



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

Texas Department of Insurance
Post Office Box 149104
Austin, Texas 78714-9104
(800)-252-3439 or 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
E-mail: 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
E-mail: 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
Columbia, South Carolina

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

Group Accidental Injury Insurance Policy

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

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

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

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

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

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

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

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

Signed for the Company at its Home Office,

Teresa White, President

J. Matthew Loudermilk, Secretary

Group Policyholder Name: Association of Professional Flight Attendants

Effective Date: 03/01/2019

Jurisdiction: Texas

**Group Accidental Injury Insurance
Non-Participating**

Group Policy Number: 25047

Anniversary Date: 03/01/2020

Non-Participating

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

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SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

PRIMARY INSURED

Eligibility

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

If this coverage is offered to members of a union, references to “Member” throughout the Plan documents shall be considered to refer to union members who are Actively at Work for their employer.

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

- **Member Coverage** – We insure only the Member. The Member is the *Primary Insured* under this Plan.
- **Member and Spouse Coverage** – We insure the Member and Spouse.
- **Member and Children Coverage** – We insure the Member and any Dependent Children.
- **Family Coverage** – We insure the Member, Spouse, and any Dependent Children.

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

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

Effective Date

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

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

The Member’s Effective Date is the date his insurance takes effect. After we receive and approve the Application, That; that date is either:

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

Termination of a Member's Insurance

A Member's insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date (the last day of the Grace Period), if the premium has not been paid.
- The date he no longer belongs to an eligible class.

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

DEPENDENT COVERAGE

Eligibility

Dependents may be eligible for coverage under this Plan. **Members should refer to the Type of Coverage on their Certificate Schedule to determine Dependent eligibility.** A *Dependent* is the Spouse of a Member or the Dependent Child of a Member. An eligible Spouse must be at least age 18 and not currently disabled or unable to work.

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

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

Effective Date

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

Termination of Dependent Insurance

Dependent coverage will terminate on the earliest of the following:

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

Plan Termination

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

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

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

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

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

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

Continuation Privilege

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

To keep his coverage in force, the Member must:

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

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

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

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

SECTION II – PREMIUM PROVISIONS

Premium Payments

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

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

Premium Changes

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

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

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

Grace Period

This Plan has a 31-day Grace Period. If a premium is not paid on or before its due date, the premium may be paid during the next 31 days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of its intention to discontinue the Plan. If the Plan is discontinued, the Plan's termination date will be the latest date for which premium has been paid.

SECTION III – DEFINITIONS

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

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

Actively at Work refers to a Member's ability to perform his regular membership duties for a full normal workday. The Member 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 membership.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Spouse is a Member's legal wife or husband.

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

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

SECTION IV – BENEFIT PROVISIONS

Initial Treatment Category

Initial Treatment Benefit

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

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

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

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

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

Ambulance Benefit

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

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

Ambulance service includes air ambulance service.

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

Major Diagnostic Testing Benefit

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

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

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

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

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

Blood/Plasma/Platelets Benefit

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

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

Concussion Benefit

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

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

Burns Benefit

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

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

Emergency Dental Work Benefit

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

Eye Injuries Benefit

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

Dislocation Benefit

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

If the dislocation requires open reduction, we will pay 200% of the amount shown in the Benefit Schedule.

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

Multiple dislocations refer to more than one dislocation requiring either open or closed reduction in any one Covered Accident. For each covered dislocation, we will pay the amounts shown in the Benefit Schedule. However, we will pay no more than 200% of the benefit amount for the dislocated joint that has the higher dollar amount.

Partial dislocation is one in which the joint is not completely separated. If a Doctor diagnoses and treats the Accidental Injury as a partial dislocation, we will pay 25% of the amount shown in the Benefit Schedule for the affected joint. (*Partial dislocation* includes subluxation.)

