



## 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,

Teresa White, President

J. Matthew Loudermilk, Secretary



**IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE  
TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION**  
(For insurers declared insolvent or impaired on or after September 1, 2011)

Texas law establishes a system to protect Texas Policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association (the "Association") administers this protection system. Only the policyholders of insurance companies that are members of the Association are eligible for this protection which is subject to the terms, limitations and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

**It is possible that the Association may not protect all or part of your policy because of statutory limitations.**

**Eligibility for Protection by the Association**

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas (**regardless of where the policyholder lived when the policy was issued**)
- Residents of other states, ONLY if the following conditions are met:
  1. The policyholder has a policy with a company domiciled in Texas;
  2. The policyholder's state of residence has a similar guaranty association; and
  3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

**Limits of Protection by the Association**

**Accident, Accident and Health, or Health Insurance:**

- For each individual covered under one or more policies: up to a total of \$500,000 for basic hospital, medical-surgical, and major medical insurance, \$300,000 for disability or long term care insurance, and \$200,000 for other types of health insurance.

**Life Insurance:**

- Net cash surrender value or net cash withdrawal value up to a total of \$100,000 under one or more policies on a single life; or
- Death benefits up to a total of \$300,000 under one or more policies on a single life; or
- Total benefits up to a total of \$5,000,000 to any owner of multiple non-group life policies.

**Individual Annuities:**

- Present value of benefits up to a total of \$250,000 under one or more contracts on any one life.

**Group Annuities:**

- Present value of allocated benefits up to a total of \$250,000 on any one life; or
- Present value of unallocated benefits up to a total of \$5,000,000 for one contract holder regardless of the number of contracts.

**Aggregate Limit:**

- \$300,000 on any one life with the exception of the \$500,000 health insurance limit, the \$5,000,000 multiple owner life insurance limits, and the \$5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

**Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.**

Texas Life, Accident, Health and Hospital  
Service Insurance Guaranty Association  
6505 Bridge Point Parkway, Suite 450  
Austin, Texas 78730  
(800)-982-6362 or [www.txlifega.org](http://www.txlifega.org)

Texas Department of Insurance  
Post Office Box 149104  
Austin, Texas 78714-9104  
(800)-252-3439 or [www.tdi.texas.gov](http://www.tdi.texas.gov)

## IMPORTANT NOTICE

To obtain information or make a complaint:

**You may call Continental American Insurance Company's toll-free telephone number for information or to make a complaint at:**

**1-800-433-3036**

You may also write to Continental American Insurance Company at:

Post Office Box 427  
Columbia, South Carolina 29202

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

**1-800-252-3439**

You may write the Texas Department of Insurance:

P.O. Box 149104  
Austin, TX 78714-9104  
Fax: (512) 490-1007  
Web: [www.tdi.texas.gov](http://www.tdi.texas.gov)  
E-mail: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

### **PREMIUM OR CLAIM DISPUTES:**

Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

### **ATTACH THIS NOTICE TO YOUR POLICY:**

This notice is for information only and does not become a part or condition of the attached document.

## AVISO IMPORANTE

Para obtener información o para presentar una queja:

**Usted puede llamar al número de teléfono gratuito de Continental American Insurance Company's para obtener información o para presentar una queja al:**

**1-800-433-3036**

Usted también puede escribir a Continental American Insurance Company:

Post Office Box 427  
Columbia, South Carolina 29202

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

**1-800-252-3439**

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104  
Austin, TX 78714-9104  
Fax: (512) 490-1007  
Sitio web: [www.tdi.texas.gov](http://www.tdi.texas.gov)  
E-mail: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

### **DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:**

Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

### **ADJUNTE ESTE AVISO A SU PÓLIZA:**

Este aviso es solamente para propósito informativos y no se convierte en parte o en condición del documento adjunto.



# CONTINENTAL AMERICAN INSURANCE COMPANY

Home Office: 2801 Devine Street, Columbia, South Carolina 29205

800.433.3036

## CERTIFICATE OF INSURANCE FOR ACCIDENTAL INJURY POLICY

THIS IS AN ACCIDENT ONLY COVERAGE AND DOES NOT PAY BENEFITS FOR LOSS FROM SICKNESS

(COVERAGE FOR SICKNESS MAY BE INCLUDED IN A SEPARATE RIDER, REQUIRING ADDITIONAL PREMIUMS.)

PLEASE READ YOUR CERTIFICATE CAREFULLY

### CERTIFICATE INDEX

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We certify that you are insured under the Accidental Injury Policy (herein called the Plan) issued to your employer, the Policyholder, subject to the definitions, exclusions and other provisions of the Plan against loss resulting from accidental injury.

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

The Effective Date of your Certificate is as shown in the Certificate Schedule if you are on that date actively at work for the Policyholder. If not, this Certificate will become effective on the next date you are actively at work as an eligible employee. This Certificate will remain in effect for the period for which the premium has been paid. This Certificate may be continued for further periods as stated in the Plan.

This Certificate is issued in consideration of the payment in advance of the required premium and of your statements and representations in the Application. A copy of your Application is attached and made a part of this Certificate.

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

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

## SECTION I        DEFINITIONS

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

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

**You and Your** - refer to an employee as defined in this Plan.

**Accidental Injury or Injuries** – means bodily injury or injuries caused either solely by or as the result of a covered accident.

**Catastrophic Accident Elimination Period** means the period of days shown on the Rider Schedule after the date of a Covered Accident during which no benefits are payable under this rider.

