



Thank you for choosing Continental American Insurance Company

1.800.433.3036

www.aflacgroupinsurance.com

Your Group Policy Number is: CTR0023714706
Product: Critical Illness
Your Policy is Effective : 01/01/2025
Your State of Issue is: Virginia

|||
SUFFOLK CITY SCHOOL BOARD
SUFFOLK CITY SCHOOL BOARD
100 N MAIN ST
STE 1
SUFFOLK VA 23434-4529



February 1, 2025

SUFFOLK CITY SCHOOL BOARD
SUFFOLK CITY SCHOOL BOARD
100 N MAIN ST
STE 1
SUFFOLK VA 23434-4529

**Re: Your SUFFOLK CITY SCHOOL BOARD Group Critical Illness Coverage
Policy No.: CTR0023714706**

Welcome to the Aflac family!

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

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

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

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

Again, welcome to the Aflac family!

MPCOVLET_A

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

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups situated in New York, group coverage is underwritten by American Family Life Assurance Company of New York (22 Corporate Woods Boulevard, Suite 2, Albany, New York 12211), and customer service is administered by CAIC.

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, you may contact the insurance company issuing this insurance at the following address and telephone number: P.O. Box 84079, Columbus, GA, 31993-9101; 800.433.3036.

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at: the national toll free number 1-877-310-6560, the Virginia-only toll free number 800-552-7945, and the local number 804-371-9691.

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.



CONTINENTAL AMERICAN INSURANCE COMPANY

Continental American Insurance Company, a wholly-owned subsidiary of Aflac Incorporated, is the insuring company.

Columbia, South Carolina

800.433.3036

NOTICE OF PROTECTION PROVIDED BY VIRGINIA LIFE, ACCIDENT AND SICKNESS INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or health insurance company licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
 - o \$300,000 in death benefits
 - o \$100,000 in cash surrender or withdrawal values
- Health Insurance
 - o \$500,000 in hospital, medical and surgical insurance benefits
 - o \$300,000 in disability income insurance benefits
 - o \$300,000 in long-term care insurance benefits
 - o \$100,000 in other types of health insurance benefits
- Annuities
 - o \$250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$350,000, except for hospital, medical and surgical insurance benefits, for which the limit is increased to \$500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association's website at www.valifega.org or contact:

VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION

c/o APM Management Services, Inc.

1503 Santa Rosa Road, Suite 101

Henrico, VA 23229-5105

804-282-2240

STATE CORPORATION COMMISSION
Bureau of Insurance
P. O. Box 1157
Richmond, VA 23218-1157
804-371-9741
Toll Free Virginia only: 1-800-552-7945
<http://www.scc.virginia.gov/division/boi/index.htm>

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



CONTINENTAL AMERICAN INSURANCE COMPANY
Continental American Insurance Company, a wholly-owned subsidiary of
Aflac Incorporated, is the insuring company.

**Columbia, South Carolina
800.433.3036**

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

Continuation of Coverage Endorsement

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

EFFECTIVE DATE

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

The following provisions are added after the Continuity of Coverage provision in your Certificate:

CONTINUATION OF COVERAGE

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

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

To keep your Certificate in force, you must:

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

PREMIUMS

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

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

TERMINATION

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

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

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

CONTRACT

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

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

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY

**Continental American Insurance Company, a wholly-owned subsidiary of Aflac Incorporated, is the insuring company.
Columbia, South Carolina
800.433.3036**

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

Group Critical Illness Insurance Policy

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

This Plan provides benefits for the Critical Illnesses listed in the Policy Schedule.

Please read it carefully.

The Policyholder as shown on the Policy Schedule applied for coverage under this Group Critical Illness Insurance Policy (the "Plan"). This Plan is issued by Continental American Insurance Company (the "Company," "CAIC," "we," "us," or "our"). Based on the Master Application and the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages.

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

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

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

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

**Group Critical Illness Insurance
Non-Participating**

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.

Table of Contents

Section I	-	Eligibility, Effective Date, and Termination
Section II	-	Premium Provisions
Section III	-	Definitions
Section IV	-	Benefit Provisions
Section V	-	Exclusions
Section VI	-	Claim Provisions
Section VII	-	General Provisions
		Schedule of Premiums

SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

PRIMARY INSURED

Eligibility

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

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

- **Employee Coverage** – We insure the Employee and any Dependent Children. The Employee is the **Primary Insured** under this Plan.
- **Employee and Spouse or Domestic Partner Coverage** – We insure the Employee, Spouse or Domestic Partner, and any Dependent Children.

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

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

Effective Date

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

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

We may require evidence of insurability satisfactory to us if the amount of coverage applied for exceeds the guaranteed-issue amount, if any, or if we do not receive the Application within 31 days after the Employee was first eligible for coverage. Evidence of insurability may also be required based on an agreement between the Policyholder and us.

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

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

Termination of an Employee's Insurance

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

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

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

DEPENDENT COVERAGE

Eligibility

Dependents may be eligible for coverage under this Plan. **Employees should refer to the Type of Coverage on their Certificate Schedule to determine Dependent eligibility.** A **Dependent** is the Spouse or Domestic Partner of an Employee or the Dependent Child of an Employee (details included in the **Definitions** section). An eligible Spouse or Domestic Partner must not currently be disabled or unable to work and be at least 18 years of age.

Effective Date

The Effective Date for a Spouse or Domestic Partner is:

- The date shown on the Certificate Schedule if that Spouse or Domestic Partner is not confined to a hospital and is eligible for coverage on that date, or
- The first day of the month following the date the Spouse or Domestic Partner is no longer confined to a hospital (if that Spouse or Domestic Partner was confined to a hospital on the Certificate Schedule date) and is eligible for coverage on that date.

A Spouse or Domestic Partner may be added to the Plan after the Employee's Effective Date within 31 days after a Life Event or during an approved enrollment period. To be added, the Employee must complete an Application to add their Spouse or Domestic Partner to the Plan. The Company will assign the Effective Date for a Spouse's or Domestic Partner's coverage after approving the application. For Spouse or Domestic Partner coverage to become effective, the Spouse or Domestic Partner must be included in the premium payment.

The Effective Date for a Dependent Child is:

- The Employee Effective Date, or
- The moment of birth for a newborn child, the date the petition is filed for adoption for adopted children, or the date of the Employee's marriage for step-children.

