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Thank you for choosing Continental American Insurance Company

1.800.433.3036
www.aflacgroupinsurance.com

Your Group Policy Number is:	CTR0026133605
Product:	Hospital Indemnity
Your Policy is Effective :	01/01/2025
Your State of Issue is:	Michigan

PLUMBERS & PIPEFITTERS UA LOCAL 85 INSUR
PLUMBERS & PIPEFITTERS UA LOCAL
700 TOWER DRIVE SUITE 300
WARREN MI 48089

MPMAIL

E

February 4, 2025

PLUMBERS & PIPEFITTERS UA LOCAL 85 INSUR
PLUMBERS & PIPEFITTERS UA LOCAL
700 TOWER DRIVE SUITE 300
WARREN MI 48089

Re: Your PLUMBERS & PIPEFITTERS UA LOCAL 85 INSUR Group Hospital Indemnity Coverage
Policy No.: CTR0026133605

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!

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

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

Group Supplemental Hospital Indemnity 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 IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

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

The notice below only applies to Insureds that are eligible for Medicare:
Cancellation during the first 30 days: During a period of 30 days after the date the Policyholder receives the Policy, the Policyholder may cancel the Policy and receive from the insurer a prompt refund of any premium paid for the Policy, including a Policy fee or other charge, by mailing or otherwise surrendering the Policy to the insurer together with a written request for cancellation. If a Policyholder or purchaser pursuant to such notice returns the Policy or contract to the Company or association at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy or contract had been issued.

Cancellation after 30 days: A Policyholder may cancel the Policy after the first 30 days following receipt of the Policy by giving written notice to the insurer effective upon receipt or on a later date as may be specified in the notice. In the event of cancellation, the insurer shall promptly refund to the Policyholder the excess of paid premium above the pro rata premium for the expired time. Cancellation is without prejudice to any claim originating prior to the effective date of cancellation.

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

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

This Plan is a legal contract between the Company and the Policyholder. All 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.

Group Supplemental Hospital Indemnity 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.

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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

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SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

Eligibility

An Employee is eligible to be covered under this Plan if he is Actively at Work for the Policyholder/his 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:

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

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

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

Effective Date

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

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

We may require evidence of insurability satisfactory to us if we do not receive the Application within 31 days after the Employee was first eligible for coverage.

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

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

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 he no longer belongs to an eligible class.

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

DEPENDENT COVERAGE

Eligibility
Dependents may be eligible for coverage under this Plan. **Employees should refer to the Type of Coverage on the Certificate Schedule to determine Dependent eligibility.** A ***Dependent*** is the Spouse of an Employee or the Dependent Child of an Employee. An eligible Spouse must be at least age 18.

Dependent Child or ***Dependent Children*** means an Employee's or an Employee's Spouse's natural children, step-children, grandchildren who are in the Employee's legal custody and residing with the Employee, 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 they turn 26 if they are incapable of self-sustaining employment due to mental or physical handicap, and are chiefly dependent on a parent for support and maintenance. The Employee or the Employee's Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday.

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 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 Coverage basis. After such notice, we will arrange for the payment of the appropriate premium due, including returning any unearned premium.

> ***Children Placed for Adoption*** are Children for whom the Employee has entered a decree of adoption or for whom he 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.

Effective Date
- A Dependent 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.
- If Employee and Children **or** Family Coverage is already in force, no additional notice or premium is required to add another Dependent Child.
- If Dependent Spouse or Dependent Child coverage is **not** in force, the Company will assign a Dependent Effective Date for a Dependent's coverage after being notified of that Dependent's eligibility. For Dependent coverage to become effective, the premium for the Dependent must be included in the premium payment. Spouse and Dependent Child coverage will begin on the date of the Life Event if notice was provided within 31 days after the Life Event.

Termination of Dependent Insurance
Dependent coverage will terminate on the earliest of the following:
- When the Certificate terminates,
- When premiums are no longer paid for Dependent coverage (subject to the Grace Period),
- For Spouse coverage, when the Insured no longer meets the definition of Spouse because of annulment, divorce, or other reason or
- For Dependent Child coverage, when the Child no longer qualifies as a Dependent because he reaches age 26 or other reason. (Dependent Children who reach age 26 will have coverage continued until the last day of the month in which they turn age 26.)

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Plan Termination

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

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

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

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

All outstanding premiums are due upon Plan termination. If the Company 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.

