



Coverage underwritten by

# CONTINENTAL AMERICAN LIFE INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

## **Endorsement to Policy and Certificate of Insurance**

This Endorsement alters the Policy and the Certificate to which it is attached. Unless specifically addressed by this Endorsement, all other Policy and Certificate provisions, definitions, and terms continue to apply.

Continental American Insurance Company's mailing addresses for claims and premium payments are changed as listed below.

**Notice of Claim** and **Proof of Loss** should be mailed to the Company at:

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

**Premium Payments** should be mailed to the Company at:

P.O. Box 84069, Columbus, Georgia, 31908-4069

If applicable, references to 2801 Devine Street, Columbia, SC 29205 are deleted.

Signed for the Company at its Home Office,

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

Teresa White, President

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

J. Matthew Loudermilk, Secretary



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## IMPORTANT NOTICE

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

## GROUP CRITICAL ILLNESS INSURANCE POLICY

**THE FOLLOWING CONDITIONS ARE NOT CONSIDERED "CRITICAL ILLNESS" UNDER THIS POLICY:**

PRE-MALIGNANT CONDITIONS, CONDITIONS WITH MALIGNANT POTENTIAL, OR THOSE PROSTATIC CANCERS THAT ARE HISTOLOGICALLY DESCRIBED AS TNM CLASSIFICATION TX OR T0 OR T1A OR T1B. ALL OTHER PROSTATIC CANCERS ARE COVERED.

Any disease or injury involving the cardiovascular system other than heart attack as defined herein.  
Cardiac arrest not caused by a myocardial infarction.

Balloon angioplasty, laser relief, stints or other non-surgical procedures used to correct narrowing or blockage of coronary arteries.

Head injury, transient ischemic attack or cerebrovascular insufficiency.  
Renal failure caused by a traumatic event, including surgical traumas.

An insured person will not receive any benefits under this critical illness coverage for any of the above named conditions.

Please note only the diseases, illnesses and conditions defined in this policy are covered. Refer to Section III – Definitions for the definition of *Critical Illness*.

**CANCER IS PAYABLE AT DIFFERENT BENEFIT AMOUNTS BASED ON THE TYPE OF CANCER: INTERNAL OR INVASIVE CANCER, NON-INVASIVE CANCER, AND SKIN CANCER. SEE EXAMPLE BELOW. REFER TO THE POLICY SCHEDULE FOR BENEFITS PAYABLE**

A diagnosis of Non-Invasive Cancer provides a reduced benefit under this Plan. Benefits payable for Non-Invasive Cancer will be payable at 25%. Please see the Insured's Benefit Schedule for specific dollar amounts.

Example - If an Insured had a tumor removed from any organ (such as breast or prostate) and that tumor had not spread (Non-Invasive Cancer), the benefit payable would be 25% of the Face Amount listed on the Certificate Schedule.

However, if that tumor had spread (metastasized) to other tissue (such as lymph nodes), the full benefit would be payable.

**California law prohibits an HIV test from being required or used by health insurance companies as a condition for obtaining health insurance coverage.**

*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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## 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 Policy Schedule.**

**Please read it carefully.**

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

**THIS IS NOT A MEDICARE SUPPLEMENT POLICY. PLEASE READ YOUR POLICY CAREFULLY.**

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. (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.

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,

Teresa White, President

J. Matthew Loudermilk, Secretary

**Group Critical Illness Insurance  
Non-Participating**

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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 his employer and included in the class that is eligible for coverage, as shown on the Master Application.

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

- The Spouse of an Employee, or
- The Dependent Child of an Employee or an Employee's Spouse (details included in the **Definitions** section).

**Insured** means an Employee or eligible Dependent, if any, who is covered under the Plan in the following categories:

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

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 schedule page. 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 may 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 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.

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.

The Effective Date for a Spouse or Dependent Child is:

- The date shown on the Certificate Schedule if that Spouse or Dependent Child is not confined to a hospital and is eligible for coverage on that date, or
- The date the Spouse or Dependent Child is no longer confined to a hospital (if that Spouse or Dependent Child 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. To be added, the Employee must complete an Application to add his 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.