Termination of Dependent Insurance

Dependent Coverage will terminate on the earliest of the following:

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

Plan Termination

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

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

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

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

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

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

Portability Privilege

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

To keep their coverage in force, the Employee must:

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

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

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

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

SECTION II – PREMIUM PROVISIONS

Premium Payments

Premiums should be paid to the Company at P.O. Box 84069, Columbus, Georgia, 31908-4069. The first premiums are due on this Plan's Effective Date. After that, premiums are due on the first day of each month that the Plan remains in effect.

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

Premium Changes

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

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

We will provide the Policyholder a 31-day advance written notice of any change to a premium.

Grace Period

This Plan has a 31-day Grace Period. If any premium, except for the first 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 in advance of the date of the discontinuance.

SECTION III - DEFINITIONS

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

Actively at Work (Active Work) refers to an Employee's ability to perform their regular employment duties for a full normal workday. The Employee may perform these activities either at their employer's regular place of business or at a location where they are required to travel to perform the regular duties of their employment.

Acute Coronary Syndrome is an obstruction of the coronary arteries that occurs as a result of Myocardial Infarction with or without ST elevation. This is determined by an electrocardiogram (ECG). Acute Coronary Syndrome includes unstable angina but does not include stable angina.

Arteriosclerosis means a disease of the arteries characterized by plaque deposits on the arteries' inner walls, resulting in their abnormal thickening and loss of elasticity.

Arteriovenous Malformation means a congenital disease of the blood vessels in the brain, brain stem, or spinal cord that is characterized by a complex, tangled web of abnormal arteries and veins and may be connected by one or more fistulas.

Atherosclerosis means a disease in which plaque builds up inside a person's arteries.

Bone Marrow Transplant (Stem Cell Transplant) means a procedure to replace damaged or destroyed bone marrow with healthy bone marrow stem cells. For a benefit to be payable, a Bone Marrow Transplant (Stem Cell Transplant) must be caused by at least one of the following diseases:

- Aplastic anemia
- Congenital neutropenia
- Severe immunodeficiency syndromes
- Sickle cell anemia
- Thalassemia
- Fanconi anemia
- Leukemia
- Lymphoma
- Multiple myeloma

The Bone Marrow Transplant (Stem Cell Transplant) benefit is not payable if the Transplant results from a covered Critical Illness for which a benefit has been paid under this Plan.

Brain Aneurysm is a weak area in the wall of a blood vessel of the brain that causes the blood vessel to bulge, balloon out, or rupture.

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

Chronic Kidney Disease means a disease characterized by the gradual loss in renal function over time due to diabetes mellitus, Hypertension, glomerulonephritis, polycystic kidney disease, autoimmune disease, or genetic disease.

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

Coronary Artery Bypass Surgery means open heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts and where such narrowing or blockage is attributed to Coronary Artery Disease or Acute Coronary Syndrome. This excludes any non-surgical procedure, such as, but not limited to, balloon angioplasty, laser relief, or stents.

Coronary Artery Disease occurs when the coronary arteries become damaged due to acute coronary occlusion, coronary atherosclerosis, aneurysm and/or dissection of the coronary arteries, or coronary atherosclerosis due to lipid rich plaque.

Critical Illness is a disease or a sickness as defined in the Plan that first manifests while your coverage is in force.

Any loss due to Critical Illness must begin while your coverage is in force. Critical Illness includes only the following, provided such Critical Illness meets all applicable definitions contained in the Plan and, where indicated, is caused by an underlying condition:

- Bone Marrow Transplant (Stem Cell Transplant)
- Coronary Artery Bypass Surgery
- Heart Attack (Myocardial Infarction)
- Kidney Failure (End-Stage Renal Failure)
- Major Organ Transplant

- Stroke
- Sudden Cardiac Arrest
- Type I Diabetes

Date of Diagnosis is defined as follows:

- **Bone Marrow Transplant (Stem Cell Transplant):** The date the surgery occurs.
- **Coronary Artery Bypass Surgery:** The date the surgery occurs.
- **Heart Attack (Myocardial Infarction):** The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the Heart Attack (Myocardial Infarction) definition.
- **Kidney Failure (End-Stage Renal Failure):** The date a Doctor recommends that an Insured begin renal dialysis.
- **Major Organ Transplant:** The date the surgery occurs.
- **Stroke:** The date the Stroke occurs (based on documented neurological deficits and neuroimaging studies).
- **Sudden Cardiac Arrest:** The date the pumping action of the heart fails (based on the Sudden Cardiac Arrest definition).
- **Type I Diabetes:** The date a Doctor Diagnoses an Insured as having Type I Diabetes based on clinical and/or laboratory findings as supported by medical records.

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

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

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

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

- Is made by a Doctor and
- Is based on clinical or laboratory investigations, as supported by the Insured's medical records.

The illness must meet the requirements outlined in this Plan for the particular Critical Illness being Diagnosed.

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

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

A Doctor does not include the Insured or any of the Insured's Family Members.

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

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

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

Domestic Partner is an unmarried same or opposite sex adult who resides with you and has registered in a state of local domestic partner registry with you and is listed on your Application.

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

Heart Attack (Myocardial Infarction) is the death of a portion of the heart muscle (myocardium) caused by a blockage of one or more coronary arteries due to Coronary Artery Disease or Acute Coronary Syndrome.

Heart Attack (Myocardial Infarction) does not include:

- Any other disease or injury involving the cardiovascular system.
- Cardiac Arrest not caused by a Heart Attack (Myocardial Infarction).

Diagnosis of a Heart Attack (Myocardial Infarction) must include the following:

- New and serial electrocardiographic (ECG) findings consistent with Heart Attack (Myocardial Infarction), and
- Elevation of cardiac enzymes above generally accepted laboratory levels of normal. (In the case of creatine phosphokinase (CPK) a CPK-MB measurement must be used.)

Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms may also be used.

Hypertension means a disease that is characterized by elevated blood pressure in the arteries with a systolic reading of at least 140 mmHg and a diastolic reading of at least 90 mmHg.

Kidney Failure (End-Stage Renal Failure) means end-stage renal failure caused by End-Stage Renal Disease, which results in the chronic, irreversible failure of both kidneys to function.

