CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Endorsement
to Policy and Certificate of Insurance

This Endorsement alters the Policy and the Certificate to which it is attached. Unless specifically addressed by this Endorsement, all other Policy and Certificate provisions, definitions, and terms continue to apply.

Continental American Insurance Company's mailing addresses for claims and premium payments are changed as listed below.

Notice of Claim and **Proof of Loss** should be mailed to the Company at:

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

Premium Payments should be mailed to the Company at:

P.O. Box 84069, Columbus, Georgia, 31908-4069

If applicable, references to 2801 Devine Street, Columbia, SC 29205 are deleted.

Signed for the Company at its Home Office,

Teresa White, President

J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

CERTIFICATE OF INSURANCE FOR GROUP CRITICAL ILLNESS POLICY

THIS CERTIFICATE PROVIDES BENEFITS FOR THE CRITICAL ILLNESSES LISTED. IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.

PLEASE READ YOUR CERTIFICATE CAREFULLY

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

CERTIFICATE INDEX

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We certify that you are insured under the Critical Illnesses Policy (herein called the Plan) issued to the Policyholder, subject to the definitions, exceptions and limitations and other provisions of the Plan against loss resulting from Critical Illness. Certain provisions of the Plan are summarized in this Certificate. All provisions of the Plan, whether contained in your Certificate or not, apply to the insurance referred to by the Certificate.

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

This Certificate is issued in consideration of the payment of the required premium and of your statements and representations in the application. This Certificate, on its Effective Date, automatically replaces any Certificate or Certificates previously issued to you under the Plan. "You" and "your" refer to the Employee or any other Insured under Family Coverage. "We", "us", and "our" refer to the Company.

Important Cancellation Information- Please Read The Provision Entitled "Termination of The Plan" on Page 2.

NO RECOVERY FOR PRE-EXISTING CONDITIONS-READ CAREFULLY. No benefits will be provided during the first twelve months of this Certificate for conditions diagnosed within the 12-month period prior to the Effective Date shown in the Certificate Schedule.

This Certificate of Insurance provides all of the benefits mandated by the North Carolina Insurance, Code, but it is issued under a group master policy located in another state and may be governed by that state's law.

SECTION I - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY

You as used in this Certificate, means a person insured under this Certificate who is:

1. an Employee of the Policyholder, or an eligible Spouse of the Employee;
2. under age 70;
3. engaged in full-time work; and
4. included in the class of Employees eligible for coverage as shown on the application.

EFFECTIVE DATE

The Effective Date of the Plan is shown on Page 1 of the Master Policy.

The Effective Date for you is as follows:

1. Your insurance will be effective on the date shown on the Certificate Schedule provided you are actively at work.

2. If you are not actively at work on the date coverage would otherwise become effective, the Effective Date of your coverage will be the date on which you are first thereafter actively at work.

The Effective Date for a Spouse or Dependent Child is the date shown on the Certificate Schedule Page subject to the following:

1. The date your insurance is effective for a Spouse or Dependent Child who is eligible on that date; for whom coverage is applied for and premium paid; and who are not hospital confined.

2. At 12:00 a.m. Standard Time, on the day a Spouse or Dependent Child is no longer hospital confined if the Spouse or Dependent Child was otherwise eligible for coverage on the date your insurance became effective.

3. For a Dependent eligible on or first acquired after your Effective Date, the Effective Date will be:

    a. For Newborn Children and Newborn Adopted Children, the Effective Date is the date of birth (see Section III, Definitions, Insured).
    b. For other Adopted Children and Foster Children, the Effective Date is the date of placement in the Employee's home.
    c. For a spouse, the Effective Date is the date we assign after approving the application for his or her coverage.

TERMINATION OF YOUR INSURANCE

Your insurance will terminate on the earliest of:
1. the date the Plan is terminated;
2. on the 31st day after the premium due date if the required premium has not been paid;
3. on the date he ceases to meet the definition of an Employee as defined in the Plan; or
4. on the date he is no longer a member of the class eligible.