Newborn children will be covered from the moment of birth, adopted children from the date the petition is filed for adoption, and step-children from the date of the Employee's marriage.

A day begins at 12:01 a.m. standard time at the Employee's, Spouse's, or Dependent Child'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 in the signed Master Application,
- The Policyholder does not provide timely information or meet any obligations required by this Plan and applicable law, or
- The Company cancels the Plan any time after the end of the first policy year. To do this, the Company must give the Policyholder 31 days' written notice.

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, if the premium has not been paid.
- The date he no longer belongs to an eligible class.

Insurance for a covered Spouse or Dependent Child will terminate on the earliest of any of the bullet points listed above, or:

- The premium due date following the date the covered Spouse or Dependent Child no longer qualifies as a Dependent.
- The premium due date following the date we receive the Employee's written request to terminate coverage for his Spouse or all Dependent Children.

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

## **Portability 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. The Employee may continue the coverage he had on the date his Certificate would otherwise terminate, including any in-force Spouse or Dependent Child coverage.

To keep his coverage in force, the Employee must:

- Notify the Company in writing within 31 days after the date his coverage would otherwise terminate, and
- Pay the required premium to the Company no later than 31 days after the date his 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 date the Employee fails to pay any required premium; or
- The date the Group Plan is terminated.

If an Employee qualifies for this Portability 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 Payments**

Premiums for this Plan should be paid to the Company at its Home Office in Columbia, South Carolina. 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**

The Plan's first Anniversary Date appears on the Policy Schedule. Subsequent anniversaries will be the same date each following year.

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

- On the Policy Anniversary Date based on renewal underwriting.
- 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 to a premium.

### **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 his employment duties for a full 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.

***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.

***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 (that is, Cancer that has metastasized), or
- A disease meeting the diagnostic criteria of malignancy. A qualified medical professional must have examined and provided a report on the histocytologic architecture or pattern of the tumor, tissue, or specimen.

Leukemia, lymphoma, and Hodgkin's disease are included in the definition of Cancer (internal or invasive). Also included are:

- 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:

- Superficial cervical cancer, superficial bladder tumors, or pre-malignant tumors or polyps
- Early breast cancer requiring lumpectomy without radiation or chemotherapy
- Early prostate (Stage A) cancer
- Non-Invasive Cancer (as defined below)
- Skin Cancer (as defined below)
- Melanoma that is Diagnosed as
  - Clark's Level I or II,
  - Breslow depth less than 0.77mm, **or**
  - Stage 1A melanomas under TNM Staging

**Non-Invasive Cancer** is a Cancer that is confined in its site of origin (In Situ) without having invaded neighboring tissue.

For the purposes of this Plan, Non-Invasive Cancer includes:

- Cancer in one organ, such as prostate or indolent cancer (this does not include Cancer that has spread throughout the organ, such as breast cancer, which would be considered an invasive cancer)
- Myelodysplastic Syndrome – RA (refractory anemia)
- Myelodysplastic Syndrome – RARS (refractory anemia with ring sideroblasts)

Skin Cancer, as defined in this Plan, 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 – that is, 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)
- Melanoma that is Diagnosed as:
  - Clark's Level I or II,
  - Breslow depth less than 0.77mm, or
  - Stage 1A melanomas under TNM Staging

These conditions are not payable under the Cancer (internal or invasive) benefit.

**Cancer, Non-Invasive 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 qualified medical professional.
2. **Clinical Diagnosis** is based only on the study of symptoms. The Company will accept a Clinical Diagnosis only if:
  - Diagnosis is consistent with professional medical standards,
  - Medical evidence exists to support the Diagnosis, and
  - A Doctor/Qualified Medical Professional is treating the Insured for Cancer or Non-Invasive Cancer.

**Cardiomyopathy** means a disease with measurable deterioration of the function of the myocardium, and is typically characterized by breathlessness and swelling of the legs.