SECTION II – PREMIUM PROVISIONS

Premium Payments

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

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

Premium Changes

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

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

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

Grace Period

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

SECTION III – DEFINITIONS

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

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

Actively at Work refers to an Employee's ability to perform his regular employment duties for a full normal workday. The Employee may perform these activities either at his employer's regular place of business or at a location where he is required to travel to perform the regular duties of his employment.

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

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

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

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

For the purposes of this definition, ***Family Member*** includes the Employee's Spouse 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.

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

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

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

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

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

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

Related – a Related Accidental Injury or Sickness is one that is in correlation to, or occurs as a result of, the initial Accidental Injury or Sickness, and would not otherwise have been sustained if that initial condition had not occurred.

Sickness means an illness, infection, disease, or any other abnormal physical condition or pregnancy that is not caused solely by, or the result of, any injury. A ***Covered Sickness*** is one that is not excluded by name, specific description, or any other provision in this Plan. For a benefit to be payable, loss arising from the Covered Sickness must occur while the applicable Insured's coverage is in force.

Spouse is an Employee's legal wife or husband , including a legally-recognized same-sex Spouse, or a person of either gender who is in a legally recognized and registered domestic partnership, civil union, reciprocal beneficiary relationship, or similar relationship with the Employee.

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

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SECTION IV – BENEFIT PROVISIONS

We will pay benefits in the amounts shown in the Benefit Schedule.

Hospital Confinement Benefit

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

The length of time shown for Hospital Confinement in the Benefit Schedule is the maximum period for which an Insured can collect benefits for Hospital Confinements resulting from Covered Sickness or from Covered Accidental Injuries received in the same Covered Accident. We will not pay benefits for confinement to an observation unit, or for emergency room Treatment or outpatient Treatment.

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

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

We will not pay this benefit for confinement to an observation unit or a recovery unit. We will not pay this benefit for emergency room Treatment or outpatient surgery or outpatient Treatment.

SECTION V – EXCLUSIONS

The exclusions shown below are applicable to the benefit in this form only.

We will not pay for loss due to:

- **War** – voluntarily participating in war or any act of war. War also includes voluntary felonious participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.
- **Racing** – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semi-professional capacity.
- **Illegal Occupation** – voluntarily participating in, committing, or attempting to commit a felony or being engaged in an illegal occupation.
- **Sports** – participating in any organized sport in a professional or semi-professional capacity for pay or profit.
- **Custodial Care** – non-medical care that helps individuals with the basic tasks of everyday life, the preparation of special diets, and the self-administration of medication which does not require the constant attention of medical personnel.
- Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including any resulting complications.
- Services performed by a Family Member.
- Services related to sex or gender change, sterilization, in vitro fertilization, vasectomy or reversal of a vasectomy, or tubal ligation.
- **Elective Abortion** – an abortion for any reason other than to preserve the life of the person upon whom the abortion is performed.
- **Dental Services** or Treatment.
- **Cosmetic surgery**, except when due to:
    - Reconstructive surgery, when the service is related to or follows surgery resulting from a Covered Accidental Injury or a Covered Sickness, or is related to or results from a congenital disease or anomaly of a covered dependent child.
    - Congenital defects in newborns.

SECTION VI – CLAIM PROVISIONS

Notice of Claim

Written Notice of Claim must be given to us:

- Within 60 days after the loss, or
- As soon as reasonably possible.

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

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

Proof of Loss

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

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

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

Proof of Loss must be given to us within 90 days of the loss. 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 loss, except in the absence of the Claimant's legal mental capacity.

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

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We may require authorizations to obtain medical and psychiatric information as well as non-medical 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, the Employee, or the employer.

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,
- To the Employee's estate.

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

Changing of Beneficiary
A change in beneficiary must be submitted in writing to our Home Office 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
- His right to ask for a review of the claim.

Appeals Procedure
Before filing any lawsuit—and no later than 60 days after notice of denial of a claim—the Employee, the Claimant, or an authorized representative of either must appeal any denial of benefits under the Plan by sending a written request for review of the denial to our Home Office.

Legal Action
The Employee may not take Legal Action against us for benefits under this Plan:
- Within 60 days after he has sent us written Proof of Loss, or
- More than three years from the time written proof is required to be given.

SECTION VII – GENERAL PROVISIONS

Entire Contract Changes
This insurance is provided under a contract of Group Supplemental Hospital Indemnity insurance with the Policyholder. The Entire Contract of Insurance is made up of:
- The Policy;
- The Certificate(s) of insurance;
- The Master Application of the Policyholder, a copy of which is attached to and made part of the Policy when issued; and
- Any Riders, Endorsements, or Amendments to the Policy or Certificate.