Laceration Benefit

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

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

If the Insured suffers multiple lacerations in a Covered Accident, and the lacerations are repaired with stitches by a Doctor within 168 hours after the accident, we will pay this benefit based on the largest single laceration that requires stitches, as shown in the Benefit Schedule. However, we will pay no more than 200% of the benefit amount for the laceration that has the higher dollar amount.

Fracture Benefit

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

If the fracture requires open reduction, we will pay 200% of the amount shown in the Benefit Schedule.

Multiple fractures refer to more than one fracture requiring either open or closed reduction. If these fractures occur in any one Covered Accident, we will pay the appropriate amounts shown in the Benefit Schedule for each fracture. However, we will pay no more than 200% of the benefit amount for the bone fractured that has the highest dollar amount.

Chip fracture refers to a piece of bone that is completely broken off near a joint. If a Doctor diagnoses the fracture as a chip fracture, we will pay 25% of the amount shown in the Benefit Schedule for the affected bone.

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

Outpatient Surgery and Anesthesia Benefit

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

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

The surgery can be performed:

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

Inpatient Surgery and Anesthesia Benefit

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

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

Transportation Benefit

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

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

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

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

Coma Benefit

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

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

Hospitalization Category

Hospital Admission Benefit

We will pay this benefit when an Insured is admitted to a Hospital and confined as an inpatient because of a Covered Accidental Injury. To be eligible to receive this benefit, an Insured must be admitted to a Hospital within six months of the date of the Covered Accident.

We will pay the Hospital Admission Benefit amount shown in the Benefit Schedule. We will not pay benefits for confinement to an observation unit, or for emergency room Treatment or outpatient Treatment. We will pay this benefit once per period of Hospital Confinement.

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

Hospital Confinement Benefit

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

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

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

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

Hospital Intensive Care Benefit

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

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

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

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

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

Family Member Lodging Benefit

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

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

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

After Care Category

Appliances Benefit

We will pay the amount shown in the Benefit Schedule if a Doctor advises the Insured to use a medical appliance.

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

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

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

Accident Follow-Up Treatment Benefit

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

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

Follow-up Treatments do not include physical, occupational, or speech therapy. Chiropractic or Acupuncture procedures are not considered Follow-up Treatment.

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

Rehabilitation Unit Benefit

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

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

Therapy Benefit

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

- The Insured receives initial Treatment within 168 hours after the Covered Accident.
- The Insured receives Doctor-prescribed therapy Treatment in one of the following categories: physical therapy provided by a licensed physical therapist, occupational therapy provided by a licensed occupational therapist, or speech therapy provided by a licensed speech therapist.
- The therapy Treatment begins within 90 days after the Covered Accident or discharge from the Hospital.

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

Chiropractic or Alternative Therapy Benefit

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

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

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

Life Change Events Category

Prosthesis Benefit

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

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

This benefit is not payable for:

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

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

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

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

SECTION V – EXCLUSIONS

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

- **War** – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the Insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion, or civil state of belligerence. War does not include acts of terrorism.
- **Suicide** – committing or attempting to commit suicide, while sane or insane.
- **Sickness** – having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for:
 - Allergic reactions.
 - Any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings.
 - An error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure for any sickness.
 - Any related medical/surgical Treatment or diagnostic procedures for such illness.
- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally.
- **Racing** – riding in or driving any motor-driven vehicle in a race, stunt show, or speed test in a professional or semi-professional capacity.
- **Illegal Occupation** – voluntarily participating in, committing, or attempting to commit a felony or illegal act or activity, or voluntarily working at, or being engaged in, an illegal occupation or job.
- **Sports** – participating in any organized sport in a professional or semi-professional capacity for pay or profit.
- **Cosmetic Surgery** – having cosmetic surgery or other elective procedures that are not medically necessary or having dental Treatment except as a result of a Covered Accident.

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

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

SECTION VI – CLAIM PROVISIONS

Notice of Claim

The Insured must give written notice of claim:

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

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

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

Proof of Loss

Proof of Loss refers to documentation that supports a claim. (This information is often found in standardized medical documents, such as Hospital bills and operative reports. It can include a statement by the treating Doctor.) Proof of Loss establishes the nature and extent of the loss, the Company's obligation to pay the claim, and the Claimant's right to receive payment.