**Cervical Cancer Screening** means conventional Pap test, a human papillomavirus screening test that is approved by the federal Food and Drug Administration, or any other cervical cancer screening test approved by the federal Food and Drug Administration.

**Clark Level** is a measurement of the thickness of a melanoma in relation to the layers of the skin. The Clark Level uses a scale of I to V (1-5) to describe which layers of the skin are involved. Example- Clark Level I would only involve the first layer of skin.

**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 evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the 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
- Coronary Artery Bypass Surgery
- Heart Attack (Myocardial Infarction)
- Kidney Failure (End-Stage Renal Failure)
- Limited Benefit Major Organ Transplant
- Non-Invasive Cancer
- Stroke
- Sudden Cardiac Arrest

**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 Non-Invasive Cancer 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/Qualified Medical Professional recommends that an Insured begin renal dialysis.
- **Limited Benefit Major Organ Transplant:** The date the surgery occurs.
- **Non-Invasive Cancer:** The day tissue specimens, blood samples, or titer(s) are taken (Diagnosis of Cancer and/or Non-Invasive Cancer 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).

**Dependent** means an Employee's Spouse or Dependent Child. **Spouse** is an Employee's legal wife or husband who is listed on the Employee's Application. The term "Spouse" also includes a person who is in a legally recognized domestic partnership with the Employee (as defined in California Family Code 297), a partner of a civil union, or similar relationship. **Dependent Children** are an Employee's or an Employee's Spouse's natural children, step-children (including existing children of new domestic partners), legally adopted children, or Children Placed for Adoption, who are younger than age 26.

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

There is an exception to the age-26 limit listed 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 dependent on a parent for support. 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.

**Diagnosis (Diagnosed)** refers to the definitive and certain identification of an illness or disease that:

- Is made by a Doctor/Qualified Medical Professional 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.

Diagnosis must be made and Treatment must be received in the United States or its territories.

**Doctor/Qualified Medical Professional** 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/Qualified Medical Professional does not include the Insured or any of the Insured's Family Members. 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      | • Mother | • Sister  |
| • Daughter | • Father | • 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.

**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.
- Sudden 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/Qualified Medical Professional 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.

**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.

**Limited Benefit 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.

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.

**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/Qualified Medical Professional based upon documented neurological deficits and confirmatory neuroimaging studies.

Stroke does not include:

- Non-permanent, brief episodes of neurological dysfunction – such as Transient Ischemic Attack (TIA) – caused by focal brain or retinal ischemia and including symptoms typically lasting less than one hour, and without evidence of acute infarction
- 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).

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

**Treatment-Free from Cancer** refers to the period of time in which you are not taking prescribed drugs and medicines for treatment of Cancer, or undergoing definitive therapy for Cancer. “Treatment” does not include Maintenance Drug Therapy or routine follow-up visits to verify whether Cancer or Non-Invasive Cancer has returned.

## **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**

We will pay the Critical Illness benefit when an Insured is Diagnosed with one of the Critical Illnesses shown in the Certificate 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 Date of Diagnosis is while his coverage is in force, and
- The Certificate does not exclude the illness or condition by name or by specific description.

If an Initial Diagnosis claim is for a Diagnosis of Cancer, the Insured:

- Must be Treatment-Free from a previously diagnosed cancer for at least 12 months before the Diagnosis Date; and
- Must be in Complete Remission from a previously diagnosed cancer prior to the date of a subsequent Diagnosis of cancer. Remission must be evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the Cancer.

Benefits will be based on the Face Amount in effect on the Critical Illness Date of Diagnosis.

**Additional Diagnosis**

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 six consecutive months, and
- The new Critical Illness is not caused or contributed to by a Critical Illness for which benefits have been paid.

If an Additional Diagnosis claim is for a Diagnosis of Cancer, the Insured:

- Must be Treatment-Free From Cancer for at least 12 months before the Diagnosis Date; and
- Must be in Complete Remission prior to the date of a subsequent Diagnosis as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the Cancer.