**Catastrophic Loss** means an injury resulting from a Covered Accident that causes total and irrecoverable:

- (1) loss of both hands or both feet; or
- (2) loss or loss of use of both arms or both legs; or
- (3) loss of one hand and one foot; or
- (4) loss or loss of use of one arm and one leg; or
- (5) loss of sight of both eyes; or
- (6) loss of the hearing of both ears; or
- (7) loss of the ability to speak

The loss of use of an arm means the loss of function of the entire arm from the shoulder to the hand. The loss of use of a leg means the loss of function of the entire leg from the hip to the foot. The loss of sight means both eyes are totally blind and that no sight can be restored. The loss of hearing means deafness in both ears, such that it cannot be corrected to any functional degree by any procedure, aid or device. The loss of the ability to speak means loss of audible communication, such that it cannot be corrected to any functional degree by any procedure, aid or device.

**Covered Accident** - means an accident which occurs on or after your Effective Date, while your certificate is in force, and which is not specifically excluded.

**Doctor or Physician** - means a person, other than the Insured or a member of the Insured's immediate family, who meets the following requirements:

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

Under the Fractures and Dislocations Benefit, a doctor means a person, other than yourself or a member of your immediate family, who is licensed by the state to practice medicine or osteopathy.

**Hospital** - A place that meets all of the following requirements:

1. legally licensed and operated as a hospital;
2. provides overnight care of injured and sick people;
3. supervised by a doctor;
4. has full-time nurses supervised by a registered nurse;
5. has on-site or pre-arranged use of x-ray equipment, laboratory and surgical facilities; and
6. maintains permanent medical history records.

**A hospital is not any of the following:**

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

**Hospital Intensive Care Unit** - means a specifically designed facility of the hospital that provides the highest level of medical care, which care is restricted to those patients who are critically ill or injured. Such facilities must be separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement. An Intensive Care Unit must be permanently equipped with special life-saving equipment for the care of the critically ill or injured. It must also be under constant and continuous observation by nursing staff assigned exclusively to the Intensive Care Unit on a full-time basis.

**Period of Hospital Confinement** - A period of time of confinement starting while the Plan is in force. If the confinement follows a previously covered confinement, We will consider it a continuation of the first unless the confinement is a result of an entirely unrelated injury or the confinements are separated by 30 days or more.

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

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

**Actively at Work** - To be considered actively at work, one must perform the regular duties of one's employment for a full normal workday at the regular place of business of the Policyholder or at a location to which one might be required to travel to perform the regular duties of employment.

**Full-Time Work** - Spending at least n/a hours per week performing your occupational duties.

**Treatment or Medical Treatment** - Consultation, care, or services provided by a physician, including diagnostic measures and taking prescribed drugs and medicines.

**Elimination Period** - means the number of days of [total disability or] hospital confinement that must elapse before benefits become payable. The number of days is shown in the Benefit Schedule. Benefits are not payable, nor do they accrue during an Elimination Period.

**On-Job Benefits** - On-job benefits means the benefits we will pay if a covered accident occurs while you are working at any job for pay or benefits.

**Off-Job Benefits** - Off-job benefits means the benefits we will pay if a covered accident occurs while you are not working at any job for pay or benefits.

## **SECTION II                      PREMIUMS AND INDIVIDUAL TERMINATIONS**

### **PREMIUMS**

**Premiums are Not Guaranteed:** The initial premium shown in the Certificate Schedule is the premium covering the period from the Effective Date to the next renewal date of this Certificate. Renewal premiums will be in accordance with the schedule of premium rates in effect at the time of renewals as set forth in the Plan.

**Certificate Term:** The first term of this certificate starts on the Effective Date in the Certificate Schedule. It ends on the first renewal date also shown. Later terms will be the periods for which renewal premiums are paid when due. All terms will begin and end at 12:01 A.M., Standard Time, at the Policyholder's address. The renewal premium for each term will be due on the day preceding term end, subject to the Grace Period.

**Grace Period:** The Plan has a 31 day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the next 31 days. During the Grace Period, your coverage under the Plan will stay in force.

### **INDIVIDUAL TERMINATIONS**

An employee's insurance will terminate on the earliest of:

1. the date the Plan is terminated;
2. the 31st day after the premium due date if the required premium has not been paid;
3. the date You cease to meet the definition of an Employee as defined in the Plan;
4. the premium due date which falls on or first follows Your 70th birthday; or
5. the date You are no longer a member of the class eligible.

Termination of any Employee's insurance will not prejudice his or her rights regarding any claim arising prior to termination.

### **SECTION III BENEFIT PROVISIONS**

The benefit amounts payable under this section are shown in the Benefit Schedules. Coverage terminates on the premium due date which falls on or first follows your 70th birthday; at that time all benefits cease regardless of the maximum benefit period.

#### **DISLOCATIONS**

**Dislocation** - A dislocation is a completely separated joint. If an Insured dislocates a joint in a covered accident and if it is diagnosed and treated by a physician within 90 days after the accident, we will pay the amount shown in the Benefit Schedule.

If the dislocation requires open reduction, we will pay 150% of the amount shown in the Benefit Schedule.

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

**Multiple Dislocations** - If more than one dislocation requiring either open or closed reduction occurs in any one covered accident, We will pay the amounts shown in the Benefit Schedule for each dislocation. However, We will pay no more than 150% of the benefit amount for the dislocated joint that has the higher dollar value.

**Partial Dislocation** - A partial dislocation is one in which the joint is not completely separated. If a physician diagnoses and treats the accidental injury as a partial dislocation, We will pay 25% of the amount shown in the Benefit Schedule for the affected joint.

