



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, appearing to read "Teresa White".

Teresa White, President

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

Certificate of Insurance For Group Hospital Indemnity Policy

Any certificates issued in the State of Ohio are governed by State of Ohio. If the benefits and terms of the policy and certificate differ, the certificate will govern.

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.

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

Your Employer (the "Policyholder") applied for coverage under this Group 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.

The Group Hospital Indemnity Policy shall be available for inspection at reasonable times at the place of business of the Policyholder by any beneficiary thereunder.

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

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

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

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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).

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.

Portability Privilege

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

To keep your coverage in force, you must:

- Notify the Company within 31 days after the date your coverage would otherwise terminate. You may notify us by sending written notice to P.O. Box 427, Columbia, South Carolina, 29202 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly to the Company no later than 31 days after the date your coverage would otherwise terminate and on each premium due date thereafter.

Your ported coverage will end on the earliest of the following dates:

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

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

SECTION II – PREMIUM PROVISIONS

Premium Payments

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

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

Premium Changes

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

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

We will provide the Policyholder a 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. 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.

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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Health Screening Benefit

We will pay the daily amount shown on the Benefit Schedule for Health Screening Tests performed while an Insured's coverage is in force. This benefit is limited to the Calendar Year Maximum shown in the Benefit Schedule. Benefits are payable for covered dependent children at 100% 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
- Hemocult stool analysis
- Immunization
- 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
- Urinalysis
- Vision screening

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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.
- Racing – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semi-professional capacity.
- Illegal Occupation – voluntarily participating in, committing, or attempting to commit a felony, or voluntarily working at, or being engaged in, an illegal occupation or job.
- Sports – participating in any organized sport in a professional 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:
 - 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.
 - Congenital defects in newborns.

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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 427, Columbia, South Carolina, 29202

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 427, Columbia, South Carolina, 29202

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

Benefits payable under the Certificate will be paid after we receive due Proof of Loss acceptable to us. We will pay, deny, or settle all clean claims* within 30 calendar days after receiving the appropriate information.

**Clean claims contain all information and/or documentation needed for processing. These claims do not require further information from the provider, you, or your Employer.*

Payment of Claims

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

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

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 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;
- The Applications, if any, of each Employee; and
- Any Riders, Endorsements, or Amendments to the Policy or Certificate.

All statements (excluding fraudulent ones) that the Policyholder or an Insured has made in the Application will be considered representations, not warranties. The Company will not void insurance or reduce benefits as a result of statements made on the Application without sending Application copies.

Changes to the 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 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

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.



CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205
800.433.3036

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE OHIO LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

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

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

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. You should check with your insurance company representative to determine if you are only covered in part or not at all.

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

Ohio Life and Health Insurance Guaranty Association
1840 Mackenzie Drive
Columbus, OH 43220

Ohio Department of Insurance
50 West Town Street
Third Floor - Suite 300
Columbus, OH 43215

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

The Association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the event they are self-funded (that is, no insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the association will not pay more than \$100,000 in cash surrender values, \$100,000 in health insurance benefits, \$250,000 in present value of annuities, or \$300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: For unallocated annuities that fund governmental retirement plans under §§401, 403(b) or 457 of the Internal Revenue Code, the limit is \$250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no even shall the association be liable to spend more than \$300,000 in the aggregate per individual. For covered unallocated annuities that fund other plans, a special limit of \$1,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

**For more information about the Ohio Life & Health Insurance Guaranty Association, visit our website at:
ohlga.org.**