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

Changes to the Plan:

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

Misstatement of Age

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

Time Limit on Certain Defenses

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

Clerical Error

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

Individual Certificates

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

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

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.

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SECTION VIII – BENEFIT SCHEDULE

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

Hospital Indemnity Benefits

	Employee	Spouse	Child
Hospital Confinement Benefit for first 4 days	$300.00/day	$300.00/day	$300.00/day
Hospital Confinement Benefit for days 6	$225.00/day	$225.00/day	$225.00/day
Hospital Confinement Benefit for days 21	$75.00/day	$75.00/day	$75.00/day
Up to maximum confinement period			
Maximum confinement period, per Covered Sickness or per Covered Accident	31 days	31 days	31 days

Accident Rider Benefits

	Employee	Spouse	Child
Initial Treatment Benefit	$150.00	$150.00	$150.00
Maximum number of payments per Covered Accident, per Insured	1	1	1
Ambulance Benefit	$300.00	$300.00	$300.00
Major Diagnostic Testing Benefit	$300.00	$300.00	$300.00
Maximum number of payments per Covered Accident, per Insured	1	1	1
Laceration Benefit	$100.00	$100.00	$100.00
Fracture Benefit			
Sternum	$2,250.00	$2,250.00	$2,250.00
Hip/thigh	$2,500.00	$2,500.00	$2,500.00
Vertebrae	$2,250.00	$2,250.00	$2,250.00
Pelvis	$2,000.00	$2,000.00	$2,000.00
Skull (depressed)	$1,875.00	$1,875.00	$1,875.00
Skull (simple)	$875.00	$875.00	$875.00
Leg	$1,500.00	$1,500.00	$1,500.00
Foot/ankle/knee cap	$1,250.00	$1,250.00	$1,250.00
Forearm/hand/wrist	$1,250.00	$1,250.00	$1,250.00
Lower jaw	$1,000.00	$1,000.00	$1,000.00
Shoulder blade/collar bone	$1,000.00	$1,000.00	$1,000.00
Upper arm/upper jaw	$875.00	$875.00	$875.00
Facial bones (except teeth)	$750.00	$750.00	$750.00
Vertebral processes	$500.00	$500.00	$500.00
Coccyx/rib/finger/toe	$200.00	$200.00	$200.00
Sacral/Sacrum	$500.00	$500.00	$500.00
Appliances Benefit			
Wheelchair	$300.00	$300.00	$300.00
Knee Scooter	$300.00	$300.00	$300.00
Body Jacket	$300.00	$300.00	$300.00
Back Brace	$300.00	$300.00	$300.00
Walking Boot	$75.00	$75.00	$75.00
Walker	$75.00	$75.00	$75.00
Crutches	$75.00	$75.00	$75.00
Leg Brace	$75.00	$75.00	$75.00
Cervical Collar	$75.00	$75.00	$75.00
Cane	$30.00	$30.00	$30.00
Ankle Brace	$30.00	$30.00	$30.00

Critical Illness Rider Benefits

EMPLOYEE CRITICAL ILLNESS FACE AMOUNT
$3,000.00

COVERED SPOUSE CRITICAL ILLNESS FACE AMOUNT
$3,000.00

COVERED DEPENDENT CHILDREN – CRITICAL ILLNESS	**CRITICAL ILLNESS PARTIAL BENEFITS PERCENTAGE**
100.00% of Employee's Face Amount	25.00%

Critical Illness

100.00% *of the Employee's Face Amount is payable for the following Critical Illnesses, provided such Critical Illness meets all applicable definitions contained in the Critical Illness Rider and is caused by an underlying disease as set forth therein:*

Bone Marrow Transplant (Stem Cell Transplant)	**Major Organ Transplant**
Cancer (internal or invasive)	**Non-Invasive Cancer**
Coronary Artery Bypass Surgery	**Stroke**
Heart Attack (Myocardial Infarction)	**Sudden Cardiac Arrest**
Kidney Failure (End-Stage Renal Failure)	

Critical Illness – Partial Benefits

Non-Invasive Cancer
Coronary Artery Bypass Surgery

Additional Benefit

Skin Cancer (Employee)	$250.00
Covered Dependent Child	$250.00
Covered Spouse	$250.00