Insurance for an insured Spouse or Dependent Child will terminate the earliest of:

1. the date the Plan is terminated;
2. on the 31st day after the premium due date if the required premium has not been paid;
3. the premium due date following the date the Spouse or Dependent Child ceases to be a dependent;
4. the premium due date following the date we receive your written request to terminate coverage for your Spouse and/or all Dependent Children.

Termination of the insurance on any Insured shall be without prejudice to his rights as regarding any claim arising prior thereto.

Portability Privilege

When coverage would otherwise terminate under this Plan because an Employee ends employment with the Employer, they may elect to continue coverage. The coverage that may be continued is that which the Employee had on the date their employment terminated, including Dependent coverage then in effect.

1. Coverage may not be continued for any of the following reasons:
    a. the Employee failed to pay any required premium;
    b. this Group Policy terminates.

2. To keep the Certificate in force the Employee must:
    a. make written Application to the Company within 31 days after the date their insurance would otherwise terminate;
    b. pay the required premium to the Company no later than 31 days after the date the Certificate would otherwise terminate.

3. Insurance will cease on the earliest of these dates:
    a. the date the Employee fails to pay any required premium;
    b. the date this Group Policy is terminated.

If an Employee qualifies for this Portability Privilege as described, then the same Benefits, Plan Provisions, and Premium Rate as shown in their Certificate as previously issued will apply.

SECTION II - PREMIUM PROVISIONS

PREMIUM PAYMENTS
Aggregate premiums for the Plan are to be paid to the Company our Home Office in Columbia, South Carolina. 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.

GRACE PERIOD
The Plan has a 31-day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the next 31 days. During the Grace Period, this Certificate will stay in force, unless the Policyholder has given the Company written notice of discontinuance of the Plan.

SECTION III - GENERAL DEFINITIONS / BENEFIT DEFINITIONS

Whenever a male pronoun is used, it includes the female unless the context clearly shows otherwise.

Actively at Work to be considered "actively at work", an Employee must perform for a full normal workday the regular duties of his employment at the regular place of business or at a location to which he may be required to travel to perform the regular duties of his employment.

Critical Illness means such illness shown in the Schedule and as defined in this Plan.

Date of Diagnosis means for:

Cancer and/or carcinoma in situ: The day the tissue specimen, blood samples and/or titer(s) are taken on which the first diagnosis of cancer or carcinoma in situ is based.

Heart attack: The date that the death (infarction) of a portion of the heart muscle occurred based on the criteria listed under the Heart Attack definition.

Stroke: The date a stroke occurred based on documented neurological deficits and neuroimaging studies.

Kidney failure: The date that a doctor or physician recommends that an Insured begin renal dialysis.

Major organ transplant surgery or coronary artery bypass surgery: The date the surgery occurs for covered transplants or covered coronary artery bypass surgery.

Dependent Child(ren) means your natural children, step-children, legally adopted children or children placed for adoption, who are unmarried, chiefly dependent on you or your Spouse for support; and younger than age 25.

a. However, if any child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, the above age of twenty-five (25) shall not apply. Proof of such incapacity and dependency must be furnished to the Company within thirty-one (31) days following such 25th birthday, and not more frequently than annually from then forward.

b. Newborn Children of an Employee and/or his/her insured spouse and newborn Adopted Children shall automatically be covered from the moment of birth, under the same terms and conditions that apply to the natural, dependent children of covered persons.

c. Other foster children and adopted children shall be treated the same as newborn infants and are eligible for coverage on the same basis upon placement in the Employee's home, under the same terms and conditions that apply to the natural, dependent children of covered persons.

d. If a parent is required by a court or administrative order to provide health benefit plan coverage for a child, and the parent is eligible for family health benefit plan coverage through a health insurer, the health insurer:
    i. Must 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.
    ii. Must 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.
    iii. May not dis-enroll or eliminate coverage of the child unless the health insurer is provided satisfactory written evidence that the court or administrative order is no longer in effect or the child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect not later than the effective date of disenrollment.
    iv. Will not impose pre-ex limitations or waiting periods.

f. If Children are covered under the dependent rider, Children born or placed in the Employee's home after the Effective Date of this Rider will also be covered from the moment of birth. No notice or additional premium is required and the enrollment period will be waived. The company will not impose pre-ex limitations or waiting periods for newborn children, foster and adopted children if they are enrolled upon placement or children covered by the court or administrative order.

