the latest date for which premium has been paid.

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SECTION III – DEFINITIONS

When the terms below are used in this Plan, the following definitions apply:

Accidental Injury means accidental bodily damage to an Insured. This must be the direct result of an accident and not the result of disease or bodily infirmity. A **Covered Accidental Injury** is an Accidental Injury that occurs while coverage is in force. A **Covered Accident** is an accident that occurs on or after an Insured's Effective Date while coverage is in force, and that is not specifically excluded by the Plan.

Actively at Work refers to an Employee's ability to perform his regular employment duties for a full normal workday. The Employee may perform these activities either at his employer's regular place of business or at a location where he is required to travel to perform the regular duties of his employment.

Calendar Year means the period beginning on the policy Effective Date and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

Claimant means a person who is authorized to make a claim under the Certificate.

Dependent means an Employee's spouse or dependent children, as defined in the applicable rider, who have been accepted for coverage.

Doctor is a person who is duly qualified as a practitioner of the healing arts acting within the scope of his license, and:

- Is licensed to practice medicine; prescribe and administer drugs; or to perform surgery, or
- Is a duly qualified medical practitioner according to the laws and regulations in the state in which Treatment is made.

A Doctor **does not** include the Insured or an Insured's Family Member.

For the purposes of this definition, **Family Member** includes the Employee's Spouse as well as the following members of the Employee's immediate family:

- Son
- Daughter
- Mother
- Father
- Sister
- Brother

This includes step-Family Members and Family-Members-in-law.

Employee is a person who meets Eligibility requirements under **Section I – Eligibility, Effective Date, and Termination** and who is covered under this Plan. The Employee is the primary Insured under this Plan.

Hospital means a place that meets all of the following criteria:

- Is legally licensed and operated as a Hospital,
- Provides overnight care of injured and sick people,
- Is supervised by a Doctor,
- Has full-time nurses supervised by a registered nurse, and
- Has on-site use of X-ray equipment, laboratory, and surgical facilities.

The term *Hospital* specifically excludes any facility not meeting the definition of Hospital as defined in this Plan, including but not limited to:

- A nursing home,
- An extended-care facility,
- A skilled nursing facility,
- A rest home or home for the aged,
- A Rehabilitation Facility,
- A facility for the Treatment of alcoholism or drug addiction, or
- An assisted living facility.

Hospital Intensive Care Unit means a place that meets all of the following criteria:

- Is a specifically designated area of the Hospital called a Hospital Intensive Care Unit;
- Provides the highest level of medical care;
- Is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- Is separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement;
- Is permanently equipped with special life-saving equipment for the care of the critically ill or injured;
- Is under close observation by a specially trained nursing staff assigned exclusively to the Hospital Intensive Care Unit 24 hours a day; and
- Has a Doctor assigned to the Hospital Intensive Care Unit on a full-time basis.

The term *Hospital Intensive Care Unit* specifically excludes any type of facility not meeting the definition of Hospital Intensive Care Unit as defined in this Plan, including but not limited to private monitored rooms, surgical recovery rooms, observation units, and the following step-down units:

- A progressive care unit,
- A sub-acute intensive care unit, or
- An intermediate care unit.

Intermediate Intensive Care Step-Down Unit means any of the following:

- A progressive care unit,
- A sub-acute intensive care unit,
- An intermediate care unit, or
- A pre- or post-intensive care unit.

An Intermediate Intensive Care Step-Down Unit is **not** a Hospital Intensive Care Unit as defined in this Plan.

Life Event means an event that qualifies an Employee to make changes to benefits at times other than his enrollment period. Events qualifying as Life Events are established solely by the Policyholder.

Rehabilitation Facility is a unit or facility providing coordinated multidisciplinary physical restorative services. These services must be provided to inpatients under a Doctor's direction. The Doctor must be knowledgeable and experienced in rehabilitative medicine. Beds must be set up in a unit or facility specifically designated and staffed for this service. This is not a facility for the Treatment of alcoholism or drug addiction.

Related – a Related Accidental Injury or Sickness is one that is in correlation to, or occurs as a result of, the initial Accidental Injury or Sickness, and would not otherwise have been sustained if that initial condition had not occurred.

Sickness means an illness, infection, disease, or any other abnormal physical condition or pregnancy that is not caused solely by, or the result of, any injury. A **Covered Sickness** is one that is not excluded by name, specific description, or any other provision in this Plan. For a benefit to be payable, loss arising from the Covered Sickness must occur while the applicable Insured's coverage is in force.

Spouse is an Employee's legal wife or husband, including a legally-recognized same-sex Spouse, or a person of either gender who is in a legally recognized and registered domestic partnership, civil union, reciprocal beneficiary relationship, or similar relationship with the Employee.

Telemedicine Service means a medical inquiry with a Doctor via audio or video communication that assists with a patient's assessment, diagnosis, and consultation.

Treatment is the consultation, care, or services provided by a Doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines. Treatment does **not** include Telemedicine Services.

SECTION IV – BENEFIT PROVISIONS

Hospitalization Benefits

Hospital Admission Benefit

We will pay this benefit when an Insured is admitted to a Hospital and confined as an inpatient because of a Covered Accidental Injury or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, an Insured must be admitted to a Hospital within six months of the date of the Covered Accident.

We will pay the Hospital Admission Benefit amount shown in the Benefit Schedule. We will not pay benefits for confinement to an observation unit, or for emergency room Treatment or outpatient Treatment.

We will pay this benefit once per period of Hospital Confinement. This benefit is limited to the maximum shown in the Benefit Schedule. We will only pay this benefit once for each Covered Accident or Covered Sickness per Calendar Year. If an Insured is confined to the Hospital because of the same or Related Accidental Injury or Sickness, we will not pay this benefit again in the same Calendar Year.

Hospital Confinement Benefit

We will pay the amount shown in the Benefit Schedule for each day that an Insured is confined to a Hospital as an inpatient as the result of a Covered Accidental Injury or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, the Insured must be confined to a Hospital within six months of the date of the Covered Accident.

The length of time shown for Hospital Confinement in the Benefit Schedule is the maximum period for which an Insured can collect benefits for Hospital Confinements resulting from Covered Sickness or from Covered Accidental Injuries received in the same Covered Accident.

If we pay benefits for confinement and the Insured becomes confined again within six months because of the same or a Related condition, we will treat this confinement as the same period of confinement.

This benefit is payable for only one Hospital Confinement at a time, even if it is caused by more than one Covered Accidental Injury, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

Hospital Intensive Care Benefit

If an Insured is confined in a Hospital Intensive Care Unit because of a Covered Accidental Injury or Covered Sickness, we will pay the daily benefit amount shown in the Benefit Schedule. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, an Insured must be admitted to a Hospital Intensive Care Unit within six months of the date of the Covered Accident.

We will pay this amount for each day of such confinement, but not to exceed the maximum benefit period shown on the Benefit Schedule during any one period of confinement.

We will pay benefits for only one confinement in a Hospital Intensive Care Unit at a time, even if it is caused by more than one Covered Accidental Injury, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

If we pay benefits for confinement in a Hospital Intensive Care Unit and an Insured becomes confined to a Hospital Intensive Care Unit again within six months because of the same or a Related condition, we will treat this confinement as the same period of confinement.

This benefit is payable in addition to the Hospital Confinement Benefit.

Intermediate Intensive Care Step-Down Unit Benefit

If an Insured is confined in an Intermediate Intensive Care Step-Down Unit because of a Covered Accidental Injury or Covered Sickness, we will pay the daily benefit amount shown on the Benefit Schedule. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, the Insured must be admitted to an Intermediate Intensive Care Step-Down Unit within six months of the date of the Covered Accident.

We will pay this amount for each day of such confinement, not to exceed the maximum benefit period shown in the Benefit Schedule during any one period of confinement.

We will pay benefits for only one confinement in an Intermediate Intensive Care Step-Down Unit at a time, even if it is caused by more than one Covered Accidental Injury, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

If we pay benefits for confinement in a Hospital's Intermediate Intensive Care Step-Down Unit and the Insured becomes confined to a Hospital's Intermediate Intensive Care Step-Down Unit again within six months because of the same or a Related condition, we will treat this confinement as the same period of confinement.

This benefit is payable in addition to the Hospital Confinement Benefit.

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SECTION V – EXCLUSIONS

Exclusions

We will not pay for loss due to:

- War – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the Insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.
- Suicide – committing or attempting to commit suicide, while sane or insane.
- Self-Inflicted Injuries – injuring or attempting to injure oneself intentionally.
- Racing – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semi-professional capacity.
- Illegal Occupation – voluntarily participating in, committing, or attempting to commit a felony or illegal act or activity, or voluntarily working at, or being engaged in, an illegal occupation or job.
- Sports – participating in any organized sport in a professional or semi-professional capacity.
- Custodial Care – this is non-medical care that helps individuals with the basic tasks of everyday life, the preparation of special diets, and the self-administration of medication which does not require the constant attention of medical personnel.
- Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including any resulting complications.
- Services performed by a Family Member.
- Services related to sex or gender change, sterilization, in vitro fertilization, vasectomy or reversal of a vasectomy, or tubal ligation.
- Elective Abortion – an abortion for any reason other than to preserve the life of the person upon whom the abortion is performed.
- Dental Services or Treatment.
- Cosmetic surgery, except when due to:
 - o Reconstructive surgery, when the service is related to or follows surgery resulting from a Covered Accidental Injury or a Covered Sickness, or is related to or results from a congenital disease or anomaly of a covered dependent child.
 - o Congenital defects in newborns.
- 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.

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SECTION VI – CLAIM PROVISIONS

Notice of Claim

Written Notice of Claim must be given to us:

- Within 60 days after the Covered Accidental Injury or Covered Sickness, or
- As soon as reasonably possible.

When we receive written Notice of Claim, we will send a claim form. If the Claimant does not receive the claim form within 15 days after the notice is sent, written Proof of Loss can be sent to us without waiting for the form. Notice must include the Employee's name and the Certificate number. Notice can be mailed to the Company at the following address:

P.O. Box 84075, Columbus, GA 31993-9103

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. It can include a statement by the treating Doctor.) Proof of Loss establishes the nature and extent of the loss, the Company's obligation to pay the claim, and the Claimant's right to receive payment.

The Claimant must provide Proof of Loss to the Company at the following address:

P.O. Box 84075, Columbus, GA 31993-9103

Proof of Loss must be given to us within 90 days of the Covered Accidental Injury or Covered Sickness. Failure to give Proof of Loss within such time shall not invalidate or reduce any claim if such Proof of Loss is given as soon as reasonably possible. The Company will not accept Proof of Loss any later than one year and three months after the Covered Accidental Injury or Covered Sickness, except in the absence of the Employee's legal mental capacity.

The Claimant will be responsible for the cost of obtaining a completed claim form. We may request additional Proof of Loss, such as records from Hospitals or Doctors. We will be responsible for the cost of obtaining these records.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

When we receive the claim and due Proof of Loss, we will review the Proof of Loss. If we approve the claim, we will pay the benefits subject to the terms of the Certificate.

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 exams or autopsy.

Time of Payment of Claims

For benefits other than for loss of time, the Company will, once we receive the required Proof of Loss, pay, deny, or settle each submitted claim no later than the 60th day after the date Proof of Loss is received. Subject to written Proof of Loss, all accrued benefits payable under the Policy for loss of time will be paid at least monthly during the period for which the Company is liable. Any balance remaining unpaid at the end of that time will be paid as soon as possible after the Proof of Loss is received.

Payment of Claims

We will pay all benefits to the Employee unless otherwise assigned. For any benefits that remain unpaid at the time of death, we will pay those benefits in the following order:

- To the beneficiary designated by the Insured or the beneficiary's assignee.
- To the Insured's surviving Spouse.
- To the Insured's estate.

Unpaid Premium

When a claim is paid, we may deduct any premium due and unpaid from the claim payment.

Changing of Beneficiary

A change in beneficiary must be submitted in writing to our Home Office in a form acceptable to us and signed by the Employee. Unless otherwise specified by the Employee, a change in beneficiary will take effect on the date the notice of change is signed. We will not be liable for any action taken before notice is received and recorded at the Home Office.

Claim Review

If a claim is denied, the Employee will be given written notice of:

- The reason for the denial,
- The Plan provision that supports the denial, and
- His right to ask for a review of the claim.

Appeals Procedure

Before filing any lawsuit—and no later than 60 days after notice of denial of a claim—the Employee, the Claimant, or an authorized representative of either must appeal any denial of benefits under the Plan by sending a written request for review of the denial to our Home Office.

Legal Action

The Employee may not take Legal Action against us for benefits under this Plan:

- Within 60 days after he has 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

This insurance is provided under a contract of Group Supplemental Hospital Indemnity insurance with the Policyholder. The Entire Contract of Insurance is made up of:

- The Policy;
- The Certificates of insurance;
- The Application of the Policyholder, a copy of which is attached to and made part of the Policy when issued; and
- Any Riders, Endorsements, or Amendments to the Policy or Certificate.

In the absence of fraud, a statement made by the Policyholder or an Insured is considered a representation and not a warranty. A statement made by the Policyholder or an Insured will not be used in any contest under the Plan, unless a copy of the written instrument containing the statement is or has been provided to:

- The person making the statement; or
- If the statement was made by the Insured and the Insured has died or become incapacitated, the Insured's beneficiary or personal representative.

Changes to the 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 or producer (nor can an agent or producer waive any Plan provisions).

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.

Successor Insured

If an Employee dies while covered under his Certificate and his Spouse is also insured under this Plan at the time of the Employee's death, then his surviving Spouse may elect to become the primary Insured. This would include continuation of any Dependent Child Rider coverage that is in force at that time.

To become the primary Insured and keep coverage in force, the surviving Spouse must:

- Notify the Company in writing within 31 days after the date of the Employee's death; and
- Pay the required premium to the Company no later than 31 days after the date of the Employee's death, and on each premium due date thereafter.

If the Certificate does not cover a surviving Spouse, the Certificate will terminate on the next premium due date following the Employee's death.

Time Limit on Certain Defenses

After two years from the Employee's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Employee's 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 such clerical error, the Company will make a premium adjustment.

Individual Certificates

The Company will give the Policyholder a Certificate for each Employee. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, and
- The rights and privileges under the Plan.

Required Information

The Policyholder will be responsible for furnishing all information and proofs that the Company may reasonably require with regard to the Plan.

Conformity with State Statutes

This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes.

POLICY SCHEDULE

Group Policyholder: CITY OF MERCEDES
Group Policy Number: CTR0015283525
Group Policy Effective Date: January 1, 2024
Group Policy Anniversary Date: January 1, 2025
Jurisdiction: Texas

*Initial premium includes the premium for any Riders purchased at the same time as the coverage provided by an Employee's Certificate.

This Plan is delivered in and governed by the laws of the jurisdiction shown above.

BENEFIT SCHEDULE

Hospitalization Category

Hospital Admission Benefit

Payable once per admission

Maximum per Insured per each Covered Sickness

Maximum per Insured per each Covered Accident

Maximum per Insured

\$2,000.00 per admission

1 time per Calendar Year

1 time per Calendar Year

1 time per Calendar Year

Hospital Confinement Benefit

Maximum confinement period

Hospital Intensive Care Benefit

Maximum confinement period

Intermediate Intensive Care Step-Down Unit Benefit

Maximum confinement period

\$200.00 per day

up to maximum confinement period

31 days per Covered Sickness or Covered Accident

\$200.00 per day

10 days per Covered Sickness or Covered Accident

\$100.00 per day

10 days Per Calendar Year

INCORPORATION OF RIDER PROVISIONS

The attached listed Riders are made a part of this Plan.

Rider Name

Dependent Spouse Benefit Rider

Dependent Children Benefit Rider

Form Number

C80301

C80302TX

SCHEDULE OF PREMIUMS

RATES TABLE FOR: CITY OF MERCEDES / HOSPITAL INDEMNITY

DEDUCTION FREQUENCY	:	Monthly (12pp / yr)
EMPLOYEE COST	:	\$20.40



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Amendment to Policy, Certificate of Insurance, and Dependent Child Rider for Group Supplemental Hospital Indemnity

This Amendment is subject to all of the provisions of the Policy and Certificate to which it is attached. Additions or changes have been made to the Policy, Certificate, and Dependent Child Rider and are indicated below.

EFFECTIVE DATE

If issued at the same time as the Certificate, this Amendment becomes effective at the same time as the Certificate. If issued after the Certificate, this Amendment will have a later Effective Date.

The following sentence is added to the Effective Date provision:

Dependent coverage will begin on the date of the Life Event if notice was provided within 31 days after the Life Event.

The Plan Termination provision is deleted and replaced with the following:

Plan Termination

The **Company** has the right to cancel the Plan on any premium due date for the following reasons:

- The premium is not paid before the end of the Grace Period,
- The number of participating Employee is less than the number mutually agreed upon by the Company and the Policyholder,
- The number of participating Employee changes by 25% or more,
- The Policyholder fails to perform any of the obligations that relate to this policy or that are required by applicable law,
- The Policyholder no longer offers coverage to a particular class of Employee,
- The Policyholder no longer serves a class of Employee who reside in a particular geographical area, or
- The Policyholder does not provide timely information that is reasonably required.

The **Policyholder** has the right to cancel the Plan on any premium due date.