**Fracture and Dislocation** - If an Insured fractures a bone and dislocates a joint in the same accident, we will pay for both. However, we will pay no more than 150% of the benefit amount for the bone fractured or for the joint dislocated, whichever has the higher dollar value.



## **FRACTURES**

**Fractures** - A fracture is a break in a bone that can be seen by x-ray. If one fractures a bone in a covered accident and if it is diagnosed and treated by a physician within 90 days after the accident, we will pay the appropriate amount shown in the Benefit Schedule.

If the fracture requires open reduction, we will pay 150% of the amount shown in the Benefit Schedule.

**Multiple Fractures** - If more than one fracture requiring either open or closed reduction occurs in any one covered accident, we will pay the amounts shown in the Benefit Schedule for each fracture. However, we will pay no more than 150% of the benefit amount for the bone fracture that has the higher dollar value.

**Chip Fracture** - A chip fracture is a piece of bone that completely breaks off near a joint. If a physician diagnoses the fracture as a chip fracture, we will pay 10% of the amount shown in the Benefit Schedule for the affected bone.

## **LACERATIONS**

**Lacerations** - If an Insured receives a laceration in a covered accident and the laceration is repaired with stitches by a physician within 72 hours after the accident, We will pay the appropriate amount shown in the Benefit Schedule. The amount paid will be based on the length of the laceration.

**No Stitches** - If an Insured receives a laceration in a covered accident and the laceration does not require stitches but is treated by a physician within 72 after the accident, we will pay the appropriate amount shown in the Benefit Schedule.

**Multiple Lacerations** - If an Insured suffers multiple lacerations in a covered accident and the lacerations are repaired with stitches by a physician within 72 hours after the accident, we will pay this benefit based on the largest single laceration which requires stitches, as shown in the Benefit Schedule.

## **CONCUSSIONS**

**Concussions** - Concussion means a head injury resulting in electroencephalogram abnormality. If an Insured is injured in a covered accident and the injury causes the Insured to have a concussion, We will pay this benefit in the amount shown in the Benefit Schedule.

## **COMA**

**Coma** - Coma means a state of profound unconsciousness caused by a covered accident. If an Insured suffers a coma lasting 30 days or more as the result of a covered accident, We will pay this benefit as shown in the Benefit Schedule.

## **EMERGENCY DENTAL WORK**

**Emergency Dental Work** - We will pay this benefit if an Insured receives an injury to sound natural teeth as the result of a covered accident. We will pay for repair with a crown or extraction as shown in the Benefit Schedule.

## **INJURIES REQUIRING SURGERY**

**Eye Injuries** - If an Insured injures an eye in a covered accident and surgical repair is performed by a physician within 90 days after the accident, We will pay the amount shown in the Benefit Schedule. If a physician removes a foreign body from an Insured's eye, with or without anesthesia, We will pay the amount shown in the Benefit Schedule.

**Tendons and Ligaments** - If an Insured tears, severs, or ruptures a tendon or a ligament in a covered accident, receives treatment from a physician within 60 days, and has surgical repair within 90 days after the accident, We will pay the appropriate amount shown in the Benefit Schedule. The amount paid will be based on the number (single or multiple) of tendons or ligaments repaired.

If an Insured is in a covered accident and fractures a bone or dislocates a joint, and tears, severs, or ruptures a tendon or ligament, We will pay only one benefit. We will pay the largest of the fracture benefit, the dislocation benefit, or the tendon and ligament benefit.

**Ruptured Disc** - If an Insured ruptures a disc in his spine in a covered accident, receives treatment from a physician within 60 days after the accident, and has surgical repair by a physician within one year after the accident, We will pay the appropriate amount shown in the Benefit Schedule. The amount paid will be based on when the accident occurred.

**Torn Knee Cartilage** - We will pay this benefit in the amount shown in the Benefit Schedule if an Insured is injured in a covered accident, and all of the following occur:

1. Accidental injuries result in torn knee cartilage;
2. Such injury requires treatment by a physician within 60 days from the date of the covered accident; and
3. Such injury requires repair by surgical operation within one year from the date of the covered accident.

The amount paid will be based on when the accident occurred.

**Internal Injuries** - We will pay this benefit as shown in the Benefits Schedule if you have internal injuries as the result of a covered accident which results in open abdominal or thoracic surgery.

**Exploratory Surgery** - If as the result of an injury in a covered accident you have exploratory surgery (without repair), we will pay the amount shown on the Benefit Schedule.

## **PARALYSIS**

**Paralysis** - Paralysis means the permanent loss of movement of two or more limbs. If an Insured is injured in a covered accident and the injury causes paralysis lasting more than 90 days and is diagnosed by a physician within 90 days after the accident, We will pay the appropriate amount shown in the Benefit Schedule. The amount paid will be based on the number of limbs paralyzed.

If this benefit is paid and the Insured later dies as a result of the same covered accident, We will pay the appropriate Death Benefit, less any amounts paid under the Paralysis Benefit.

## **BURNS**

**Burns** - If an Insured is burned in a covered accident and treated by a physician within 72 hours after the accident, We will pay the burn benefit shown in the Benefit Schedule according to the percentage of body surface burned.

First-degree burns are not covered.

## **SERVICES**

**Blood/Plasma** - If you are injured in a covered accident and receive blood or plasma as a result of the injury within 90 days after the accident, we will pay the amount shown in the Benefit Schedule.