Kidney Failure (End-Stage Renal Failure) is covered only under the following conditions:

- A Doctor advises that regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) is necessary to treat the Kidney Failure (End-Stage Renal Failure); or
- The Kidney Failure (End-Stage Renal Failure) results in kidney transplantation.

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

Major Organ Transplant means undergoing surgery as a recipient of a covered transplant of a human heart, lung, liver, kidney, or pancreas. A transplant must be caused by one or more of the following diseases:

- Bronchiectasis, which is a lung disease state defined by localized, irreversible dilation of the bronchial tree caused by destruction of the muscle and elastic tissue.
- Cardiomyopathy, which is a heart disease characterized by the measurable deterioration of the function of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid.
- Cirrhosis, which is a liver disease characterized by replacement of liver tissue by fibrosis, scar tissue, and regenerative nodules, leading to loss of liver function.
- Chronic obstructive pulmonary disease, which is a lung disease characterized by persistently poor airflow as a result of breakdown of lung tissue and dysfunction of the small airways.
- Congenital Heart Disease, which is heart disease characterized by abnormalities in cardiovascular structures that occur before birth.
- Coronary Artery Disease
- Cystic fibrosis, which is a hereditary disease of the exocrine glands affecting the pancreas, respiratory system, and sweat glands. It is characterized by the production of abnormally viscous mucus by the affected glands.

- Hepatitis, which is a disease caused by the hepatitis A, B, or C virus and is characterized by the inflammation of the liver.
- Interstitial lung disease, which is a lung disease that affects the interstitium of the lungs.
- Lymphangioleiomyomatosis, which is a lung disease characterized by an indolent, progressive growth of smooth muscles cells throughout the lungs, pulmonary blood vessels, lymphatics, and pleurae.
- Polycystic liver disease, which is characterized by multiple variable-sized cysts lined by cuboidal epithelium.
- Pulmonary fibrosis, which is a lung disease where the lung tissue becomes thickened, stiff, and scarred due to chronic inflammation.
- Pulmonary hypertension, which is a disease characterized by increased pressure in the pulmonary artery and results in the thickening of the pulmonary arteries and the narrowing of these blood vessels, which causes the right side of the heart to become enlarged.
- Sarcoidosis, which is a disease characterized by the growth of granulomatous lesions that appear in the body.
- Valvular heart disease, which is a disease of the heart valves.

If, while the Certificate in force, the Insured is placed on a transplant list for a Major Organ Transplant due to one of the above-identified diseases, we will pay 25% of the Critical Illness benefit. The remainder of the Critical Illness benefit will become payable on the date the surgery occurs. A Major Organ Transplant benefit is not payable if the Major Organ Transplant results from a covered Critical Illness for which a benefit has been paid.

Malignant Hypertension is blood pressure that is so high that it actually causes damage to organs, particularly in the nervous system, the cardiovascular system, and/or the kidneys. One type of such damage is called papilledema, a condition in which the optic nerve leading to the eye becomes dangerously swollen, threatening vision.

Pathologist is a Doctor who is:

- Licensed to practice medicine, and
- Licensed by the American Board of Pathology to practice pathologic anatomy.

A Pathologist also includes an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Signs and/or Symptoms are the evidence of disease or physical disturbance observed by a Doctor or other medical professional. The Doctor (or other medical professional) must observe these Signs while acting within the scope of their license.

Spouse is your legal wife or husband who is listed on your Application.

Stroke means apoplexy due to rupture or acute occlusion of a cerebral artery. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. Stroke must be either:

- **Ischemic:** Due to advanced Arteriosclerosis or Arteriosclerosis of the arteries of the neck or brain, or vascular embolism, or
- **Hemorrhagic:** Due to uncontrolled Hypertension, Malignant Hypertension, Brain Aneurysm, or Arteriovenous Malformation.

The Stroke must be positively Diagnosed by a Doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

Stroke does not include:

- Transient Ischemic Attacks (TIAs)
- Head injury
- Chronic cerebrovascular insufficiency
- Reversible ischemic neurological deficits unless brain tissue damage is confirmed by neurological imaging

Stroke will be covered only if the Insured submits evidence of the neurological damage by providing:

- Computed Axial Tomography (CAT scan) images, or
- Magnetic Resonance Imaging (MRI).

Sudden Cardiac Arrest is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to Coronary Artery Disease, Cardiomyopathy, or Hypertension.

Sudden Cardiac Arrest is not a Heart Attack (Myocardial Infarction). A Sudden Cardiac Arrest benefit is not payable if the Sudden Cardiac Arrest is caused by or contributed to by a Heart Attack (Myocardial Infarction).

Transient Ischemic Attack (TIA) occurs when blood flow to part of the brain is temporarily blocked or reduced. For a benefit to be payable, the TIA must be caused by one or more of the following diseases:

- Advanced Arteriosclerosis
- Arteriosclerosis of the arteries of the neck or brain
- Vascular embolism
- Hypertension
- Malignant Hypertension
- Brain Aneurysm
- Arteriovenous Malformation.

The TIA must be positively Diagnosed by a Doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

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

Type I Diabetes means a form of diabetes mellitus causing total insulin deficiency of an Insured along with continuous dependence on exogenous insulin in order to maintain life. Type I Diabetes excludes Gestational Diabetes and Prediabetes.

SECTION IV - BENEFIT PROVISIONS

The benefit amounts payable under this section are shown in the Policy Schedule. The Company will pay benefits for a Critical Illness in the order the events occur.

Critical Illness Benefit

Initial Diagnosis Benefit

We will pay the Critical Illness benefit when an Insured is Diagnosed with one of the Critical Illnesses shown in the Benefit Schedule, and when such Diagnosis is caused by or solely attributed to an underlying disease as identified herein. We will pay this benefit if:

- The initial Date of Diagnosis is while the Insured's coverage is in force, and
- The Certificate does not exclude the illness or condition by name or by specific description.

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

Additional Diagnosis Benefit

Once benefits have been paid for a Critical Illness, the Company will pay benefits for each different Critical Illness when the Date of Diagnosis for the new Critical Illness is separated from the prior, different Critical Illness by at least 6 consecutive months and the new Critical Illness is not caused or contributed by a Critical Illness for which benefits have been paid.

Reoccurrence Benefit

Once benefits have been paid for a Critical Illness, benefits are payable for that same Critical Illness when the Date of Diagnosis for the Reoccurrence of that Critical Illness is separated from the prior occurrence of that Critical Illness by at least 6 consecutive months and the Critical Illness is not caused or contributed by a Critical Illness for which benefits have been paid.