- To do this, the Policyholder must give the Company at least 31 days' written notice.
- The Plan will end on the date in the written notice or the date the Company receives the notice, whichever is later.

All outstanding premiums are due upon Plan termination. If the Company accepts premium payments after the Plan terminates, this will not reinstate the Plan.

The Policyholder has the sole responsibility of notifying Certificateholders in writing of the Plan's termination as soon as reasonably possible. If the Plan terminates, it—and all Certificates and Riders issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

The Termination of Your Insurance provision is deleted and replaced with the following:

Termination of Your Insurance

Your insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.

- The 31st day after the premium due date (the last day of the Grace Period), if the premium has not been paid.
- The date you no longer belong to an eligible class.

If an Insured's coverage terminates, we will provide benefits for valid claims that arose while your coverage was active.

The Continuation Privilege provision is deleted and replaced with the following:

Continuation Privilege

When you are no longer a member of an eligible class and your coverage would otherwise end, you may elect to continue your coverage under this Plan. You may continue the coverage you had on the date your Certificate would otherwise terminate, including any in-force Dependent Spouse Rider or Dependent Child Rider coverage, without any additional underwriting requirements.

To keep your coverage in force, you must:

- Notify the Company within 31 days after the date your coverage would otherwise terminate. You may notify us by sending written notice to P.O. Box 84079, Columbus, GA 31993-9101 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly to the Company no later than 31 days after the date your coverage would otherwise terminate and on each premium due date thereafter.

Your continued coverage will end on the earliest of the following dates:

- 31 days after the premium due date (the last day of the Grace Period), if the premium has not been paid, or
- The date the Group Plan is terminated.

If you qualify for this Continuation Privilege, then the Company will apply the same Benefits, Premium Rate, and Plan Provisions as shown in your previously-issued Certificate. Notification of any changes in the Plan will be provided directly by the Company.

The Grace Period provision is deleted and replaced with the following:

Grace Period

This Plan has a 31-day Grace Period. If a 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. If the Plan is discontinued, the Plan's termination date will be the latest date for which premium has been paid.

The definition of Dependent Child or Dependent Children is deleted and replaced with the following:

Dependent Child or ***Dependent Children*** means your or your Spouse's natural children, step-children, grandchildren who are in your legal custody and residing with you, foster children, children subject to legal guardianship, adopted children, or Children Placed for Adoption, who are younger than age 26. However, we will continue coverage for Dependent Children insured under the Plan after the age of 26 if they are incapable of self-sustaining employment due to mental or physical disability, and are chiefly dependent on a parent for support and maintenance. You or your Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday.

The insurance on any Dependent Child will terminate on the last day of the month in which the Dependent Child turns age 26; it is your responsibility to notify us in writing when coverage on a Dependent Child terminates. Termination will be without prejudice to any claim originating prior to the date of termination. Our acceptance of premium after such date will be considered as premium for only the remaining persons who qualify as Insureds under this Plan. When coverage on all Dependent Children terminates, you must notify the Company, in writing, and elect whether to continue this Plan on an Employee or Employee and Spouse Coverage basis. After such notice, we will arrange for the payment of the appropriate premium due, including returning any unearned premium.

Children Placed for Adoption are children for whom you have entered a decree of adoption, have initiated adoption proceedings, or are a party to a suit in which you seek to adopt the child. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. You must continue to have custody pursuant to the decree of the court.

Your natural Dependent Children born after the Effective Date of this Rider will be covered from the moment of live birth. No notice or additional premium is required.

The definition below is added to the Definitions section:

Observation Unit means a unit in which observation services are given through Hospital outpatient services to help the Doctor decide if the patient needs to be admitted as an inpatient or can be discharged. Observation services may be given in the emergency department or another area of the Hospital.

Hospitalization Benefits

The Hospital Admission Benefit is deleted and replaced with the following:

Hospital Admission Benefit

We will pay this benefit when an Insured is admitted to a Hospital and confined as an inpatient because of a Covered Accidental Injury or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, an Insured must be admitted to a Hospital within six months of the date of the Covered Accident.

We will pay the Hospital Admission Benefit amount shown in the Benefit Schedule. We will not pay benefits for confinement to an Observation Unit, or for emergency room Treatment or outpatient Treatment. We will not pay benefits for Hospital Admission of a newborn child following his birth. However, we will pay for a newborn's admission to a Hospital Intensive Care Unit if, following birth, he is confined as an inpatient as a result of a Covered Accidental Injury or Covered Sickness (including congenital defects, birth abnormalities, and/or premature birth).

We will pay this benefit once per period of Hospital Confinement. This benefit is limited to the maximum shown in the Benefit Schedule. We will only pay this benefit once for each Covered Accident or Covered Sickness per Calendar Year. If an Insured is confined to the Hospital because of the same or Related Accidental Injury or Sickness, we will not pay this benefit again in the same Calendar Year.

The Hospital Confinement Benefit is deleted and replaced with the following:

Hospital Confinement Benefit

We will pay the amount shown in the Benefit Schedule for each day that an Insured is confined to a Hospital as an inpatient as the result of a Covered Accidental Injury or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, the Insured must be confined to a Hospital within six months of the date of the Covered Accident.

The length of time shown for Hospital Confinement in the Benefit Schedule is the maximum period for which an Insured can collect benefits for Hospital Confinements resulting from Covered Sicknesses or from Covered Accidental Injuries received in the same Covered Accident. We will not pay benefits for confinement to an Observation Unit, or for emergency room Treatment or outpatient Treatment.

If we pay benefits for confinement and the Insured becomes confined again within six months because of the same or a Related condition, we will treat this confinement as the same period of confinement.

This benefit is payable for only one Hospital Confinement at a time, even if it is caused by more than one Covered Accidental Injury, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

The Proof of Loss provision is deleted and replaced with the following:

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. It can include a statement by the treating Doctor.) Proof of Loss establishes the nature and extent of the loss, the Company's obligation to pay the claim, and the Claimant's right to receive payment.

The Claimant must provide Proof of Loss to the Company at the following address:

P.O. Box 84075, Columbus, Georgia, 31993-9103

Proof of Loss must be given to us within 90 days of the Covered Accidental Injury or Covered Sickness. Failure to give Proof of Loss within such time shall not invalidate or reduce any claim if such Proof of Loss is given as soon as reasonably possible. The Company will not accept Proof of Loss any later than one year and three months after the Covered Accidental Injury or Covered Sickness, except in the absence of the Claimant's legal mental capacity.

The Claimant will be responsible for the cost of obtaining a completed claim form. We may request additional Proof of Loss, such as records from Hospitals or Doctors. The Claimant will be responsible for the cost of obtaining these records.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

When we receive the claim and due Proof of Loss, we will review the Proof of Loss. If we approve the claim, we will pay the benefits subject to the terms of the Certificate.

The Successor Insured provision is deleted and replaced with the following:

Successor Insured

If you die while covered under this Certificate and your Spouse is also insured under this Plan at the time of your death, then your surviving Spouse may elect to become the primary Insured. This would include continuation of any Dependent Child Rider coverage that is in force at that time.

To become the primary Insured and keep coverage in force, your surviving Spouse must:

- Notify the Company in writing within 31 days after the date of your death; and
- Pay the required premium to the Company no later than 31 days after the date of your death, and on each premium due date thereafter.

If the Certificate does not cover a surviving Spouse, the Certificate will terminate on the next premium due date following your death.

The Individual Certificates provision is deleted and replaced with the following:

Individual Certificates

The Company will give the Policyholder a Certificate for each Employee. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, and
- The rights and privileges under the Plan.

CONTRACT

This Amendment is part of the Policy and Certificate and will terminate when the Policy or Certificate terminates.

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Dependent Spouse Benefit Rider To Certificate of Insurance for Group Supplemental Hospital Indemnity Policy

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- We have accepted your Application, and
- You have paid the additional premium for this Rider.

This Rider is subject to all the definitions, exclusions, limitations, terms, and other provisions of the Certificate to which it is attached, unless those terms are inconsistent with this Rider.

EFFECTIVE DATE

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date. Dependent Spouse coverage will become effective on the Effective Date of the Rider if the Dependent Spouse is Active on that date. Otherwise, the Effective Date will be deferred until the day following the date he becomes Active.

DEFINITIONS

When the terms below are used in this Rider, the following definitions apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

Active refers to a Dependent Spouse who is not confined in a Hospital and who is able to carry on regular activities customary of a person in good health of the same age and gender.

Dependent Spouse is your legal wife or husband, who is at least age 18 and is listed on your Application.

BENEFITS

If a Dependent Spouse qualifies for benefits because of a Covered Accidental Injury or Covered Sickness, we will provide the benefits shown in the Dependent Spouse Benefit Schedule issued with this Rider. The only benefits for which a Dependent Spouse is eligible are those shown in the Dependent Spouse Benefit Schedule.

GENERAL PROVISIONS

If your Dependent Spouse's coverage terminates, we will provide benefits for valid claims that arose while Dependent Spouse coverage was active.

Time Limit on Certain Defenses

After two years from the Insured's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Application. This does not apply to fraudulent misstatements.

CONTRACT

This Rider is part of the Group Supplemental Hospital Indemnity Certificate. It will terminate:

- When the Certificate terminates,
- On the premium due date following the date the covered Spouse no longer qualifies as a Dependent,

- On the premium due date following the date we receive your written request to terminate coverage for your Spouse, or
- When premiums are no longer paid for this Rider.

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary

DEPENDENT SPOUSE BENEFITS SCHEDULE

Hospitalization Category

Hospital Admission Benefit	\$2,000.00 per admission
Payable once per admission	
Maximum per Insured per each Covered Sickness	1 time per Calendar Year
Maximum per Insured per each Covered Accident	1 time per Calendar Year
Maximum per Insured	1 time per Calendar Year
Hospital Confinement Benefit	\$200.00 per day
Maximum confinement period	up to maximum confinement period 31 days per Covered Sickness or Covered Accident
Hospital Intensive Care Benefit	\$200.00 per day
Maximum confinement period	10 days per Covered Sickness or Covered Accident
Intermediate Intensive Care Step-Down Unit Benefit	\$100.00 per day
Maximum confinement period	10 days Per Calendar Year



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Dependent Children Benefit Rider To Certificate of Insurance for Group Supplemental Hospital Indemnity Policy

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- We have accepted your Application, and
- You have paid the additional premium for this Rider.

This Rider is subject to all the definitions, exclusions, limitations, terms, and other provisions of the Certificate to which it is attached, unless those terms are inconsistent with this Rider.

EFFECTIVE DATE

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date. Dependent Child coverage will become effective on the Effective Date of the Rider if the Dependent Child is Active on that date. Otherwise, the Effective Date will be deferred until the day following the date he becomes Active.

DEFINITIONS

When the terms below are used in this Rider, the following definitions apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

Active refers to a Dependent Child who is not confined in a Hospital and who is able to carry on regular activities customary of a person in good health of the same age and gender.

Dependent Child or **Dependent Children** means your or your Spouse's natural children, step-children, grandchildren who are in your legal custody and residing with you, foster children, children subject to legal guardianship, legally adopted children, or Children Placed for Adoption. Dependent Children must be younger than age 26.

Children Placed for Adoption are Children for whom you have entered a decree of adoption or for whom you have initiated adoption proceedings. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. You must continue to have custody pursuant to the decree of the court.

A child is considered to be the child of an Insured if the Insured is a party to a suit in which the Insured seeks to adopt the child.

There is an exception to the age-26 limit above. This limit will not apply to any Dependent Child who is incapable of self-sustaining employment due to mental or physical handicap and is chiefly dependent on a parent for support and maintenance. You or your Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday.

Your natural Dependent Children born after the Effective Date of this Rider will be covered from the moment of live birth. No notice or additional premium is required.

BENEFITS

If a Dependent Child qualifies for benefits because of a Covered Accidental Injury or Covered Sickness, we will provide the benefits shown in the Dependent Children Benefit Schedule

issued with this Rider. The only benefits for which a Dependent Child is eligible are those shown in the Dependent Children Benefit Schedule.

GENERAL PROVISIONS

If your Dependent Child's coverage terminates, we will provide benefits for valid claims that arose while his coverage was active.

Time Limit on Certain Defenses

After two years from the Insured's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Application. This does not apply to fraudulent misstatements.

CONTRACT

This Rider is part of the Group Supplemental Hospital Indemnity Certificate. It will terminate:

- When the Certificate terminates,
- On the premium due date following the date the covered Child no longer qualifies as a Dependent,
- When the covered Dependent Child reaches age 26 (details in the **Definitions** section of this Rider),
- On the premium due date following the date we receive your written request to terminate coverage for your Child, or
- When premiums are no longer paid for this Rider.

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary

DEPENDENT CHILDREN BENEFITS SCHEDULE

Hospitalization Category

Hospital Admission Benefit	\$2,000.00 per admission
Payable once per admission	
Maximum per Insured per each Covered Sickness	1 time per Calendar Year
Maximum per Insured per each Covered Accident	1 time per Calendar Year
Maximum per Insured	1 time per Calendar Year
Hospital Confinement Benefit	\$200.00 per day
	up to maximum confinement period
Maximum confinement period	31 days per Covered Sickness or Covered Accident
Hospital Intensive Care Benefit	\$200.00 per day
Maximum confinement period	10 days per Covered Sickness or Covered Accident
Intermediate Intensive Care Step-Down Unit Benefit	\$100.00 per day
Maximum confinement period	10 days Per Calendar Year



CONTINENTAL AMERICAN INSURANCE COMPANY

**Columbia, South Carolina
800.433.3036**

Please call the toll-free number above with any questions about this coverage.

Certificate of Insurance For Group Supplemental Hospital Indemnity Policy

This limited Plan provides supplemental benefits only. It does not constitute comprehensive health insurance coverage and does not satisfy the requirement of Minimum Essential Coverage under the Affordable Care Act.

THIS PLAN IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

This Certificate is not a Medicare Supplement Certificate. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

This Plan provides the benefits listed in the Benefit Schedule. Please read it carefully.

Your Employer (the "Policyholder") applied for coverage under this Group Supplemental Hospital Indemnity Insurance Policy (the "Plan"). This Plan is issued by Continental American Insurance Company (the "Company," "CAIC," "we," "us," or "our"). For the purposes of this Plan, "you" (including "your" and "yours") refers to you. Based on the application process and the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. (Please note that male pronouns—such as "he," "him," and "his"—are used for both males and females, unless the context clearly shows otherwise.)

You will notice that certain words and phrases (including some medical terms and the names of Plan documents) in this document are capitalized. The capitalized words refer to terms with very specific definitions as they apply to this insurance Plan.

We certify that you are insured under the Group Supplemental Hospital Indemnity Policy (the "Plan"). The Plan was issued to the Policyholder. The Certificate is subject to the Definitions, Exclusions, and other provisions of the Plan.

Certain provisions of the Plan are summarized in this Certificate. All provisions of the Plan, whether contained in your Certificate or not, apply to the insurance referred to by the Certificate.

The Certificate Effective Date is shown in the Certificate Schedule. The Certificate will terminate as provided in the provision titled "Termination of Your Insurance" in Section I. 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.

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SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

Eligibility

You are eligible to be covered under this Plan if you are Actively at Work for the Policyholder and included in the class that is eligible for coverage, as shown on the Master Application.

Insureds are defined as those who might be eligible for coverage under this Plan in the following categories:

- **Employee Coverage** – We insure only the Employee.
- **Employee and Spouse Coverage** – We insure the Employee and spouse (as defined in the applicable rider).
- **Employee and Children Coverage** – We insure the Employee and any dependent children (as defined in the applicable rider).
- **Family Coverage** – We insure the Employee, spouse, and any dependent children (as defined in the applicable rider).

We will not insure anyone specifically excluded from coverage by Endorsement to the Certificate or by application, even if that person would otherwise be eligible for coverage.

Details for adding Insureds to your coverage are outlined in the Effective Date section.

Effective Date

Your Employee Effective Date is shown on the Certificate Schedule.

Your Employee Effective Date is the date your insurance takes effect. After we receive and approve the Application, that date is either:

- The date shown on the Certificate Schedule if you are Actively at Work on that date, or
- The date you return to an Actively-at-Work status if you were not Actively at Work on the date shown on the Certificate Schedule.

If Employee and Spouse, Employee and Children, or Family Coverage is offered:

- A Dependent may be added to the Plan after the Employee's Effective Date within 31 days of a Life Event or during an approved enrollment period.
- If Dependent Child Rider coverage is **already in force**, no additional notice or premium is required to add another dependent child.
- If Dependent Spouse Rider or Dependent Child Rider coverage is **not** in force, the Employee must complete an Application to add a Dependent to the Plan. The Company will assign a Dependent Rider Effective Date for a Dependent's coverage after approving the Application. For Dependent coverage to become effective, the premium for the Dependent must be included in the premium payment.
- If Dependent Child Rider coverage is not already in force, **newborn** children are automatically covered from the moment of birth for 60 days. **Newly adopted** children are automatically covered from the earlier of a) placement for adoption, b) the date of entry of an order granting custody of the child for the purposes of adoption, or c) the effective date of adoption, for 60 days. To extend coverage beyond 60 days with no gap in coverage, the Employee must contact the Company within the 60-day time period following the child's birth or adoption. No premium is due for the first 60 days of newborn/newly adopted coverage.