SECTION IX – POLICY SCHEDULE

EMPLOYER-PAID PLAN

GROUP POLICYHOLDER:	PLUMBERS & PIPEFITTERS UA LOCAL 85 INSUR
GROUP POLICY NUMBER:	CTR0026133605
GROUP POLICY EFFECTIVE DATE:	January 1, 2025
GROUP POLICY ANNIVERSARY DATE:	January 1, 2026
JURISDICTION:	Michigan
TOTAL INITIAL PREMIUM*	$0.00
TYPE OF COVERAGE:	Family
ACCIDENT BENEFITS EFFECTIVE DATE:	January 1, 2025
CRITICAL ILLNESS BENEFITS EFFECTIVE DATE:	January 1, 2025

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

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

INCORPORATION OF RIDER PROVISIONS

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

Rider Name	Form Number
Accident Rider	C81301MI
Critical Illness Rider	C81302MI

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SCHEDULE OF PREMIUMS

RATES TABLE FOR: PLUMBERS & PIPEFITTERS UA LOCAL 85 INSUR / HOSPITAL INDEMNITY

DEDUCTION FREQUENCY : Monthly (12pp / yr)

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

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

Accident Rider
To Certificate of Insurance for Group Supplemental Hospital Indemnity Policy

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

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

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

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

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

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

BENEFIT PROVISIONS
We will pay benefits in the amounts shown in the Benefit Schedule.

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

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

The Initial Treatment must be received within 168 hours after the Covered Accident for benefits to be payable. This benefit is **not** payable for telemedicine services. (For the purposes of this Plan, *"telemedicine service"* means a medical inquiry with a Doctor via audio or video communication that assists with a patient's assessment, diagnosis, and consultation.)

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

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

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

Ambulance service includes air ambulance service.

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

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

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

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

Laceration Benefit
We will pay the amount shown in the Benefit Schedule if an Insured receives a laceration in a Covered Accident. The laceration must be repaired with stitches by a Doctor within 168 hours after the accident for a benefit to be payable. (*Stitches* can also include liquid skin adhesive.)

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

Multiple fractures refers to more than one fracture. If these fractures occur in any one Covered Accident, we will pay the appropriate amounts shown in the Benefit Schedule for each fracture. However, we will pay no more than 200.00% of the benefit amount for the bone fractured that has the highest dollar amount.

Chip fracture refers to a piece of bone that is completely broken off near a joint. If a Doctor diagnoses the fracture as a chip fracture, we will pay 25.00% of the amount shown in the Benefit Schedule for the affected bone.

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

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

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

EXCLUSIONS
The exclusions below are applicable to the benefits in this Rider form only.

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

- **War** – voluntarily participating in war or any act of war. War also includes voluntary felonious participation in an insurrection, riot, civil commotion, or civil state of belligerence. War does not include acts of terrorism.
- **Sickness** – having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for:
    - Allergic reactions
    - Any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings
    - An error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure for any sickness
    - Any related medical/surgical Treatment or diagnostic procedures for such illness
- **Racing** – riding in or driving any motor-driven vehicle in a race, stunt show, or speed test in a professional or semi-professional capacity.
- **Sports** – participating in any organized sport in a professional or semi-professional capacity for pay or profit.
- **Cosmetic Surgery** – having cosmetic surgery or other elective procedures that are not medically necessary or having dental Treatment except as a result of a Covered Accident.

GENERAL PROVISIONS

Time Limit on Certain Defenses

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

CONTRACT

This Rider is part of the Group Supplemental Hospital Indemnity Policy. It will terminate when:

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

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

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

Critical Illness Rider
To Certificate of Insurance for Group Supplemental Hospital Indemnity Policy

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

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

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

Benefit Definitions

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.

Cancer (internal or invasive) is a disease that meets either of the following definitions:

- A malignant tumor characterized by:
  - The uncontrolled growth and spread of malignant cells, and
  - The invasion of distant tissue.
- A disease meeting the diagnostic criteria of malignancy, as established by the American Board of Pathology. A Pathologist must have examined and provided a report on the histocytologic architecture or pattern of the tumor, tissue, or specimen.

Cancer (internal or invasive) also includes:

- Melanoma that is Clark's Level III ***or*** higher or Breslow depth equal to or greater than 0.77mm,
- Myelodysplastic syndrome – RCMD (refractory cytopenia with multilineage dysplasia),
- Myelodysplastic syndrome – RAEB (refractory anemia with excess blasts),
- Myelodysplastic syndrome – RAEB-T (refractory anemia with excess blasts in transformation), or
- Myelodysplastic syndrome – CMML (chronic myelomonocytic leukemia).

The following are **not** considered internal or invasive Cancers:

- Pre-malignant tumors or polyps
- Carcinomas in Situ
- Any superficial, non-invasive Skin Cancers including basal cell and squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is Diagnosed as
  - Clark's Level I or II,
  - Breslow depth less than 0.77mm, or
  - Stage 1A melanomas under TNM Staging

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.

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 physphokinase (CPK) a CPK-MB measurement must be used.)

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

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.

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 is in force, the Insured is placed on a transplant list for a Major Organ Transplant, 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.

Non-Invasive Cancer is a Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

For the purposes of this Plan, a Non-Invasive Cancer is:
- Internal Carcinoma in Situ
- Myelodysplastic Syndrome – RA (refractory anemia)
- Myelodysplastic Syndrome – RARS (refractory anemia with ring sideroblasts)

Skin Cancer, as defined in this Plan, is not payable under the Non-Invasive Cancer benefit.

Skin Cancer is a Cancer that forms in the tissues of the skin. The following are considered Skin Cancers:
- Basal cell carcinoma
- Squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is Diagnosed as:
  - Clark's Level I or II,
  - Breslow depth less than 0.77mm, or
  - Stage 1A melanomas under TNM Staging

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

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).

General Definitions

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.

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.

Carcinoma in Situ is Non-Invasive Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

Cancer or Non-Invasive Cancer, or Skin Cancer must be **Diagnosed** in one of two ways:

1. ***Pathological Diagnosis*** is a Diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This Diagnosis must be made by a certified Pathologist and conform to the American Board of Pathology standards.

2. ***Clinical Diagnosis*** is based only on the study of symptoms. The Company will accept a Clinical Diagnosis only if:
   - A Doctor cannot make a Pathological Diagnosis because it is medically inappropriate or life-threatening,
   - Medical evidence exists to support the Diagnosis, and
   - A Doctor is treating the Insured for Cancer or Carcinoma in Situ.

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

End-Stage Renal 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.

Complete Remission is defined as having no Symptoms and no Signs that can be identified to indicate the presence of Cancer.

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 this Rider 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 this Rider and, where indicated, is caused by an underlying condition:

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

Date of Diagnosis is defined as follows:

- *Bone Marrow Transplant (Stem Cell Transplant)*: The date the surgery occurs.
- *Cancer*: The day tissue specimens, blood samples, or titer(s) are taken (Diagnosis of Cancer and/or Non-Invasive Cancer is based on such specimens).
- *Coronary Artery Bypass Surgery*: The date the surgery occurs.
- *Heart Attack (Myocardial Infarction)*: The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the Heart Attack (Myocardial Infarction) definition.
- *Kidney Failure (End-Stage Renal Failure)*: The date a Doctor recommends that an Insured begin renal dialysis.
- *Major Organ Transplant*: The date the surgery occurs.
- *Non-Invasive Cancer*: The day tissue specimens, blood samples, or titer(s) are taken (Diagnosis of Cancer and/or Non-Invasive Cancer is based on such specimens).
- *Skin Cancer*: The date the skin biopsy samples are taken for microscopic examination.
- *Stroke*: The date the Stroke occurs (based on documented neurological deficits and neuroimaging studies).
- *Sudden Cardiac Arrest*: The date the pumping action of the heart fails (based on the Sudden Cardiac Arrest definition).

For the purposes of administering this Plan, the Date of Diagnosis is considered to be the date on which loss occurs.

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 Rider for the particular Critical Illness being Diagnosed.

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.

Maintenance Drug Therapy is a course of systemic medication given to a patient after a Cancer goes into Complete Remission because of primary Treatment. Maintenance Drug Therapy includes ongoing hormonal therapy, immunotherapy, or chemo-prevention therapy. Maintenance Drug Therapy is meant to decrease the risk of Cancer recurrence; it is not meant to treat a Cancer that is still present.

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.

Melanoma in Situ means melanoma cells that occur only on the outer layer of the skin (the epidermis), where there is no invasion of the deeper layer (the dermis).

Pathologist is a Doctor who is licensed:
- To practice medicine, and
- 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 his license.

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

Treatment-Free From Cancer refers to the period of time without the consultation, care, or services provided by a Doctor. This includes receiving diagnostic measures and taking prescribed drugs and medicines. Treatment does not include Maintenance Drug Therapy or routine follow-up visits to verify whether Cancer or Non-Invasive Cancer has returned.

BENEFIT PROVISIONS
We will pay benefits in the amounts shown in the Benefit Schedule.

The Company will pay benefits for a Critical Illness in the order the events occur.

Critical Illness Benefit

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

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

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

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

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

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

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

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

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

Non-Invasive Cancer
We will pay the amount shown in the Benefit Schedule for the Diagnosis of a Non-Invasive Cancer.

Coronary Artery Bypass Surgery
We will pay the amount shown in the Benefit Schedule for Coronary Artery Bypass Surgery.

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

Skin Cancer Benefit
We will pay the amount shown in the Benefit Schedule for the Diagnosis of Skin Cancer. This benefit is payable once per Plan Year.

EXCLUSIONS

Exclusions
The exclusions below are applicable to the benefits in this Rider form only.

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

- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job
- **War** – voluntarily participating in war or any act of war. War also includes voluntary felonious participation in an insurrection, riot, civil commotion, or civil state of belligerence. War does not include acts of terrorism.

GENERAL PROVISIONS

Time Limit on Certain Defenses
After two years from the effective date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Application. This does not apply to fraudulent misstatements.

CONTRACT
This Rider is part of the Group Supplemental Hospital Indemnity Policy. It will terminate when:

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

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

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

Certificate of Insurance For
Group Supplemental Hospital Indemnity 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 IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

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

The notice below only applies to Insureds that are eligible for Medicare:
Cancellation during the first 30 days: During a period of 30 days after the date the Policyholder receives the Policy, the Policyholder may cancel the Policy and receive from the insurer a prompt refund of any premium paid for the Policy, including a Policy fee or other charge, by mailing or otherwise surrendering the Policy to the insurer together with a written request for cancellation. If a Policyholder or purchaser pursuant to such notice returns the Policy or contract to the Company or association at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy or contract had been issued.

Cancellation after 30 days: A Policyholder may cancel the Policy after the first 30 days following receipt of the Policy by giving written notice to the insurer effective upon receipt or on a later date as may be specified in the notice. In the event of cancellation, the insurer shall promptly refund to the Policyholder the excess of paid premium above the pro rata premium for the expired time. Cancellation is without prejudice to any claim originating prior to the effective date of cancellation.

PLUMBERS & PIPEFITTERS UA LOCAL 85 INSUR (the “Policyholder”) applied for coverage under this Group Supplemental Hospital Indemnity Insurance Policy (the “Plan”). This Plan is issued by Continental American Insurance Company (the “Company,” “CAIC,” “we,” “us,” or “our”). For the purposes of this Plan, “you” (including “your” and “yours”) refers to you. Based on the application process and the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. (Please note that male pronouns—such as “he,” “him,” and “his”—are used for both males and females, unless the context clearly shows otherwise.) The Policyholder may add new Insureds from time to time, according to the Plan’s terms.

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

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

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

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

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SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

Eligibility

You are eligible to be covered under this Plan if you are Actively at Work for the Policyholder/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:

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

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

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

Effective Date

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

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

We may require evidence of insurability satisfactory to us if we do not receive the Application within 31 days after the Employee was first eligible for coverage.

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

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

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 coverage was active.

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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 your Dependent Child. An eligible Spouse must be at least age 18.

Dependent Child or ***Dependent Children*** means your or your Spouse's natural children, step-children, grandchildren who are in your legal custody and residing with you, 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 they turn 26 if they are incapable of self-sustaining employment due to mental or physical handicap, and are chiefly dependent on a parent for support and maintenance. You or your Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday.

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

> ***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.

Effective Date
- A Dependent may be added to the Plan after your Effective Date within 31 days after a Life Event or during an approved enrollment period.
- If Employee and Children **or** Family Coverage is already in force, no additional notice or premium is required to add another Dependent Child.
- If Dependent Spouse or Dependent Child coverage is **not** in force, the Company will assign a Dependent Effective Date for a Dependent's coverage after being notified of that Dependent's eligibility. For Dependent coverage to become effective, the premium for the Dependent must be included in the premium payment. Spouse and Dependent Child coverage will begin on the date of the Life Event if notice was provided within 31 days after the Life Event.

Termination of Dependent Insurance
Dependent coverage will terminate on the earliest of the following:
- When the Certificate terminates,
- When premiums are no longer paid for Dependent coverage (subject to the Grace Period),
- For Spouse coverage, when the Insured no longer meets the definition of Spouse because of annulment, divorce, or other reason or
- For Dependent Child coverage, when the Child no longer qualifies as a Dependent because he reaches age 26 or other reason. (Dependent Children who reach age 26 will have coverage continued until the last day of the month in which they turn age 26.)

Plan Termination

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

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

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

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

All outstanding premiums are due upon Plan termination. If the Company 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.

SECTION II – PREMIUM PROVISIONS

Premium Payments

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

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

Premium Changes

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

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

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

Grace Period

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

SECTION III – DEFINITIONS

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

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

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

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

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

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

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

For the purposes of this definition, ***Family Member*** includes the Employee's Spouse 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.

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

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

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

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

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

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

Related – a Related Accidental Injury or Sickness is one that is in correlation to, or occurs as a result of, the initial Accidental Injury or Sickness, and would not otherwise have been sustained if that initial condition had not occurred.

Sickness means an illness, infection, disease, or any other abnormal physical condition or pregnancy that is not caused solely by, or the result of, any injury. A ***Covered Sickness*** is one that is not excluded by name, specific description, or any other provision in this Plan. For a benefit to be payable, loss arising from the Covered Sickness must occur while the applicable Insured's coverage is in force.

Spouse is your legal wife or husband , including a legally-recognized same-sex Spouse, or a person of either gender who is in a legally recognized and registered domestic partnership, civil union, reciprocal beneficiary relationship, or similar relationship with you.

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

SECTION IV – BENEFIT PROVISIONS

We will pay benefits in the amounts shown in the Benefit Schedule.

Hospital Confinement Benefit

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

The length of time shown for Hospital Confinement in the Benefit Schedule is the maximum period for which an Insured can collect benefits for Hospital Confinements resulting from Covered Sickness or from Covered Accidental Injuries received in the same Covered Accident. We will not pay benefits for confinement to an observation unit, or for emergency room Treatment or outpatient Treatment.

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

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

We will not pay this benefit for confinement to an observation unit or a recovery unit. We will not pay this benefit for emergency room Treatment or outpatient surgery or outpatient Treatment.

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SECTION V – EXCLUSIONS

The exclusions shown below are applicable to the benefit in this form only.

We will not pay for loss due to:

- **War** – voluntarily participating in war or any act of war. War also includes voluntary felonious participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.
- **Racing** – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semi-professional capacity.
- **Illegal Occupation** – voluntarily participating in, committing, or attempting to commit a felony or voluntarily working at, or being engaged in an illegal occupation.
- **Sports** – participating in any organized sport in a professional or semi-professional capacity for pay or profit.
- **Custodial Care** – non-medical care that helps individuals with the basic tasks of everyday life, the preparation of special diets, and the self-administration of medication which does not require the constant attention of medical personnel.
- Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including any resulting complications.
- Services performed by a Family Member.
- Services related to sex or gender change, sterilization, in vitro fertilization, vasectomy or reversal of a vasectomy, or tubal ligation.
- **Elective Abortion** – an abortion for any reason other than to preserve the life of the person upon whom the abortion is performed.
- **Dental Services** or Treatment.
- **Cosmetic surgery**, except when due to:
    - Reconstructive surgery, when the service is related to or follows surgery resulting from a Covered Accidental Injury or a Covered Sickness, or is related to or results from a congenital disease or anomaly of a covered dependent child.
    - Congenital defects in newborns.

SECTION VI – CLAIM PROVISIONS

Notice of Claim

Written Notice of Claim must be given to us:

- Within 60 days after the loss, or
- As soon as reasonably possible.

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

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

Proof of Loss

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

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

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

Proof of Loss must be given to us within 90 days of the loss. 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 loss, except in the absence of your legal mental capacity.

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

We may require authorizations to obtain medical and psychiatric information as well as non-medical information.

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

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

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

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

Payment of Claims
We will pay all benefits to you unless otherwise assigned. For any benefits that remain unpaid at the time of death, we will pay those benefits in the following order:
- To any approved assignee,
- To your beneficiary,
- To your surviving Spouse,
- To your estate.

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

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

Claim Review
If a claim is denied, you will be given written notice of:
- The reason for the denial,
- The Plan provision that supports the denial, and
- Your right to ask for a review of the claim.

Appeals Procedure
Before filing any lawsuit—and no later than 60 days after notice of denial of a claim—you, the Claimant, or an authorized representative of either must appeal any denial of benefits under the Plan by sending a written request for review of the denial to our Home Office.

Legal Action
You may not take Legal Action against us for benefits under this Plan:
- Within 60 days after you have sent us written Proof of Loss, or
- More than 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 Supplemental Hospital Indemnity insurance with the Policyholder. The Entire Contract of Insurance is made up of:
- The Policy;
- The Certificate(s) of insurance;
- The Master Application of the Policyholder, a copy of which is attached to and made part of the Policy when issued; and
- Any Riders, Endorsements, or Amendments to the Policy or Certificate.

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

Changes to the Plan:

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

Misstatement of Age

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

Time Limit on Certain Defenses

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

Clerical Error

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

Individual Certificates

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

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

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.

SECTION VIII – BENEFIT SCHEDULE

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

Hospital Indemnity Benefits

	Employee	Spouse	Child
Hospital Confinement Benefit for first 4 days	$300.00/day	$300.00/day	$300.00/day
Hospital Confinement Benefit for days 6	$225.00/day	$225.00/day	$225.00/day
Hospital Confinement Benefit for days 21	$75.00/day	$75.00/day	$75.00/day
Up to maximum confinement period			
Maximum confinement period, per Covered Sickness or per Covered Accident	31 days	31 days	31 days

Accident Rider Benefits

	Employee	Spouse	Child
Initial Treatment Benefit	$150.00	$150.00	$150.00
Maximum number of payments per Covered Accident, per Insured	1	1	1
Ambulance Benefit	$300.00	$300.00	$300.00
Major Diagnostic Testing Benefit	$300.00	$300.00	$300.00
Maximum number of payments per Covered Accident, per Insured	1	1	1
Laceration Benefit	$100.00	$100.00	$100.00
Fracture Benefit			
Sternum	$2,250.00	$2,250.00	$2,250.00
Hip/thigh	$2,500.00	$2,500.00	$2,500.00
Vertebrae	$2,250.00	$2,250.00	$2,250.00
Pelvis	$2,000.00	$2,000.00	$2,000.00
Skull (depressed)	$1,875.00	$1,875.00	$1,875.00
Skull (simple)	$875.00	$875.00	$875.00
Leg	$1,500.00	$1,500.00	$1,500.00
Foot/ankle/knee cap	$1,250.00	$1,250.00	$1,250.00
Forearm/hand/wrist	$1,250.00	$1,250.00	$1,250.00
Lower jaw	$1,000.00	$1,000.00	$1,000.00
Shoulder blade/collar bone	$1,000.00	$1,000.00	$1,000.00
Upper arm/upper jaw	$875.00	$875.00	$875.00
Facial bones (except teeth)	$750.00	$750.00	$750.00
Vertebral processes	$500.00	$500.00	$500.00
Coccyx/rib/finger/toe	$200.00	$200.00	$200.00
Sacral/Sacrum	$500.00	$500.00	$500.00
Appliances Benefit			
Wheelchair	$300.00	$300.00	$300.00
Knee Scooter	$300.00	$300.00	$300.00
Body Jacket	$300.00	$300.00	$300.00
Back Brace	$300.00	$300.00	$300.00
Walking Boot	$75.00	$75.00	$75.00
Walker	$75.00	$75.00	$75.00
Crutches	$75.00	$75.00	$75.00
Leg Brace	$75.00	$75.00	$75.00
Cervical Collar	$75.00	$75.00	$75.00
Cane	$30.00	$30.00	$30.00
Ankle Brace	$30.00	$30.00	$30.00

Critical Illness Rider Benefits

EMPLOYEE CRITICAL ILLNESS FACE AMOUNT
$3,000.00

COVERED SPOUSE CRITICAL ILLNESS FACE AMOUNT
$3,000.00

COVERED DEPENDENT CHILDREN – CRITICAL ILLNESS	CRITICAL ILLNESS PARTIAL BENEFITS PERCENTAGE
100.00% of Employee's Face Amount	25.00%

Critical Illness

100.00% *of the Employee's Face Amount is payable for the following Critical Illnesses, provided such Critical Illness meets all applicable definitions contained in the Critical Illness Rider and is caused by an underlying disease as set forth therein:*

Bone Marrow Transplant (Stem Cell Transplant)	**Major Organ Transplant**
Cancer (internal or invasive)	**Non-Invasive Cancer**
Coronary Artery Bypass Surgery	**Stroke**
Heart Attack (Myocardial Infarction)	**Sudden Cardiac Arrest**
Kidney Failure (End-Stage Renal Failure)	

Critical Illness – Partial Benefits

Non-Invasive Cancer
Coronary Artery Bypass Surgery

Additional Benefit

Skin Cancer (Employee)	$250.00
Covered Dependent Child	$250.00
Covered Spouse	$250.00