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

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

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

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

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

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

Physical Examination and Autopsy

The Company may have an Insured examined as often as reasonably necessary while a claim is pending. In the case of death, the Company may also require an autopsy, unless prohibited by law. The Company will cover all costs for exams and/or autopsy.

Time of Payment of Claims

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

Payment of Claims

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

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

Unpaid Premium

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

Changing of Beneficiary

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

Claim Review

If a claim is denied, the Member 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 Member, the Claimant, or an authorized representative of either must appeal any denial of benefits under the Plan by sending a written request for review of the denial to our Home Office.

Legal Action

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

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

SECTION VII – GENERAL PROVISIONS

Entire Contract Changes

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

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

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

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

Changes to the Plan:

- Will not be valid unless approved in writing by an executive officer of the Company.
- Must be noted on or attached to the Contract.
- May not be made by any agent or producer (nor can an agent or producer waive any Plan provisions).

Misstatement of Age

If an age has been misstated on the Application, the benefits will be those that the paid premium would have purchased at the correct age.

Successor Insured

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

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

- Notify the Company in writing within 31 days after the date of the Member's death; and
- Pay the required premium to the Company no later than 31 days after the date of the Member'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 Member's death.

Time Limit on Certain Defenses

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

Clerical Error

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

Individual Certificates

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

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

Required Information

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

Conformity with State Statutes

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

POLICY SCHEDULE

Group Policyholder:	Association of Professional Flight Attendants
Group Policy Number:	25047
Group Policy Effective Date:	03/01/2019
Group Policy Anniversary Date:	03/01/2020
Jurisdiction:	TX
24-Hour Coverage	

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

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

BENEFIT SCHEDULE

	Primary Insured	Spouse	Child(ren)
Initial Treatment Category-Low			
Initial Treatment Benefit			
<i>Hospital emergency room with X-Ray</i>	\$75	\$75	\$40
<i>Hospital emergency room without X-Ray</i>	\$50	\$50	\$25
<i>Urgent Care facility with X-Ray</i>	\$75	\$75	\$40
<i>Urgent Care facility without X-Ray</i>	\$50	\$50	\$25
<i>Office or facility (other than a Hospital emergency room or Urgent Care) with X-Ray</i>	\$75	\$75	\$40
<i>Office or facility (other than a Hospital emergency room or Urgent Care) without X-Ray</i>	\$50	\$50	\$25
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Ambulance Benefit	\$200	\$200	\$100
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Air Ambulance Benefit	\$750	\$750	\$375
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Major Diagnostic Testing Benefit	\$100	\$100	\$50
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Blood/Plasma/Platelets Benefit	\$300	\$300	\$150
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Concussion Benefit	\$150	\$150	\$75
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Burns Benefit			
<i>Second Degree</i>			
Less than 10%	\$25	\$25	\$13
At least 10% but less than 25%	\$50	\$50	\$25
At least 25% but less than 35%	\$125	\$125	\$63
35% or more	\$250	\$250	\$125
<i>Third Degree</i>			
Less than 10%	\$250	\$250	\$125
At least 10% but less than 25%	\$1,250	\$1,250	\$625
At least 25% but less than 35%	\$2,500	\$2,500	\$1,250
35% or more	\$5,000	\$5,000	\$2,500
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Emergency Dental Work Benefit			
Repair with crown	\$100	\$100	\$50
Extraction	\$50	\$50	\$25
Eye Injuries Benefit	\$200	\$200	\$100
Dislocation Benefit			
Hip	\$1,500	\$1,500	\$750
Knee (not knee cap)	\$975	\$975	\$488
Shoulder	\$750	\$750	\$375
Foot/ankle	\$600	\$600	\$300
Hand	\$525	\$525	\$263
Lower jaw	\$450	\$450	\$225
Wrist	\$375	\$375	\$188
Elbow	\$300	\$300	\$150
Finger/toe	\$120	\$120	\$60
Laceration Benefit			
Over 15 centimeters	\$200	\$200	\$100
5 to 15 centimeters	\$50	\$50	\$25
Under 5 centimeters	\$0	\$0	\$0
Lacerations not requiring stitches	\$0	\$0	\$0