**Ambulance** - If you are injured in a covered accident and require transportation to a hospital by a professional ambulance service (including "air ambulance" service) within 90 days after the accident, we will pay the appropriate amount shown in the Benefit Schedule.

**Transportation** - We will pay this benefit if you are injured in a covered accident and the injury causes the attending physician to recommend hospital treatment or diagnostic study which is not available in your city of residence. We will pay the applicable amount shown in the Benefit Schedule for transportation by train, plane, or bus for each covered accident. Use of such transportation must begin within 90 days from the date of the covered accident. The distance to the location of the hospital treatment or diagnostic study must be greater than 50 miles from your residence.

**Family Member Lodging** - We will pay this benefit in amount and for the number of days shown in the Benefit Schedule, for each night's lodging in a motel/hotel room for an adult member of your immediate family when you are confined to a hospital for treatment of an injury due to a covered accident. The Hospital and motel/hotel must be more than 100 miles from your residence. The treatment must be prescribed by your local physician.

**Medical Fees** - If you are injured in a covered accident and receive treatment within one year after the accident, we will pay the amount shown in the Benefit Schedule for the following:

1. emergency room services and supplies;
2. x-rays; or
3. physician services.

We will pay for these services up to the total amount shown for medical fees in the Benefit Schedule, for each covered accident.

This benefit is payable if you received initial treatment within 60 days after the accident.

**Prosthesis** - We will pay the amount shown in the Benefit Schedule for each prosthetic device you use as the result of an injury received in a covered accident. We do not cover hearing aids, wigs, or dental aids including but not limited to false teeth.

**Appliances** - If you are advised by a physician to use a medical appliance as an aid in personal locomotion as the result of an injury received in a covered accident, we will pay the amount shown in the Benefit Schedule. Medical appliance means crutches, wheelchairs, leg braces, back braces, and walkers.

**Accident Follow-up Treatment** - We will pay this benefit when you receive follow-up treatment for an injury received as a result of a covered accident. We will pay for a maximum of 6 treatments per covered accident. You must have received initial treatment within 72 hours of a covered accident, and follow-up treatment must begin within 30 days of the covered accident or discharge from the hospital.

**Physical Therapy** - If an Insured is injured in a covered accident and that injury requires physical therapy, We will pay this benefit for a maximum of 6 physical therapy sessions per covered accident. The Insured must have received initial treatment for the injury within 72 hours of the covered accident, and physical therapy must begin within 30 days of the covered accident or discharge from the hospital. Treatment must take place within 6 months after the accident. We will not pay this benefit for the same visit for which We also pay the Accident Follow-up Treatment benefit.

## **HOSPITAL BENEFITS**

**Hospital Admission** – We will pay this benefit when you are injured in a covered accident and the injury requires hospital confinement as a resident bed patient within 6 months of the date of the accident.

We will pay the Hospital Admission benefit amount shown in the Benefit Schedule. We will not pay this benefit for confinement to an observation unit or for emergency room treatment or outpatient treatment.

We will pay this benefit once per calendar year per insured.

**Hospital Confinement** - If you are injured in a covered accident and the injury causes you to be confined to a hospital within 90 days after the accident, we will pay the amount shown in the Benefit Schedule, subject to the elimination period if any, for each day that you are confined to a hospital. The length of time shown for hospital confinement in the Benefit Schedule is the maximum period for which you can collect benefits for hospital confinements resulting from the same injury.

This benefit is payable once per hospital confinement even if the confinement is caused by more than one accidental injury.

**Hospital Intensive Care** - If you are injured in a covered accident and the injury causes you to be confined to a hospital intensive care unit, we will pay this benefit in amount and for the number of days shown in the Benefit Schedule per covered accident. This benefit is payable in addition to the Hospital Confinement benefit above.

**Major Diagnostic Exams** - If a covered person requires one of the following exams for Injuries sustained in a Covered Accident and a charge is incurred, we will pay the amount shown in the Benefit Schedule for the following exams:

- CT (computerized tomography) scan;
- MRI (magnetic resonance imaging); or
- EEG (electroencephalogram).

These exams must be performed in a Hospital, a Physician's office, or an Ambulatory Surgical Center. The Insured must incur a charge for the exam. This benefit is limited to one payment per calendar year, per covered person. No lifetime maximum.

**Limitation** - Exams listed in the Major Diagnostic Exams Benefit are not payable under the Medical Fees Benefit.

**Rehabilitation Unit Benefit** - When a covered person is confined in a Hospital and is transferred to a bed in a Rehabilitation Unit of a Hospital for a covered Injury, we will pay the amount shown in the Benefit Schedule for each day you are charged for a room. This benefit is limited to 30 days for each Insured per Period of Confinement and is limited to a calendar year maximum of 60 days. No lifetime maximum.

**Limitation** - The Hospital Confinement benefit and the Rehabilitation Unit benefit will not be paid on the same day; only the highest eligible benefit will be paid.

## **DISMEMBERMENT**

**Dismemberment** - If you are injured in a covered accident and the injury causes loss of a hand, foot, or sight within 90 days after a Covered Accident, we will pay the amount shown in the Benefit Schedule.

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

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

If you lose one or more finger or toe in a covered accident, we will pay the finger/toe benefit shown in the Benefit Schedule.

Dismemberment means any of the following:

1. **Loss of a hand:** the hand is cut off at or above the wrist joint; or
2. **Loss of a foot:** the foot is cut off at or above the ankle; or
3. **Loss of sight:** at least 80% of the vision in one eye is lost. Such loss of sight must be permanent and irrecoverable or
4. **Loss of a finger/toe:** the finger or toe is cut off at or above the joint where it is attached to the hand or foot.