A day begins at 12:01 a.m. standard time at the Employee's place of residence.

Plan Termination

The **Company** has the right to cancel the Plan on any premium due date for the following reasons:

- The premium is not paid before the end of the Grace Period,
- The number of participating Employees is less than the number mutually agreed upon by the Company and the Policyholder,
- The number of participating Employees changes by 25% or more,
- The Policyholder fails to perform any of the obligations that relate to this policy or that are required by applicable law,
- The Policyholder no longer offers coverage to a particular class of Employees,
- The Policyholder no longer serves a class of Employees who reside in a particular geographical area, or

- The Policyholder does not provide timely information that is reasonably required.

The **Policyholder** has the right to cancel the Plan on any premium due date.

- To do this, the Policyholder must give the Company at least 31 days' written notice.
- The Plan will end on the date in the written notice or the date the Company receives the notice, whichever is later.

All outstanding premiums are due upon Plan termination. If the Company accepts premium payments after the Plan terminates, this will not reinstate the Plan; we will refund any excess premium.

The Policyholder has the sole responsibility of notifying Certificateholders in writing of the Plan's termination as soon as reasonably possible. If the Plan terminates, it—and all Certificates and Riders issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

Termination of Your Insurance

Your insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date (the last day of the Grace Period), if the premium has not been paid.
- The date you no longer belong to an eligible class.

If an Insured's coverage terminates, we will provide benefits for valid claims that arose while your coverage was active.

Continuation Privilege

When you are no longer a member of an eligible class and your coverage would otherwise end, you may elect to continue your coverage under this Plan. You may continue the coverage you had on the date your Certificate would otherwise terminate, including any in-force Dependent Spouse Rider or Dependent Child Rider coverage, without any additional underwriting requirements.

To keep your coverage in force, you must:

- Notify the Company within 31 days after the date your coverage would otherwise terminate. You may notify us by sending written notice to P.O. Box 84079, Columbus, GA 31993-9101 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly to the Company no later than 31 days after the date your coverage would otherwise terminate and on each premium due date thereafter.

Your ported coverage will end on the earliest of the following dates:

- 31 days after the premium due date (the last day of the Grace Period), if the premium has not been paid, or
- The date the Group Plan is terminated.

If you qualify for this Continuation Privilege, then the Company will apply the same Benefits Plan Provisions, and Premium Rate as shown in your previously-issued Certificate. Notification of any changes in the Plan will be provided directly by the Company.

SECTION II – PREMIUM PROVISIONS

Premium Payments

Premiums should be paid to the Company at its Home Office in Columbia, South Carolina. The first premiums are due on the Plan's Effective Date. After that, premiums are due on the first day of each month that the Plan remains in effect.

Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period provision.

Premium Changes

Unless we have agreed in writing not to increase premiums, the premium may change:

- On the Group Policy Anniversary Date based on renewal underwriting. (The Group Policy Anniversary Date is shown on the Policy Schedule and falls on the same date each year thereafter.)
- Whenever the terms or conditions of the Plan are modified. The new premium rates will apply only to premiums due on or after the rate change takes effect.

We will provide the Policyholder a 31-day advance written notice of any change in premiums.

Grace Period

This Plan has a 31 -day Grace Period. If a premium is not paid on or before its due date, the premium may be paid during the next 31days. 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. If the Plan is discontinued, the Plan's termination date will be the latest date for which premium has been paid.

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SECTION III – DEFINITIONS

When the terms below are used in this Plan, the following definitions apply:

Accidental Injury means accidental bodily damage to an Insured. This must be the direct result of an accident and not the result of disease or bodily infirmity. A **Covered Accidental Injury** is an Accidental Injury that occurs while coverage is in force. A **Covered Accident** is an accident that occurs on or after an Insured's Effective Date while coverage is in force, and that is not specifically excluded by the Plan.

Actively at Work refers to your ability to perform your regular employment duties for a full normal workday. You may perform these activities either at your Employer's regular place of business or at a location where you are required to travel to perform the regular duties of your employment.

Calendar Year means the period beginning on the policy Effective Date and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

Claimant means a person who is authorized to make a claim under the Certificate.

Dependent means your spouse or dependent children, as defined in the applicable rider, who have been accepted for coverage.

Doctor is a person who is duly qualified as a practitioner of the healing arts acting within the scope of his license, and:

- Is licensed to practice medicine; prescribe and administer drugs; or to perform surgery, or
- Is a duly qualified medical practitioner according to the laws and regulations in the state in which Treatment is made.

A Doctor **does not** include you or any of your Family Members.

For the purposes of this definition, **Family Member** includes your Spouse as well as the following members of your immediate family:

- Son
- Daughter
- Mother
- Father
- Sister
- Brother

This includes step-Family Members and Family-Members-in-law.

Employee is a person who meets Eligibility requirements under **Section I – Eligibility, Effective Date, and Termination**, and who is covered under this Plan. The Employee is the primary Insured under this Plan.

Hospital means a place that meets all of the following criteria:

- Is legally licensed and operated as a Hospital,
- Provides overnight care of injured and sick people,
- Is supervised by a Doctor,
- Has full-time nurses supervised by a registered nurse, and
- Has on-site use of X-ray equipment, laboratory, and surgical facilities.

The term *Hospital* specifically excludes any facility not meeting the definition of Hospital as defined in this Plan, including but not limited to:

- A nursing home,
- An extended care facility,
- A skilled nursing facility,
- A rest home or home for the aged,
- A Rehabilitation Facility,
- A facility for the Treatment of alcoholism or drug addiction, or
- An assisted living facility.

Hospital Intensive Care Unit means a place that meets all of the following criteria:

- Is a specifically designated area of the Hospital called a Hospital Intensive Care Unit;
- Provides the highest level of medical care;
- Is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- Is separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement;
- Is permanently equipped with special life-saving equipment for the care of the critically ill or injured;
- Is under close observation by a specially trained nursing staff assigned exclusively to the Hospital Intensive Care Unit 24 hours a day; and
- Has a Doctor assigned to the Hospital Intensive Care Unit on a full-time basis.

The term *Hospital Intensive Care Unit* specifically excludes any type of facility not meeting the definition of Hospital Intensive Care Unit as defined in this Plan, including but not limited to private monitored rooms, surgical recovery rooms, observation units, and the following step-down units:

- A progressive care unit,
- A sub-acute intensive care unit, or
- An intermediate care unit.

Intermediate Intensive Care Step-Down Unit means any of the following:

- A progressive care unit,
- A sub-acute intensive care unit,
- An intermediate care unit, or
- A pre- or post-intensive care unit.

An Intermediate Intensive Care Step-Down Unit is **not** a Hospital Intensive Care Unit as defined in this Plan.

Life Event means an event that qualifies you to make changes to benefits at times other than your enrollment period. Events qualifying as Life Events are established solely by the Policyholder.

Rehabilitation Facility is a unit or facility providing coordinated multidisciplinary physical restorative services. These services must be provided to inpatients under a Doctor's direction. The Doctor must be knowledgeable and experienced in rehabilitative medicine. Beds must be set up in a unit or facility specifically designated and staffed for this service. This is not a facility for the Treatment of alcoholism or drug addiction.

Related – a Related Accidental Injury or Sickness is one that is in correlation to, or occurs as a result of, the initial Accidental Injury or Sickness, and would not otherwise have been sustained if that initial condition had not occurred.

Sickness means an illness, infection, disease, or any other abnormal physical condition or pregnancy that is not caused solely by, or the result of, any injury. A **Covered Sickness** is one that is not excluded by name, specific description, or any other provision in this Plan. For a benefit to be payable, loss arising from the Covered Sickness must occur while the applicable Insured's coverage is in force.

Spouse is your legal wife or husband , including a legally-recognized same-sex Spouse , or a person of either gender who is in a legally recognized and registered domestic partnership, civil union, reciprocal beneficiary relationship, or similar relationship with you.

Telemedicine Service means a medical inquiry with a Doctor via audio or video communication that assists with a patient's assessment, diagnosis, and consultation.

Treatment is the consultation, care, or services provided by a Doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines. Treatment does **not** include Telemedicine Services.

SECTION IV – BENEFIT PROVISIONS

Hospitalization Benefits

Hospital Admission Benefit

We will pay this benefit when an Insured is admitted to a Hospital and confined as an inpatient because of a Covered Accidental Injury or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, an Insured must be admitted to a Hospital within six months of the date of the Covered Accident.

We will pay the Hospital Admission Benefit amount shown in the Benefit Schedule. We will not pay benefits for confinement to an observation unit, or for emergency room Treatment or outpatient Treatment..

We will pay this benefit once per period of Hospital Confinement. This benefit is limited to the maximum shown in the Benefit Schedule. We will only pay this benefit once for each Covered Accident or Covered Sickness per Calendar Year. If an Insured is confined to the Hospital because of the same or Related Accidental Injury or Sickness, we will not pay this benefit again in the same Calendar Year.

Hospital Confinement Benefit

We will pay the amount shown in the Benefit Schedule for each day that an Insured is confined to a Hospital as an inpatient as the result of a Covered Accidental Injury or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, the Insured must be confined to a Hospital within six months of the date of the Covered Accident.

The length of time shown for Hospital Confinement in the Benefit Schedule is the maximum period for which an Insured can collect benefits for Hospital Confinements resulting from Covered Sickness or from Covered Accidental Injuries received in the same Covered Accident.

If we pay benefits for confinement and the Insured becomes confined again within six months because of the same or a Related condition, we will treat this confinement as the same period of confinement.

This benefit is payable for only one Hospital Confinement at a time, even if it is caused by more than one Covered Accidental Injury, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

Hospital Intensive Care Benefit

If an Insured is confined in a Hospital Intensive Care Unit because of a Covered Accidental Injury or Covered Sickness, we will pay the daily benefit amount shown in the Benefit Schedule. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, an Insured must be admitted to a Hospital Intensive Care Unit within six months of the date of the Covered Accident.

We will pay this amount for each day of such confinement, but not to exceed the maximum benefit period shown on the Benefit Schedule during any one period of confinement.

We will pay benefits for only one confinement in a Hospital Intensive Care Unit at a time, even if it is caused by more than one Covered Accidental Injury, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

If we pay benefits for confinement in a Hospital Intensive Care Unit and an Insured becomes confined to a Hospital Intensive Care Unit again within six months because of the same or a Related condition, we will treat this confinement as the same period of confinement.

This benefit is payable in addition to the Hospital Confinement Benefit.

Intermediate Intensive Care Step-Down Unit Benefit

If an Insured is confined in an Intermediate Intensive Care Step-Down Unit because of a Covered Accidental Injury or Covered Sickness, we will pay the daily benefit amount shown on the Benefit Schedule. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, the Insured must be admitted to an Intermediate Intensive Care Step-Down Unit within six months of the date of the Covered Accident.

We will pay this amount for each day of such confinement, not to exceed the maximum benefit period shown in the Benefit Schedule during any one period of confinement.

We will pay benefits for only one confinement in an Intermediate Intensive Care Step-Down Unit at a time, even if it is caused by more than one Covered Accidental Injury, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

If we pay benefits for confinement in a Hospital's Intermediate Intensive Care Step-Down Unit and the Insured becomes confined to a Hospital's Intermediate Intensive Care Step-Down Unit again within six months because of the same or a Related condition, we will treat this confinement as the same period of confinement.

This benefit is payable in addition to the Hospital Confinement Benefit.

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SECTION V – EXCLUSIONS

Exclusions

We will not pay for loss due to:

- War – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the Insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.
- Suicide – committing or attempting to commit suicide, while sane or insane.
- Self-Inflicted Injuries – injuring or attempting to injure oneself intentionally.
- Racing – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semi-professional capacity.
- Illegal Occupation – voluntarily participating in, committing, or attempting to commit a felony or illegal act or activity, or voluntarily working at, or being engaged in, an illegal occupation or job.
- Sports – participating in any organized sport in a professional or semi-professional capacity.
- Custodial Care – this is non-medical care that helps individuals with the basic tasks of everyday life, the preparation of special diets, and the self-administration of medication which does not require the constant attention of medical personnel.
- Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including any resulting complications.
- Services performed by a Family Member.
- Services related to sex or gender change, sterilization, in vitro fertilization, vasectomy or reversal of a vasectomy, or tubal ligation.
- Elective Abortion – an abortion for any reason other than to preserve the life of the person upon whom the abortion is performed.
- Dental Services or Treatment.
- Cosmetic surgery, except when due to:
 - o Reconstructive surgery, when the service is related to or follows surgery resulting from a Covered Accidental Injury or a Covered Sickness, or is related to or results from a congenital disease or anomaly of a covered dependent child.
 - o Congenital defects in newborns.
- 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.

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SECTION VI - CLAIM PROVISIONS

Notice of Claim

Written Notice of Claim must be given to us:

- Within 60 days after the Covered Accidental Injury or Covered Sickness, or
- As soon as reasonably possible.

When we receive written Notice of Claim, we will send a claim form. If the Claimant does not receive the claim form within 15 days after the notice is sent, written Proof of Loss can be sent to us without waiting for the form. Notice must include the Employee's name and the Certificate number. Notice can be mailed to the Company at the following address:

P.O. Box 84075, Columbus, GA 31993-9103

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. It can include a statement by the treating Doctor.) Proof of Loss establishes the nature and extent of the loss, the Company's obligation to pay the claim, and the Claimant's right to receive payment.

The Claimant must provide Proof of Loss to the Company at the following address:

P.O. Box 84075, Columbus, GA 31993-9103

Proof of Loss must be given to us within 90 days of the Covered Accidental Injury or Covered Sickness. Failure to give Proof of Loss within such time shall not invalidate or reduce any claim if such Proof of Loss is given as soon as reasonably possible. The Company will not accept Proof of Loss any later than one year and three months after the Covered Accidental Injury or Covered Sickness, except in the absence of your legal mental capacity.

The Claimant will be responsible for the cost of obtaining a completed claim form. We may request additional Proof of Loss, such as records from Hospitals or Doctors. We will be responsible for the cost of obtaining these records.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

When we receive the claim and due Proof of Loss, we will review the Proof of Loss. If we approve the claim, we will pay the benefits subject to the terms of the Certificate.

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 exams or autopsy.

Time of Payment of Claims

For benefits other than for loss of time, the Company will, once we receive the required Proof of Loss, pay, deny, or settle each submitted claim no later than the 60th day after the date Proof of Loss is received. Subject to written Proof of Loss, all accrued benefits payable under the Policy for loss of time will be paid at least monthly during the period for which the Company is liable. Any balance remaining unpaid at the end of that time will be paid as soon as possible after the Proof of Loss is received.

Payment of Claims

We will pay all benefits to you unless otherwise assigned. For any benefits that remain unpaid at the time of death, we will pay those benefits in the following order:

- To your designated beneficiary or the beneficiary's assignee,
- To your surviving Spouse,
- To your estate.

Unpaid Premium

When a claim is paid, we may deduct any premium due and unpaid from the claim payment.

Changing of Beneficiary

A change in beneficiary must be submitted in writing to our Home Office in a form acceptable to us and signed by you. Unless otherwise specified by you, a change in beneficiary will take effect on the date the notice of change is signed. We will not be liable for any action taken before notice is received and recorded at the Home Office.

Claim Review

If a claim is denied, you will be given written notice of:

- The reason for the denial,
- The Plan provision that supports the denial, and
- Your right to ask for a review of the claim.

Appeals Procedure

Before filing any lawsuit—and no later than 60 days after notice of denial of a claim—you, the Claimant, or an authorized representative of either must appeal any denial of benefits under the Plan by sending a written request for review of the denial to our Home Office.

Legal Action

You may not 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

Your insurance is provided under a contract of Group Supplemental Hospital Indemnity insurance with the Policyholder. The Entire Contract of Insurance is made up of:

- The Policy;
- The Certificate of insurance;
- The Application of the Policyholder, a copy of which is attached to and made part of the Policy when issued; and
- Any Riders, Endorsements, or Amendments to the Policy or Certificate.

In the absence of fraud, a statement made by the Policyholder or an Insured is considered a representation and not a warranty. A statement made by the Policyholder or an Insured will not be used in any contest under the Plan, unless a copy of the written instrument containing the statement is or has been provided to:

- The person making the statement; or
- If the statement was made by the Insured and the Insured has died or become incapacitated, the Insured's beneficiary or personal representative.

Changes to the 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 or producer (nor can an agent or producer waive any Plan provisions).

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.

Successor Insured

If you die while covered under this Certificate and your Spouse is also insured under this Plan at the time of your death, then your surviving Spouse may elect to become the primary Insured. This would include continuation of any Dependent Child Rider coverage that is in force at that time.

To become the primary Insured and keep coverage in force, your surviving Spouse must:

- Notify the Company in writing within 31 days after the date of your death; and
- Pay the required premium to the Company no later than 31 days after the date of your death, and on each premium due date thereafter.

If the Certificate does not cover a surviving Spouse, the Certificate will terminate on the next premium due date following your death.

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 such clerical error, the Company will make a premium adjustment.

Individual Certificates

The Company will give the Policyholder a Certificate for each Employee. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, and
- The rights and privileges under the Plan.

Required Information

The Policyholder will be responsible for furnishing all information and proofs that the Company may reasonably require with regard to the Plan.

Conformity with State Statutes

This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes.