Additional Benefits

Additional Benefits are payable if the Date of Diagnosis is while the Insured's coverage is in force, and the Certificate does not exclude the illness or condition by name or by specific description.

Waiver of Premium Benefit

If an Employee becomes Totally Disabled as defined in this Plan due to a covered Critical Illness, we will waive premiums for the Employee and any currently covered Dependents (this includes any Riders that are in force).

Total Disability or **Totally Disabled** means the Employee is:

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

After 90 days of Total Disability, all Plan premiums will be waived if:

- The Employee's Total Disability began before the age of 65;
- The Employee's Total Disability has continued without interruption for at least 90 days, during which time the Employee and/or the Policyholder have paid premiums; and
- The Employee provides proof of Total Disability as required by us. Satisfactory Proof of Loss for Total Disability must be provided at least once every 12 months.

Pending our approval of a claim for the Waiver of Premium Benefit, premiums should be paid as they are due. Premiums that were paid for the first 90 days of Total Disability will be refunded after the claim for this benefit is approved.

Waiver of Premium will continue until the earliest of the following:

- The premium due date following the Employee's 65th birthday,
- The date the Company has waived premiums for a total of 24 months of Total Disability,

- The date the Employee refuses to provide proof of continuing Total Disability,
- The date the Employee's Total Disability ends, or
- The date coverage ends according to the Termination provisions in **Section I – Eligibility, Effective Date, and Termination.**

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

SECTION V – EXCLUSIONS

Exclusions

We will not pay for loss due to any of the following:

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured
- **Suicide** – committing or attempting to commit suicide, while sane or insane
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job
- **Participation in Aggressive Conflict** of any kind, including:
 - o War (declared or undeclared) or military conflicts
 - o Insurrection or riot
 - o Civil commotion or civil state of belligerence
- **Illegal substance abuse, which includes the following:**
 - o Abuse of legally-obtained prescription medication
 - o Illegal use of non-prescription drugs
- An error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure

SECTION VI – CLAIM PROVISIONS

If the Policyholder requests a complete record of their claims experience under the group policy, the Company will provide it. We will provide this record within 30 days before the premiums or contractual terms of the Policy are amended. If coverage is being terminated because of unpaid premiums, we will send a written letter to the Policyholder notifying them of the termination date. We will send notice no less than 15 days before the termination date.

Notice of Claim

Written notice of claim must be given to us:

- Within 60 days after the Date of Diagnosis, or
- As soon as reasonably possible.

Failure to provide notice within 60 days will not invalidate or reduce any claim if the Insured can show that notice was given as soon as reasonably possible.

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

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

Proof of Loss

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

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

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

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

We may request additional Proof of Loss, such as records from hospitals or Doctors.

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

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

Physical Examination and Autopsy

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

Time of Payment of Claims

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

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

Payment of Claims

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

- To any approved assignee,
- To the Employee's beneficiary,
- To the Employee's surviving Spouse or Domestic Partner,
- To the Employee's estate.

Changing of Beneficiary

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

Claim Review

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

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

Appeals Procedure

No later than 60 days after notice of denial of a claim—the Employee, the Claimant, or an authorized representative of either may appeal any denial of benefits under the Plan by sending a written request for review of the denial to our Home Office.

Legal Action

The Employee cannot take legal action against us for benefits under this Plan:

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

SECTION VII – GENERAL PROVISIONS

Entire Contract Changes

This insurance is provided under a contract of Group Critical Illness insurance with the Policyholder. The entire Contract of Insurance is made up of:

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

All statements that the Policyholder or an Insured has made in the Application will be considered representations, not warranties. The Company will not void insurance or reduce benefits as a result of statements made on the Application without sending Application copies. No written statement by an Insured will be used in any contest unless a copy of the statement is furnished to the person, his beneficiary, or his personal representative.

Changes to this Plan:

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

Misstatement of Age

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

Successor Insured

If an Employee dies while covered under their Certificate and their Spouse or Domestic Partner is also insured under this Plan at the time of their death, then their surviving Spouse or Domestic Partner may elect to become the Primary Insured at the current Spouse or Domestic Partner Face Amount. This would include continuation of any Dependent Child coverage that is in force at that time.

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

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

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

Time Limit on Certain Defenses

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

No statement made by an Employee relating to his insurability or the insurability of his Dependents shall be used in contesting the validity of the insurance with respect to which such statement was made: (1) after the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made; and (2) unless the statement is contained in a written instrument signed by the person.

Clerical Error

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

Individual Certificates

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

- The coverage (including any limitations, reductions, and exclusions),
- Any family member or dependent 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.

Important Information Regarding Your Insurance

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, you may contact the insurance company issuing this insurance at the following address and telephone number: P.O. Box 427, Columbia, South Carolina, 29202, 800.433.3036 (toll free).

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at: P.O. Box 1157, Richmond, VA 23218, 804-371-9741, (toll free) 1-877-310-6560 or TDD 804-371-9206, fax 804-371-9944.

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

POLICY SCHEDULE

Group Policyholder:	SUFFOLK CITY SCHOOL BOARD
Group Policy Number:	CTR0023714706
Group Policy Effective Date:	January 1, 2025
Group Policy Anniversary Date:	January 1, 2026
Jurisdiction:	Virginia
Face Amount:	See Certificates
Spouse or Domestic Partner Amount:	See Certificates
Covered Dependent Children:	50.00% of applicable Face Amount
Benefit Percentages:	
Bone Marrow Transplant (Stem Cell Transplant)	100.00% of applicable Face Amount
Coronary Artery Bypass Surgery	100.00% of applicable Face Amount
Heart Attack (Myocardial Infarction)	100.00% of applicable Face Amount
Kidney Failure (End-Stage Renal Failure)	100.00% of applicable Face Amount
Major Organ Transplant	100.00% of applicable Face Amount
Stroke	100.00% of applicable Face Amount
Sudden Cardiac Arrest	100.00% of applicable Face Amount
Type I Diabetes	100.00% of applicable Face Amount
Maximum Payable for Additional Diagnosis Benefit:	1 per 6 months
Maximum Payable for Reoccurrence Benefit:	1 per 6 months
Additional Benefits:	
Waiver of Premium:	Yes