**Reoccurrence**

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 to by a Critical Illness for which benefits have been paid.

If a Reoccurrence claim is for a Diagnosis of Cancer, the Insured:

- Must be Treatment-Free From Cancer for at least 12 months before the Diagnosis Date; and
- Must be in Complete Remission prior to the date of a subsequent Diagnosis as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the Cancer.

**Partial Benefits**

Partial 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.

**Non-Invasive Cancer**

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.

**Coronary Artery Bypass Surgery**

We will pay the amount shown in the Policy Schedule for Coronary Artery Bypass Surgery. This benefit is payable in addition to all other applicable benefits.

**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 once per calendar year.

**Mammography**

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

- a) A baseline mammogram for women age 35 to 39, inclusive.
- b) A mammogram for women age 40 to 49, inclusive, every two years or more frequently based on the women's physicians' recommendations.

- c) A mammogram every year for women age 50 and over.

Payment of this benefit will not reduce the face amount of the certificate.

### **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 once per calendar year, per Insured. Benefits are not payable for Covered Dependent Children.

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
- DNA stool analysis
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Cervical Cancer Screening
- 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
- Any other medically accepted cancer screening test

### **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:

- Not working at any job for pay or benefits,
- Under the care of a Doctor/Qualified Medical Professional for the Treatment of a covered Critical Illness, and
- **Unable to Work**, which means either:
  - During the first 365 days of Total Disability, the Employee is unable to work at the occupation he was performing when his Total Disability began; or
  - After the first 365 days of Total Disability, the Employee is unable to work at any gainful occupation for which he is suited by education, training, or experience.

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 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 65<sup>th</sup> 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 he returns to Active Work, coverage for any Insured may be continued if premium payments are resumed.

## **Section V – Limitations and Exclusions**

### **Cancer Diagnosis Limitation**

Benefits are payable for Cancer and/or Non-Invasive Cancer as long as the Insured:

- Is Treatment-Free From Cancer for at least 12 months before the Diagnosis Date; and
- Is in Complete Remission prior to the date of a subsequent Diagnosis, as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the Cancer.

### **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 Occupation**- committing or attempting to commit a felony, or being engaged in an illegal occupation
- **Participation in Aggressive Conflict** of any kind, including:
  - War (declared or undeclared) or military conflicts
  - Insurrection or riot
- **Intoxicants and controlled substances**-loss sustained or contracted in consequence of the Insured's being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician

## **Section VI – General Provisions**

### **Entire Contract Changes**

This policy constitutes the entire contract between the parties, and no statement made by the employer or by an employee whose eligibility has been accepted by the insurer shall (avoid the insurance or reduce the benefits under this policy or) be used in defense to a claim hereunder.

No change in this policy shall be valid unless approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or waive any of its provisions.

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

After three years from the date of issue of this policy, no misstatement of the policyholder, except a fraudulent misstatement, made in his application shall be used to void the policy; and after three years from the effective date of the coverage with respect to which any claim is made no misstatement of any employee eligible for coverage under the policy, except a fraudulent misstatement, made in an application under the policy shall be used to deny a claim for loss incurred or disability commencing after expiration of such three years.

No claim for loss incurred or disability commencing after three years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made.



### **Grace Period**

A grace period of 31 days will be granted for the payment of premiums accruing after the first premium, during which grace period the policy shall continue in force, but the employer shall be liable to the insurer for the payment of the premium accruing for the period the policy continues in force.

### **Notice of Claim**

Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the insurer at **P.O. Box 427, Columbia, South Carolina, 29202**, or to any authorized agent of the insurer, with information sufficient to identify the insured employee, shall be deemed notice to the insurer.

### **Claim Forms**

The insurer, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

### **Proof of Loss**

Written proof of loss must be furnished to the insurer, in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which the insurer is liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the employee, later than one year from the time proof is otherwise required.