BENEFIT SCHEDULE

Hospitalization Category

Hospital Admission Benefit

Payable once per admission

Maximum per Insured per each Covered Sickness

Maximum per Insured per each Covered Accident

Maximum per Insured

\$2,000.00 per admission

1 time per Calendar Year

1 time per Calendar Year

1 time per Calendar Year

Hospital Confinement Benefit

Maximum confinement period

Hospital Intensive Care Benefit

Maximum confinement period

Intermediate Intensive Care Step-Down Unit Benefit

Maximum confinement period

\$200.00 per day

up to maximum confinement period

31 days per Covered Sickness or Covered Accident

\$200.00 per day

10 days per Covered Sickness or Covered Accident

\$100.00 per day

10 days per Calendar Year



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Amendment to Policy, Certificate of Insurance, and Dependent Child Rider for Group Supplemental Hospital Indemnity

This Amendment is subject to all of the provisions of the Policy and Certificate to which it is attached. Additions or changes have been made to the Policy, Certificate, and Dependent Child Rider and are indicated below.

EFFECTIVE DATE

If issued at the same time as the Certificate, this Amendment becomes effective at the same time as the Certificate. If issued after the Certificate, this Amendment will have a later Effective Date.

The following sentence is added to the Effective Date provision:

Dependent coverage will begin on the date of the Life Event if notice was provided within 31 days after the Life Event.

The Plan Termination provision is deleted and replaced with the following:

Plan Termination

The **Company** has the right to cancel the Plan on any premium due date for the following reasons:

- The premium is not paid before the end of the Grace Period,
- The number of participating Employee is less than the number mutually agreed upon by the Company and the Policyholder,
- The number of participating Employee changes by 25% or more,
- The Policyholder fails to perform any of the obligations that relate to this policy or that are required by applicable law,
- The Policyholder no longer offers coverage to a particular class of Employee,
- The Policyholder no longer serves a class of Employee who reside in a particular geographical area, or
- The Policyholder does not provide timely information that is reasonably required.

The **Policyholder** has the right to cancel the Plan on any premium due date.

- To do this, the Policyholder must give the Company at least 31 days' written notice.
- The Plan will end on the date in the written notice or the date the Company receives the notice, whichever is later.

All outstanding premiums are due upon Plan termination. If the Company accepts premium payments after the Plan terminates, this will not reinstate the Plan.

The Policyholder has the sole responsibility of notifying Certificateholders in writing of the Plan's termination as soon as reasonably possible. If the Plan terminates, it—and all Certificates and Riders issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

The Termination of Your Insurance provision is deleted and replaced with the following:

Termination of Your Insurance

Your insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.

- The 31st day after the premium due date (the last day of the Grace Period), if the premium has not been paid.
- The date you no longer belong to an eligible class.

If an Insured's coverage terminates, we will provide benefits for valid claims that arose while your coverage was active.

The Continuation Privilege provision is deleted and replaced with the following:

Continuation Privilege

When you are no longer a member of an eligible class and your coverage would otherwise end, you may elect to continue your coverage under this Plan. You may continue the coverage you had on the date your Certificate would otherwise terminate, including any in-force Dependent Spouse Rider or Dependent Child Rider coverage, without any additional underwriting requirements.

To keep your coverage in force, you must:

- Notify the Company within 31 days after the date your coverage would otherwise terminate. You may notify us by sending written notice to P.O. Box 84079, Columbus, GA 31993-9101 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly to the Company no later than 31 days after the date your coverage would otherwise terminate and on each premium due date thereafter.

Your continued coverage will end on the earliest of the following dates:

- 31 days after the premium due date (the last day of the Grace Period), if the premium has not been paid, or
- The date the Group Plan is terminated.

If you qualify for this Continuation Privilege, then the Company will apply the same Benefits, Premium Rate, and Plan Provisions as shown in your previously-issued Certificate. Notification of any changes in the Plan will be provided directly by the Company.

The Grace Period provision is deleted and replaced with the following:

Grace Period

This Plan has a 31-day Grace Period. If a 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. If the Plan is discontinued, the Plan's termination date will be the latest date for which premium has been paid.

The definition of Dependent Child or Dependent Children is deleted and replaced with the following:

Dependent Child or ***Dependent Children*** means your or your Spouse's natural children, step-children, grandchildren who are in your legal custody and residing with you, foster children, children subject to legal guardianship, adopted children, or Children Placed for Adoption, who are younger than age 26. However, we will continue coverage for Dependent Children insured under the Plan after the age of 26 if they are incapable of self-sustaining employment due to mental or physical disability, and are chiefly dependent on a parent for support and maintenance. You or your Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday.

The insurance on any Dependent Child will terminate on the last day of the month in which the Dependent Child turns age 26; it is your responsibility to notify us in writing when coverage on a Dependent Child terminates. Termination will be without prejudice to any claim originating prior to the date of termination. Our acceptance of premium after such date will be considered as premium for only the remaining persons who qualify as Insureds under this Plan. When coverage on all Dependent Children terminates, you must notify the Company, in writing, and elect whether to continue this Plan on an Employee or Employee and Spouse Coverage basis. After such notice, we will arrange for the payment of the appropriate premium due, including returning any unearned premium.

Children Placed for Adoption are children for whom you have entered a decree of adoption, have initiated adoption proceedings, or are a party to a suit in which you seek to adopt the child. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. You must continue to have custody pursuant to the decree of the court.

Your natural Dependent Children born after the Effective Date of this Rider will be covered from the moment of live birth. No notice or additional premium is required.

The definition below is added to the Definitions section:

Observation Unit means a unit in which observation services are given through Hospital outpatient services to help the Doctor decide if the patient needs to be admitted as an inpatient or can be discharged. Observation services may be given in the emergency department or another area of the Hospital.

Hospitalization Benefits

The Hospital Admission Benefit is deleted and replaced with the following:

Hospital Admission Benefit

We will pay this benefit when an Insured is admitted to a Hospital and confined as an inpatient because of a Covered Accidental Injury or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, an Insured must be admitted to a Hospital within six months of the date of the Covered Accident.

We will pay the Hospital Admission Benefit amount shown in the Benefit Schedule. We will not pay benefits for confinement to an Observation Unit, or for emergency room Treatment or outpatient Treatment. We will not pay benefits for Hospital Admission of a newborn child following his birth. However, we will pay for a newborn's admission to a Hospital Intensive Care Unit if, following birth, he is confined as an inpatient as a result of a Covered Accidental Injury or Covered Sickness (including congenital defects, birth abnormalities, and/or premature birth).

We will pay this benefit once per period of Hospital Confinement. This benefit is limited to the maximum shown in the Benefit Schedule. We will only pay this benefit once for each Covered Accident or Covered Sickness per Calendar Year. If an Insured is confined to the Hospital because of the same or Related Accidental Injury or Sickness, we will not pay this benefit again in the same Calendar Year.

The Hospital Confinement Benefit is deleted and replaced with the following:

Hospital Confinement Benefit

We will pay the amount shown in the Benefit Schedule for each day that an Insured is confined to a Hospital as an inpatient as the result of a Covered Accidental Injury or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, the Insured must be confined to a Hospital within six months of the date of the Covered Accident.

The length of time shown for Hospital Confinement in the Benefit Schedule is the maximum period for which an Insured can collect benefits for Hospital Confinements resulting from Covered Sicknesses or from Covered Accidental Injuries received in the same Covered Accident. We will not pay benefits for confinement to an Observation Unit, or for emergency room Treatment or outpatient Treatment.

If we pay benefits for confinement and the Insured becomes confined again within six months because of the same or a Related condition, we will treat this confinement as the same period of confinement.

This benefit is payable for only one Hospital Confinement at a time, even if it is caused by more than one Covered Accidental Injury, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

The Proof of Loss provision is deleted and replaced with the following:

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. It can include a statement by the treating Doctor.) Proof of Loss establishes the nature and extent of the loss, the Company's obligation to pay the claim, and the Claimant's right to receive payment.

The Claimant must provide Proof of Loss to the Company at the following address:

P.O. Box 84075, Columbus, Georgia, 31993-9103

Proof of Loss must be given to us within 90 days of the Covered Accidental Injury or Covered Sickness. Failure to give Proof of Loss within such time shall not invalidate or reduce any claim if such Proof of Loss is given as soon as reasonably possible. The Company will not accept Proof of Loss any later than one year and three months after the Covered Accidental Injury or Covered Sickness, except in the absence of the Claimant's legal mental capacity.

The Claimant will be responsible for the cost of obtaining a completed claim form. We may request additional Proof of Loss, such as records from Hospitals or Doctors. The Claimant will be responsible for the cost of obtaining these records.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

When we receive the claim and due Proof of Loss, we will review the Proof of Loss. If we approve the claim, we will pay the benefits subject to the terms of the Certificate.

The Successor Insured provision is deleted and replaced with the following:

Successor Insured

If you die while covered under this Certificate and your Spouse is also insured under this Plan at the time of your death, then your surviving Spouse may elect to become the primary Insured. This would include continuation of any Dependent Child Rider coverage that is in force at that time.

To become the primary Insured and keep coverage in force, your surviving Spouse must:

- Notify the Company in writing within 31 days after the date of your death; and
- Pay the required premium to the Company no later than 31 days after the date of your death, and on each premium due date thereafter.

If the Certificate does not cover a surviving Spouse, the Certificate will terminate on the next premium due date following your death.

The Individual Certificates provision is deleted and replaced with the following:

Individual Certificates

The Company will give the Policyholder a Certificate for each Employee. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, and
- The rights and privileges under the Plan.

CONTRACT

This Amendment is part of the Policy and Certificate and will terminate when the Policy or Certificate terminates.

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary



Thank you for choosing Continental American Insurance Company

1.800.433.3036

www.aflacgroupinsurance.com

Your Group Policy Number is:

CTR0015283525

Product:

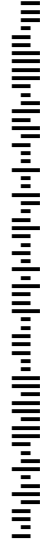
Hospital Indemnity

Your Policy is Effective :

01/01/2024

Your State of Issue is:

Texas



CITY OF MERCEDES
400 S OHIO AVE
MERCEDES TX 78570-3120



March 14, 2024

CITY OF MERCEDES
400 S OHIO AVE
MERCEDES TX 78570-3120

**Re: Your CITY OF MERCEDES Group Hospital Indemnity Coverage
Policy No.: CTR0015283525**

Welcome to the Aflac family!

Thank you so much for adding Aflac coverage in your employee benefits offering. We take commitments to our accounts very seriously and promise to be there when you and your employees need us. Enclosed, you'll find:

A Master Policy packet for the Aflac group plan you've chosen to make available to your employees. Each packet includes:

- A master policy, which indicates your group coverage effective date and other coverage details,
- A copy of your master application, **and**
- A copy of your employees' coverage certificate. **(We'll let employees know they can request copies of their certificates from you, so please be sure to make the coverage documents available. Of course, employees are also welcome to call us directly to request copies of their certificates.)**

If you have any questions about your group plan or your employees' coverage, please reach out to your account manager, or give us a call at 1.866.319.8089 Monday through Friday, from 9 a.m. to 7 p.m. Eastern time.

Again, welcome to the Aflac family!

MPCOVLET_A

Continental American Insurance Company • Columbia, South Carolina • 1.800.433.3036 toll-free

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 New York, group coverage is underwritten by American Family Life Assurance Company of New York (22 Corporate Woods Boulevard, Suite 2, Albany, New York 12211), and customer service is administered by CAIC.

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Continental American Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: Continental American Insurance Company at 1-800-433-3036

Toll-free:

1-800-433-3036

Email: cscmail@aflac.com

Mail: Continental American Insurance Company
Post Office Box 427
Columbia, South Carolina 29202

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call: 1-800-252-3439

Online: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Continental American Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Continental American Insurance Company al 1-800-433-3036

Teléfono gratuito:

1-800-433-3036

Correo electrónico: cscmail@aflac.com

Dirección postal: Continental American Insurance Company
Post Office Box 427
Columbia, South Carolina 29202

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame: 1-800-252-3439

En línea: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
 - o Up to \$500,000 for health benefit plans, with some exceptions.
 - o Up to \$300,000 for disability income benefits.
 - o Up to \$300,000 for long-term care insurance benefits.
 - o Up to \$200,000 for all other types of health insurance.
- **Life insurance:**
 - o Up to \$100,000 in net cash surrender or withdrawal value.
 - o Up to \$300,000 in death benefits.
- **Individual annuities:** Up to \$250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to \$300,000 per person, regardless of the number of policies or contracts. A limit of \$500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

<p>To learn more about the Association and your protections, contact:</p> <p>Texas Life and Health Insurance Guaranty Association 1601 Congress Avenue Austin, TX 78701 1-800-982-6362 or www.txlifega.org</p>	<p>For questions about insurance, contact:</p> <p>Texas Department of Insurance P.O. Box 149104 Austin, TX 78714-9104 1-800-252-3439 or www.tdi.texas.gov</p>
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Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.



CONTINENTAL AMERICAN INSURANCE COMPANY
Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Continuation of Coverage Endorsement

This Endorsement is part of the Policy and Certificate to which it is attached. This Endorsement is subject to all the definitions, terms, and other provisions of the Policy and Certificate to which it is attached, unless those terms are inconsistent with this Endorsement.

EFFECTIVE DATE

If issued at the same time as the Certificate, this Endorsement becomes effective when the Certificate becomes effective. If issued after the Certificate, this Endorsement will have a later Effective Date.

The following provisions are added after the Continuation Privilege provision in your Certificate:

CONTINUATION OF COVERAGE

If the Group Policy is terminated by the Policyholder and is not replaced with another group policy you may apply to continue the coverage you had on the Group Policy termination date. This includes any in-force Spouse or Dependent Child coverage. The Group Policy will be continued as if the Group Policy is in force for those who have applied to continue their coverage under this provision. The members will continue to have coverage, with their Certificates remaining in force.

The Company will apply the same benefits and plan provisions as shown in your Certificate on the date you are eligible to continue coverage under this provision. Your continued coverage is subject to all of the provisions, exclusions and limitations of the Group Policy.

To keep your Certificate in force, you must:

- Apply to the Company in writing under this Continuation of Coverage provision within 31 days after the date your Certificate would terminate, **and**
- Pay the required premium no later than 31 days after the date the Certificate would terminate and on each premium due date thereafter to the Company at our Customer Service Center in Columbus, Georgia.

PREMIUMS

Initial premium rates will be based on the rates in effect at the time you apply to continue your coverage. Premium rates can be changed by the Company at any time upon 60 days written notice to you. Any such change will be applied to all Certificates in your class and will not be based on your or your Spouse and Dependent Children's health or other individual factors.

You may decrease, but not increase, the amount of your coverage, and the amount of your Spouse's coverage, if any.

TERMINATION

Your continued coverage, including any in-force Spouse or Dependent Child coverage, will end:

- 31 days after the date you fail to pay any required premium.

- When coverage is terminated by the Company. We will provide you a 31-day advance written notice of any termination.
- On the date you die (unless your Spouse elects to become the Primary Insured under the Successor Insured provision, if applicable).

Once continued coverage is cancelled it cannot be reinstated. If your coverage terminates, we will provide benefits for valid claims that arose while your coverage was active.

CONTRACT

This Endorsement is part of the Certificate. It will terminate when:

- The Certificate terminates, or
- Premiums are no longer paid for this Endorsement.

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY
Columbia, South Carolina
800.433.3036

**Endorsement
to Policy and Certificate of Insurance**

This Endorsement alters the Policy and the Certificate to which it is attached. Unless specifically addressed by this Endorsement, all other Policy and Certificate provisions, definitions, and terms continue to apply.

Continental American Insurance Company's mailing addresses for claims and premium payments are changed as listed below.

Notice of Claim and Proof of Loss should be mailed to the Company at:

P.O. Box 84075, Columbus, Georgia, 31993-9103

Premium Payments should be mailed to the Company at:

P.O. Box 84069, Columbus, Georgia, 31908-4069

If applicable, references to 2801 Devine Street, Columbia, SC 29205 are deleted.

Signed for the Company at its Home Office,

A handwritten signature in black ink that reads "Virgil R. Miller".

Virgil R. Miller, President

A handwritten signature in black ink that reads "J. Matthew Loudermilk".

J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Group Supplemental Hospital Indemnity Policy

This limited Plan provides supplemental benefits only. It does not constitute comprehensive health insurance coverage and does not satisfy the requirement of Minimum Essential Coverage under the Affordable Care Act.

THIS PLAN IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

This Policy is not a Medicare Supplement Policy. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

This Plan provides the benefits listed in the Benefit Schedule. Please read it carefully.

The Policyholder as shown on the Policy Schedule applied for coverage under this Group Supplemental Hospital Indemnity Insurance Policy (the "Plan"). This Plan is issued by Continental American Insurance Company (the "Company," "CAIC," "we," "us," or "our"). Based on the Master Application and the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. (Please note that male pronouns—such as "he," "him," and "his"—are used for both males and females, unless the context clearly shows otherwise.) The Policyholder may add new Insureds from time to time, according to the Plan's terms.

You will notice that certain words and phrases (including some medical terms and the names of Plan documents) in this document are capitalized. The capitalized words refer to terms with very specific definitions as they apply to this insurance Plan.

This Plan is a legal contract between the Company and the Policyholder. All material printed by the Company on the following pages is part of the Plan. This Plan is delivered in and governed by the laws of the jurisdiction shown on the Policy Schedule.