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

BENEFIT SCHEDULE

Critical Illness Benefits

The applicable benefit amount is payable for the following Critical Illnesses, provided such Critical Illness meets all applicable definitions contained in the Plan and is caused by an underlying disease as set forth herein:

- Bone Marrow Transplant (Stem Cell Transplant)
- Coronary Artery Bypass Surgery
- Heart Attack (Myocardial Infarction)
- Kidney Failure (End-Stage Renal Failure)
- Major Organ Transplant
- Stroke
- Sudden Cardiac Arrest
- Type I Diabetes

Additional Benefits

Waiver of Premium Benefit

Schedule of Premiums

SUFFOLK CITY SCHOOL BOARD - Monthly

Non Tobacco-Employee							
Issue Age	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000
18- 29	0.58	1.16	1.74	2.32	2.90	3.48	4.06
30 - 39	1.25	2.50	3.74	4.99	6.24	7.49	8.74
40 - 49	2.35	4.69	7.04	9.39	11.74	14.08	16.43
50 - 59	4.18	8.37	12.55	16.74	20.92	25.10	29.29
60 +	6.94	13.89	20.83	27.77	34.72	41.66	48.60

Non Tobacco-Spouse							
Issue Age	\$2,500	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500
18- 29	0.29	0.58	0.87	1.16	1.45	1.74	2.03
30 - 39	0.62	1.25	1.87	2.50	3.12	3.74	4.37
40 - 49	1.17	2.35	3.52	4.69	5.87	7.04	8.22
50 - 59	2.09	4.18	6.28	8.37	10.46	12.55	14.64
60 +	3.47	6.94	10.42	13.89	17.36	20.83	24.30

Tobacco-Employee							
Issue Age	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000
18- 29	1.09	2.19	3.28	4.38	5.47	6.57	7.66
30 - 39	2.96	5.92	8.88	11.84	14.80	17.76	20.73
40 - 49	5.23	10.46	15.70	20.93	26.16	31.39	36.62
50 - 59	8.43	16.87	25.30	33.73	42.17	50.60	59.03
60 +	13.49	26.98	40.47	53.96	67.45	80.94	94.43

Tobacco-Spouse							
Issue Age	\$2,500	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500
18- 29	0.55	1.09	1.64	2.19	2.74	3.28	3.83
30 - 39	1.48	2.96	4.44	5.92	7.40	8.88	10.36
40 - 49	2.62	5.23	7.85	10.46	13.08	15.70	18.31
50 - 59	4.22	8.43	12.65	16.87	21.08	25.30	29.52
60 +	6.74	13.49	20.23	26.98	33.72	40.47	47.21

B000282167302371470660000600343



CONTINENTAL AMERICAN INSURANCE COMPANY

**Continental American Insurance Company, a wholly-owned subsidiary of Aflac Incorporated, is the insuring company.
Columbia, South Carolina
800.433.3036**

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

Certificate of Insurance For Group Critical Illness Insurance Policy

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

This Plan provides benefits for the Critical Illnesses listed in the Benefit Schedule.

Please read it carefully.

Your Employer (the "Policyholder") applied for coverage under this Group Critical Illness Insurance Policy (the "Plan"). This Plan is issued by Continental American Insurance Company (the "Company," "CAIC," "we," "us," or "our"). For the purposes of this Plan, "you" (including "your" and "yours") refers to you. Based on the application process and the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages.

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

We certify that you are insured under the Group Critical Illness Policy (the "Plan"). The Plan was issued to the Policyholder. This coverage provides benefits for loss resulting from Critical Illness. The Certificate is subject to the Definitions, Exclusions, and other provisions of the Plan.

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

This Certificate, when it becomes effective, automatically replaces any Certificate or Certificates previously issued to you under the Plan.

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

TABLE OF CONTENTS

Section I	-	Eligibility, Effective Date, and Termination
Section II	-	Premium Provisions
Section III	-	Definitions
Section IV	-	Benefit Provisions
Section V	-	Exclusions
Section VI	-	Claim Provisions
Section VII	-	General Provisions

SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

PRIMARY INSURED

Eligibility

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

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

- **Employee Coverage** – We insure the Employee and any Dependent Children. The Employee is the **Primary Insured** under this Plan.
- **Employee and Spouse or Domestic Partner Coverage** – We insure the Employee, Spouse or Domestic Partner, and any Dependent Children.

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

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

Effective Date

Your Employee Effective Date is shown on the Certificate Schedule.

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

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

Termination of Your Insurance

Your insurance will terminate on whichever occurs first:

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

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

DEPENDENT COVERAGE

Eligibility

Dependents may be eligible for coverage under this Plan. **You should refer to the Type of Coverage on the Certificate Schedule to determine Dependent eligibility.** A **Dependent** is your Spouse or Domestic Partner or your Dependent Child (details included in the **Definitions** section). An eligible Spouse or Domestic Partner must not currently be disabled or unable to work and be at least 18 years of age.

Effective Date

The Effective Date for a Spouse or Domestic Partner is:

- The date shown on the Certificate Schedule if that Spouse or Domestic Partner is not confined to a hospital and is eligible for coverage on that date, or
- The first day of the month following the date the Spouse or Domestic Partner is no longer confined to a hospital (if that Spouse or Domestic Partner was confined to a hospital on the Certificate Schedule date) and is eligible for coverage on that date.

A Spouse or Domestic Partner may be added to the Plan after the Employee's Effective Date within 31 days after a Life Event or during an approved enrollment period. To be added, the Employee must complete an Application to add their Spouse or Domestic Partner to the Plan. The Company will assign the Effective Date for a Spouse or Domestic Partner coverage after approving the application. For Spouse or Domestic Partner coverage to become effective, the Spouse or Domestic Partner must be included in the premium payment.

The Effective Date for a Dependent Child is:

- The Employee Effective Date, or
- The moment of birth for a newborn child, the date the petition is filed for adoption for adopted children, or the date of the Employee's marriage for step-children.

A day begins at 12:01 a.m. standard time at the Employee's, Spouse's or Domestic Partner's, or Dependent Child's place of residence.