Fracture Benefit			
Hip/thigh	\$1,000	\$500	\$500
Vertebrae	\$300	\$150	\$150
Pelvis	\$500	\$250	\$250
Skull (depressed)	\$1,500	\$750	\$750
Skull (simple)	\$250	\$125	\$125
Leg	\$300	\$150	\$150
Foot/ankle/knee cap	\$250	\$125	\$125
Forearm/hand/wrist	\$250	\$125	\$125
Lower jaw	\$250	\$125	\$125
Shoulder blade/collar bone	\$250	\$125	\$125
Upper arm/upper jaw	\$250	\$125	\$125
Facial bones (except teeth)	\$150	\$75	\$75
Vertebral processes	\$250	\$125	\$125
Coccyx/rib/finger/toe	\$100	\$50	\$50
Sternum	\$300	\$150	\$150
Sacral/Sacrum	\$250	\$125	\$125
Outpatient Surgery and Anesthesia Benefit			
<i>Hospital Outpatient or Ambulatory Surgical Center</i>	\$500/day	\$500/day	\$250/day
<i>Doctor's Office or Emergency Room</i>	\$100/day	\$100/day	\$50/day
<i>(Maximum is applicable only to Doctor's office or Emergency Room)</i>			
<i>Maximum number of payments per Covered Accident, per Insured</i>	2	2	2
Inpatient Surgery and Anesthesia Benefit	\$1000/day	\$1000/day	\$500/day
<i>Maximum number of payments per Covered Accident, per Insured</i>	No Max	No Max	No Max
Transportation Benefit			
Plane	\$200	\$200	\$100
Any Ground Transportation	\$200	\$200	\$100
<i>Maximum number of payments per Covered Accident, per Insured</i>	3	3	3
Coma Benefit	\$5,000	\$5,000	\$2,500
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1

BENEFIT SCHEDULE

	Primary Insured	Spouse	Child(ren)
Hospitalization Category Low			
Hospital Admission Benefit	\$500	\$500	\$250
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
Hospital Confinement Benefit			
<i>Maximum Benefit Period: 365 days</i>	\$100/day	\$100/day	\$50/day
Hospital Intensive Care Benefit			
<i>Maximum Benefit Period: 30 days</i>	\$100/day	\$100/day	\$50/day
Family Member Lodging Benefit			
<i>Maximum Benefit Period: 30 days</i>	\$100/day	\$100/day	\$50/day

BENEFIT SCHEDULE

	Primary Insured	Spouse	Child(ren)
After Care Category-Low			
Appliances Benefit			
<i>Cane</i>	\$75	\$75	\$25
<i>Ankle Brace</i>	\$75	\$75	\$25
<i>Walking Boot</i>	\$75	\$75	\$25
<i>Walker</i>	\$75	\$75	\$25
<i>Crutches</i>	\$75	\$75	\$25
<i>Leg Brace</i>	\$75	\$75	\$25
<i>Wheelchair</i>	\$75	\$75	\$25
<i>Knee Scooter</i>	\$75	\$75	\$25
<i>Body Jacket</i>	\$75	\$75	\$25
<i>Back Brace</i>	\$75	\$75	\$25
<i>Cervical Collar</i>	\$75	\$75	\$25
<i>Maximum number of payments per Covered Accident, per Insured</i>	No Max	No Max	No Max
Accident Follow-Up Treatment Benefit	\$50	\$50	\$25
<i>Maximum number of payments per Covered Accident, per Insured</i>	3	3	3
Rehabilitation Unit Benefit	\$100 /day	\$100 /day	\$50 /day
<i>Maximum Benefit Period per Hospital confinement</i>	15 days	15 days	15 days
<i>Calendar Year Maximum</i>	30 days	30 days	30 days
Therapy Benefit	\$25	\$25	\$15
<i>Maximum number of payments per Covered Accident, per Insured</i>	10	10	10
Chiropractic or Alternative Therapy Benefit	\$25	\$25	\$15
<i>Maximum number of payments per Covered Accident, per Insured</i>	10	10	10