### **Time of Payment of Claims**

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

### **Payment of Claims**

We will pay all benefits to 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 any approved assignee;
2. To the Insured's beneficiary;
3. To the Insured's surviving Spouse;
4. To the Insured's estate.

### **Physical Examination and Autopsy**

The insurer at its own expense shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as it may reasonably require during the Pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

### **Legal Action**

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

### **Changing of Beneficiary**

The right to change of beneficiary is reserved to the insured employee, and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary.

### **Misstatement of Age**

If the age of any individual covered under this policy has been misstated, the amount payable shall be such as the premium paid for the coverage of such individual would have purchased at the correct age.

### **Conformity with State Statutes**

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

### **Successor Insured**

If an Employee dies while covered under his Certificate and his Spouse is also insured under this Plan at this time of his death, then his 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 on the next premium due date following the Employee's death.

### **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.

### **Clerical Error**

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

### **Individual Certificate**

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

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

### **Required Information**

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

## **California Department of Insurance Contact Information**

Please contact the California Department of Insurance if you have an issue that cannot be solved with Continental American Life Insurance Company.

**California Department of Insurance  
Consumer Communications Bureau  
300 South Spring Street, South Tower  
Los Angeles, CA 90013**

**Consumer Hotline  
1-800-927-Help (4357)  
or  
1-213-897-8921  
TDD Number  
1-800-482-4TDD (4833)**

## **Section VIII – Incorporation of Rider Provisions**

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

**Rider Name**

**Form Number**

**Policy Schedule**

<b>Policyholder:</b>	Bass Medical
<b>Jurisdiction:</b>	California
<b>Policy Number:</b>	27145
<b>Policy Effective Date:</b>	January 1, 2021
<b>Policy Anniversary Date:</b>	January 1, 2022
<b>Face Amount:</b>	See Certificates
<b>Spouse Amount:</b>	See Certificates
<b>Covered Dependent Children:</b>	50% of applicable Face Amount
<b>Mammography</b>	\$200 payable once per calendar year
<b>Partial Benefits Percentage:</b>	25% of applicable Face Amount
<b>Additional Benefits:</b>	
<b>Health Screening Benefit Amount:</b>	\$50 per Insured per calendar year
<b>Skin Cancer:</b>	\$250
Skin Cancer for Covered Dependent Children:	50% of Skin Cancer Benefit Amount
<b>Waiver of Premium:</b>	es

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

## **Benefit Schedule**

### **Critical Illness Benefits**

The applicable benefit amount (Face 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
- Heart Attack (Myocardial Infarction)
- Kidney Failure (End-Stage Renal Failure)
- Limited Benefit Major Organ Transplant
- Stroke
- Sudden Cardiac Arrest

### **Partial Benefits**

Non-Invasive Cancer

Coronary Artery Bypass Surgery

### **Additional Benefits**

Health Screening Benefit

Skin Cancer

Waiver of Premium

Mammography

**Classifications and Schedule of Premiums**

RATES TABLE FOR: BASS MEDICAL GROUP - GP-23276 / GROUP CRITICAL ILLNESS - PLAN-160499

DEDUCTION FREQUENCY : Monthly (12pp / yr)

Employee - Non-Tobacco

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-25	\$2.70	\$3.89	\$5.07	\$6.26	\$7.44	\$8.63	\$9.81	\$11.00	\$12.18	\$13.37
26-30	\$3.27	\$5.02	\$6.77	\$8.53	\$10.28	\$12.03	\$13.78	\$15.53	\$17.28	\$19.04
31-35	\$3.64	\$5.76	\$7.87	\$9.99	\$12.11	\$14.23	\$16.34	\$18.46	\$20.58	\$22.70
36-40	\$4.44	\$7.37	\$10.29	\$13.22	\$16.14	\$19.06	\$21.99	\$24.91	\$27.83	\$30.76
41-45	\$5.17	\$8.81	\$12.46	\$16.10	\$19.75	\$23.40	\$27.04	\$30.69	\$34.33	\$37.98
46-50	\$5.98	\$10.44	\$14.89	\$19.35	\$23.81	\$28.27	\$32.73	\$37.19	\$41.64	\$46.10
51-55	\$8.73	\$15.93	\$23.14	\$30.35	\$37.55	\$44.76	\$51.96	\$59.17	\$66.38	\$73.58
56-60	\$8.52	\$15.52	\$22.53	\$29.53	\$36.53	\$43.53	\$50.54	\$57.54	\$64.54	\$71.54
61-65	\$16.62	\$31.72	\$46.81	\$61.91	\$77.01	\$92.11	\$107.21	\$122.30	\$137.40	\$152.50
66+	\$28.72	\$55.93	\$83.13	\$110.34	\$137.54	\$164.74	\$191.95	\$219.15	\$246.36	\$273.56