In witness whereof, the Company executes this Plan at its home office in Columbia, South Carolina, on the Effective Date.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

**Group Supplemental Hospital Indemnity Insurance
Non-Participating**

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.

Notice of Non-Insurance Benefits

The Company may offer or provide goods and/or services that are not related to insurance. These goods and services, which could be offered or provided to some people who apply for Continental American Insurance Company (CAIC) coverage or become insured by CAIC, may include (but are not limited to) the following:

- Enrollment services
- Educational services
- Benefit statement services
- Payroll or plan administration services

The services listed above will fall under the same benefit plan that includes or is related to the applicable CAIC coverage, individual wellness programs, and related services.

In addition, CAIC may arrange for third-party service providers to provide discounted goods and services to people who apply for CAIC coverage or who become insured by CAIC.

Though CAIC has arranged these goods, services, and/or third-party provider discounts, the third-party providers—**not CAIC**—are liable to applicants/insureds for these goods and services. CAIC is not responsible for providing the goods and/or services, nor is CAIC liable to applicants/insureds for the negligent provision of these goods and/or services by third-party service providers.

For information about this notice, call 800.433.3036.

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Section III	-	Definitions
Section IV	-	Benefit Provisions
Section V	-	Exclusions
Section VI	-	Claim Provisions
Section VII	-	General Provisions
		Incorporation of Rider Provisions
		Schedule of Premiums

SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

Eligibility

An Employee is eligible to be covered under this Plan if he is Actively at Work for the Policyholder and included in the class that is eligible for coverage, as shown on the Master Application.

Insureds are defined as those who might be eligible for coverage under this Plan in the following categories:

- **Employee Coverage** – We insure only the Employee.
- **Employee and Spouse Coverage** – We insure the Employee and spouse (as defined in the applicable rider).
- **Employee and Children Coverage** – We insure the Employee and any dependent children (as defined in the applicable rider).
- **Family Coverage** – We insure the Employee, spouse, and any dependent children (as defined in the applicable rider).

We will not insure anyone specifically excluded from coverage by Endorsement to the Certificate or by application, even if that person would otherwise be eligible for coverage.

Details for adding Insureds to Plan coverage are outlined in the Effective Date section.

Effective Date

The Plan's Effective Date is shown on the Policy Schedule. This Plan becomes effective on the Policy Effective Date at 12:01 a.m., as determined by the Policyholder's address.

An eligible Employee must enroll in this Plan and agree to pay the required premiums for coverage to become effective. He must enroll within 31 days of the date he first becomes eligible for coverage. *The first premium must have been paid for coverage to become effective.*

We may require evidence of insurability satisfactory to us if we do not receive the Application within 31 days after the Employee was first eligible for coverage. Evidence of insurability may also be required based on an agreement between the Policyholder and us.

An Employee's Effective Date is the date his insurance takes effect. After we receive and approve the Application, that date is either:

- The date shown on the Certificate Schedule if the Employee is Actively at Work on that date, or
- The date the Employee returns to an Actively-at-Work status if he was not Actively at Work on the date shown on the Certificate Schedule.

If Employee and Spouse, Employee and Children, or Family Coverage is offered:

- A Dependent may be added to the Plan after the Employee's Effective Date within 31 days of a Life Event or during an approved enrollment period.
- If Dependent Child Rider coverage **is already in force**, no additional notice or premium is required to add another dependent child.
- If Dependent Spouse Rider or Dependent Child Rider coverage is **not** in force, the Employee must complete an Application to add a Dependent to the Plan. The Company will assign a Dependent Rider Effective Date for a Dependent's coverage after approving the Application. For Dependent coverage to become effective, the premium for the Dependent must be included in the premium payment.
- If Dependent Child Rider coverage is not already in force, **newborn** children are automatically covered from the moment of birth for 60 days. **Newly adopted** children are automatically covered from the earlier of a) placement for adoption, b) the date of entry of an order granting custody of the child for the purposes of adoption, or c) the effective date of adoption, for 60 days. To extend coverage beyond 60 days with no gap in coverage, the Employee must contact the Company within the 60-day time period following the child's birth or adoption. No premium is due for the first 60 days of newborn/newly adopted coverage.

A day begins at 12:01 a.m. standard time at the Employee's place of residence.

Plan Termination

The **Company** has the right to cancel the Plan on any premium due date for the following reasons:

- The premium is not paid before the end of the Grace Period,
- The number of participating Employees is less than the number mutually agreed upon by the Company and the Policyholder,
- The number of participating Employees changes by 25% or more,
- The Policyholder fails to perform any of the obligations that relate to this policy or that are required by applicable law,
- The Policyholder no longer offers coverage to a particular class of Employees,
- The Policyholder no longer serves a class of Employees who reside in a particular geographical area, or
- The Policyholder does not provide timely information that is reasonably required.

The **Policyholder** has the right to cancel the Plan on any premium due date.

- To do this, the Policyholder must give the Company at least 31 days' written notice.
- The Plan will end on the date in the written notice or the date the Company receives the notice, whichever is later.

All outstanding premiums are due upon Plan termination. If the Company accepts premium payments after the Plan terminates, this will not reinstate the Plan; we will refund any excess premium.

The Policyholder has the sole responsibility of notifying Certificateholders in writing of the Plan's termination as soon as reasonably possible. If the Plan terminates, it—and all Certificates and Riders issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

Termination of an Employee's Insurance

An Employee's insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date (the last day of the Grace Period), if the premium has not been paid.
- The date he no longer belongs to an eligible class.

If an Insured's coverage terminates, we will provide benefits for valid claims that arose while his coverage was active.

Continuation Privilege

When an Employee is no longer a member of an eligible class and his coverage would otherwise end, he may elect to continue his coverage under this Plan. He may continue the coverage he had on the date his Certificate would otherwise terminate, including any in-force Dependent Spouse Rider or Dependent Child Rider coverage, without any additional underwriting requirements.

To keep his coverage in force, the Employee must:

- Notify the Company within 31 days after the date his coverage would otherwise terminate. He may notify us by sending written notice to P.O. Box 84079, Columbus, GA 31993-9101 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly to the Company no later than 31 days after the date his coverage would otherwise terminate and on each premium due date thereafter.

The Employee's ported coverage will end on the earliest of the following dates:

- 31 days after the premium due date (the last day of the Grace Period), if the premium has not been paid, or
- The date the Group Plan is terminated.

If the Employee qualifies for this Continuation Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate as shown in his previously-issued Certificate. Notification of any changes in the Plan will be provided directly by the Company.

(This space left intentionally blank.)

SECTION II – PREMIUM PROVISIONS

Premium Payments

Premiums should be paid to the Company at its Home Office in Columbia, South Carolina. The first premiums are due on the Plan's Effective Date. After that, premiums are due on the first day of each month that the Plan remains in effect.

Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period provision.

Premium Changes

Unless we have agreed in writing not to increase premiums, the premium may change:

- On the Group Policy Anniversary Date based on renewal underwriting. (The Group Policy Anniversary Date is shown on the Policy Schedule and falls on the same date each year thereafter.)
- Whenever the terms or conditions of the Plan are modified. The new premium rates will apply only to premiums due on or after the rate change takes effect.

We will provide the Policyholder a 31-day advance written notice of any change in premiums.

Grace Period

This Plan has a 31-day Grace Period. If a 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. If the Plan is discontinued, the Plan's termination date will be the latest date for which premium has been paid.

(This space left intentionally blank.)

SECTION III – DEFINITIONS

When the terms below are used in this Plan, the following definitions apply:

Accidental Injury means accidental bodily damage to an Insured. This must be the direct result of an accident and not the result of disease or bodily infirmity. A **Covered Accidental Injury** is an Accidental Injury that occurs while coverage is in force. A **Covered Accident** is an accident that occurs on or after an Insured's Effective Date while coverage is in force, and that is not specifically excluded by the Plan.

Actively at Work refers to an Employee's ability to perform his regular employment duties for a full normal workday. The Employee may perform these activities either at his employer's regular place of business or at a location where he is required to travel to perform the regular duties of his employment.

Calendar Year means the period beginning on the policy Effective Date and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

Claimant means a person who is authorized to make a claim under the Certificate.

Dependent means an Employee's spouse or dependent children, as defined in the applicable rider, who have been accepted for coverage.

Doctor is a person who is duly qualified as a practitioner of the healing arts acting within the scope of his license, and:

- Is licensed to practice medicine; prescribe and administer drugs; or to perform surgery, or
- Is a duly qualified medical practitioner according to the laws and regulations in the state in which Treatment is made.

A Doctor **does not** include the Insured or an Insured's Family Member.

For the purposes of this definition, **Family Member** includes the Employee's Spouse as well as the following members of the Employee's immediate family:

- Son
- Daughter
- Mother
- Father
- Sister
- Brother

This includes step-Family Members and Family-Members-in-law.

Employee is a person who meets Eligibility requirements under **Section I – Eligibility, Effective Date, and Termination** and who is covered under this Plan. The Employee is the primary Insured under this Plan.

Hospital means a place that meets all of the following criteria:

- Is legally licensed and operated as a Hospital,
- Provides overnight care of injured and sick people,
- Is supervised by a Doctor,
- Has full-time nurses supervised by a registered nurse, and
- Has on-site use of X-ray equipment, laboratory, and surgical facilities.

The term *Hospital* specifically excludes any facility not meeting the definition of Hospital as defined in this Plan, including but not limited to:

- A nursing home,
- An extended-care facility,
- A skilled nursing facility,
- A rest home or home for the aged,
- A Rehabilitation Facility,
- A facility for the Treatment of alcoholism or drug addiction, or
- An assisted living facility.

Hospital Intensive Care Unit means a place that meets all of the following criteria:

- Is a specifically designated area of the Hospital called a Hospital Intensive Care Unit;
- Provides the highest level of medical care;
- Is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- Is separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement;
- Is permanently equipped with special life-saving equipment for the care of the critically ill or injured;
- Is under close observation by a specially trained nursing staff assigned exclusively to the Hospital Intensive Care Unit 24 hours a day; and
- Has a Doctor assigned to the Hospital Intensive Care Unit on a full-time basis.

The term *Hospital Intensive Care Unit* specifically excludes any type of facility not meeting the definition of Hospital Intensive Care Unit as defined in this Plan, including but not limited to private monitored rooms, surgical recovery rooms, observation units, and the following step-down units:

- A progressive care unit,
- A sub-acute intensive care unit, or
- An intermediate care unit.

Intermediate Intensive Care Step-Down Unit means any of the following:

- A progressive care unit,
- A sub-acute intensive care unit,
- An intermediate care unit, or
- A pre- or post-intensive care unit.

An Intermediate Intensive Care Step-Down Unit is **not** a Hospital Intensive Care Unit as defined in this Plan.

Life Event means an event that qualifies an Employee to make changes to benefits at times other than his enrollment period. Events qualifying as Life Events are established solely by the Policyholder.

Rehabilitation Facility is a unit or facility providing coordinated multidisciplinary physical restorative services. These services must be provided to inpatients under a Doctor's direction. The Doctor must be knowledgeable and experienced in rehabilitative medicine. Beds must be set up in a unit or facility specifically designated and staffed for this service. This is not a facility for the Treatment of alcoholism or drug addiction.

Related – a Related Accidental Injury or Sickness is one that is in correlation to, or occurs as a result of, the initial Accidental Injury or Sickness, and would not otherwise have been sustained if that initial condition had not occurred.

Sickness means an illness, infection, disease, or any other abnormal physical condition or pregnancy that is not caused solely by, or the result of, any injury. A **Covered Sickness** is one that is not excluded by name, specific description, or any other provision in this Plan. For a benefit to be payable, loss arising from the Covered Sickness must occur while the applicable Insured's coverage is in force.

Spouse is an Employee's legal wife or husband, including a legally-recognized same-sex Spouse, or a person of either gender who is in a legally recognized and registered domestic partnership, civil union, reciprocal beneficiary relationship, or similar relationship with the Employee.

Telemedicine Service means a medical inquiry with a Doctor via audio or video communication that assists with a patient's assessment, diagnosis, and consultation.

Treatment is the consultation, care, or services provided by a Doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines. Treatment does **not** include Telemedicine Services.

SECTION IV – BENEFIT PROVISIONS

Hospitalization Benefits

Hospital Admission Benefit

We will pay this benefit when an Insured is admitted to a Hospital and confined as an inpatient because of a Covered Accidental Injury or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, an Insured must be admitted to a Hospital within six months of the date of the Covered Accident.

We will pay the Hospital Admission Benefit amount shown in the Benefit Schedule. We will not pay benefits for confinement to an observation unit, or for emergency room Treatment or outpatient Treatment.

We will pay this benefit once per period of Hospital Confinement. This benefit is limited to the maximum shown in the Benefit Schedule. We will only pay this benefit once for each Covered Accident or Covered Sickness per Calendar Year. If an Insured is confined to the Hospital because of the same or Related Accidental Injury or Sickness, we will not pay this benefit again in the same Calendar Year.

Hospital Confinement Benefit

We will pay the amount shown in the Benefit Schedule for each day that an Insured is confined to a Hospital as an inpatient as the result of a Covered Accidental Injury or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, the Insured must be confined to a Hospital within six months of the date of the Covered Accident.

The length of time shown for Hospital Confinement in the Benefit Schedule is the maximum period for which an Insured can collect benefits for Hospital Confinements resulting from Covered Sickness or from Covered Accidental Injuries received in the same Covered Accident.

If we pay benefits for confinement and the Insured becomes confined again within six months because of the same or a Related condition, we will treat this confinement as the same period of confinement.

This benefit is payable for only one Hospital Confinement at a time, even if it is caused by more than one Covered Accidental Injury, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

Hospital Intensive Care Benefit

If an Insured is confined in a Hospital Intensive Care Unit because of a Covered Accidental Injury or Covered Sickness, we will pay the daily benefit amount shown in the Benefit Schedule. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, an Insured must be admitted to a Hospital Intensive Care Unit within six months of the date of the Covered Accident.

We will pay this amount for each day of such confinement, but not to exceed the maximum benefit period shown on the Benefit Schedule during any one period of confinement.

We will pay benefits for only one confinement in a Hospital Intensive Care Unit at a time, even if it is caused by more than one Covered Accidental Injury, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

If we pay benefits for confinement in a Hospital Intensive Care Unit and an Insured becomes confined to a Hospital Intensive Care Unit again within six months because of the same or a Related condition, we will treat this confinement as the same period of confinement.

This benefit is payable in addition to the Hospital Confinement Benefit.

Intermediate Intensive Care Step-Down Unit Benefit

If an Insured is confined in an Intermediate Intensive Care Step-Down Unit because of a Covered Accidental Injury or Covered Sickness, we will pay the daily benefit amount shown on the Benefit Schedule. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, the Insured must be admitted to an Intermediate Intensive Care Step-Down Unit within six months of the date of the Covered Accident.

We will pay this amount for each day of such confinement, not to exceed the maximum benefit period shown in the Benefit Schedule during any one period of confinement.

We will pay benefits for only one confinement in an Intermediate Intensive Care Step-Down Unit at a time, even if it is caused by more than one Covered Accidental Injury, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

If we pay benefits for confinement in a Hospital's Intermediate Intensive Care Step-Down Unit and the Insured becomes confined to a Hospital's Intermediate Intensive Care Step-Down Unit again within six months because of the same or a Related condition, we will treat this confinement as the same period of confinement.

This benefit is payable in addition to the Hospital Confinement Benefit.

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SECTION V – EXCLUSIONS

Exclusions

We will not pay for loss due to:

- War – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the Insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.
- Suicide – committing or attempting to commit suicide, while sane or insane.
- Self-Inflicted Injuries – injuring or attempting to injure oneself intentionally.
- Racing – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semi-professional capacity.
- Illegal Occupation – voluntarily participating in, committing, or attempting to commit a felony or illegal act or activity, or voluntarily working at, or being engaged in, an illegal occupation or job.
- Sports – participating in any organized sport in a professional or semi-professional capacity.
- Custodial Care – this is non-medical care that helps individuals with the basic tasks of everyday life, the preparation of special diets, and the self-administration of medication which does not require the constant attention of medical personnel.
- Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including any resulting complications.
- Services performed by a Family Member.
- Services related to sex or gender change, sterilization, in vitro fertilization, vasectomy or reversal of a vasectomy, or tubal ligation.
- Elective Abortion – an abortion for any reason other than to preserve the life of the person upon whom the abortion is performed.
- Dental Services or Treatment.
- Cosmetic surgery, except when due to:
 - o Reconstructive surgery, when the service is related to or follows surgery resulting from a Covered Accidental Injury or a Covered Sickness, or is related to or results from a congenital disease or anomaly of a covered dependent child.
 - o Congenital defects in newborns.
- 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.

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SECTION VI – CLAIM PROVISIONS

Notice of Claim

Written Notice of Claim must be given to us:

- Within 60 days after the Covered Accidental Injury or Covered Sickness, or
- As soon as reasonably possible.

When we receive written Notice of Claim, we will send a claim form. If the Claimant does not receive the claim form within 15 days after the notice is sent, written Proof of Loss can be sent to us without waiting for the form. Notice must include the Employee's name and the Certificate number. Notice can be mailed to the Company at the following address:

P.O. Box 84075, Columbus, GA 31993-9103

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. It can include a statement by the treating Doctor.) Proof of Loss establishes the nature and extent of the loss, the Company's obligation to pay the claim, and the Claimant's right to receive payment.