BENEFIT SCHEDULE

	Primary Insured	Spouse	Child(ren)
Life Change Events Category-Low			
Prosthesis Benefit			
<i>Once per accident, up to 2 prosthetic devices and one replacement per device per insured</i>	\$500	\$500	\$250

OCCUPATIONAL CLASSIFICATIONS AND SCHEDULE OF PREMIUMS

Group Accident

APFA - Semimonthly (24pp/yr)

Coverage	Rates
Employee	\$2.72
Employee & Dependent Spouse	\$4.41
Employee & Dependent Child(ren)	\$4.13
Family	\$5.82

<i>Initial Accident Treatment Category</i>	Custom
<i>Hospitalization Category</i>	Custom
<i>After Care Category</i>	Custom
<i>Life-Changing Events Category</i>	Custom

Provisions:
24 hour (on and off job) protection
Rate Guarantee: 2 Years
Portability: Standard

Group Attributes:
Situs State: TX
Group Size: 26000

Please note: Premiums shown are accurate as of publication. They are subject to change.

Published: Aug-18

Series C70000 - TX

AC70000-180829-144335-001JoqRV-000fBTT3-0Cq4JTVc-12086

Product Code: AC180829-144335



CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205
800.433.3036

NOTICE OF NON-INSURANCE BENEFITS ENDORSEMENT

This Endorsement is added to and part of the Certificate to which it is attached.

From time to time, Continental American Insurance Company (CAIC) may offer or provide goods and/or services that are not related to insurance. The services will fall under the same benefit plan that includes or is related to the applicable CAIC coverage, individual wellness programs, and related services.

Though CAIC has arranged these goods, services, and/or third-party provider discounts, the third-party providers—**not CAIC**—are liable to applicants/insureds for these goods and services. CAIC is not responsible for providing the goods and/or services, nor is CAIC liable to applicants/insureds for the negligent provision of these goods and/or services by third-party service providers. The third-party providers will address inquiries from applicants/insureds about the provision of these goods, services, and/or third-party discounts.

The services listed below are provided to all Employees who are covered under the Plan to which this Endorsement is attached. (Plan coverage is extended to Employees as described in the Master Policy.) Access to these services will end when Plan coverage ends, as described in the Termination provisions in the Master Policy.

- **Core Advocacy** – this third-party service offers access to a dedicated, Personal Health Advocate who can help solve a wide variety of health- and insurance-related issues, such as:
 - Reviewing and explaining medical coverage and offering advice on care options and costs
 - Locating providers for second opinions
 - Scheduling appointments with specialists
 - Clarifying complex conditions
 - Resolving insurance claims
 - Addressing eldercare issues and coordinating long-distance support for family members
- **Medical Bill Saver** – this third-party service offers highly skilled negotiators to work on the Employees' behalf to obtain a discount on any medical or dental bill over \$400 not covered by insurance, regardless of insurance or benefit status
- **MeMD Telemedicine** – this third-party service offers a low-cost option for medical care by enabling Employees to connect with a medical provider online and receive personalized treatment. There is a \$35 cost for this Telemedicine visit. When medically appropriate, MeMD providers submit an e-prescription to a local pharmacy for purchase, pick up, and review (in person) with a local pharmacist.

Signed for the Company at its Home Office,

Teresa White, President

J. Matthew Loudermilk, Secretary

For assistance or information about this notice, call 800.433.3036.