Termination of Dependent Insurance

Dependent Coverage will terminate on the earliest of the following:

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

Plan Termination

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

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

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

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

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

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

Portability Privilege

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

To keep your coverage in force, you must:

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

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

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

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

SECTION II – PREMIUM PROVISIONS

Premium Payments

Premiums should be paid to the Company at P.O. Box 84069, Columbus, Georgia, 31908-4069.

The first premiums are due on this Plan's Effective Date. After that, premiums are due on the first day of each month that the Plan remains in effect.

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

Premium Changes

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

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

We will provide the Policyholder a 31-day advance written notice of any change to a premium.

Grace Period

This Plan has a 31-day Grace Period. If any premium, except for the first 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 in advance of the date of the discontinuance.

SECTION III - DEFINITIONS

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

Actively at Work (Active Work) refers to your ability to perform your regular employment duties for a full normal workday. You may perform these activities either at your employer's regular place of business or at a location where you are required to travel to perform the regular duties of your employment.

Acute Coronary Syndrome is an obstruction of the coronary arteries that occurs as a result of Myocardial Infarction with or without ST elevation. This is determined by an electrocardiogram (ECG). Acute Coronary Syndrome includes unstable angina but does not include stable angina.

Arteriosclerosis means a disease of the arteries characterized by plaque deposits on the arteries' inner walls, resulting in their abnormal thickening and loss of elasticity.

Arteriovenous Malformation means a congenital disease of the blood vessels in the brain, brain stem, or spinal cord that is characterized by a complex, tangled web of abnormal arteries and veins and may be connected by one or more fistulas.

Atherosclerosis means a disease in which plaque builds up inside a person's arteries.

Bone Marrow Transplant (Stem Cell Transplant) means a procedure to replace damaged or destroyed bone marrow with healthy bone marrow stem cells. For a benefit to be payable, a Bone Marrow Transplant (Stem Cell Transplant) must be caused by at least one of the following diseases:

- Aplastic anemia
- Congenital neutropenia
- Severe immunodeficiency syndromes
- Sickle cell anemia
- Thalassemia
- Fanconi anemia
- Leukemia
- Lymphoma
- Multiple myeloma

The Bone Marrow Transplant (Stem Cell Transplant) benefit is not payable if the Transplant results from a covered Critical Illness for which a benefit has been paid under this Plan.

Brain Aneurysm is a weak area in the wall of a blood vessel of the brain that causes the blood vessel to bulge, balloon out, or rupture.

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

Chronic Kidney Disease means a disease characterized by the gradual loss in renal function over time due to diabetes mellitus, Hypertension, glomerulonephritis, polycystic kidney disease, autoimmune disease, or genetic disease.

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

Coronary Artery Bypass Surgery means open heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts and where such narrowing or blockage is attributed to Coronary Artery Disease or Acute Coronary Syndrome. This excludes any non-surgical procedure, such as, but not limited to, balloon angioplasty, laser relief, or stents.

Coronary Artery Disease occurs when the coronary arteries become damaged due to acute coronary occlusion, coronary atherosclerosis, aneurysm and/or dissection of the coronary arteries, or coronary atherosclerosis due to lipid rich plaque.

Critical Illness is a disease or a sickness as defined in the Plan that first manifests while your coverage is in force.

Any loss due to Critical Illness must begin while your coverage is in force. Critical Illness includes only the following, provided such Critical Illness meets all applicable definitions contained in the Plan and, where indicated, is caused by an underlying condition:

- Bone Marrow Transplant (Stem Cell Transplant)
- Coronary Artery Bypass Surgery
- Heart Attack (Myocardial Infarction)
- Kidney Failure (End-Stage Renal Failure)
- Major Organ Transplant
- Stroke
- Sudden Cardiac Arrest
- Type I Diabetes

Date of Diagnosis is defined as follows:

- **Bone Marrow Transplant (Stem Cell Transplant):** The date the surgery occurs.
- **Coronary Artery Bypass Surgery:** The date the surgery occurs.
- **Heart Attack (Myocardial Infarction):** The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the Heart Attack (Myocardial Infarction) definition.
- **Kidney Failure (End-Stage Renal Failure):** The date a Doctor recommends that an Insured begin renal dialysis.
- **Major Organ Transplant:** The date the surgery occurs.
- **Stroke:** The date the Stroke occurs (based on documented neurological deficits and neuroimaging studies).
- **Sudden Cardiac Arrest:** The date the pumping action of the heart fails (based on the Sudden Cardiac Arrest definition).
- **Type I Diabetes:** The date a Doctor Diagnoses an Insured as having Type I Diabetes based on clinical and/or laboratory findings as supported by medical records.

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

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

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

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

- Is made by a Doctor and
- Is based on clinical or laboratory investigations, as supported by your medical records.

The illness must meet the requirements outlined in this Plan for the particular Critical Illness being Diagnosed.

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

- Is licensed to practice medicine; prescribe and administer drugs; or to perform surgery, or

- Is a duly qualified medical practitioner according to the laws and regulations in the state in which Treatment is made.

A Doctor **does not** include you or any of your Family Members.

For the purposes of this definition, **Family Member** includes your Spouse or Domestic Partner as well as the following members of your immediate family:

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

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

Domestic Partner is an unmarried same or opposite sex adult who resides with you and has registered in a state of local domestic partner registry with you and is listed on your Application.

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

Heart Attack (Myocardial Infarction) is the death of a portion of the heart muscle (myocardium) caused by a blockage of one or more coronary arteries due to Coronary Artery Disease or Acute Coronary Syndrome.

Heart Attack (Myocardial Infarction) does not include:

- Any other disease or injury involving the cardiovascular system.
- Cardiac Arrest not caused by a Heart Attack (Myocardial Infarction).

Diagnosis of a Heart Attack (Myocardial Infarction) must include the following:

- New and serial electrocardiographic (ECG) findings consistent with Heart Attack (Myocardial Infarction), and
- Elevation of cardiac enzymes above generally accepted laboratory levels of normal. (In the case of creatine phosphokinase (CPK) a CPK-MB measurement must be used.)

Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms may also be used.

Hypertension means a disease that is characterized by elevated blood pressure in the arteries with a systolic reading of at least 140 mmHg and a diastolic reading of at least 90 mmHg.

Kidney Failure (End-Stage Renal Failure) means end-stage renal failure caused by End-Stage Renal Disease, which results in the chronic, irreversible failure of both kidneys to function.