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

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

## **ACCIDENTAL DEATH**

**Accidental Death** - If you are injured in a covered accident and the injury causes you to die within 90 days after the accident, we will pay the Accidental Death Benefit shown in the Benefit Schedule. If the Accidental Death Benefit is paid, we will not pay the Accidental Common Carrier Death Benefit.

**Accidental Common Carrier Death** - If you are injured in a covered accident and the injury causes you to die within 90 days after the accident, we will pay the Accidental Common Carrier Death Benefit in the amount shown in the Benefit Schedule if the injury is the result of traveling as a fare-paying passenger on a common carrier, as defined below.

Common Carrier means:

1. an airline carrier which is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports;
2. a railroad train which is licensed and operated for passenger service only; or
3. a boat or ship which is licensed for passenger service and operated on a regular schedule between established ports.

If the Accidental Common Carrier Death Benefit is paid, we will not pay the Accidental Death Benefit.

**Catastrophic Accident** - We will pay the applicable amount shown in the benefit schedule at the end of the Catastrophic Accident Elimination Period if any Insured:

- (1) sustains a Catastrophic Loss as the result of a Covered Accident;
- (2) is under the appropriate care of a Physician during the Catastrophic Accident Elimination Period; and
- (3) remains alive at the end of the Catastrophic Accident Elimination Period.

## **SECTION IV**

### **LIMITATIONS AND EXCLUSIONS**

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

**PRE-EXISTING CONDITION** - Pre-existing Condition means within the 12-month period prior to the Effective Date of the Certificate and attached Riders, as applicable, those conditions for which medical advice or treatment was received or

recommended.

We will not pay benefits for any loss or injury that is caused by, contributed to by, or results from a pre-existing condition for 12 months after the Effective Date of the Certificate and attached riders, as applicable.

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

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

## EXCLUSIONS

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

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

1. **Aviation** - operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those which are not motor-driven.
2. **Illegal Acts** - participating or attempting to participate in an illegal activity, or working at an illegal job.
3. **Intoxication** - being legally intoxicated, or being under the influence of any narcotic, unless such is taken under the direction of a physician.
4. **Self-Inflicted Injuries** - injuring or attempting to injure yourself intentionally.
5. **Sickness** - having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness.
6. **Racing** - Riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.
7. **Sports** - participating in any professional or semi-professional organized sport.
8. **Suicide** - committing or attempting to commit suicide, while sane or insane.
9. **Traveling** - traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, Bermuda, and Jamaica, except under the Accidental Common Carrier Death Benefit.
10. **War** - participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. We will return the prorated premium for any period not covered by this certificate when you are in such service.

## SECTION V

## CLAIM PROVISIONS

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

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

**Proof of Loss** - You must give us written proof within 90 days after the loss for which you are seeking benefits. If it is not reasonably possible to give written proof in the time required, we shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one year from the covered accident unless you were legally incapacitated during that time.

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

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

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

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

**Unpaid Premium** - When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

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

**Legal Action** - You cannot take legal action against us for benefits under this Plan under the following circumstances:

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

## **SECTION VI GENERAL PROVISIONS**

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

1. the Plan;
2. the application of the policyholder; and
3. if applicable, your application(s).

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

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

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

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

**Time Limit On Certain Defenses** - After the Plan has been in force for two years as respects an employee, only fraudulent misstatements in the application of that employee may be used to void his or her coverage or to deny any claim for loss incurred or disability that starts after the two year period.

**Clerical Error**- Clerical error by the policyholder will not end coverage or continue terminated coverage. In the event of such clerical error, a premium adjustment will be made.

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



**SECTION VII****BENEFIT SCHEDULE**

<b>FRACTURES</b>	<b><u>Closed</u> <u>Reduction</u></b>	<b><u>Open</u> <u>Reduction</u></b>
Hip/thigh	4,500	6,750
Vertebrae	4,050	6,075
Pelvis	3,600	5,400
Skull (depressed)	3,375	5,063
Leg	2,700	4,050
Forearm/hand/wrist	2,250	3,375
Foot/ankle/knee cap	2,250	3,375
Shoulder blade/collar bone	1,800	2,700
Lower jaw (Mandible)	1,800	2,700
Skull (simple)	1,575	2,363
Upper arm/upper jaw	1,575	2,363
Facial bones (except teeth)	1,350	2,025
Vertebral processes	900	1,350
Coccyx/rib/finger/toe	360	540
<b>DISLOCATIONS</b>	<b><u>Closed Reduction</u></b>	<b><u>Open Reduction</u></b>
Hip	2,700	4,050
Knee (not knee cap)	1,950	2,925
Shoulder	1,500	2,250
Foot/ankle	1,200	1,800
Hand	1,050	1,575
Lower jaw	900	1,350
Wrist	750	1,125
Elbow	600	900
Finger/toe	240	360
<b>LACERATIONS</b>		
2" to 5"	200	
Lacerations not requiring stitches	25	
<b>CONCUSSIONS</b>	200	
<b>COMA</b>	10,000	
<b>EMERGENCY DENTAL WORK</b>		
Repair with crown	150	
Extraction	50	
<b>INJURIES REQUIRING SURGERY</b>		
<b>Eye injuries</b>		
Requiring surgical repair	250	
Removal of a foreign body	50	

<b>Tendons/ligaments</b>	
Single	400
Multiple	600

<b>Ruptured disc</b>	
Date of injury occurs during first certificate year	100
Date of injury occurs after first certificate year	400