AFLAC CUSTOMER PRIVACY POLICY

Protecting the privacy and confidentiality of information about our customers is very important to American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac"). Accordingly, Aflac has developed and adopted this "Customer Privacy Policy" which is designed to ensure that our collection and use of customer information complies with the following commitments:

- **Aflac does not sell, rent, lease or otherwise disclose nonpublic personal information (NPI) of its customers for purposes unrelated to Aflac products and services.** Our customers' NPI is of paramount importance to us. Therefore, we provide your NPI only to our affiliates, employees, agents and third parties as necessary to facilitate the development and delivery of our insurance and employee benefit products and services. Aflac may also provide your NPI to its affiliates for marketing purposes consistent with the terms disclosed herein (see *Sharing Information*, below).
- **Aflac works to ensure information integrity and security.** We use technology tools and design our business practices to help ensure that our customers' NPI is properly gathered, stored and processed. We also work to maintain the security of our customers' NPI through the use of technology and our business practices.
- **Aflac expects its agents and employees to respect customer NPI.** Aflac has adopted internal policies and procedures designed to ensure that employees and agents adhere to Aflac's privacy policies and otherwise protect our customers' NPI. Both employees and agents are subject to censure, dismissal, or termination for violation of these policies.

This Customer Privacy Policy applies to those individuals who receive our products and services, as well as to individuals who provide us with NPI in the course of submitting an application to us for our products and services. .

PRIVACY NOTICE

Aflac provides this notice to let you know about our current privacy practices with respect to the collection, sharing and protection of your NPI. **You do not need to do anything in response to this notice, unless you would like to prohibit the use of your NPI by our affiliates to market products and services to you, as described below.**

Collecting Information

As part of Aflac's normal underwriting and operating procedures, Aflac (and our agents acting on our behalf) needs to obtain information to determine an individual's eligibility for our products and services, and to perform our insurance functions. Aflac and our agents may collect NPI about Aflac's customers, including:

- Information from our customers (including names, addresses, and financial and health information).
- Information about our customers' transactions with Aflac or our agents (including claims and payment information).
- Information from or about your transactions with nonaffiliated third parties (including, but not limited to, accident reports, claims, health and insurance application histories, health history, and salary data).

Sharing Information

- Aflac shares the NPI it collects about you, as described above, among Aflac and its affiliates so that Aflac and its affiliates may perform their everyday business functions, such as processing your transactions and claims, or otherwise maintaining your policies. Aflac also reserves the right to share your NPI with its affiliates to enable Aflac affiliates to market their products and services directly to you. You can prevent the use of your NPI for this purpose by following the "opt-out" procedure described below, "*Opting Out of Information Sharing*."
- Aflac does not share, and does not reserve the right to share, customer NPI with nonaffiliated third parties except as permitted or required by applicable law.
- Aflac agents will share your NPI only while acting on Aflac's behalf and, furthermore, will share your NPI only to the extent Aflac itself is permitted to do so.
- Neither Aflac nor its agents will disclose the NPI of former customers unless the disclosure is authorized by or at the request of the former customer, or is otherwise permitted or required by law.

Opting Out of Information Sharing

As described above, Aflac shares your NPI when permitted or required by law. You are not able to limit Aflac's ability to share your NPI for these purposes.

Affiliate Marketing Opt Out

If you would prefer not to receive marketing materials from Aflac's affiliates about their products or services, you can opt out of such affiliate marketing by either (1) calling 1.800.433.3036; or (2) visiting www.aflacgroupinsurance.com and downloading, completing, and returning the Affiliate Marketing Opt-Out Form to Aflac at the referenced address. If you opt-out and later change your mind, please let Aflac know and we will change your choice. Your opt out does not prevent Aflac

from sending you information about products or services offered by Aflac or its affiliates. Similarly, your opt out will not prevent an Aflac affiliate from using NPI received from Aflac to market affiliate products and services to you if (a) you have a pre-existing relationship with such affiliate, or (b) you contact such affiliate directly and request information about such affiliate's products or services.