Employee - Tobacco

	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
18-25	\$3.31	\$5.09	\$6.88	\$8.67	\$10.46	\$12.24	\$14.03	\$15.82	\$17.60	\$19.39
26-30	\$4.09	\$6.66	\$9.22	\$11.79	\$14.36	\$16.93	\$19.50	\$22.07	\$24.63	\$27.20
31-35	\$4.88	\$8.23	\$11.59	\$14.94	\$18.30	\$21.66	\$25.01	\$28.37	\$31.72	\$35.08
36-40	\$6.27	\$11.03	\$15.78	\$20.54	\$25.29	\$30.05	\$34.80	\$39.56	\$44.31	\$49.07
41-45	\$7.37	\$13.21	\$19.06	\$24.91	\$30.75	\$36.60	\$42.44	\$48.29	\$54.14	\$59.98
46-50	\$8.62	\$15.72	\$22.83	\$29.93	\$37.03	\$44.13	\$51.23	\$58.34	\$65.44	\$72.54
51-55	\$13.06	\$24.60	\$36.14	\$47.68	\$59.23	\$70.77	\$82.31	\$93.85	\$105.39	\$116.93
56-60	\$13.19	\$24.86	\$36.53	\$48.20	\$59.87	\$71.54	\$83.21	\$94.88	\$106.55	\$118.22
61-65	\$25.51	\$49.50	\$73.49	\$97.47	\$121.46	\$145.45	\$169.44	\$193.43	\$217.42	\$241.41
66+	\$43.42	\$85.31	\$127.21	\$169.10	\$211.00	\$252.89	\$294.79	\$336.69	\$378.58	\$420.48

Spouse - Non-Tobacco

	\$2,500	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000
18-25	\$2.11	\$2.70	\$3.30	\$3.89	\$4.48	\$5.07	\$5.67	\$6.26	\$6.85	\$7.44
26-30	\$2.40	\$3.27	\$4.15	\$5.02	\$5.90	\$6.77	\$7.65	\$8.53	\$9.40	\$10.28
31-35	\$2.58	\$3.64	\$4.70	\$5.76	\$6.81	\$7.87	\$8.93	\$9.99	\$11.05	\$12.11
36-40	\$2.98	\$4.44	\$5.91	\$7.37	\$8.83	\$10.29	\$11.75	\$13.22	\$14.68	\$16.14
41-45	\$3.34	\$5.17	\$6.99	\$8.81	\$10.64	\$12.46	\$14.28	\$16.10	\$17.93	\$19.75
46-50	\$3.75	\$5.98	\$8.21	\$10.44	\$12.67	\$14.89	\$17.12	\$19.35	\$21.58	\$23.81
51-55	\$5.12	\$8.73	\$12.33	\$15.93	\$19.54	\$23.14	\$26.74	\$30.35	\$33.95	\$37.55
56-60	\$5.02	\$8.52	\$12.02	\$15.52	\$19.03	\$22.53	\$26.03	\$29.53	\$33.03	\$36.53



61-65	\$9.07	\$16.62	\$24.17	\$31.72	\$39.26	\$46.81	\$54.36	\$61.91	\$69.46	\$77.01
66+	\$15.12	\$28.72	\$42.33	\$55.93	\$69.53	\$83.13	\$96.73	\$110.34	\$123.94	\$137.54