<b>Torn knee cartilage</b>	
Date of injury occurs during first certificate year	100
Date of injury occurs after first certificate year	400

**Internal Injuries** 1,000

**Exploratory Surgery (without repair)** 250

**PARALYSIS**

Two Limbs (Paraplegia)	5,000
Four Limbs (Quadriplegias)	10,000

**BURNS**

<b>Second Degree</b>	
Less than 10%	180
At least 10% but less than 25%	360
At least 25% but less than 35%	900
35% or more	1,800

<b>Third Degree</b>	
Less than 10%	900
At least 10% but less than 25%	5,400
At least 25% but less than 35%	12,600
35% or more	18,000

**SERVICES**

**Blood/plasma** 200

**Ambulance** 500

**Air ambulance** 1500

**Transportation**  
    Train, Plane or Bus 300

**Family Member Lodging** 100/per night  
    Maximum Benefit - 30 days

<b>Medical fees</b>	
Maximum per accident	250
<b>Prosthesis</b>	500
<b>Appliances</b>	100
<b>Accident Follow-up Treatment</b>	35
Maximum of 6 treatments per covered accident	
<b>Physician Therapy</b>	50
Maximum of 6 treatments per covered accident	
<b>HOSPITAL ADMISSION</b>	1,500
Payable once per calendar year	
<b>HOSPITAL CONFINEMENT</b>	300 /day
Maximum Benefit - 365 days	
0 Day elimination Period	
<b>HOSPITAL INTENSIVE CARE</b>	600 /day
Maximum Benefit - 30 days	
0 Day elimination Period	
<b>MAJOR DIAGNOSTIC EXAM</b>	200
Once per 12- month period	
<b>REHABILITATION UNIT BENEFIT</b>	150 / day
Maximum Benefit –	
30 days per covered accident	
60 days per calendar year	
<b>ACCIDENTAL DISMEMBERMENT</b>	
Loss of hand, foot, or sight	
Single loss	6,250
Double loss	25,000
Loss of one or more fingers or toes	1,250
Partial Amputation of finger(s) or toe(s)	100
Including at least one joint	
<b>ACCIDENTAL DEATH</b>	50,000
<b>ACCIDENTAL COMMON CARRIER DEATH</b>	100,000
<b>CATASTROPHIC ACCIDENT</b>	100,000

**SECTION VIII**

**CERTIFICATE SCHEDULE**

**HOSPITAL ADMISSION** \$1,500  
Payable once per calendar year

**HOSPITAL CONFINEMENT** \$300/ day  
Maximum Benefit - 365 days  
0 Day elimination Period

**HOSPITAL INTENSIVE CARE** \$600 / day  
Maximum Benefit - 15 days  
0 Day elimination Period

**Coverage Includes Other Benefits Shown In The Benefit Schedule**

\*Initial premium includes the premium for any riders purchased at the same time as the coverage provided by your certificate.



## CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205  
800.433.3036

### ENHANCED GROUP CONTINUATION RIDER

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

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

The Continuation Privilege—as well as any other references to continuation—in the Certificate and previously attached Rider(s), if applicable, are deleted and replaced by this Rider.

Unless amended by this Rider, all Certificate definitions, exclusions, limitations, terms, and other provisions apply.

#### **Effective Date**

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date provided that you are actively at work on that date.

#### **Continuation Privilege**

When an Employee ends employment with the Employer and his coverage would terminate, that Employee may elect to continue the coverage he had on the date his employment ended, including any in-force Spouse or Dependent Child coverage.

- To keep his Certificate in force, the Employee must:
  - Apply to the Company in writing within 31 days after the date his Certificate would terminate, **and**
  - Pay the required premium to the Company no later than 31 days after the date the Certificate would terminate and on each premium due date thereafter.
- Continued coverage will end:
  - 31 days after the date the Employee fails to pay any required premium, **or**
  - When the coverage is terminated by the Company.

When the Group Policy is terminated by the Policyholder and a current Employee's coverage would terminate, that Employee may apply to continue the coverage he had on the date the Group Policy was terminated, including any in-force Spouse or Dependent Child coverage. If an Employee qualifies for this Continuation Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate as shown in his previously issued Certificate.

- To keep his Certificate in force, the Employee must:
  - Apply to the Company in writing within 31 days after the date his Certificate would terminate, **and**
  - Pay the required premium to the Company no later than 31 days after the date the Certificate would terminate and on each premium due date thereafter.
- Continued coverage will end:
  - 31 days after the date the Employee fails to pay any required premium, **or**
  - When coverage is terminated by the Company.

## General Provisions

### Time Limit on Certain Defenses

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

- This Rider is part of the Certificate to which it is attached and will terminate when that Certificate terminates, or when premiums are no longer paid for this Rider.
- This Rider is subject to all the terms of the Certificate to which it is attached unless any such items are inconsistent with the terms of this Rider.

Signed for the Company at its Home Office,



Teresa White, President



J. Matthew Loudermilk, Secretary



## CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205  
800.433.3036

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

### **Waiver of Premium Rider To Certificate of Insurance for Group Accidental Injury Policy**

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

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

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

#### **EFFECTIVE DATE**

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

#### **DEFINITIONS**

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

**Total Disability or Totally Disabled** means that due to an Accidental Injury the Insured is:

- Not able to perform the substantial and material duties of his occupation, and
- Receiving a Doctor's care that is appropriate for the condition causing the disability, and
- Unable to Work.