Confidentiality and Security

Aflac and its agents safeguard customer (and former customer) NPI by maintaining administrative, technical, and physical safeguards to ensure the security and confidentiality of such NPI. This includes having security practices in place to protect against anticipated threats or hazards, and to protect against unauthorized access to or use of customer and former customer NPI.

Aflac limits access to NPI to only those employees who need access to such information to perform their job functions. Employees who misuse NPI are subject to disciplinary actions. Aflac provides privacy training and awareness to all of its employees.

NOTICE OF INFORMATION PRACTICES

California, Connecticut, Georgia, Illinois, Kansas, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia require insurers and agents to describe their information practices in addition to providing a Privacy Notice. There is significant overlap between the two notices, but in general our Information Practices include the following: Aflac may obtain information about you and any other persons proposed for insurance. Some of this information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. Residents of these states have the right to access and correct the information collected about them except information that relates to a claim or to a civil or criminal proceeding. They also have the right to receive the specific reason for an adverse underwriting decision in writing. If you wish to have a more detailed explanation of our information practices required by your state, please submit a written request to Aflac, ATTN: Privacy Office, P.O. Box 427, Columbia, SC 29202.

STATE SPECIFIC DISCLOSURES

Customer NPI shall be collected, used and stored in accordance with applicable federal privacy laws. To the extent that the privacy laws of a Customer's state of residence are more protective of the Customer's NPI than federal privacy laws, Aflac will protect the Customer's NPI in accordance with such state law.

Attention Washington Residents: You have the right to limit disclosures of your nonpublic personal information under the circumstances described in WAC 284-04-510. For instance, you may request in writing that Aflac limit the disclosure of nonpublic personal information to specified individuals if the disclosure of the information to those individuals could jeopardize your safety. In addition, you may also request, in writing, that Aflac limit certain disclosures of information regarding reproductive health, sexually transmitted diseases, chemical dependency and mental health. For more information or if you wish to submit a request, please write to: Aflac, ATTN: Privacy Office, P.O. Box 427, Columbia, SC 29202.

NOTICE OF PRIVACY PRACTICES - PROTECTED HEALTH INFORMATION

If you would like a copy of Aflac's *Notice of Privacy Practices - Protected Health Information*, issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), copies are available by visiting Aflac's website, www.aflacgroupinsurance.com, or sending a written request to: Aflac, ATTN: Privacy Office, P.O. Box 427, Columbia, SC 29202.

NOTICE OF PRIVACY PRACTICES – PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. The terms of this Notice of Privacy Practices – Protected Health Information (“Notice”) apply to Protected Health Information (defined below) associated with Health Plans (defined below) issued by American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, Continental American Insurance Company and Continental American Life Insurance Company (collectively, “we,” “our,” or “Aflac”) ¹. This Notice describes how Aflac may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) to maintain the privacy of Protected Health Information and to provide our policyholders and certificateholders with notice of our legal duties and privacy practices concerning Protected Health Information. In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of Protected Health Information, as set forth below, we will restrict our uses or disclosure of your Protected Health Information in accordance with the more stringent standard. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, we will mail copies of revised notices to all policyholders and certificateholders then covered by a Health Plan. Copies of our current Notice may be obtained by contacting Aflac at the telephone number or address below, or on our Web site at www.aflacgroupinsurance.com.

DEFINITIONS

Health Plan means, for purposes of this Notice, the following plans issued by Aflac: dental, specified disease (e.g., cancer), hospital indemnity and other coverages that meet the definition of Health Plan contained in HIPAA. The following products are not considered Health Plans: coverage only for accident, or disability income insurance, or any combination thereof, life insurance, and other coverages that do not meet the definition of Health Plan contained in HIPAA.

Protected Health Information (“PHI”) means individually identifiable health information, as defined by HIPAA, that is created or received by Aflac and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased, unless the person has been deceased more than 50 years.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Uses and Disclosures for Payment – We may make requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims. We may also disclose your PHI for the payment purposes of a health care provider or another Health Plan.