The Claimant must provide Proof of Loss to the Company at the following address:

P.O. Box 84075, Columbus, GA 31993-9103

Proof of Loss must be given to us within 90 days of the Covered Accidental Injury or Covered Sickness. Failure to give Proof of Loss within such time shall not invalidate or reduce any claim if such Proof of Loss is given as soon as reasonably possible. The Company will not accept Proof of Loss any later than one year and three months after the Covered Accidental Injury or Covered Sickness, except in the absence of the Employee's legal mental capacity.

The Claimant will be responsible for the cost of obtaining a completed claim form. We may request additional Proof of Loss, such as records from Hospitals or Doctors. We will be responsible for the cost of obtaining these records.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

When we receive the claim and due Proof of Loss, we will review the Proof of Loss. If we approve the claim, we will pay the benefits subject to the terms of the Certificate.

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 exams or autopsy.

Time of Payment of Claims

For benefits other than for loss of time, the Company will, once we receive the required Proof of Loss, pay, deny, or settle each submitted claim no later than the 60th day after the date Proof of Loss is received. Subject to written Proof of Loss, all accrued benefits payable under the Policy for loss of time will be paid at least monthly during the period for which the Company is liable. Any balance remaining unpaid at the end of that time will be paid as soon as possible after the Proof of Loss is received.

Payment of Claims

We will pay all benefits to the Employee unless otherwise assigned. For any benefits that remain unpaid at the time of death, we will pay those benefits in the following order:

- To the beneficiary designated by the Insured or the beneficiary's assignee.
- To the Insured's surviving Spouse.
- To the Insured's estate.

Unpaid Premium

When a claim is paid, we may deduct any premium due and unpaid from the claim payment.

Changing of Beneficiary

A change in beneficiary must be submitted in writing to our Home Office in a form acceptable to us and signed by the Employee. Unless otherwise specified by the Employee, a change in beneficiary will take effect on the date the notice of change is signed. We will not be liable for any action taken before notice is received and recorded at the Home Office.

Claim Review

If a claim is denied, the Employee will be given written notice of:

- The reason for the denial,
- The Plan provision that supports the denial, and
- His right to ask for a review of the claim.

Appeals Procedure

Before filing any lawsuit—and no later than 60 days after notice of denial of a claim—the Employee, the Claimant, or an authorized representative of either must appeal any denial of benefits under the Plan by sending a written request for review of the denial to our Home Office.

Legal Action

The Employee may not take Legal Action against us for benefits under this Plan:

- Within 60 days after he has 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

This insurance is provided under a contract of Group Supplemental Hospital Indemnity insurance with the Policyholder. The Entire Contract of Insurance is made up of:

- The Policy;
- The Certificates of insurance;
- The Application of the Policyholder, a copy of which is attached to and made part of the Policy when issued; and
- Any Riders, Endorsements, or Amendments to the Policy or Certificate.

In the absence of fraud, a statement made by the Policyholder or an Insured is considered a representation and not a warranty. A statement made by the Policyholder or an Insured will not be used in any contest under the Plan, unless a copy of the written instrument containing the statement is or has been provided to:

- The person making the statement; or
- If the statement was made by the Insured and the Insured has died or become incapacitated, the Insured's beneficiary or personal representative.

Changes to the 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 or producer (nor can an agent or producer waive any Plan provisions).

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.

Successor Insured

If an Employee dies while covered under his Certificate and his Spouse is also insured under this Plan at the time of the Employee's death, then his surviving Spouse may elect to become the primary Insured. This would include continuation of any Dependent Child Rider coverage that is in force at that time.

To become the primary Insured and keep coverage in force, the surviving Spouse must:

- Notify the Company in writing within 31 days after the date of the Employee's death; and
- Pay the required premium to the Company no later than 31 days after the date of the Employee's death, and on each premium due date thereafter.

If the Certificate does not cover a surviving Spouse, the Certificate will terminate on the next premium due date following the Employee's death.

Time Limit on Certain Defenses

After two years from the Employee's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Employee's 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 such clerical error, the Company will make a premium adjustment.

Individual Certificates

The Company will give the Policyholder a Certificate for each Employee. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, and
- The rights and privileges under the Plan.

Required Information

The Policyholder will be responsible for furnishing all information and proofs that the Company may reasonably require with regard to the Plan.

Conformity with State Statutes

This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes.

POLICY SCHEDULE

Group Policyholder: CITY OF MERCEDES
Group Policy Number: CTR0015283525
Group Policy Effective Date: January 1, 2024
Group Policy Anniversary Date: January 1, 2025
Jurisdiction: Texas

*Initial premium includes the premium for any Riders purchased at the same time as the coverage provided by an Employee's Certificate.

This Plan is delivered in and governed by the laws of the jurisdiction shown above.

BENEFIT SCHEDULE

Hospitalization Category

Hospital Admission Benefit

Payable once per admission

Maximum per Insured per each Covered Sickness

Maximum per Insured per each Covered Accident

Maximum per Insured

\$500.00 per admission

1 time per Calendar Year

1 time per Calendar Year

1 time per Calendar Year

Hospital Confinement Benefit

Maximum confinement period

Hospital Intensive Care Benefit

Maximum confinement period

Intermediate Intensive Care Step-Down Unit Benefit

Maximum confinement period

\$100.00 per day

up to maximum confinement period

31 days per Covered Sickness or Covered Accident

\$100.00 per day

10 days per Covered Sickness or Covered Accident

\$50.00 per day

10 days Per Calendar Year

INCORPORATION OF RIDER PROVISIONS

The attached listed Riders are made a part of this Plan.

Rider Name

Dependent Spouse Benefit Rider

Dependent Children Benefit Rider

Form Number

C80301

C80302TX

SCHEDULE OF PREMIUMS

RATES TABLE FOR: CITY OF MERCEDES / HOSPITAL INDEMNITY

DEDUCTION FREQUENCY	:	Monthly (12pp / yr)
EMPLOYEE COST	:	\$9.32



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Amendment to Policy, Certificate of Insurance, and Dependent Child Rider for Group Supplemental Hospital Indemnity

This Amendment is subject to all of the provisions of the Policy and Certificate to which it is attached. Additions or changes have been made to the Policy, Certificate, and Dependent Child Rider and are indicated below.

EFFECTIVE DATE

If issued at the same time as the Certificate, this Amendment becomes effective at the same time as the Certificate. If issued after the Certificate, this Amendment will have a later Effective Date.

The following sentence is added to the Effective Date provision:

Dependent coverage will begin on the date of the Life Event if notice was provided within 31 days after the Life Event.

The Plan Termination provision is deleted and replaced with the following:

Plan Termination

The **Company** has the right to cancel the Plan on any premium due date for the following reasons:

- The premium is not paid before the end of the Grace Period,
- The number of participating Employee is less than the number mutually agreed upon by the Company and the Policyholder,
- The number of participating Employee changes by 25% or more,
- The Policyholder fails to perform any of the obligations that relate to this policy or that are required by applicable law,
- The Policyholder no longer offers coverage to a particular class of Employee,
- The Policyholder no longer serves a class of Employee who reside in a particular geographical area, or
- The Policyholder does not provide timely information that is reasonably required.

The **Policyholder** has the right to cancel the Plan on any premium due date.

- To do this, the Policyholder must give the Company at least 31 days' written notice.
- The Plan will end on the date in the written notice or the date the Company receives the notice, whichever is later.

All outstanding premiums are due upon Plan termination. If the Company accepts premium payments after the Plan terminates, this will not reinstate the Plan.

The Policyholder has the sole responsibility of notifying Certificateholders in writing of the Plan's termination as soon as reasonably possible. If the Plan terminates, it—and all Certificates and Riders issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

The Termination of Your Insurance provision is deleted and replaced with the following:

Termination of Your Insurance

Your insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.

- The 31st day after the premium due date (the last day of the Grace Period), if the premium has not been paid.
- The date you no longer belong to an eligible class.

If an Insured's coverage terminates, we will provide benefits for valid claims that arose while your coverage was active.

The Continuation Privilege provision is deleted and replaced with the following:

Continuation Privilege

When you are no longer a member of an eligible class and your coverage would otherwise end, you may elect to continue your coverage under this Plan. You may continue the coverage you had on the date your Certificate would otherwise terminate, including any in-force Dependent Spouse Rider or Dependent Child Rider coverage, without any additional underwriting requirements.

To keep your coverage in force, you must:

- Notify the Company within 31 days after the date your coverage would otherwise terminate. You may notify us by sending written notice to P.O. Box 84079, Columbus, GA 31993-9101 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly to the Company no later than 31 days after the date your coverage would otherwise terminate and on each premium due date thereafter.

Your continued coverage will end on the earliest of the following dates:

- 31 days after the premium due date (the last day of the Grace Period), if the premium has not been paid, or
- The date the Group Plan is terminated.

If you qualify for this Continuation Privilege, then the Company will apply the same Benefits, Premium Rate, and Plan Provisions as shown in your previously-issued Certificate. Notification of any changes in the Plan will be provided directly by the Company.

The Grace Period provision is deleted and replaced with the following:

Grace Period

This Plan has a 31-day Grace Period. If a 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. If the Plan is discontinued, the Plan's termination date will be the latest date for which premium has been paid.

The definition of Dependent Child or Dependent Children is deleted and replaced with the following:

Dependent Child or ***Dependent Children*** means your or your Spouse's natural children, step-children, grandchildren who are in your legal custody and residing with you, foster children, children subject to legal guardianship, adopted children, or Children Placed for Adoption, who are younger than age 26. However, we will continue coverage for Dependent Children insured under the Plan after the age of 26 if they are incapable of self-sustaining employment due to mental or physical disability, and are chiefly dependent on a parent for support and maintenance. You or your Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday.

The insurance on any Dependent Child will terminate on the last day of the month in which the Dependent Child turns age 26; it is your responsibility to notify us in writing when coverage on a Dependent Child terminates. Termination will be without prejudice to any claim originating prior to the date of termination. Our acceptance of premium after such date will be considered as premium for only the remaining persons who qualify as Insureds under this Plan. When coverage on all Dependent Children terminates, you must notify the Company, in writing, and elect whether to continue this Plan on an Employee or Employee and Spouse Coverage basis. After such notice, we will arrange for the payment of the appropriate premium due, including returning any unearned premium.

Children Placed for Adoption are children for whom you have entered a decree of adoption, have initiated adoption proceedings, or are a party to a suit in which you seek to adopt the child. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. You must continue to have custody pursuant to the decree of the court.

Your natural Dependent Children born after the Effective Date of this Rider will be covered from the moment of live birth. No notice or additional premium is required.

The definition below is added to the Definitions section:

Observation Unit means a unit in which observation services are given through Hospital outpatient services to help the Doctor decide if the patient needs to be admitted as an inpatient or can be discharged. Observation services may be given in the emergency department or another area of the Hospital.

Hospitalization Benefits

The Hospital Admission Benefit is deleted and replaced with the following:

Hospital Admission Benefit

We will pay this benefit when an Insured is admitted to a Hospital and confined as an inpatient because of a Covered Accidental Injury or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, an Insured must be admitted to a Hospital within six months of the date of the Covered Accident.

We will pay the Hospital Admission Benefit amount shown in the Benefit Schedule. We will not pay benefits for confinement to an Observation Unit, or for emergency room Treatment or outpatient Treatment. We will not pay benefits for Hospital Admission of a newborn child following his birth. However, we will pay for a newborn's admission to a Hospital Intensive Care Unit if, following birth, he is confined as an inpatient as a result of a Covered Accidental Injury or Covered Sickness (including congenital defects, birth abnormalities, and/or premature birth).

We will pay this benefit once per period of Hospital Confinement. This benefit is limited to the maximum shown in the Benefit Schedule. We will only pay this benefit once for each Covered Accident or Covered Sickness per Calendar Year. If an Insured is confined to the Hospital because of the same or Related Accidental Injury or Sickness, we will not pay this benefit again in the same Calendar Year.

The Hospital Confinement Benefit is deleted and replaced with the following:

Hospital Confinement Benefit

We will pay the amount shown in the Benefit Schedule for each day that an Insured is confined to a Hospital as an inpatient as the result of a Covered Accidental Injury or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, the Insured must be confined to a Hospital within six months of the date of the Covered Accident.

The length of time shown for Hospital Confinement in the Benefit Schedule is the maximum period for which an Insured can collect benefits for Hospital Confinements resulting from Covered Sicknesses or from Covered Accidental Injuries received in the same Covered Accident. We will not pay benefits for confinement to an Observation Unit, or for emergency room Treatment or outpatient Treatment.

If we pay benefits for confinement and the Insured becomes confined again within six months because of the same or a Related condition, we will treat this confinement as the same period of confinement.

This benefit is payable for only one Hospital Confinement at a time, even if it is caused by more than one Covered Accidental Injury, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

The Proof of Loss provision is deleted and replaced with the following:

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. It can include a statement by the treating Doctor.) Proof of Loss establishes the nature and extent of the loss, the Company's obligation to pay the claim, and the Claimant's right to receive payment.

The Claimant must provide Proof of Loss to the Company at the following address:

P.O. Box 84075, Columbus, Georgia, 31993-9103

Proof of Loss must be given to us within 90 days of the Covered Accidental Injury or Covered Sickness. Failure to give Proof of Loss within such time shall not invalidate or reduce any claim if such Proof of Loss is given as soon as reasonably possible. The Company will not accept Proof of Loss any later than one year and three months after the Covered Accidental Injury or Covered Sickness, except in the absence of the Claimant's legal mental capacity.

The Claimant will be responsible for the cost of obtaining a completed claim form. We may request additional Proof of Loss, such as records from Hospitals or Doctors. The Claimant will be responsible for the cost of obtaining these records.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

When we receive the claim and due Proof of Loss, we will review the Proof of Loss. If we approve the claim, we will pay the benefits subject to the terms of the Certificate.

The Successor Insured provision is deleted and replaced with the following:

Successor Insured

If you die while covered under this Certificate and your Spouse is also insured under this Plan at the time of your death, then your surviving Spouse may elect to become the primary Insured. This would include continuation of any Dependent Child Rider coverage that is in force at that time.

To become the primary Insured and keep coverage in force, your surviving Spouse must:

- Notify the Company in writing within 31 days after the date of your death; and
- Pay the required premium to the Company no later than 31 days after the date of your death, and on each premium due date thereafter.

If the Certificate does not cover a surviving Spouse, the Certificate will terminate on the next premium due date following your death.

The Individual Certificates provision is deleted and replaced with the following:

Individual Certificates

The Company will give the Policyholder a Certificate for each Employee. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, and
- The rights and privileges under the Plan.

CONTRACT

This Amendment is part of the Policy and Certificate and will terminate when the Policy or Certificate terminates.

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Dependent Spouse Benefit Rider To Certificate of Insurance for Group Supplemental Hospital Indemnity Policy

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- We have accepted your Application, and
- You have paid the additional premium for this Rider.

This Rider is subject to all the definitions, exclusions, limitations, terms, and other provisions of the Certificate to which it is attached, unless those terms are inconsistent with this Rider.

EFFECTIVE DATE

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date. Dependent Spouse coverage will become effective on the Effective Date of the Rider if the Dependent Spouse is Active on that date. Otherwise, the Effective Date will be deferred until the day following the date he becomes Active.

DEFINITIONS

When the terms below are used in this Rider, the following definitions apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

Active refers to a Dependent Spouse who is not confined in a Hospital and who is able to carry on regular activities customary of a person in good health of the same age and gender.

Dependent Spouse is your legal wife or husband, who is at least age 18 and is listed on your Application.

BENEFITS

If a Dependent Spouse qualifies for benefits because of a Covered Accidental Injury or Covered Sickness, we will provide the benefits shown in the Dependent Spouse Benefit Schedule issued with this Rider. The only benefits for which a Dependent Spouse is eligible are those shown in the Dependent Spouse Benefit Schedule.

GENERAL PROVISIONS

If your Dependent Spouse's coverage terminates, we will provide benefits for valid claims that arose while Dependent Spouse coverage was active.

Time Limit on Certain Defenses

After two years from the Insured's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Application. This does not apply to fraudulent misstatements.

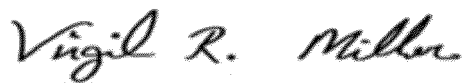
CONTRACT

This Rider is part of the Group Supplemental Hospital Indemnity Certificate. It will terminate:

- When the Certificate terminates,
- On the premium due date following the date the covered Spouse no longer qualifies as a Dependent,

- On the premium due date following the date we receive your written request to terminate coverage for your Spouse, or
- When premiums are no longer paid for this Rider.

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary

DEPENDENT SPOUSE BENEFITS SCHEDULE

Hospitalization Category

Hospital Admission Benefit

Payable once per admission

Maximum per Insured per each Covered Sickness

Maximum per Insured per each Covered Accident

Maximum per Insured

\$500.00 per admission

1 time per Calendar Year

1 time per Calendar Year

1 time per Calendar Year

Hospital Confinement Benefit

Maximum confinement period

\$100.00 per day

up to maximum confinement period

31 days per Covered Sickness or Covered Accident

Hospital Intensive Care Benefit

Maximum confinement period

\$100.00 per day

10 days per Covered Sickness or Covered Accident

Intermediate Intensive Care Step-Down Unit Benefit

Maximum confinement period

\$50.00 per day

10 days Per Calendar Year



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Dependent Children Benefit Rider To Certificate of Insurance for Group Supplemental Hospital Indemnity Policy

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- We have accepted your Application, and
- You have paid the additional premium for this Rider.