Doctor or Physician means any licensed practitioner of the healing arts acting within the scope of his license in treating a Critical Illness. It doesn't include an Insured or their family member.

Licensed Health Care Practitioner means an individual who has successfully completed a prescribed program of study in a variety of health fields and who has obtained a license or certificate indicating his or her competence to practice in that field.

Employee means the Insured as shown in the Certificate Schedule.

Family Member means an Insured's spouse, son, daughter, mother, father, sister, or brother.

Illness means sickness or disease which first manifests while the Insured's coverage is in force and after any applicable Waiting Period. Any loss due to illness must begin while the Insured's coverage is in force.

Injury means bodily injury solely due to an accident. It includes all complications of and all injuries from the same accident.

Insured(s) -

1. If Employee coverage is shown in the Certificate Schedule, we insure the Employee.
2. If coverage is for the Spouse of an eligible Employee, we insure the Insured as shown on the Certificate Schedule.
3. Coverage for Dependent Children may be included in an attached rider (if applicable).
4. If any person who would otherwise be an Insured is specifically excluded from coverage by endorsement to the Certificate or by the application, then such person shall not be an Insured.
5. Any other additions to the Insured class must be added by endorsement after applying to the Company.

Pathologist means a doctor, other than an Insured or a family member, who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A Pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Spouse means an Employee's legal wife or husband.

Successor Insured - If an Employee dies while covered under a Certificate, then their surviving Spouse shall become the Insured if such Spouse is an Insured. If there is no surviving Spouse covered under the Certificate, then the Certificate shall terminate on the next premium due date.

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

Treatment free means a period of time without the consultation, care, or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

Waiting Period means the number of days after the Effective Date before we will pay benefits for loss due to a Critical Illness. We won't pay benefits for a Critical Illness that begins during the Waiting Period.

BENEFIT DEFINITIONS

Cancer (internal or invasive) means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes Leukemia. Excluded are Cancers that are non-invasive such as:

1. Pre-malignant tumors or polyps;
2. Carcinoma in Situ;
3. Any skin cancers except melanomas;
4. Basal cell carcinoma and squamous cell carcinoma of the skin; and
5. Melanoma that is diagnosed as Clark's Level I or II or Breslow less than .77mm.

Cancer is also defined as a disease which meets the diagnosis criteria of malignancy established by The American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen.

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

Cancer and/or Carcinoma in Situ must be diagnosed in one of two ways:

1. **Pathological Diagnosis** - A Pathological Diagnosis of Cancer or Carcinoma in Situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a Certified Pathologist whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology.

2. **Clinical Diagnosis** - A Clinical Diagnosis of Cancer or Carcinoma in Situ is based on the study of symptoms.

If the requisite pathological clinical diagnosis can only be made postmortem, we will assume liability retroactively for the forty-five (45) day period before death.

We will pay benefits for a Clinical Diagnosis only if:

1. A Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; and
2. there is medical evidence to support the diagnosis; and
3. a doctor is treating an Insured for Cancer and/or Carcinoma in Situ.

Heart Attack (Myocardial Infarction) means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart Attack does not include any other disease or injury involving the cardiovascular system. Cardiac Arrest not caused by a Myocardial Infarction is not a Heart Attack. The diagnosis must include all of the following criteria:

1. New and serial Electrocardiographic (EKG) findings consistent with Myocardial Infarction;
2. Elevation of cardiac enzymes above generally accepted laboratory levels of normal in case of creatine physphokinase (CPK), a CPK-MB measurement must be used; and
3. Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.

Coronary Artery Bypass Surgery means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to balloon angioplasty, laser relief, stints or other non-surgical procedures.

Major Organ Transplant means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas.