Spouse - Tobacco

	\$2,500	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000
18-25	\$2.41	\$3.31	\$4.20	\$5.09	\$5.99	\$6.88	\$7.78	\$8.67	\$9.56	\$10.46
26-30	\$2.80	\$4.09	\$5.37	\$6.66	\$7.94	\$9.22	\$10.51	\$11.79	\$13.08	\$14.36
31-35	\$3.20	\$4.88	\$6.55	\$8.23	\$9.91	\$11.59	\$13.27	\$14.94	\$16.62	\$18.30
36-40	\$3.90	\$6.27	\$8.65	\$11.03	\$13.41	\$15.78	\$18.16	\$20.54	\$22.92	\$25.29
41-45	\$4.44	\$7.37	\$10.29	\$13.21	\$16.14	\$19.06	\$21.98	\$24.91	\$27.83	\$30.75
46-50	\$5.07	\$8.62	\$12.17	\$15.72	\$19.28	\$22.83	\$26.38	\$29.93	\$33.48	\$37.03
51-55	\$7.29	\$13.06	\$18.83	\$24.60	\$30.37	\$36.14	\$41.91	\$47.68	\$53.46	\$59.23
56-60	\$7.36	\$13.19	\$19.03	\$24.86	\$30.70	\$36.53	\$42.37	\$48.20	\$54.04	\$59.87
61-65	\$13.51	\$25.51	\$37.50	\$49.50	\$61.49	\$73.49	\$85.48	\$97.47	\$109.47	\$121.46
66+	\$22.47	\$43.42	\$64.36	\$85.31	\$106.26	\$127.21	\$148.15	\$169.10	\$190.05	\$211.00



Coverage underwritten by

# CONTINENTAL AMERICAN LIFE INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

## **Amendment to Policy and Certificate of Insurance for Group Critical Illness**

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

### **Effective Date**

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

*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 Employees is less than the number mutually agreed upon by the Company and the Policyholder in the signed Master Application,
- The Policyholder does not provide timely information or meet any obligations required by this Plan and applicable law, or
- The Company cancels the Plan any time after the end of the first policy year. To do this, the Company must give the Policyholder 31 days' written notice.

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.

*The Portability Privilege provision is deleted and replaced with the following:*

### **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 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.

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, 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 Additional Diagnosis provision is deleted and replaced with the following:***

**Additional Diagnosis**

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 six consecutive months.

If an Additional Diagnosis claim is for a Diagnosis of Cancer, the Insured:

- Must be Treatment-Free From Cancer for at least 12 months before the Diagnosis Date; and
- Must be in Complete Remission prior to the date of a subsequent Diagnosis as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the Cancer.

***The Reoccurrence provision is deleted and replaced with the following:***

**Reoccurrence**

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 six consecutive months.

If a Reoccurrence claim is for a Diagnosis of Cancer, the Insured:

- Must be Treatment-Free From Cancer for at least 12 months before the Diagnosis Date; and
- Must be in Complete Remission prior to the date of a subsequent Diagnosis as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the Cancer.

***The Health Screening Benefit is deleted and replaced with the following:***

**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 once per calendar year, per Insured. Benefits are not payable for Covered Dependent Children.

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
- DNA stool analysis

- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Cervical Cancer Screening
- 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
- Any other medically accepted cancer screening test
- HIV test performed via nucleic acid test (NAT)
- HPV test performed via Pap smear

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

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.

## **General Provisions**

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

This Amendment is subject to all of the terms of the Group Critical Illness Policy and Certificate to which it is attached unless any such items are inconsistent with the terms of this Amendment.