This Rider is subject to all the definitions, exclusions, limitations, terms, and other provisions of the Certificate to which it is attached, unless those terms are inconsistent with this Rider.

EFFECTIVE DATE

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date. Dependent Child coverage will become effective on the Effective Date of the Rider if the Dependent Child is Active on that date. Otherwise, the Effective Date will be deferred until the day following the date he becomes Active.

DEFINITIONS

When the terms below are used in this Rider, the following definitions apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

Active refers to a Dependent Child who is not confined in a Hospital and who is able to carry on regular activities customary of a person in good health of the same age and gender.

Dependent Child or Dependent Children means your or your Spouse's natural children, step-children, grandchildren who are in your legal custody and residing with you, foster children, children subject to legal guardianship, legally adopted children, or Children Placed for Adoption. Dependent Children must be younger than age 26.

Children Placed for Adoption are Children for whom you have entered a decree of adoption or for whom you have initiated adoption proceedings. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. You must continue to have custody pursuant to the decree of the court.

A child is considered to be the child of an Insured if the Insured is a party to a suit in which the Insured seeks to adopt the child.

There is an exception to the age-26 limit above. This limit will not apply to any Dependent Child who is incapable of self-sustaining employment due to mental or physical handicap and is chiefly dependent on a parent for support and maintenance. You or your Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday.

Your natural Dependent Children born after the Effective Date of this Rider will be covered from the moment of live birth. No notice or additional premium is required.

BENEFITS

If a Dependent Child qualifies for benefits because of a Covered Accidental Injury or Covered Sickness, we will provide the benefits shown in the Dependent Children Benefit Schedule

issued with this Rider. The only benefits for which a Dependent Child is eligible are those shown in the Dependent Children Benefit Schedule.

GENERAL PROVISIONS

If your Dependent Child's coverage terminates, we will provide benefits for valid claims that arose while his coverage was active.

Time Limit on Certain Defenses


After two years from the Insured's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Application. This does not apply to fraudulent misstatements.

CONTRACT

This Rider is part of the Group Supplemental Hospital Indemnity Certificate. It will terminate:

- When the Certificate terminates,
- On the premium due date following the date the covered Child no longer qualifies as a Dependent,
- When the covered Dependent Child reaches age 26 (details in the **Definitions** section of this Rider),
- On the premium due date following the date we receive your written request to terminate coverage for your Child, or
- When premiums are no longer paid for this Rider.

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary

DEPENDENT CHILDREN BENEFITS SCHEDULE

Hospitalization Category

Hospital Admission Benefit

Payable once per admission
Maximum per Insured per each Covered Sickness
Maximum per Insured per each Covered Accident
Maximum per Insured

\$500.00 per admission
1 time per Calendar Year
1 time per Calendar Year
1 time per Calendar Year

Hospital Confinement Benefit

Maximum confinement period

\$100.00 per day
up to maximum confinement period
31 days per Covered Sickness or Covered Accident

Hospital Intensive Care Benefit

Maximum confinement period

\$100.00 per day
10 days per Covered Sickness or Covered Accident

Intermediate Intensive Care Step-Down Unit Benefit

Maximum confinement period

\$50.00 per day
10 days Per Calendar Year



CONTINENTAL AMERICAN INSURANCE COMPANY

**Columbia, South Carolina
800.433.3036**

Please call the toll-free number above with any questions about this coverage.

Certificate of Insurance For Group Supplemental Hospital Indemnity Policy

This limited Plan provides supplemental benefits only. It does not constitute comprehensive health insurance coverage and does not satisfy the requirement of Minimum Essential Coverage under the Affordable Care Act.

THIS PLAN IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

This Certificate is not a Medicare Supplement Certificate. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

This Plan provides the benefits listed in the Benefit Schedule. Please read it carefully.

Your Employer (the "Policyholder") applied for coverage under this Group Supplemental Hospital Indemnity Insurance Policy (the "Plan"). This Plan is issued by Continental American Insurance Company (the "Company," "CAIC," "we," "us," or "our"). For the purposes of this Plan, "you" (including "your" and "yours") refers to you. Based on the application process and the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. (Please note that male pronouns—such as "he," "him," and "his"—are used for both males and females, unless the context clearly shows otherwise.)

You will notice that certain words and phrases (including some medical terms and the names of Plan documents) in this document are capitalized. The capitalized words refer to terms with very specific definitions as they apply to this insurance Plan.

We certify that you are insured under the Group Supplemental Hospital Indemnity Policy (the "Plan"). The Plan was issued to the Policyholder. The Certificate is subject to the Definitions, Exclusions, and other provisions of the Plan.

Certain provisions of the Plan are summarized in this Certificate. All provisions of the Plan, whether contained in your Certificate or not, apply to the insurance referred to by the Certificate.

The Certificate Effective Date is shown in the Certificate Schedule. The Certificate will terminate as provided in the provision titled "Termination of Your Insurance" in Section I. 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.

TABLE OF CONTENTS

Section I	-	Eligibility, Effective Date, and Termination
Section II	-	Premium Provisions
Section III	-	Definitions
Section IV	-	Benefit Provisions
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Section VI	-	Claim Provisions
Section VII	-	General Provisions

SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

Eligibility

You are eligible to be covered under this Plan if you are Actively at Work for the Policyholder and included in the class that is eligible for coverage, as shown on the Master Application.

Insureds are defined as those who might be eligible for coverage under this Plan in the following categories:

- **Employee Coverage** – We insure only the Employee.
- **Employee and Spouse Coverage** – We insure the Employee and spouse (as defined in the applicable rider).
- **Employee and Children Coverage** – We insure the Employee and any dependent children (as defined in the applicable rider).
- **Family Coverage** – We insure the Employee, spouse, and any dependent children (as defined in the applicable rider).

We will not insure anyone specifically excluded from coverage by Endorsement to the Certificate or by application, even if that person would otherwise be eligible for coverage.

Details for adding Insureds to your coverage are outlined in the Effective Date section.

Effective Date

Your Employee Effective Date is shown on the Certificate Schedule.

Your Employee Effective Date is the date your insurance takes effect. After we receive and approve the Application, that date is either:

- The date shown on the Certificate Schedule if you are Actively at Work on that date, or
- The date you return to an Actively-at-Work status if you were not Actively at Work on the date shown on the Certificate Schedule.

If Employee and Spouse, Employee and Children, or Family Coverage is offered:

- A Dependent may be added to the Plan after the Employee's Effective Date within 31 days of a Life Event or during an approved enrollment period.
- If Dependent Child Rider coverage is **already in force**, no additional notice or premium is required to add another dependent child.
- If Dependent Spouse Rider or Dependent Child Rider coverage is **not** in force, the Employee must complete an Application to add a Dependent to the Plan. The Company will assign a Dependent Rider Effective Date for a Dependent's coverage after approving the Application. For Dependent coverage to become effective, the premium for the Dependent must be included in the premium payment.
- If Dependent Child Rider coverage is not already in force, **newborn** children are automatically covered from the moment of birth for 60 days. **Newly adopted** children are automatically covered from the earlier of a) placement for adoption, b) the date of entry of an order granting custody of the child for the purposes of adoption, or c) the effective date of adoption, for 60 days. To extend coverage beyond 60 days with no gap in coverage, the Employee must contact the Company within the 60-day time period following the child's birth or adoption. No premium is due for the first 60 days of newborn/newly adopted coverage.

A day begins at 12:01 a.m. standard time at the Employee's place of residence.

Plan Termination

The **Company** has the right to cancel the Plan on any premium due date for the following reasons:

- The premium is not paid before the end of the Grace Period,
- The number of participating Employees is less than the number mutually agreed upon by the Company and the Policyholder,
- The number of participating Employees changes by 25% or more,
- The Policyholder fails to perform any of the obligations that relate to this policy or that are required by applicable law,
- The Policyholder no longer offers coverage to a particular class of Employees,
- The Policyholder no longer serves a class of Employees who reside in a particular geographical area, or

- The Policyholder does not provide timely information that is reasonably required.

The **Policyholder** has the right to cancel the Plan on any premium due date.

- To do this, the Policyholder must give the Company at least 31 days' written notice.
- The Plan will end on the date in the written notice or the date the Company receives the notice, whichever is later.

All outstanding premiums are due upon Plan termination. If the Company accepts premium payments after the Plan terminates, this will not reinstate the Plan; we will refund any excess premium.

The Policyholder has the sole responsibility of notifying Certificateholders in writing of the Plan's termination as soon as reasonably possible. If the Plan terminates, it—and all Certificates and Riders issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

Termination of Your Insurance

Your insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date (the last day of the Grace Period), if the premium has not been paid.
- The date you no longer belong to an eligible class.

If an Insured's coverage terminates, we will provide benefits for valid claims that arose while your coverage was active.

Continuation Privilege

When you are no longer a member of an eligible class and your coverage would otherwise end, you may elect to continue your coverage under this Plan. You may continue the coverage you had on the date your Certificate would otherwise terminate, including any in-force Dependent Spouse Rider or Dependent Child Rider coverage, without any additional underwriting requirements.

To keep your coverage in force, you must:

- Notify the Company within 31 days after the date your coverage would otherwise terminate. You may notify us by sending written notice to P.O. Box 84079, Columbus, GA 31993-9101 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly to the Company no later than 31 days after the date your coverage would otherwise terminate and on each premium due date thereafter.

Your ported coverage will end on the earliest of the following dates:

- 31 days after the premium due date (the last day of the Grace Period), if the premium has not been paid, or
- The date the Group Plan is terminated.

If you qualify for this Continuation Privilege, then the Company will apply the same Benefits Plan Provisions, and Premium Rate as shown in your previously-issued Certificate. Notification of any changes in the Plan will be provided directly by the Company.

SECTION II – PREMIUM PROVISIONS

Premium Payments

Premiums should be paid to the Company at its Home Office in Columbia, South Carolina. The first premiums are due on the Plan's Effective Date. After that, premiums are due on the first day of each month that the Plan remains in effect.

Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period provision.

Premium Changes

Unless we have agreed in writing not to increase premiums, the premium may change:

- On the Group Policy Anniversary Date based on renewal underwriting. (The Group Policy Anniversary Date is shown on the Policy Schedule and falls on the same date each year thereafter.)
- Whenever the terms or conditions of the Plan are modified. The new premium rates will apply only to premiums due on or after the rate change takes effect.

We will provide the Policyholder a 31-day advance written notice of any change in premiums.

Grace Period

This Plan has a 31 -day Grace Period. If a premium is not paid on or before its due date, the premium may be paid during the next 31days. 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. If the Plan is discontinued, the Plan's termination date will be the latest date for which premium has been paid.

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SECTION III – DEFINITIONS

When the terms below are used in this Plan, the following definitions apply:

Accidental Injury means accidental bodily damage to an Insured. This must be the direct result of an accident and not the result of disease or bodily infirmity. A **Covered Accidental Injury** is an Accidental Injury that occurs while coverage is in force. A **Covered Accident** is an accident that occurs on or after an Insured's Effective Date while coverage is in force, and that is not specifically excluded by the Plan.

Actively at Work refers to your ability to perform your regular employment duties for a full normal workday. You may perform these activities either at your Employer's regular place of business or at a location where you are required to travel to perform the regular duties of your employment.

Calendar Year means the period beginning on the policy Effective Date and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

Claimant means a person who is authorized to make a claim under the Certificate.

Dependent means your spouse or dependent children, as defined in the applicable rider, who have been accepted for coverage.

Doctor is a person who is duly qualified as a practitioner of the healing arts acting within the scope of his license, and:

- Is licensed to practice medicine; prescribe and administer drugs; or to perform surgery, or
- Is a duly qualified medical practitioner according to the laws and regulations in the state in which Treatment is made.

A Doctor **does not** include you or any of your Family Members.

For the purposes of this definition, **Family Member** includes your Spouse as well as the following members of your immediate family:

- Son
- Daughter
- Mother
- Father
- Sister
- Brother

This includes step-Family Members and Family-Members-in-law.

Employee is a person who meets Eligibility requirements under **Section I – Eligibility, Effective Date, and Termination**, and who is covered under this Plan. The Employee is the primary Insured under this Plan.

Hospital means a place that meets all of the following criteria:

- Is legally licensed and operated as a Hospital,
- Provides overnight care of injured and sick people,
- Is supervised by a Doctor,
- Has full-time nurses supervised by a registered nurse, and
- Has on-site use of X-ray equipment, laboratory, and surgical facilities.

The term *Hospital* specifically excludes any facility not meeting the definition of Hospital as defined in this Plan, including but not limited to:

- A nursing home,
- An extended care facility,
- A skilled nursing facility,
- A rest home or home for the aged,
- A Rehabilitation Facility,
- A facility for the Treatment of alcoholism or drug addiction, or
- An assisted living facility.

Hospital Intensive Care Unit means a place that meets all of the following criteria:

- Is a specifically designated area of the Hospital called a Hospital Intensive Care Unit;
- Provides the highest level of medical care;
- Is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- Is separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement;
- Is permanently equipped with special life-saving equipment for the care of the critically ill or injured;
- Is under close observation by a specially trained nursing staff assigned exclusively to the Hospital Intensive Care Unit 24 hours a day; and
- Has a Doctor assigned to the Hospital Intensive Care Unit on a full-time basis.

The term *Hospital Intensive Care Unit* specifically excludes any type of facility not meeting the definition of Hospital Intensive Care Unit as defined in this Plan, including but not limited to private monitored rooms, surgical recovery rooms, observation units, and the following step-down units:

- A progressive care unit,
- A sub-acute intensive care unit, or
- An intermediate care unit.

Intermediate Intensive Care Step-Down Unit means any of the following:

- A progressive care unit,
- A sub-acute intensive care unit,
- An intermediate care unit, or
- A pre- or post-intensive care unit.

An Intermediate Intensive Care Step-Down Unit is **not** a Hospital Intensive Care Unit as defined in this Plan.

Life Event means an event that qualifies you to make changes to benefits at times other than your enrollment period. Events qualifying as Life Events are established solely by the Policyholder.

Rehabilitation Facility is a unit or facility providing coordinated multidisciplinary physical restorative services. These services must be provided to inpatients under a Doctor's direction. The Doctor must be knowledgeable and experienced in rehabilitative medicine. Beds must be set up in a unit or facility specifically designated and staffed for this service. This is not a facility for the Treatment of alcoholism or drug addiction.

Related – a Related Accidental Injury or Sickness is one that is in correlation to, or occurs as a result of, the initial Accidental Injury or Sickness, and would not otherwise have been sustained if that initial condition had not occurred.

Sickness means an illness, infection, disease, or any other abnormal physical condition or pregnancy that is not caused solely by, or the result of, any injury. A **Covered Sickness** is one that is not excluded by name, specific description, or any other provision in this Plan. For a benefit to be payable, loss arising from the Covered Sickness must occur while the applicable Insured's coverage is in force.

Spouse is your legal wife or husband , including a legally-recognized same-sex Spouse , or a person of either gender who is in a legally recognized and registered domestic partnership, civil union, reciprocal beneficiary relationship, or similar relationship with you.

Telemedicine Service means a medical inquiry with a Doctor via audio or video communication that assists with a patient's assessment, diagnosis, and consultation.

Treatment is the consultation, care, or services provided by a Doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines. Treatment does **not** include Telemedicine Services.

SECTION IV – BENEFIT PROVISIONS

Hospitalization Benefits

Hospital Admission Benefit

We will pay this benefit when an Insured is admitted to a Hospital and confined as an inpatient because of a Covered Accidental Injury or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, an Insured must be admitted to a Hospital within six months of the date of the Covered Accident.

We will pay the Hospital Admission Benefit amount shown in the Benefit Schedule. We will not pay benefits for confinement to an observation unit, or for emergency room Treatment or outpatient Treatment..

We will pay this benefit once per period of Hospital Confinement. This benefit is limited to the maximum shown in the Benefit Schedule. We will only pay this benefit once for each Covered Accident or Covered Sickness per Calendar Year. If an Insured is confined to the Hospital because of the same or Related Accidental Injury or Sickness, we will not pay this benefit again in the same Calendar Year.

Hospital Confinement Benefit

We will pay the amount shown in the Benefit Schedule for each day that an Insured is confined to a Hospital as an inpatient as the result of a Covered Accidental Injury or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, the Insured must be confined to a Hospital within six months of the date of the Covered Accident.

The length of time shown for Hospital Confinement in the Benefit Schedule is the maximum period for which an Insured can collect benefits for Hospital Confinements resulting from Covered Sickness or from Covered Accidental Injuries received in the same Covered Accident.

If we pay benefits for confinement and the Insured becomes confined again within six months because of the same or a Related condition, we will treat this confinement as the same period of confinement.