Kidney Failure (End-Stage Renal Failure) is covered only under the following conditions:

- A Doctor advises that regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) is necessary to treat the Kidney Failure (End-Stage Renal Failure); or
- The Kidney Failure (End-Stage Renal Failure) results in kidney transplantation.

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

Major Organ Transplant means undergoing surgery as a recipient of a covered transplant of a human heart, lung, liver, kidney, or pancreas. A transplant must be caused by one or more of the following diseases:

- Bronchiectasis, which is a lung disease state defined by localized, irreversible dilation of the bronchial tree caused by destruction of the muscle and elastic tissue.
- Cardiomyopathy, which is a heart disease characterized by the measurable deterioration of the function of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid.
- Cirrhosis, which is a liver disease characterized by replacement of liver tissue by fibrosis, scar tissue, and regenerative nodules, leading to loss of liver function.
- Chronic obstructive pulmonary disease, which is a lung disease characterized by persistently poor airflow as a result of breakdown of lung tissue and dysfunction of the small airways.

- Congenital Heart Disease, which is heart disease characterized by abnormalities in cardiovascular structures that occur before birth.
- Coronary Artery Disease
- Cystic fibrosis, which is a hereditary disease of the exocrine glands affecting the pancreas, respiratory system, and sweat glands. It is characterized by the production of abnormally viscous mucus by the affected glands.
- Hepatitis, which is a disease caused by the hepatitis A, B, or C virus and is characterized by the inflammation of the liver.
- Interstitial lung disease, which is a lung disease that affects the interstitium of the lungs.
- Lymphangiomyomatosis, which is a lung disease characterized by an indolent, progressive growth of smooth muscles cells throughout the lungs, pulmonary blood vessels, lymphatics, and pleurae.
- Polycystic liver disease, which is characterized by multiple variable-sized cysts lined by cuboidal epithelium.
- Pulmonary fibrosis, which is a lung disease where the lung tissue becomes thickened, stiff, and scarred due to chronic inflammation.
- Pulmonary hypertension, which is a disease characterized by increased pressure in the pulmonary artery and results in the thickening of the pulmonary arteries and the narrowing of these blood vessels, which causes the right side of the heart to become enlarged.
- Sarcoidosis, which is a disease characterized by the growth of granulomatous lesions that appear in the body.
- Valvular heart disease, which is a disease of the heart valves.

If, while the Certificate in force, the Insured is placed on a transplant list for a Major Organ Transplant due to one of the above-identified diseases, we will pay 25% of the Critical Illness benefit. The remainder of the Critical Illness benefit will become payable on the date the surgery occurs. A Major Organ Transplant benefit is not payable if the Major Organ Transplant results from a covered Critical Illness for which a benefit has been paid.

Malignant Hypertension is blood pressure that is so high that it actually causes damage to organs, particularly in the nervous system, the cardiovascular system, and/or the kidneys. One type of such damage is called papilledema, a condition in which the optic nerve leading to the eye becomes dangerously swollen, threatening vision.

Pathologist is a Doctor who is:

- Licensed to practice medicine, and
- Licensed by the American Board of Pathology to practice pathologic anatomy.

A Pathologist also includes an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Signs and/or Symptoms are the evidence of disease or physical disturbance observed by a Doctor or other medical professional. The Doctor (or other medical professional) must observe these Signs while acting within the scope of their license.

Spouse is your legal wife or husband who is listed on your Application.

Stroke means apoplexy due to rupture or acute occlusion of a cerebral artery. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. Stroke must be either:

- **Ischemic:** Due to advanced Arteriosclerosis or Arteriosclerosis of the arteries of the neck or brain, or vascular embolism, or
- **Hemorrhagic:** Due to uncontrolled Hypertension, Malignant Hypertension, Brain Aneurysm, or Arteriovenous Malformation.

The Stroke must be positively Diagnosed by a Doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

Stroke does not include:

- Transient Ischemic Attacks (TIAs)
- Head injury

- Chronic cerebrovascular insufficiency
- Reversible ischemic neurological deficits unless brain tissue damage is confirmed by neurological imaging

Stroke will be covered only if the Insured submits evidence of the neurological damage by providing:

- Computed Axial Tomography (CAT scan) images, or
- Magnetic Resonance Imaging (MRI).

Sudden Cardiac Arrest is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to Coronary Artery Disease, Cardiomyopathy, or Hypertension.

Sudden Cardiac Arrest is not a Heart Attack (Myocardial Infarction). A Sudden Cardiac Arrest benefit is not payable if the Sudden Cardiac Arrest is caused by or contributed to by a Heart Attack (Myocardial Infarction).

Transient Ischemic Attack (TIA) occurs when blood flow to part of the brain is temporarily blocked or reduced. For a benefit to be payable, the TIA must be caused by one or more of the following diseases:

- Advanced Arteriosclerosis
- Arteriosclerosis of the arteries of the neck or brain
- Vascular embolism
- Hypertension
- Malignant Hypertension
- Brain Aneurysm
- Arteriovenous Malformation.

The TIA must be positively Diagnosed by a Doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

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

Type I Diabetes means a form of diabetes mellitus causing total insulin deficiency of an Insured along with continuous dependence on exogenous insulin in order to maintain life. Type I Diabetes excludes Gestational Diabetes and Prediabetes.

SECTION IV - BENEFIT PROVISIONS

The benefit amounts payable under this section are shown in the Certificate Schedule. The Company will pay benefits for a Critical Illness in the order the events occur.

Critical Illness Benefit

Initial Diagnosis Benefit

We will pay the Critical Illness benefit when an Insured is Diagnosed with one of the Critical Illnesses shown in the Benefit Schedule, and when such Diagnosis is caused by or solely attributed to an underlying disease as identified herein. We will pay this benefit if:

- The initial Date of Diagnosis is while the Insured's coverage is in force, and
- The Certificate does not exclude the illness or condition by name or by specific description.

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

Additional Diagnosis Benefit

Once benefits have been paid for a Critical Illness, the Company will pay benefits for each different Critical Illness when the Date of Diagnosis for the new Critical Illness is separated from the prior, different Critical Illness by at least 6 consecutive months and the new Critical Illness is not caused or contributed by a Critical Illness for which benefits have been paid.