Signed for the Company at its Home Office,



**Teresa White, President**



**J. Matthew Loudermilk, Secretary**



Coverage underwritten by

# CONTINENTAL AMERICAN LIFE INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

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

## **Amendment to Policy and Certificate of Insurance for Group Critical Illness**

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 definition of Dependent is deleted and replaced with the following:**

**Dependent** means your Spouse or your Dependent Child. **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 (as defined in California Family Code 297), civil union, reciprocal beneficiary relationship, or similar relationship with you, who is listed on your Application. **Dependent Children** are your or your Spouse's natural children, step-children (including existing children of new domestic partners), foster children, children subject to legal guardianship, legally adopted children, or Children Placed for Adoption, who are younger than age 26. However, we will continue coverage for Dependent Children insured under the Plan after the age of 26 if they are incapable of self-sustaining employment due to mental or physical handicap, and are chiefly dependent on a parent for support and maintenance. You or your Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday.

The insurance on any Dependent Child will terminate on the last day of the month in which the Dependent Child turns age 26; it is your responsibility to notify us in writing when coverage on a Dependent Child terminates. Termination will be without prejudice to any claim originating prior to the date of termination. Our acceptance of 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 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.

### **The definition of Limited Benefit Major Organ Transplant is deleted and replaced with the following:**

**Limited Benefit 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 Limited Benefit 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 Limited Benefit Major Organ Transplant benefit is not payable if the Limited Benefit Major Organ Transplant results from a covered Critical Illness for which a benefit has been paid.

#### **CONTRACT**

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

Signed for the Company at its Home Office,



**Teresa White, President**



**J. Matthew Loudermilk, Secretary**



Coverage underwritten by

# CONTINENTAL AMERICAN LIFE INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

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

## Continuation of Coverage Endorsement

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

### EFFECTIVE DATE

If issued at the same time as the Certificate, this Endorsement becomes effective when the Certificate becomes effective.

If issued after the Certificate, this Endorsement will have a later Effective Date.

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

### CONTINUATION OF COVERAGE

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

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

To keep your Certificate in force, you must:

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

### PREMIUMS

Initial premium rates will be based on the rates in effect at the time you apply to continue your coverage. Premium rates can be changed by the Company at any time upon 31 days written notice to you. Any such change will be applied to all Certificates in your class and will not be based on your or your Spouse and Dependent Children's health or other individual factors.

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

## **TERMINATION**

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

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

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

## **CONTRACT**

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

- The Certificate terminates.

Signed for the Company at its Home Office,



Teresa White, President



J. Matthew Loudermilk, Secretary





Coverage underwritten by

# **CONTINENTAL AMERICAN LIFE INSURANCE COMPANY**

**2801 Devine Street, Columbia, South Carolina 29205  
800.433.3036**

**Please contact the California Department of Insurance if you have an issue that can not be solved with  
Continental American Life Insurance Company.**

**California Department of Insurance  
Consumer Communications Bureau  
300 South Spring Street, South Tower  
Los Angeles, CA 90013**

**Consumer Hotline  
1-800-927-Help (4357) or 1-213-897-8921**

**TDD Number  
1- 800-482-4TDD (4833)**

**Internet Web Site  
[www.insurance.ca.gov](http://www.insurance.ca.gov)**



Coverage underwritten by  
**CONTINENTAL AMERICAN LIFE INSURANCE COMPANY**

**Columbia, South Carolina**  
**800.433.3036**

## **NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION**

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage. Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

### **COVERAGE**

#### **• Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives **in** California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

#### **• Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

##### **• Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

##### **• Life Insurance**

80% of death benefits but not to exceed \$300,000

80% of cash surrender or withdrawal values but not to exceed \$100,000

##### **• Annuities and Structured Settlement Annuities**

80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed \$250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is \$300,000, regardless of the number of policies or contracts covering the individual.

##### **• Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is \$546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website [www.califega.org](http://www.califega.org).

## COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section I 067.02(b)(2)(C)

## NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at [www.califega.org](http://www.califega.org), or contact either of the following:

California Life and Health Insurance  
Guarantee Association  
P.O. Box 16860  
Beverly Hills, CA 90209-33 19  
(323) 782-0182

California Department of Insurance  
Consumer Communications Bureau  
300 South Spring Street  
Los Angeles, CA 900 13  
(800) 927- 4357

**Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.**