**Unable to Work** means either:

- You are unable to work at the occupation you were performing when your Total Disability began, which was during the first 365 days of Total Disability; or
- You are unable to work at any gainful occupation for which you are suited by education, training, or experience after the first 365 days of Total Disability.

#### **WAIVER OF PREMIUM BENEFIT**

Injuries may result in more than 90 days of Total Disability for an Insured. If the Insured is disabled for 90 days, the Company will waive the premium payments for this coverage for up to 12 months of Total Disability. At the end of the premium waiver period, the Insured must resume paying premiums to keep this coverage in force. Premiums waived will include those for in-force Dependents and Riders.

For premiums to be waived, the Insured must provide satisfactory proof of Total Disability.

Premium will continue to be waived until the earliest of the following:

- The date the Company has waived premiums for a total of 24 months of Total Disability,
- The date you refuse to provide proof of continuing Total Disability,
- The date your Total Disability ends, or
- The date coverage ends according to the Termination provisions in **Section I** of your Certificate.

If you are still eligible for coverage when you return to Active Work, coverage for any Insured may be continued if premium payments are resumed.

## **LIMITATIONS**

### **Pre-Existing Condition Limitation**

*Pre-existing Condition* is a Sickness or physical condition that existed within the 12-month period before the Insured's Effective Date. For the condition to be considered pre-existing, it must have resulted in the Insured's receiving advice, diagnosis, or Treatment from a medical professional during this preceding time period.

We will not pay benefits for any loss resulting from or affected by a Pre-existing Condition if the loss occurs within the 12-month period after the Insured's Effective Date.

The Company will not reduce or deny a claim for benefits for any loss that occurred more than 12 months after the Insured's Effective Date on the grounds that it is caused by a Pre-Existing Condition.

## **GENERAL PROVISIONS**

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

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

## **CONTRACT**

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

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

Signed for the Company at its Home Office,



Teresa White, President



J. Matthew Loudermilk, Secretary





# CONTINENTAL AMERICAN INSURANCE COMPANY

Home Office: 2801 Devine Street, Columbia, South Carolina 29205  
800.433.3036

## DEPENDENT ACCIDENT RIDER TO CERTIFICATE OF INSURANCE FOR ACCIDENTAL INJURY

This Rider is a part of the Certificate to which it is attached. We have issued this Rider to you because: (1) you paid the additional premium for this Rider; and (2) we relied on the Application you made. Unless amended by this Rider, Certificate Definitions, Exclusions and Limitations, other Provisions and terms apply to this Rider.

**Effective Date** - If issued at the same time as the Certificate, this rider becomes effective when the Certificate becomes effective. If issued after the Certificate becomes effective, this Rider will have a later Effective Date, which will be shown in the Rider Schedule issued with this Rider. The insurance of a dependent will become effective on the rider date if such person is active on that date. Otherwise, the Effective Date will be deferred until the day following the date he or she becomes active.

### DEFINITIONS

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

**YOU, YOUR** Means the person named in the Certificate Schedule.

**SPOUSE** Means the person married to you on the Effective Date of this Rider.

This Rider may only be issued to your spouse if your spouse is between ages 18 and 64, inclusive. Coverage on your spouse terminates when your spouse attains age 70.

**CHILDREN** Means your natural children, step-children, foster children, adopted children or children placed for adoption, who are younger than age 26.

Dependent Children also include grandchildren, who are (1) unmarried; (2) under age 26; and (3) if they are the employee's dependents for federal income tax purposes, or (4) if the employee must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in this state.

However, if any child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on his parent(s) for support, the above age of twenty-six (26) shall not apply. Proof of such incapacity and dependency must be furnished to the Company within thirty-one (31) days following such 26th birthday.

If your children are covered under this Rider, your children born or placed in your home after the Effective Date of this Rider will also be covered from the moment of live birth or placement. No notice or additional premium is required.

**DEPENDENT**

Means your spouse, child, or children, named in the application for this rider for whom a premium is paid.

**ACTIVE**

"Active" as used refers to a dependent who is not confined in a hospital and who is able to carry on regular activities customary of a person in good health of the same age and sex.

**TREATMENT**

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

**BENEFITS**

If a dependent is injured in an accident, we will provide the benefits contained in the Certificate under the Benefits Section. The appropriate benefit amounts we will pay for the dependent are shown in the Dependent Benefit Schedule issued with this Rider.

**LIMITATIONS AND EXCLUSIONS**

The applicable limitations and exclusions are shown in your Certificate under the Limitations and Exclusions section.

**GENERAL PROVISIONS**

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

**TIME LIMIT  
ON CERTAIN  
DEFENSES**

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

**CONTRACT**

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

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

Signed by the Company at its Home Office.



Teresa White, President



J. Matthew Loudermilk, Secretary

**DEPENDENT  
BENEFIT SCHEDULE**

**SPOUSE AND CHILD**

	<u>Closed Reduction</u>	<u>Open Reduction</u>
<b>FRACTURES</b>		
Hip/thigh	4,500	6,750
Vertebrae	4,050	6,075
Pelvis	3,600	5,400
Skull (depressed)	3,375	5,063
Leg	2,700	4,050
Forearm/hand/wrist	2,250	3,375
Foot/ankle/knee cap	2,250	3,375
Shoulder blade/collar bone	1,800	2,700
Lower jaw (Mandible)	1,800	2,700
Skull (simple)	1,575	2,363
Upper arm/upper jaw	1,575	2,363
Facial bones (except teeth)	1,350	2,025
Vertebral processes	900	1,350
Coccyx/rib/finger/toe	360	540
 <b>DISLOCATIONS</b>	 <b><u>Closed Reduction</u></b>	 <b><u>Open Reduction</u></b>
Hip	2,700	4,050
Knee (not knee cap)	1,950	2,925
Shoulder	1,500	2,250
Foot/ankle	1,200	1,800
Hand	1,050	1,575
Lower jaw	900	1,350
Wrist	750	1,125
Elbow	600	900
Finger/toe	240	360
 <b>LACERATIONS</b>		
2" to 5"	200	
Lacerations not requiring stitches	25	
 <b>CONCUSSIONS</b>	 200	
 <b>COMA</b>	 10,000	