Reoccurrence Benefit

Once benefits have been paid for a Critical Illness, benefits are payable for that same Critical Illness when the Date of Diagnosis for the Reoccurrence of that Critical Illness is separated from the prior occurrence of that Critical Illness by at least 6 consecutive months and the Critical Illness is not caused or contributed by a Critical Illness for which benefits have been paid.

Additional Benefits

Additional Benefits are payable if the Date of Diagnosis is while the Insured's coverage is in force, and the Certificate does not exclude the illness or condition by name or by specific description.

Waiver of Premium Benefit

If you become Totally Disabled as defined in this Plan due to a covered Critical Illness, we will waive premiums for you and any currently covered Dependents (this includes any Riders that are in force).

Total Disability or **Totally Disabled** means you are:

- Not working at any job for pay or benefits,
- Under the care of a Doctor for the Treatment of a covered Critical Illness, and
- **Unable to Work**, which means either:
 - During the first 365 days of Total Disability, you are unable to work at the occupation you were performing when your Total Disability began; or
 - After the first 365 days of Total Disability, you are unable to work at any gainful occupation for which you are suited by education, training, or experience.

After 90 days of Total Disability, all Plan premiums will be waived if:

- Your Total Disability began before your age of 65;
- Your Total Disability has continued without interruption for at least 90 days, during which time you and/or the Policyholder have paid premiums; and
- You provide proof of Total Disability as required by us. Satisfactory Proof of Loss for Total Disability must be provided at least once every 12 months.

Pending our approval of a claim for the Waiver of Premium Benefit, premiums should be paid as they are due. Premiums that were paid for the first 90 days of Total Disability will be refunded after your claim for this benefit is approved.

Waiver of Premium will continue until the earliest of the following:

- The premium due date following your 65th birthday,
- The date the Company has waived premiums for a total of 24 months of Total Disability,
- The date you refuse to provide proof of continuing Total Disability,

- The date your Total Disability ends, or
- The date coverage ends according to the Termination provisions in **Section I – Eligibility, Effective Date, and Termination.**

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

SECTION V – EXCLUSIONS

Exclusions

We will not pay for loss due to any of the following:

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured
- **Suicide** – committing or attempting to commit suicide, while sane or insane
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job
- **Participation in Aggressive Conflict** of any kind, including:
 - o War (declared or undeclared) or military conflicts
 - o Insurrection or riot
 - o Civil commotion or civil state of belligerence
- **Illegal substance abuse, which includes the following:**
 - o Abuse of legally-obtained prescription medication
 - o Illegal use of non-prescription drugs
- An error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure

SECTION VI – CLAIM PROVISIONS

If the Policyholder requests a complete record of their claims experience under the group Policy, the Company will provide it. We will provide this record within 30 days before the premiums or contractual terms of the Policy are amended. If coverage is being terminated because of unpaid premiums, we will send a written letter to the Policyholder notifying them of the termination date. We will send notice no less than 15 days before the termination date.

Notice of Claim

Written notice of claim must be given to us:

- Within 60 days after the Date of Diagnosis, or
- As soon as reasonably possible.

Failure to provide notice within 60 days will not invalidate or reduce any claim if the Insured can show that notice was given as soon as reasonably possible.

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

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

Proof of Loss

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

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

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

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

We may request additional Proof of Loss, such as records from hospitals or Doctors.

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

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

Physical Examination and Autopsy

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

Time of Payment of Claims

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

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

Payment of Claims

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

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

Changing of Beneficiary

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

Claim Review

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

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

Appeals Procedure

No later than 60 days after notice of denial of a claim—you, the Claimant, or an authorized representative of either may appeal any denial of benefits under the Plan by sending a written request for review of the denial to our Home Office.

Legal Action

You cannot take legal action against us for benefits under this Plan:

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

SECTION VII – GENERAL PROVISIONS

Entire Contract Changes

Your insurance is provided under a contract of Group Critical Illness insurance with the Policyholder. The entire Contract of Insurance is made up of:

- The Policy;
- The Certificate of insurance;
- The Application of the Policyholder, a copy of which is attached to and made part of the Policy when issued; and
- The Applications, if any, of each Employee; and
- Any Riders, Endorsements, or Amendments to the Policy or Certificate.

All statements that the Policyholder or an Insured has made in the Application will be considered representations, not warranties. The Company will not void insurance or reduce benefits as a result of statements made on the Application without sending Application copies. No written statement by an insured person will be used in any contest unless a copy of the statement is furnished to the person, his beneficiary, or his personal representative.

Changes to this Plan:

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

Misstatement of Age

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

Successor Insured

If you die while covered under this Certificate and your Spouse or Domestic Partner is also insured under this Plan at the time of your death, then your surviving Spouse or Domestic Partner may elect to become the Primary Insured at the current Spouse or Domestic Partner Face Amount. This would include continuation of any Dependent Child coverage that is in force at that time.

To become the Primary Insured and keep coverage in force, your surviving Spouse or Domestic Partner must:

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

If the Certificate does not cover a surviving Spouse or Domestic Partner, the Certificate will terminate on the next premium due date following your death.

Time Limit on Certain Defenses

After two years from your Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on your Application.

No statement made by you relating to your insurability or the insurability of your Dependents shall be used in contesting the validity of the insurance with respect to which such statement was made: (1) after the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made; and (2) unless the statement is contained in a written instrument signed by the person.

Clerical Error

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

Individual Certificates

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

- The coverage (including any limitations, reductions, and exclusions),
- Any family member or dependent 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.

Important Information Regarding Your Insurance

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, you may contact the insurance company issuing this insurance at the following address and telephone number: P.O. Box 427, Columbia, South Carolina, 29202, 800.433.3036 (toll free).

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at: P.O. Box 1157, Richmond, VA 23218, 804-371-9741, (toll free) 1-877-310-6560 or TDD 804-371-9206, fax 804-371-9944.

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

BENEFITS SCHEDULE

Critical Illness Benefits

The applicable benefit amount is payable for the following Critical Illnesses, provided such Critical Illness meets all applicable definitions contained in the Plan and is caused by an underlying disease as set forth herein:

- Bone Marrow Transplant (Stem Cell Transplant)
- Coronary Artery Bypass Surgery
- Heart Attack (Myocardial Infarction)
- Kidney Failure (End-Stage Renal Failure)
- Major Organ Transplant
- Stroke
- Sudden Cardiac Arrest
- Type I Diabetes

Additional Benefits

Waiver of Premium Benefit