Uses and Disclosures for Health Care Operations – We may use and disclose your PHI as necessary for our health care operations. Examples of health care operations include underwriting, premium rating, or other activities relating to the creation, renewal, or replacement of a Health Plan, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to your Health Plan. Although underwriting falls within the definition of health care operations, we will not use or disclose genetic information for purposes of underwriting. Genetic information is defined under the Genetic Information Nondiscrimination Act (GINA).

¹ *With respect to its Health Plans, American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York and Continental American Insurance Company are affiliated covered entities (see 45 CFR 164.105).*

Family and Friends Involved in Your Care – If you are available and do not object, we may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals. For example, we may use our professional judgment to disclose PHI to your spouse concerning the processing of a claim. If you do not wish Aflac to share PHI with your spouse or others, you may exercise your right to request a restriction on Aflac's disclosures of your PHI (see below).

Business Associates – Certain aspects and components of our services are performed through contracts with outside persons or organizations. Examples of these outside persons and organizations include our duly-appointed insurance agents and vendors that help us process your claims. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations.

Other Products and Services – We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your PHI for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing Health Plan coverage, and about health-related products and services that may add value to your Health Plan.

Other Uses and Disclosures – We may make certain other uses and disclosures of your PHI without your authorization:

- We may use or disclose your PHI for any purpose required by law. For example, Aflac may be required by law to use or disclose your PHI to respond to a court order.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for cadaveric organ, eye or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to workers' compensation agencies for your workers' compensation benefit determination.
- We will, if required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.

Your Authorization – Except as outlined above, we will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. Specifically, most uses and disclosures of psychotherapy notes, uses or disclosures for marketing purposes and disclosures that constitute a sale of PHI require an authorization. You have the right to revoke that authorization in writing except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining insurance, and we have the right, under other law, to contest a claim under the plan itself.

- The following are examples of when your authorization would be required prior to use and disclosure:
 - Most uses and disclosures of your psychotherapy notes.
 - Uses and disclosures of your PHI for marketing purposes.
 - Uses and disclosures that constitute a sale of PHI.

Breach of Unsecured PHI – If Aflac or a Business Associate of Aflac causes a breach to occur that involved your unsecured PHI, we are required by law to notify you of the incident.

RIGHTS THAT YOU HAVE

Access to Your PHI – You have the right to copy and/or inspect certain PHI that we maintain about you. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI and must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). We must provide you with access to your PHI in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a form or format agreed upon by you and Aflac. Access request forms are available from Aflac at the address below. We may charge you a fee for copying and postage. We may deny your request for access in certain very limited circumstances, such as request to access psychotherapy notes.

Amendments to Your PHI – You have the right to request that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your representative, and must state the reasons for the amendment/correction request. Amendment request forms are available from Aflac at the address below.

Accounting for Disclosures of Your PHI – You have the right to receive an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, your accounting requests must be in writing and signed by you or your representative. Accounting request forms are available from Aflac at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your PHI – You have the right to request restrictions on certain of our uses and disclosures of your PHI for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. HIPAA does not require us to agree to your request but we will accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. Requests for a restriction (or termination of an existing restriction) may be made by contacting Aflac at the telephone number or address below.

However, we are authorized by law to refuse to honor any request to restrict disclosures for treatment, payment or health care operations. Nonetheless, we will comply with a restriction request if (i) the disclosure is to the Health Plan for purposes of carrying out payment or healthcare operations, except as otherwise required by law, (ii) the PHI relates solely to a health care item or service for which the healthcare provider involved has been paid out-of-pocket in full.

Request for Confidential Communications – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to Aflac at the address below.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting Aflac at the telephone number or address below.

Complaints – If you believe your privacy rights have been violated, you can file a complaint with Aflac in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact Aflac's Privacy Office by writing to: Aflac, Attn: Privacy Office, P.O. Box 427, Columbia, SC 29202, or by calling 1-800-433-3036.

EFFECTIVE DATE

This Notice is effective January 6, 2017.