This benefit is payable for only one Hospital Confinement at a time, even if it is caused by more than one Covered Accidental Injury, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

Hospital Intensive Care Benefit

If an Insured is confined in a Hospital Intensive Care Unit because of a Covered Accidental Injury or Covered Sickness, we will pay the daily benefit amount shown in the Benefit Schedule. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, an Insured must be admitted to a Hospital Intensive Care Unit within six months of the date of the Covered Accident.

We will pay this amount for each day of such confinement, but not to exceed the maximum benefit period shown on the Benefit Schedule during any one period of confinement.

We will pay benefits for only one confinement in a Hospital Intensive Care Unit at a time, even if it is caused by more than one Covered Accidental Injury, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

If we pay benefits for confinement in a Hospital Intensive Care Unit and an Insured becomes confined to a Hospital Intensive Care Unit again within six months because of the same or a Related condition, we will treat this confinement as the same period of confinement.

This benefit is payable in addition to the Hospital Confinement Benefit.

Intermediate Intensive Care Step-Down Unit Benefit

If an Insured is confined in an Intermediate Intensive Care Step-Down Unit because of a Covered Accidental Injury or Covered Sickness, we will pay the daily benefit amount shown on the Benefit Schedule. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, the Insured must be admitted to an Intermediate Intensive Care Step-Down Unit within six months of the date of the Covered Accident.

We will pay this amount for each day of such confinement, not to exceed the maximum benefit period shown in the Benefit Schedule during any one period of confinement.

We will pay benefits for only one confinement in an Intermediate Intensive Care Step-Down Unit at a time, even if it is caused by more than one Covered Accidental Injury, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

If we pay benefits for confinement in a Hospital's Intermediate Intensive Care Step-Down Unit and the Insured becomes confined to a Hospital's Intermediate Intensive Care Step-Down Unit again within six months because of the same or a Related condition, we will treat this confinement as the same period of confinement.

This benefit is payable in addition to the Hospital Confinement Benefit.

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SECTION V – EXCLUSIONS

Exclusions

We will not pay for loss due to:

- War – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the Insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.
- Suicide – committing or attempting to commit suicide, while sane or insane.
- Self-Inflicted Injuries – injuring or attempting to injure oneself intentionally.
- Racing – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semi-professional capacity.
- Illegal Occupation – voluntarily participating in, committing, or attempting to commit a felony or illegal act or activity, or voluntarily working at, or being engaged in, an illegal occupation or job.
- Sports – participating in any organized sport in a professional or semi-professional capacity.
- Custodial Care – this is non-medical care that helps individuals with the basic tasks of everyday life, the preparation of special diets, and the self-administration of medication which does not require the constant attention of medical personnel.
- Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including any resulting complications.
- Services performed by a Family Member.
- Services related to sex or gender change, sterilization, in vitro fertilization, vasectomy or reversal of a vasectomy, or tubal ligation.
- Elective Abortion – an abortion for any reason other than to preserve the life of the person upon whom the abortion is performed.
- Dental Services or Treatment.
- Cosmetic surgery, except when due to:
 - o Reconstructive surgery, when the service is related to or follows surgery resulting from a Covered Accidental Injury or a Covered Sickness, or is related to or results from a congenital disease or anomaly of a covered dependent child.
 - o Congenital defects in newborns.
- 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.

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SECTION VI - CLAIM PROVISIONS

Notice of Claim

Written Notice of Claim must be given to us:

- Within 60 days after the Covered Accidental Injury or Covered Sickness, or
- As soon as reasonably possible.

When we receive written Notice of Claim, we will send a claim form. If the Claimant does not receive the claim form within 15 days after the notice is sent, written Proof of Loss can be sent to us without waiting for the form. Notice must include the Employee's name and the Certificate number. Notice can be mailed to the Company at the following address:

P.O. Box 84075, Columbus, GA 31993-9103

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. It can include a statement by the treating Doctor.) Proof of Loss establishes the nature and extent of the loss, the Company's obligation to pay the claim, and the Claimant's right to receive payment.

The Claimant must provide Proof of Loss to the Company at the following address:

P.O. Box 84075, Columbus, GA 31993-9103

Proof of Loss must be given to us within 90 days of the Covered Accidental Injury or Covered Sickness. Failure to give Proof of Loss within such time shall not invalidate or reduce any claim if such Proof of Loss is given as soon as reasonably possible. The Company will not accept Proof of Loss any later than one year and three months after the Covered Accidental Injury or Covered Sickness, except in the absence of your legal mental capacity.

The Claimant will be responsible for the cost of obtaining a completed claim form. We may request additional Proof of Loss, such as records from Hospitals or Doctors. We will be responsible for the cost of obtaining these records.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

When we receive the claim and due Proof of Loss, we will review the Proof of Loss. If we approve the claim, we will pay the benefits subject to the terms of the Certificate.

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 exams or autopsy.

Time of Payment of Claims

For benefits other than for loss of time, the Company will, once we receive the required Proof of Loss, pay, deny, or settle each submitted claim no later than the 60th day after the date Proof of Loss is received. Subject to written Proof of Loss, all accrued benefits payable under the Policy for loss of time will be paid at least monthly during the period for which the Company is liable. Any balance remaining unpaid at the end of that time will be paid as soon as possible after the Proof of Loss is received.

Payment of Claims

We will pay all benefits to you unless otherwise assigned. For any benefits that remain unpaid at the time of death, we will pay those benefits in the following order:

- To your designated beneficiary or the beneficiary's assignee,
- To your surviving Spouse,
- To your estate.

Unpaid Premium

When a claim is paid, we may deduct any premium due and unpaid from the claim payment.

Changing of Beneficiary

A change in beneficiary must be submitted in writing to our Home Office in a form acceptable to us and signed by you. Unless otherwise specified by you, a change in beneficiary will take effect on the date the notice of change is signed. We will not be liable for any action taken before notice is received and recorded at the Home Office.

Claim Review

If a claim is denied, you will be given written notice of:

- The reason for the denial,
- The Plan provision that supports the denial, and
- Your right to ask for a review of the claim.

Appeals Procedure

Before filing any lawsuit—and no later than 60 days after notice of denial of a claim—you, the Claimant, or an authorized representative of either must appeal any denial of benefits under the Plan by sending a written request for review of the denial to our Home Office.

Legal Action

You may not 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

Your insurance is provided under a contract of Group Supplemental Hospital Indemnity insurance with the Policyholder. The Entire Contract of Insurance is made up of:

- The Policy;
- The Certificate of insurance;
- The Application of the Policyholder, a copy of which is attached to and made part of the Policy when issued; and
- Any Riders, Endorsements, or Amendments to the Policy or Certificate.

In the absence of fraud, a statement made by the Policyholder or an Insured is considered a representation and not a warranty. A statement made by the Policyholder or an Insured will not be used in any contest under the Plan, unless a copy of the written instrument containing the statement is or has been provided to:

- The person making the statement; or
- If the statement was made by the Insured and the Insured has died or become incapacitated, the Insured's beneficiary or personal representative.

Changes to the 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 or producer (nor can an agent or producer waive any Plan provisions).

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.

Successor Insured

If you die while covered under this Certificate and your Spouse is also insured under this Plan at the time of your death, then your surviving Spouse may elect to become the primary Insured. This would include continuation of any Dependent Child Rider coverage that is in force at that time.

To become the primary Insured and keep coverage in force, your surviving Spouse must:

- Notify the Company in writing within 31 days after the date of your death; and
- Pay the required premium to the Company no later than 31 days after the date of your death, and on each premium due date thereafter.

If the Certificate does not cover a surviving Spouse, the Certificate will terminate on the next premium due date following your death.

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 such clerical error, the Company will make a premium adjustment.

Individual Certificates

The Company will give the Policyholder a Certificate for each Employee. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, and
- The rights and privileges under the Plan.

Required Information

The Policyholder will be responsible for furnishing all information and proofs that the Company may reasonably require with regard to the Plan.

Conformity with State Statutes

This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes.

BENEFIT SCHEDULE

Hospitalization Category

Hospital Admission Benefit

Payable once per admission

Maximum per Insured per each Covered Sickness

Maximum per Insured per each Covered Accident

Maximum per Insured

\$500.00 per admission

1 time per Calendar Year

1 time per Calendar Year

1 time per Calendar Year

Hospital Confinement Benefit

Maximum confinement period

Hospital Intensive Care Benefit

Maximum confinement period

Intermediate Intensive Care Step-Down Unit Benefit

Maximum confinement period

\$100.00 per day

up to maximum confinement period

31 days per Covered Sickness or Covered Accident

\$100.00 per day

10 days per Covered Sickness or Covered Accident

\$50.00 per day

10 days per Calendar Year



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Amendment to Policy, Certificate of Insurance, and Dependent Child Rider for Group Supplemental Hospital Indemnity

This Amendment is subject to all of the provisions of the Policy and Certificate to which it is attached. Additions or changes have been made to the Policy, Certificate, and Dependent Child Rider and are indicated below.

EFFECTIVE DATE

If issued at the same time as the Certificate, this Amendment becomes effective at the same time as the Certificate. If issued after the Certificate, this Amendment will have a later Effective Date.

The following sentence is added to the Effective Date provision:

Dependent coverage will begin on the date of the Life Event if notice was provided within 31 days after the Life Event.

The Plan Termination provision is deleted and replaced with the following:

Plan Termination

The **Company** has the right to cancel the Plan on any premium due date for the following reasons:

- The premium is not paid before the end of the Grace Period,
- The number of participating Employee is less than the number mutually agreed upon by the Company and the Policyholder,
- The number of participating Employee changes by 25% or more,
- The Policyholder fails to perform any of the obligations that relate to this policy or that are required by applicable law,
- The Policyholder no longer offers coverage to a particular class of Employee,
- The Policyholder no longer serves a class of Employee who reside in a particular geographical area, or
- The Policyholder does not provide timely information that is reasonably required.

The **Policyholder** has the right to cancel the Plan on any premium due date.

- To do this, the Policyholder must give the Company at least 31 days' written notice.
- The Plan will end on the date in the written notice or the date the Company receives the notice, whichever is later.

All outstanding premiums are due upon Plan termination. If the Company accepts premium payments after the Plan terminates, this will not reinstate the Plan.

The Policyholder has the sole responsibility of notifying Certificateholders in writing of the Plan's termination as soon as reasonably possible. If the Plan terminates, it—and all Certificates and Riders issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

The Termination of Your Insurance provision is deleted and replaced with the following:

Termination of Your Insurance

Your insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.

- The 31st day after the premium due date (the last day of the Grace Period), if the premium has not been paid.
- The date you no longer belong to an eligible class.

If an Insured's coverage terminates, we will provide benefits for valid claims that arose while your coverage was active.

The Continuation Privilege provision is deleted and replaced with the following:

Continuation Privilege

When you are no longer a member of an eligible class and your coverage would otherwise end, you may elect to continue your coverage under this Plan. You may continue the coverage you had on the date your Certificate would otherwise terminate, including any in-force Dependent Spouse Rider or Dependent Child Rider coverage, without any additional underwriting requirements.

To keep your coverage in force, you must:

- Notify the Company within 31 days after the date your coverage would otherwise terminate. You may notify us by sending written notice to P.O. Box 84079, Columbus, GA 31993-9101 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly to the Company no later than 31 days after the date your coverage would otherwise terminate and on each premium due date thereafter.

Your continued coverage will end on the earliest of the following dates:

- 31 days after the premium due date (the last day of the Grace Period), if the premium has not been paid, or
- The date the Group Plan is terminated.

If you qualify for this Continuation Privilege, then the Company will apply the same Benefits, Premium Rate, and Plan Provisions as shown in your previously-issued Certificate. Notification of any changes in the Plan will be provided directly by the Company.

The Grace Period provision is deleted and replaced with the following:

Grace Period

This Plan has a 31-day Grace Period. If a 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. If the Plan is discontinued, the Plan's termination date will be the latest date for which premium has been paid.

The definition of Dependent Child or Dependent Children is deleted and replaced with the following:

Dependent Child or ***Dependent Children*** means your or your Spouse's natural children, step-children, grandchildren who are in your legal custody and residing with you, foster children, children subject to legal guardianship, adopted children, or Children Placed for Adoption, who are younger than age 26. However, we will continue coverage for Dependent Children insured under the Plan after the age of 26 if they are incapable of self-sustaining employment due to mental or physical disability, and are chiefly dependent on a parent for support and maintenance. You or your Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday.

The insurance on any Dependent Child will terminate on the last day of the month in which the Dependent Child turns age 26; it is your responsibility to notify us in writing when coverage on a Dependent Child terminates. Termination will be without prejudice to any claim originating prior to the date of termination. Our acceptance of premium after such date will be considered as premium for only the remaining persons who qualify as Insureds under this Plan. When coverage on all Dependent Children terminates, you must notify the Company, in writing, and elect whether to continue this Plan on an Employee or Employee and Spouse Coverage basis. After such notice, we will arrange for the payment of the appropriate premium due, including returning any unearned premium.

Children Placed for Adoption are children for whom you have entered a decree of adoption, have initiated adoption proceedings, or are a party to a suit in which you seek to adopt the child. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. You must continue to have custody pursuant to the decree of the court.

Your natural Dependent Children born after the Effective Date of this Rider will be covered from the moment of live birth. No notice or additional premium is required.

The definition below is added to the Definitions section:

Observation Unit means a unit in which observation services are given through Hospital outpatient services to help the Doctor decide if the patient needs to be admitted as an inpatient or can be discharged. Observation services may be given in the emergency department or another area of the Hospital.

Hospitalization Benefits

The Hospital Admission Benefit is deleted and replaced with the following:

Hospital Admission Benefit

We will pay this benefit when an Insured is admitted to a Hospital and confined as an inpatient because of a Covered Accidental Injury or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, an Insured must be admitted to a Hospital within six months of the date of the Covered Accident.

We will pay the Hospital Admission Benefit amount shown in the Benefit Schedule. We will not pay benefits for confinement to an Observation Unit, or for emergency room Treatment or outpatient Treatment. We will not pay benefits for Hospital Admission of a newborn child following his birth. However, we will pay for a newborn's admission to a Hospital Intensive Care Unit if, following birth, he is confined as an inpatient as a result of a Covered Accidental Injury or Covered Sickness (including congenital defects, birth abnormalities, and/or premature birth).

We will pay this benefit once per period of Hospital Confinement. This benefit is limited to the maximum shown in the Benefit Schedule. We will only pay this benefit once for each Covered Accident or Covered Sickness per Calendar Year. If an Insured is confined to the Hospital because of the same or Related Accidental Injury or Sickness, we will not pay this benefit again in the same Calendar Year.

The Hospital Confinement Benefit is deleted and replaced with the following:

Hospital Confinement Benefit

We will pay the amount shown in the Benefit Schedule for each day that an Insured is confined to a Hospital as an inpatient as the result of a Covered Accidental Injury or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, the Insured must be confined to a Hospital within six months of the date of the Covered Accident.

The length of time shown for Hospital Confinement in the Benefit Schedule is the maximum period for which an Insured can collect benefits for Hospital Confinements resulting from Covered Sicknesses or from Covered Accidental Injuries received in the same Covered Accident. We will not pay benefits for confinement to an Observation Unit, or for emergency room Treatment or outpatient Treatment.

If we pay benefits for confinement and the Insured becomes confined again within six months because of the same or a Related condition, we will treat this confinement as the same period of confinement.

This benefit is payable for only one Hospital Confinement at a time, even if it is caused by more than one Covered Accidental Injury, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

The Proof of Loss provision is deleted and replaced with the following:

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. It can include a statement by the treating Doctor.) Proof of Loss establishes the nature and extent of the loss, the Company's obligation to pay the claim, and the Claimant's right to receive payment.

The Claimant must provide Proof of Loss to the Company at the following address:

P.O. Box 84075, Columbus, Georgia, 31993-9103

Proof of Loss must be given to us within 90 days of the Covered Accidental Injury or Covered Sickness. Failure to give Proof of Loss within such time shall not invalidate or reduce any claim if such Proof of Loss is given as soon as reasonably possible. The Company will not accept Proof of Loss any later than one year and three months after the Covered Accidental Injury or Covered Sickness, except in the absence of the Claimant's legal mental capacity.

The Claimant will be responsible for the cost of obtaining a completed claim form. We may request additional Proof of Loss, such as records from Hospitals or Doctors. The Claimant will be responsible for the cost of obtaining these records.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

When we receive the claim and due Proof of Loss, we will review the Proof of Loss. If we approve the claim, we will pay the benefits subject to the terms of the Certificate.

The Successor Insured provision is deleted and replaced with the following:

Successor Insured

If you die while covered under this Certificate and your Spouse is also insured under this Plan at the time of your death, then your surviving Spouse may elect to become the primary Insured. This would include continuation of any Dependent Child Rider coverage that is in force at that time.

To become the primary Insured and keep coverage in force, your surviving Spouse must:

- Notify the Company in writing within 31 days after the date of your death; and
- Pay the required premium to the Company no later than 31 days after the date of your death, and on each premium due date thereafter.

If the Certificate does not cover a surviving Spouse, the Certificate will terminate on the next premium due date following your death.

The Individual Certificates provision is deleted and replaced with the following:

Individual Certificates

The Company will give the Policyholder a Certificate for each Employee. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, and
- The rights and privileges under the Plan.

CONTRACT

This Amendment is part of the Policy and Certificate and will terminate when the Policy or Certificate terminates.

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary