



## CONTINENTAL AMERICAN INSURANCE COMPANY

P.O Box 427, Columbia, South Carolina 29202  
800.433.3036

### **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.**

**THIS IS NOT A MEDICARE SUPPLEMENT POLICY.**

**THIS IS A LEGAL CONTRACT. PLEASE READ YOUR CERTIFICATE CAREFULLY.**

**If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the Company.**

**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 and the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. (Please note that male pronouns— such as "he," "him," and "his"—are used for both males and females, unless the context clearly shows otherwise.)

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

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

***Important Cancellation Information: Please Read The Provision Entitled, "Plan Termination", On Page "4."***

*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**

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

## **Section I – Eligibility, Effective Date, and Termination**

### **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.

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

- Your Spouse, **or**
- The Dependent Child of you or your Spouse (details included in the **Definitions** section).

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

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

We will not insure anyone specifically excluded from coverage by Endorsement to the Certificate or by application, even if that person would otherwise be eligible for coverage.

Details for adding an Insured to your coverage are outlined in the Effective Date section.

### **Effective Date**

Your Certificate Effective Date is shown on the Certificate Schedule.

Your Certificate 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.

The Effective Date of coverage will be no later than your 91<sup>st</sup> day of employment.

The Effective Date for a Spouse or Dependent Child is:

- The date shown on the Certificate Schedule if that Spouse or Dependent Child is not confined to a hospital and is eligible for coverage on that date, **or**
- The date the Spouse or Dependent Child is no longer confined to a hospital (if that Spouse or Dependent Child was confined to a hospital on the Certificate Schedule date) and is eligible for coverage on that date.

A Spouse may be added to the Plan after the Employee's Effective Date. To be added, the Employee must complete an Application to add his Spouse to the Plan. The Company will assign the Effective Date for a Spouse's coverage after approving the application. For Spouse coverage to become effective, the Spouse must be included in the premium payment.

Newborn children will be covered from the moment of birth and step-children from the date of the Employee's marriage. Foster children and adopted children will be treated the same as newborn infants and eligible for coverage on the same basis upon placement in the foster home or placement for adoption.

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

### **Plan Termination**

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

- The premium is not paid before the end of the Grace Period,
- The number of participating Employees is less than the number mutually agreed upon by the Company and the Policyholder in the signed Master Application,

- The Policyholder does not provide timely information or meet any obligations required by this Plan and applicable law, **or**
- The Company cancels the Plan any time after the end of the first policy year. To do this, the Company must give the Policyholder 45 days' written notice.

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

- To do this, the Policyholder must give the Company at least 45 days' written notice.
- The Plan will end on the date in the written notice or the date the Company receives the notice, whichever is later.

All outstanding premiums are due upon Plan termination. If the Company accepts premium payments after the Plan terminates, this will not reinstate the Plan; we will refund any excess premium.

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

### **Termination of 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, if the premium has not been paid.
- The date you no longer belong to an eligible class.

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

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

If your coverage terminates, we will provide benefits for valid claims that arose while your coverage was active.

### **Reinstatement**

If any renewal premium is not paid on time (as outlined in the initial payment agreement) for the Plan, the Company (or an agent who is authorized by the Company) may accept the late premium and reinstate the Plan without requiring a new Application.

However, if the Company (or authorized agent) does require an Application for reinstatement and issues a conditional receipt for the premium tendered, the Plan will be reinstated:

- Upon the Company's approval, **or**
- Lacking such approval, upon the 45<sup>th</sup> day following the date of the conditional receipt (unless the Company has previously notified the Policyholder in writing of its disapproval of such Application).

The reinstated Plan covers only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects, the Policyholder and the Company will have the same rights they had under the Plan immediately before the due date of the defaulted premium (subject to any provisions endorsed with or attached to the reinstatement).

Any premium accepted with a reinstatement will:

- Be applied to a period for which premium has not been previously paid, **but**
- Not to any period more than 60 days prior to the date of reinstatement.

## **Section II – Premium Provisions**

### **Premium Payments**

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

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

### **Premium Changes**

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

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

- On the Policy Anniversary Date based on renewal underwriting.
- Whenever the terms or conditions of the Plan are modified. The new premium rates will apply only to premiums due on or after the rate change takes effect.

A change in premium rate will not take effect until at least one year after the Policy Effective Date. However, we may change premium rates at any time, though never more than every 6 months thereafter based upon 12 months of experience.

We will provide the Policyholder a 45-day advance written notice of any change to a premium.

### **Grace Period**

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

## **Section III – Definitions**

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

**Accident** means an event that results in accidental bodily injury to an Insured, independent of disease or bodily infirmity. A **Covered Accident** is an Accident that occurs while coverage is in force.

**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.

**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.

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.

**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.

**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).

**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.

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

1. **Pathological Diagnosis** is a Diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system.
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,
  - A Doctor is treating the Insured for Cancer or Carcinoma in Situ, **or**
  - A positive Diagnosis cannot otherwise be made by a Doctor without jeopardizing the life of the Claimant.

If a Pathological or Clinical Diagnosis can only be made postmortem, liability shall be assumed retroactively beginning with the date of the terminal admission to the hospital for not less than 45 days before the date of death.

**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.

**Coma** means a state of continuous, profound unconsciousness, lasting at least seven consecutive days, and characterized by the absence of:

- Spontaneous eye movements,
- Response to painful stimuli, **and**
- Vocalization.

Coma does not include a medically-induced coma.

To be payable as an Accident benefit, the Coma must be caused solely by or be solely attributed to a Covered Accident.

To be considered a Critical Illness, the Coma must be caused solely by or be solely attributed to one of the following diseases:

- **Brain Aneurysm**, which is an excessive, localized enlargement of an artery in the brain caused by a weakening of the artery wall, usually due to a defect in the vessel at birth or resulting from high blood pressure.
- **Diabetes**, which is a metabolic disease characterized by the inadequate secretion or utilization of insulin, by excessive urine production, by excessive amounts of sugar in the blood and urine, and by thirst, hunger, and loss of weight.
- **Encephalitis**, which is a disease characterized by inflammation of the brain, usually caused by a direct viral infection or a hypersensitive reaction to a virus or foreign protein.
- **Epilepsy**, which is a neurological disease characterized by sudden, recurring attacks of motor, sensory, or psychic malfunction with or without loss of consciousness or convulsive seizures.
- **Hyperglycemia**, which is a disease where an excessive amount of glucose circulates in the blood plasma.
- **Hypoglycemia**, which is a disease where blood glucose concentrations fall below the necessary level to support the body's need for energy and stability throughout its cells.
- **Meningitis**, which is a disease caused by viral or bacterial infection and characterized by inflammation of the meninges.

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

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

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

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

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

- Bone Marrow Transplant (Stem Cell Transplant).
- Cancer.
- Coma.
- Coronary Artery Bypass Surgery.
- Heart Attack (Myocardial Infarction).
- Kidney Failure (End-Stage Renal Failure).
- Loss of Sight, Speech, or Hearing.
- Major Organ Transplant.
- Non-Invasive Cancer.



- Paralysis.
- 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, biopsy, culture, blood samples, or titer(s) are taken upon which the positive medical Diagnosis is the date the Diagnosis is communicated to the Insured. (Diagnosis of Cancer and/or Carcinoma in Situ is based on such specimens).
- **Coma:** The first day of the period for which a Doctor confirms a Coma that is due to one of the underlying diseases and that has lasted for at least seven consecutive days.
- **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.
- **Loss of Sight, Speech, or Hearing:** The date the loss due to one of the underlying diseases is objectively determined by a Doctor to be total and irreversible.
- **Major Organ Transplant:** The date the surgery occurs.
- **Non-Invasive Cancer:** The day tissue specimens, biopsy, culture, blood samples, or titer(s) are taken upon which the positive medical Diagnosis is the date the Diagnosis is communicated to the Insured. (Diagnosis of Cancer and/or Carcinoma in Situ is based on such specimens).
- **Paralysis:** The date a Doctor Diagnoses an Insured with Paralysis due to one of the underlying diseases as specified in this Plan, where such Diagnosis is based on clinical and/or laboratory findings as supported by the Insured's medical records.
- **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).
- **Transient Ischemic Attack (TIA):** The date the Transient Ischemic Attack occurs (based on documented diagnostic tests, such as a CT scan or an MRI of the brain, a Doppler ultrasound, or an echocardiogram of the heart).

**Dependent** means your Spouse or your Dependent Child. **Spouse** is your legal wife or husband, who is listed on your Application. **Dependent Children** are your or your Spouse's natural children, foster children, step-children, legally adopted children or Children Placed for Adoption, who are younger than age 26.

However, there is an exception to the age-26 limit listed above. This limit will not apply to any Dependent Child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. The Employee or the Employee's Spouse must provide us with proof of this incapacity and dependency within 31 days following the Dependent Child's 26th birthday, but not more frequently than annually.

Newborn, adopted and foster children are equally considered under this plan. A newborn child will be covered from the moment of birth, if the birth occurs while the plan is in force. Foster children and adopted children will be treated the same as newborn infants and eligible for coverage on the same basis upon placement in the foster home or placement for adoption. Prior notification will not be required unless an additional premium charge to add the dependent is due. If an additional premium charge is due to cover the dependent, we will cover the newborn child, foster child or adopted child from the moment of birth or placement if the child is enrolled within 30 days after the date of birth or placement.

If a parent is required by a court or administrative order to provide insurance for a child, and the parent is eligible for family insurance coverage, we:

- Will allow the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions.
- Will enroll the child under family coverage upon application of the child's other parent or the Department of Health and Human Services in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the parent is enrolled but fails to make application to obtain coverage for the child.
- Will not disenroll or eliminate coverage of the child unless we are provided satisfactory written evidence that:
  - a. The court or administrative order is no longer in effect; **or**
  - b. The child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect no later than the Effective Date of disenrollment.

We will not decline enrollment of a child on the grounds the child was born out of wedlock, the child was not claimed as dependent on the parent's federal tax return; or the child does not reside with the parent or the insurer's service area.

**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.

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

**Doctor** is a person who is:

- Legally qualified to practice medicine,
- Licensed as a Doctor by the state where Treatment is received, **and**
- Licensed to treat the type of condition for which a claim 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 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.

**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.

### **Loss of Sight, Speech, or Hearing**

**Loss of Sight** means the total and irreversible loss of all sight in both eyes.

To be payable as an Accident benefit, Loss of Sight must be caused solely by or be solely attributed to a Covered Accident.

To be considered a Critical Illness, Loss of Sight must be caused solely by or be solely attributed to one of the following diseases:

- **Retinal Disease**, which is a disease that affects the retina of the eye;
- **Optic Nerve Disease**, which is a disease that affects the optic nerve of the eye; **or**
- **Hypoxia**, which is a disease characterized by a deficiency in the amount of oxygen reaching the tissues of the eyes.

**Loss of Speech** means the total and permanent loss of the ability to speak.

To be payable as an Accident benefit, Loss of Speech must be caused solely by or be solely attributed to a Covered Accident.

To be considered a Critical Illness, Loss of Speech must be caused solely by or be solely attributable to one of the following diseases:

- **Alzheimer's Disease**, which is a progressive mental deterioration due to generalized degeneration of the brain; **or**
- **Arteriovenous Malformation**, which is a congenital disease of blood vessels in the brain, brain stem, or spinal cord that is characterized by a complex, tangled web of abnormal arteries and veins connected by one or more fistulas.

**Loss of Hearing** means the total and irreversible loss of hearing in both ears. Loss of Hearing does not include hearing loss that can be corrected by the use of a hearing aid or device.

To be payable as an Accident benefit, Loss of Hearing must be caused solely by or be solely attributed to a Covered Accident.

To be considered a Critical Illness, Loss of Hearing must be caused solely by or be solely attributed to one of the following diseases:

- **Alport Syndrome**, which is an inherited disease of the kidney caused by a genetic mutation and can be characterized by hearing loss;

- **Autoimmune Inner Ear Disease**, which is an inflammatory condition of the inner ear occurring when the body's immune system attacks cells in the inner ear that are mistaken for bacteria or a virus;
- **Chicken Pox**, which is an acute contagious disease that is caused by the varicella-zoster virus and is characterized by skin eruptions, slight fever, and malaise;
- **Diabetes**, which is a metabolic disease characterized by the inadequate secretion or utilization of insulin, by excessive urine production, by excessive amounts of sugar in the blood and urine, and by thirst, hunger, and loss of weight;
- **Goldenhar Syndrome**, which is rare congenital disease that causes abnormalities in the face and head and can cause hearing loss;
- **Meniere's Disease**, which is a disorder of the inner ear that causes spontaneous episodes of vertigo, hearing loss, ear ringing, and a feeling of fullness or pressure in the ear;
- **Meningitis**, which is a disease characterized by inflammation of the meninges caused by viral or bacterial infection; **or**
- **Mumps**, which is an infectious disease caused by paramyxovirus and characterized by inflammatory swelling of the parotid and/or other salivary glands.

**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.

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

- Bronchiectasis, which is a lung disease state defined by localized, irreversible dilation of the bronchial tree caused by destruction of the muscle and elastic tissue.
- Cardiomyopathy, which is a heart disease characterized by the measurable deterioration of the function of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid.
- Cirrhosis, which is a liver disease characterized by replacement of liver tissue by fibrosis, scar tissue, and regenerative nodules, leading to loss of liver function.
- Chronic obstructive pulmonary disease, which is a lung disease characterized by persistently poor airflow as a result of breakdown of lung tissue and dysfunction of the small airways.
- Congenital Heart Disease, which is heart disease characterized by abnormalities in cardiovascular structures that occur before birth.
- Coronary Artery Disease.
- Cystic fibrosis, which is a hereditary disease of the exocrine glands affecting the pancreas, respiratory system, and sweat glands. It is characterized by the production of abnormally viscous mucus by the affected glands.
- Hepatitis, which is a disease caused by the hepatitis A, B, or C virus and is characterized by the inflammation of the liver.
- Interstitial lung disease, which is a lung disease that affects the interstitium of the lungs.
- Lymphangioleiomyomatosis, which is a lung disease characterized by an indolent, progressive growth of smooth muscles cells throughout the lungs, pulmonary blood vessels, lymphatics, and pleurae.
- Polycystic liver disease, which is characterized by multiple variable-sized cysts lined by cuboidal epithelium.
- Pulmonary fibrosis, which is a lung disease where the lung tissue becomes thickened, stiff, and scarred due to chronic inflammation.
- Pulmonary hypertension, which is a disease characterized by increased pressure in the pulmonary artery and results in the thickening of the pulmonary arteries and the narrowing of these blood vessels, which causes the right side of the heart to become enlarged.
- Sarcoidosis, which is a disease characterized by the growth of granulomatous lesions that appear in the body.
- Valvular heart disease, which is a disease of the heart valves.

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

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

**Paralysis or Paralyzed** means the permanent, total, and irreversible loss of muscle function to the whole of at least two limbs.

To be payable as an Accident benefit, the Paralysis must be caused solely by or be solely attributed to a Covered Accident.

To be considered a Critical Illness, Paralysis must be caused solely by or be solely attributed to one or more of the following diseases:

- **Amyotrophic Lateral Sclerosis**, which is a progressive degeneration of the motor neurons of the central nervous system, leading to wasting of the muscles and paralysis;
- **Cerebral Palsy**, which is a disorder of movement, muscle tone, or posture that is caused by injury or abnormal development in the immature brain. Cerebral Palsy can be characterized by stiffness and movement difficulties, or by involuntary and uncontrolled movements;
- **Parkinson's disease**, which is a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement; **or**
- **Poliomyelitis**, which is an acute infectious disease caused by the poliovirus and characterized by fever, motor paralysis, and atrophy of skeletal muscles. This often results in permanent disability and deformity, and is marked by inflammation of nerve cells in the anterior gray matter in each lateral half of the spinal cord.

The Diagnosis of Paralysis must be supported by neurological evidence.

**Severe Burn or Severely Burned** means a burn resulting from fire, heat, caustics, electricity, or radiation. The burn must meet all of the following criteria:

- Be a full-thickness or third-degree burn, as determined by a Doctor. A **Full-Thickness Burn** or **Third-Degree Burn** is the destruction of the skin through the entire thickness or depth of the dermis (or possibly into underlying tissues). This results in loss of fluid and sometimes shock.
- Cause cosmetic disfigurement to the body's surface area of at least 35 square inches.
- Be caused solely by or be solely attributed to a Covered Accident.

**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.

**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.

**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 Carcinoma in Situ has returned.

## **Section IV – Benefit Provisions**

The benefit amounts payable under this section are 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 Certificate Schedule, and when such Diagnosis is caused by or solely attributed to an underlying disease as identified herein. We will pay this benefit if:

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

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

- Must be Treatment-Free From 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 6 consecutive months, **and**
- The new Critical Illness is not caused or contributed to by a Critical Illness for which benefits have been paid.

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

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

### **Reoccurrence**

Once benefits have been paid for a Critical Illness, benefits are payable for that same Critical Illness when:

- The Date of Diagnosis for the Reoccurrence of that Critical Illness is separated from the prior occurrence of that Critical Illness by at least 6 consecutive months, **and**
- The Critical Illness is not caused or contributed to by a Critical Illness for which benefits have been paid.

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

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

### **Partial Benefits**

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

### **Non-Invasive Cancer**

We will pay the amount shown in the Certificate Schedule for the Diagnosis of a Non-Invasive Cancer. This benefit is payable in addition to all other applicable benefits.

### **Coronary Artery Bypass Surgery**

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

### **Additional Benefits**

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

### **Skin Cancer Benefit**

We will pay the amount shown in the Certificate Schedule for the Diagnosis of Skin Cancer. This benefit is payable once per calendar year.

### **Transient Ischemic Attack (TIA)**

We will pay the amount shown in the Certificate Schedule for the Diagnosis of a Transient Ischemic Attack (TIA). This benefit is payable in addition to all other applicable benefits. Only one TIA benefit is payable under this Plan. This benefit is payable once per calendar year.

### **Health Screening Benefit**

We will pay the amount shown in the Policy Schedule for Health Screening Tests performed while an Insured's coverage is in force. This benefit is payable once per calendar year, per Insured. Benefits are not payable for Covered Dependent Children.

This benefit is only payable for Health Screening Tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

Health Screening Tests include, but are not limited to, the following:

- Blood test for triglycerides.
- Bone marrow testing.
- Breast ultrasound.
- CA 15-3 (blood test for breast cancer).
- CA 125 (blood test for ovarian cancer).
- CEA (blood test for colon cancer).
- Chest X-ray.
- Colonoscopy.
- DNA stool analysis.
- Fasting blood glucose test.
- Flexible sigmoidoscopy.
- Hemocult stool analysis.
- Mammography.
- Pap smear.
- PSA (blood test for prostate cancer).
- Serum cholesterol test to determine level of HDL and LDL.
- Serum protein electrophoresis (blood test for myeloma).
- Spiral CT screening for lung cancer.
- Stress test on a bicycle or treadmill.
- Thermography.

### **Accident Benefit**

We will pay the amount shown in the Benefit Schedule if an Insured sustains a Covered Accident and suffers any of the following, which is solely due to, caused by, and attributed to, the Covered Accident:

- Coma.
- Loss of Sight, Speech, or Hearing.
- Severe Burn.
- Paralysis.

### **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 65<sup>th</sup> 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 – Limitations and Exclusions**

### **Cancer Diagnosis Limitation**

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

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

### **Exclusions**

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

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured.
- **Suicide** – committing or attempting to commit suicide, while sane or insane.
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job.
- **Participation in Aggressive Conflict** of any kind, including:
  - War (declared or undeclared) or military conflicts. This does not include terrorism.
  - Insurrection or riot.
  - Civil commotion or civil state of belligerence.
- **Illegal substance abuse, which includes the following:**
  - Abuse of legally-obtained prescription medication.
  - Illegal use of non-prescription drugs.

## **Section VI – Claim Provisions**

### **Notice of Claim**

Written notice of claim must be given to us:

- Within 20 days after the occurrence or commencement of any loss covered by the Certificate, **or**
- As soon as reasonably possible.

Notice must include your name and Certificate number. Notice can be mailed to the Company at:  
**P.O. Box 427, Columbia, South Carolina, 29202.**

The notice may also be given to an authorized agent of the Company.

### **Claim Forms**

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.

### **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 427, Columbia, South Carolina, 29202.**

Proof of Loss must be given to us within 180 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 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. We will be responsible for the cost of obtaining these records.

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

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

### **Physical Examination and Autopsy**

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

If we can pay any benefits under this Plan to the Insured's estate or to an Insured or beneficiary who is a minor, or otherwise not competent to give a valid release, we may decide to pay those benefits to any relative by blood or connection by marriage of the Insured or beneficiary who we determine is rightfully allowed. The benefit amount will not exceed \$3,000.

### **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**
- 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—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 cannot 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**

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**
- 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.

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 is also insured under this Plan at the time of your death, then your surviving Spouse may elect to become the primary Insured at the current Spouse Face Amount. This would include continuation of any Dependent Child coverage that is in force at that time.

To become the primary Insured and keep coverage in force, your surviving Spouse 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, 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. The Company will not use fraudulent misstatements as a basis for contesting the Certificate after coverage has been in force for more than two years.

### **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,
- 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.



# CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205  
800.433.3036

## **Portability Privilege Amendment**

This Amendment is part of the form to which it is attached. Unless amended by this document, all definitions, exclusions, limitations, terms, and other provisions apply. For the purpose of this Amendment, “you” (including “your” and “yours”) refers to the Insured named in the Certificate Schedule.

### **Effective Date**

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

### **Portability Privilege**

The following language replaces the ELIGIBILITY provision found under SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION of the Master Policy and the Certificate of Insurance:

#### **ELIGIBILITY — CLASSES OF COVERAGE**

##### **Class I**

All full-time and part-time benefit-eligible Employees are eligible for Class I coverage. That eligibility extends to their spouses and children under age 26.

##### **Class II**

A Class I primary insured is eligible for Class II coverage if he:

- was previously insured under Class I; and
- is no longer employed by the Policyholder.

The Employee must elect Class II coverage under the Portability Privilege within 31 days after the date for which his class I eligibility would otherwise terminate.

Only Dependents covered under Class I coverage are eligible for continued coverage under Class II.

Class II insureds cannot continue coverage through the employer’s payroll deduction process. They must remit premiums directly to the Company.

The following language replaces the TERMINATION OF THE PLAN provision found under SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION of the Master Policy.

#### **TERMINATION OF THE PLAN**

The Plan will cease if the premium is not paid before the end of the Grace Period.

After the end of the first Plan year, the Company has the right to cancel the Plan. To do so, the Company must give 45 days’ written notice that the plan will end on the date before the next premium due date.

The Policyholder has the right to cancel the Plan on the date before any premium due date by giving 45 days’ written notice.

Upon such termination, Class I and Class II coverage will be affected as follows:

**Class I**

If terminated, this Plan and all certificates issued under this class will terminate on such date at 12:01 a.m. Standard Time at the Policyholder's address. This will be without prejudice to the rights of any Insured regarding any claim arising while the Plan is in force.

The Policyholder has the sole responsibility to notify Class I Employees of such termination. When notice of termination is received by the Company, the Portability Privilege under Class I coverage is no longer available.

**Class II**

The group policy will remain active, and coverage under Class II will continue as long as premiums are paid, subject to the premium grace period. Notification of any changes in the plan will be provided directly to each insured by the Company. The Policyholder will lose any rights and obligations under the Plan.

The following language replaces the TERMINATION OF AN EMPLOYEE'S INSURANCE provision found under SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION of the Master Policy and the Certificate of Insurance.

**TERMINATION OF AN EMPLOYEE'S INSURANCE**

An Employee's insurance will terminate on the earliest of the following:

1. the date the Plan is terminated, for Class I insureds;
2. the 31<sup>st</sup> day after the premium due date if the required premium has not been paid;
3. the date he ceases to meet the definition of an Employee as defined in the Plan, for Class I insureds; or
4. the date he is no longer a member of the Class eligible for coverage.

Insurance for Dependents will terminate on the earliest of the following:

1. the date the Plan is terminated, for Dependents of Class I insureds;
2. the 31<sup>st</sup> day after the premium due date, if the required premium has not been paid;
3. the date the Spouse or Dependent Child ceases to be a dependent; or
4. the premium due date following the date we receive the Employee's written request to terminate coverage for his Spouse and/or all Dependent Children.

Termination of the insurance on any Insured will not prejudice his rights regarding any claim arising prior to termination.

The following language replaces the PORTABILITY PRIVILEGE provision found under SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION of the Master Policy and the Certificate of Insurance.

**PORTABILITY PRIVILEGE**

Under the Portability Privilege provision, when coverage would otherwise terminate because an Employee ends his employment, coverage may be continued. He may exercise the Portability Privilege when there is a change to his coverage class. The Employee — and any covered dependents — will continue the coverage that is in-force on the date employment ends. The continued coverage will be provided under Class II.

The premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least 45 days before any change is to take effect.

The Employee may continue the coverage until the earlier of:

- the date he fails to pay the required premium; or
- the date the class of coverage is terminated.

Coverage may not be continued:

- if the Employee fails to pay any required premium; or
- if the Company receives notice of Class I plan termination.

## **General Provisions**

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

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

### **Contract**

This Amendment is part of the form to which it is attached. It will terminate when that form terminates.

This Amendment is subject to all of the terms of the form to which it is attached unless those terms are inconsistent with this Amendment.

Signed for the Company at its Home Office,



Paul S. Amos II, President



J. Matthew Loudermilk, Secretary



## CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205  
800.433.3036

### **Optional Benefits Rider To Certificate of Insurance for Group Critical Illness**

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

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

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

The benefits are available to those Insureds designated in the Certificate Schedule. Diagnosis must occur while this Rider is in force.

#### **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):

*Activities of Daily Living (ADLs)* are activities used in measuring levels of personal functioning capacity. These activities are normally performed without assistance, allowing personal independence in everyday living. For the purposes of this Plan, ADLs include the following:

- **Bathing** – the ability to wash oneself in a tub, shower, or by sponge bath. This includes the ability to get into and out of the tub or shower with or without the assistance of equipment;
- **Dressing** – the ability to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;
- **Toileting** – the ability to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene with or without the assistance of equipment;
- **Transferring** – the ability to move in and out of a bed, chair, or wheelchair with or without the assistance of equipment;
- **Mobility** – the ability to walk or wheel on a level surface from one room to another with or without the assistance of equipment;
- **Eating** – the ability to get nourishment into the body by any means once it has been prepared and made available with or without the assistance of equipment; and
- **Continence** – the ability to voluntarily maintain control of bowel and/or bladder function. In the event of incontinence, the ability to maintain a reasonable level of personal hygiene.



*Date of Diagnosis* is defined as follows:

- **Advanced Alzheimer's Disease:** The date a Doctor Diagnoses the Insured as incapacitated due to Alzheimer's disease.
- **Advanced Parkinson's Disease:** The date a Doctor Diagnoses the Insured as incapacitated due to Parkinson's disease.
- **Benign Brain Tumor:** The date a Doctor determines a Benign Brain Tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

*Advanced Alzheimer's Disease* means Alzheimer's Disease that causes the Insured to be incapacitated. Alzheimer's Disease is a progressive degenerative disease of the brain that is Diagnosed by a psychiatrist or neurologist as Alzheimer's Disease. To be incapacitated due to Alzheimer's Disease, the Insured must:

- Exhibit the loss of intellectual capacity involving impairment of memory and judgment, resulting in a significant reduction in mental and social functioning; **and**
- Require substantial physical assistance from another adult to perform at least three ADLs.

*Advanced Parkinson's Disease* means Parkinson's Disease that causes the Insured to be incapacitated. Parkinson's Disease is a brain disorder that is Diagnosed by a psychiatrist or neurologist as Parkinson's Disease. To be incapacitated due to Parkinson's Disease, the Insured must:

- Exhibit at least two of the following clinical manifestations:
  - Muscle rigidity.
  - Tremor.
  - Bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses); **and**
- Require substantial physical assistance from another adult to perform at least three ADLs.

*Benign Brain Tumor* is a mass or growth of abnormal, noncancerous cells in the brain. The tumor is composed of similar cells that do not follow normal cell division and growth patterns and develop into a mass of cells that microscopically do not have the characteristic appearance of a Cancer. Benign Brain Tumor must be caused by Multiple Endocrine Neoplasia, Neurofibromatosis, or Von Hippel-Lindau Syndrome.

*Multiple Endocrine Neoplasia* is a genetic disease in which one or more of the endocrine glands are overactive or form a tumor.

*Neurofibromatosis* is a genetic disease in which the nerve tissue grows tumors that may be benign and may cause serious damage by compressing nerves and other tissue.

*Von Hippel-Lindau Syndrome* is a genetic disease that predisposes a person to have benign or malignant tumors.

## **Benefit Provisions**

We will pay the benefit shown if an Insured is Diagnosed with one of the conditions listed in the Rider Schedule if the Date of Diagnosis is while this Rider is in force.

**Payment of benefits contained in this Rider is subject to the Critical Illness Benefit provisions in your Certificate.** The benefits contained in this Rider are considered to be Critical Illnesses as defined in your Certificate.

## **General Provisions**

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

After two years from the Insured's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Application. The Company will not use fraudulent misstatements as a basis for contesting the Certificate after coverage has been in force for more than two years.

## Contract

This Rider is part of the Critical Illness Certificate. It will terminate when:

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

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

Signed for the Company at its Home Office,



Paul S. Amos II, President



J. Matthew Loudermilk, Secretary



## CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205  
800.433.3036

### **Heart Event Rider To Certificate of Insurance for Group Critical Illness**

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

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

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

The benefits are available to those Insureds designated in the Certificate Schedule. Treatment must occur while this Rider is in force.

#### **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):

*Covered Heart Procedure* is one of the Category I or Category II procedures defined below:

##### **Category I – Specified Surgeries of the Heart**

*Specified Surgeries of the Heart (Open Heart Surgery)* refers to open chest surgery, where the heart is exposed and/or manipulated for open cardiothoracic situations. We will pay benefits for the following Open Heart Surgery procedures when they are performed as a direct result of one of the following: Acute Coronary Syndrome, Atherosclerosis, Coronary Artery Disease, Cardiomyopathy, or Valvular Heart Disease.

- **Coronary Artery Bypass Surgery** (also **Coronary Artery Bypass Graft Surgery** or **Bypass Surgery**) is a surgical procedure performed to relieve angina and reduce the risk of death from Coronary Artery Disease.
  - **Off-Pump Coronary Artery Bypass (OPCAB)** is a form of bypass surgery that does not stop the heart or use the heart-lung machine.
  - **Coronary Artery Bypass Grafting (CABG)** is used to treat a narrowing of the coronary arteries. A blood vessel is grafted onto the blocked artery, creating a bypass around the blockage. **If more than one artery is blocked, a bypass can be done on each, but only one benefit is payable under this Rider.**
- **Mitral Valve Replacement** or **Repair** is a surgical procedure in which a patient's mitral valve is repaired or replaced by a different valve.
- **Aortic Valve Replacement** or **Repair** is a surgical procedure in which a patient's aortic valve is repaired or replaced by a different valve.
- **Surgical Treatment of Abdominal Aortic Aneurysm** involves opening the abdomen and repairing or removing an abdominal aortic aneurysm.

## **Category II – Invasive Procedures and Techniques of the Heart**

We will pay Category II benefits for the following Invasive Procedures and Techniques of the Heart when they are performed as a result of one of the following: Acute Coronary Syndrome, Atherosclerosis, Coronary Artery Disease, Cardiomyopathy, or Valvular Heart Disease.

- **AngioJet Clot Busting** clears blood clots from coronary arteries before angioplasty and stenting. The device delivers a high-pressure saline solution through the artery to the clot, breaking it up and simultaneously drawing it out.
- **Balloon Angioplasty** (or **Balloon Valvuloplasty**) opens a clogged blood vessel. A thin tube is threaded through an artery to the narrowed heart vessel, where a small balloon at its tip is inflated. A balloon opens the narrowing by compressing atherosclerotic plaque against the vessel wall. The balloon is then deflated and removed.
- **Laser Angioplasty** uses a laser tip to burn/break down plaque in the clogged blood vessel.
- **Atherectomy** opens blocked coronary arteries or clears bypass grafts by using a device on the end of a catheter to cut or shave away atherosclerotic plaque.
- **Stent Implantation** is the implantation of a stainless steel mesh coil in a narrowed part of an artery to keep it propped open.
- **Cardiac Catheterization** (also **Heart Catheterization**) is a diagnostic and occasionally therapeutic procedure that allows a comprehensive examination of the heart and surrounding blood vessels.
- **Automatic Implantable** (or **Internal**) **Cardioverter Defibrillator (AICD)** refers to the initial placement of the AICD. AICDs are used for treating irregular heartbeats. The defibrillator is surgically placed inside the patient's chest where it monitors the heart's rhythm. When it identifies a serious arrhythmia, it produces an electrical shock to disrupt the arrhythmia.
- **Pacemaker Placement** refers to the initial placement/implantation of a pacemaker, which sends electrical signals to make the heart beat when a person's natural pacemaker is not working properly. This electrical device is placed under the skin. A lead extends from the device to the right side of the heart. Most pacemakers are used to correct a slow heart rate.

**Valvular Heart Disease** is a disease characterized by damage to or a defect in one of the four heart valves.

## **Benefit Provisions**

We will pay the applicable Category I or Category II benefit shown if an Insured is treated with one of the Covered Heart Procedures listed on the Rider Schedule which is caused by a defined underlying disease, and:

- Treatment is incurred while this Rider is in force,
- Treatment is recommended by a Doctor, **and**
- It is not excluded by name or specific description in this Rider.

We will only pay for procedures specifically listed in this Rider.

## **Category I – Specified Surgeries of the Heart**

You are eligible to receive one payment per calendar year for Category I procedures. We will pay a Category I benefit when an Insured has one of the Specified Surgeries of the Heart listed in the Rider Schedule that is a result of a defined underlying disease. Only one benefit will be payable under Category I when multiple Category I procedures are performed at the same time.

## **Category II – Invasive Procedures and Techniques of the Heart**

You are eligible to receive one payment per calendar year for Category II procedures. We will pay a Category II benefit when an Insured has one of the Invasive Procedures and Techniques of the Heart listed in this Rider that is a result of a defined underlying disease. Only one benefit will be payable under Category II when multiple Category II procedures are performed at the same time.

If Category I and Category II procedures are performed at the same time, benefits will be payable only at the highest benefit level and will not exceed the applicable face amount shown on the Rider Schedule.

## **General Provisions**

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

After two years from the Insured's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Application. The Company will not use fraudulent misstatements as a basis for contesting the Certificate after coverage has been in force for more than two years.

### **Contract**

This Rider is part of the Critical Illness Certificate. It will terminate when:

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

This Rider is subject to all of the terms of the Critical Illness Certificate to which it is attached unless those terms are inconsistent with this Rider.

Signed for the Company at its Home Office,



Paul S. Amos II, President



J. Matthew Loudermilk, Secretary

## **NOTICE TO INSURANCE FIDUCIARY**

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

## NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

**The North Carolina Life and Health Insurance Guaranty Association  
Post Office Box 10218  
Raleigh, North Carolina, 27605**

**North Carolina Department of Insurance, Consumer Services Division  
1201 Mail Service Center  
Raleigh, NC 27699-1201**

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. *On the back of this page* is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

## COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

## EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed the average rate specified in the law;
- dividends;
- experience or other credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.
- A policy or contract commonly known as Medicare Part C or Part D or any regulations issued pursuant thereto.

## LIMITS ON AMOUNT OF COVERAGE

(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.

(2) Except as provided in (3), (4), and (5) below, the guaranty association will pay a maximum of \$300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.

(3) The guaranty association will pay a maximum of \$500,000 with respect to basic hospital, medical and surgical insurance and major medical insurance.



(4) The guaranty association will pay a maximum of \$1,000,000 with respect to the payee of a structured settlement annuity.

(5) The guaranty association will pay a maximum of \$5,000,000 to any one unallocated annuity contract holder.

## **NOTICE OF PRIVACY PRACTICES – PROTECTED HEALTH INFORMATION**

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

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

### **DEFINITIONS**

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

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

### **USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION**

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

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

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

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

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

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

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

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

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

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

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

### **RIGHTS THAT YOU HAVE**

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

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

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

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

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

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

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

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

**FOR FURTHER INFORMATION**

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

**EFFECTIVE DATE**

This Notice is effective August 16, 2013.

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 California, coverage is underwritten by Continental American Life Insurance Company. For groups situated in New York, coverage is underwritten by American Family Life Assurance Company of New York.

## **PRIVACY PRACTICES**

Protecting the privacy and confidentiality of information about our customers is very important to American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, Continental American Insurance Company (CAIC), and Continental American Life Insurance Company collectively, "Aflac". Accordingly, we strive to comply with each of the following practices in everything we do:

- **We do not sell, rent, lease or otherwise disclose personal information of our customers for purposes unrelated to our products and services.** The personal information of our customers is of paramount importance to us. Therefore, we provide this information only to our employees, agents and third parties as required to allow them to help us develop and provide our insurance and employee benefit products and services.
- **We work to ensure information integrity and security.** We use technology tools and design our business practices to help ensure that the personal information of our customers is properly gathered, stored and processed. We also work to maintain the security of, and internal and external access to, the personal information of our customers through the use of technology and our business practices.
- **We expect our agents and employees to respect the personal information of our customers.** Aflac has business policies and practices in place to help ensure that our employees and agents carry out these practices and otherwise protect personal information about our customers. Both employees and agents are subject to censure, dismissal, or termination for violation of these policies.

These Privacy Practices apply to our U.S. customers. Due to legal and cultural differences, our practices may vary outside the United States.

## **PRIVACY NOTICE**

Aflac and our agents provide this notice to let you know about the current privacy practices of Aflac and our agents. **You do not need to do anything in response to this notice. This notice is merely to inform you about how we safeguard your information.**

### **Collection of Information**

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

- Information from our customers (including names, addresses, financial and health information).
- Information about the customers' transactions with Aflac or our agents (including claims and payment information).
- Information from consumer reporting agencies (including creditworthiness and credit history); motor vehicle records agencies (including accident reports and violations); investigators (including information regarding general character and participation in hazardous activities); insurance support organizations such as the Medical Information Bureau, Inc. (including claims, and health and insurance application histories); and the customers' health care providers (including health history), employers (including salary and benefits information), and family members.

### **Disclosure of Information**

Aflac may disclose the nonpublic personal financial information we collect, as described above, as well as information about your transactions with us (such as your plan coverage, premiums, and payment history) to our agents or other third parties who perform services or functions on our behalf, including in some circumstances the marketing of Aflac products. We may also disclose the nonpublic personal financial information we collect to other third parties as authorized by you, or as required or permitted by law.

Our agents will make disclosures of our customers' nonpublic personal financial information only while acting on Aflac's behalf and, furthermore, will make such disclosures only as Aflac itself is permitted to make.

Neither Aflac nor our agents will use or share with other parties any nonpublic personal health information about Aflac customers for any purpose other than disclosures for the performance of insurance functions by Aflac or on our behalf, disclosures that are permitted or required by law, or disclosures that the customer has authorized.

Neither Aflac nor our agents will further disclose any nonpublic personal information about a former customer of Aflac other than as may be required or permitted by law.

### **Confidentiality and Security**

Aflac and our agents will safeguard, according to strict standards of security and confidentiality, any information we collect, receive or maintain about Aflac's customers. Aflac maintains administrative, technical, and physical safeguards to ensure the security and confidentiality of our customer information and records, to protect against anticipated threats or hazards to such records, and to protect against unauthorized access to or use of such information or records.

Internally, Aflac limits access to our customers' information to only those employees who need access to the information to perform their job functions. Employees who misuse information are subject to disciplinary actions. Externally, we do not disclose customer information to any third parties unless we have previously informed the customer of the disclosure, have been authorized to do so by the customer, or are required or permitted to make the disclosure by law or our regulators.

### **NOTICE OF INFORMATION PRACTICES**

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

### **NOTICE OF PRIVACY PRACTICES - PROTECTED HEALTH INFORMATION**

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

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. **Aflac** is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups situated in California, coverage is underwritten by Continental American Life Insurance Company. For groups situated in New York, coverage is underwritten by American Family Life Assurance Company of New York.

Continental American Insurance Company • P.O. Box 427 • Columbia, South Carolina 29202 1-800-433-3036 toll-free