## EMERGENCY DENTAL WORK

Repair with crown	150
Extraction	50

## INJURIES REQUIRING SURGERY

### Eye injuries

Requiring surgical repair	250
Removal of a foreign body	50

### Tendons/ligaments

Single	400
Multiple	600

### Ruptured disc

Date of injury occurs during first certificate year	100
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Date of injury occurs after first certificate year	400
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### Torn knee cartilage

Date of injury occurs during first certificate year	100
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Date of injury occurs after first certificate year	400
--	-----

<b>Internal injuries</b> (resulting in abdominal or thoracic surgery)	1,000
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<b>Exploratory surgery</b> (without repair)	250
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## PARALYSIS

Two limbs (Paraplegia)	5,000
Four Limbs (Quadriplegia)	10,000

## BURNS

Second Degree	
Less than 10%	180
At least 10% but less than 25%	360
At least 25% but less than 35%	900
35% or more	1,800

Third Degree	
Less than 10%	900
At least 10% but less than 25%	5,400
At least 25% but less than 35%	12,600
35% or more	18,000

**SERVICES**

<b>Blood/plasma</b>	200
<b>Ambulance</b>	500
<b>Air ambulance</b>	1500
<b>Transportation</b>	
Train Plane or Bus	300
<b>Family Member Lodging</b>	100/per night
Maximum Benefit - 30 days	
<b>Prosthesis</b>	500
<b>Appliances</b>	100
<b>Accident Follow-up Treatment</b>	35
Maximum of 6 treatments per covered accident	
<b>Physical Therapy</b>	50
Maximum of 6 treatments per covered accident	

<b>HOSPITAL ADMISSION</b>	1,500
Payable once per calendar year	

<b>HOSPITAL CONFINEMENT</b>	300 /day
Maximum Benefit - 365 days	
0 Day elimination Period	

<b>HOSPITAL INTENSIVE CARE</b>	600/day
Maximum Benefit - 30 days	
0 Day elimination Period	

<b>MAJOR DIAGNOSTIC EXAM</b>	200
Once per 12 month period	

<b>REHABILITATION UNIT BENEFIT</b>	150 /day
Maximum Benefit –	
30 days per covered accident	
60 days per calendar year	

	<b>SPOUSE</b>	<b>CHILD</b>
<b>Medical fees</b>		
Maximum per accident	250	125

**ACCIDENTAL DISMEMBERMENT**

Loss of hand, foot, or sight		
Single loss	2,500	1,250
Double loss	10,000	5,000
Loss of one or more fingers or toes	500	250

Partial Amputation of finger(s) or toe(s) Including at least one joint	100	100
<b>ACCIDENTAL DEATH</b>	25,000	10,000
<b>ACCIDENTAL COMMON CARRIER DEATH</b>	50,000	50,000
<b>CATASTROPHIC ACCIDENT</b>	50,000	50,000



## CONTINENTAL AMERICAN INSURANCE COMPANY

Home Office: 2801 Devine Street, Columbia, South Carolina 29205

800.433.3036

### Children Definition Rider

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

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

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

Children also include grandchildren, who are (1) unmarried; (2) under age 26; and (3) if they are the employee's dependents for federal income tax purposes, or (4) if the employee must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in this state.

Your natural Children born after the Effective Date of this Rider will be covered from the moment of birth. An adopted child of an insured may be enrolled, the date the insured becomes a party to a suit in which the insured seeks to adopt the child or the date the adoption becomes final, at the insured's option. If Employee or Employee/Spouse coverage is in force and an employee desires uninterrupted coverage for a newborn or adopted child, he must notify us within 31 days of the child's birth or the date the insured becomes a party to a suit in which the insured seeks to adopt the child or the date the adoption becomes final. Coverage for newborn or adopted children will be in effect through the 31st day following the date of such event. Upon notification, we will advise him of the additional premium due.

If your children are covered under this Rider, it is not necessary for an employee to notify us of the birth of a child or the date the insured becomes a party to a suit in which the insured seeks to adopt the child or the date the adoption becomes final, and an additional premium payment will not be required.

Coverage on a Child(ren) will terminate on the child's 26<sup>th</sup> birthday. However, if any child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on his parent(s) for support, the above age of twenty-six (26) shall not apply. Proof of such incapacity and dependency must be furnished to the Company within thirty-one (31) days following such 26th birthday.

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

Signed by the Company at its Home Office.

Teresa White, President

J. Matthew Loudermilk, Secretary



## **CONTINENTAL AMERICAN INSURANCE COMPANY**

Home Office/Oficina Central: 2801 Devine Street, Columbia, South Carolina 29205

**If you need assistance in Spanish or would like to request a Spanish translation of this document, please call our Customer Service Department toll-free at 1.800.466.3036.**

**Si necesita asistencia en español o desea solicitar una traducción de este documento en español, por favor llame a nuestro Departamento de Servicios al Cliente a la línea gratuita al 1.800. 466.3036.**