Stroke means apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident, which is first manifested on or after an Insured's Effective Date. Stroke does not include Transient Ischemic Attacks and attacks of Verterbrobasilar Ischemia. We will pay a benefit for Stroke which produces permanent clinical neurological sequela following an initial diagnosis made after any applicable Waiting Period. We must receive evidence of the permanent neurological damage provided from Computed Axial Tomography (CAT scan) or magnetic Resonance Imaging (MRI). **Stroke does not mean head injury, transient ischemic attack or chronic cerebrovascular insufficiency.**

Kidney Failure (Renal Failure) means the end stage renal failure presenting as chronic, irreversible failure of both kidneys to function. The Kidney Failure must necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly); or which results in kidney transplantation. Renal failure is covered, provided it is not caused by a traumatic event, including surgical traumas.

SECTION IV - BENEFITS

Critical Illness Benefit

We will pay this benefit when an Insured is diagnosed with one of the Critical Illnesses shown on the Certificate Schedule if:

1. The date of diagnosis is after the Waiting Period;
2. The date of diagnosis is while the his coverage is in force; and
3. It is not excluded by name or specific description in the Certificate.

If the date of diagnosis of a Critical Illness occurs during the Waiting Period, the Certificate may be returned for a full refund of premium.

The Certificate's Initial Maximum Benefit amount is shown in the Schedule. If the Schedule shows a Maximum Benefit Reduction Date, a Certificate's Maximum Benefit will be reduced to the Reduced Maximum Benefit Amount, also shown in the Schedule, on that date. Benefits will be based on the Maximum Benefit amount in effect on the Critical Illness Date of Diagnosis. Any partial benefits paid will be deducted from the appropriate Critical Illness.

Payment of benefits is subject to the following:

1. We will pay benefits for each different Critical Illness in the order the events occur. We will pay benefits for any one Critical Illness once every six months. Therefore, no benefits are payable for each different Critical Illness after the first unless its date of diagnosis is separated from the prior Critical Illness by at least 6 months.

2. Re-Occurrence Benefits - We will pay benefits for the re-occurrence any one Critical Illness once every twelve months. Therefore, once benefits have been paid for Critical Illness, no additional benefits are payable **for that same Critical Illness** unless the dates of diagnosis are separated by at least 12 months (Cancer benefits must be medically unrelated to any cancer for which benefits have already been paid).

Health Screening Benefit (Calendar Year Limit)

We will pay the amount shown in the Benefit Schedule for Health Screening Tests performed after the Waiting Period and while an Insured's coverage is in force. This Benefit is payable once per calendar year up to the Maximum Benefit amount shown in the Benefit Schedule. Payment of this benefit will not reduce the Critical Illness benefit available under this Certificate.

Health Screening Tests include but are not limited to:

1. Stress test on a bicycle or treadmill,
2. Fasting blood glucose test,
3. Blood test for triglycerides,
4. Serum cholesterol test to determine level of HDL and LDL,
5. Bone marrow testing,
6. Breast ultrasound,
7. CA 15-3 (blood test for breast cancer),
8. CA 125 (blood test for ovarian cancer),
9. CEA (blood test for colon cancer),
10. Chest X-ray,
11. Colonoscopy,
12. Flexible sigmoidoscopy,
13. Hemocult stool analysis,
14. Mammography,
15. Pap smear,
16. PSA (blood test for prostate cancer),
17. Serum Protein Electrophoresis (blood test for myeloma),
18. Thermography.

There is no limit to the number of years an Insured can receive benefits for Health Screening Tests, as long as this Plan is in force.

We will pay this benefit regardless of the results of the test.

SECTION V – EXCEPTIONS

This Certificate contains a 30-day "Waiting Period". This means no benefits are payable for any Insured who has been diagnosed before their coverage has been in force for 30 days from their Effective Date. If an Insured is first diagnosed during the "Waiting Period", benefits for treatment of that Critical Illness will apply only to loss commencing after 12 months from their Effective Date; or, at your option, you may elect to void the Certificate from the beginning and receive a full refund of premium.

PRE-EXISTING CONDITIONS LIMITATION & EXCEPTIONS

"Pre-existing Condition" means a sickness or physical condition which, within the 12-month period prior to an Insured's Effective Date resulted in the Insured receiving medical advice or treatment.

We will not pay benefits for any Critical Illness starting within 12 months of an Insured's Effective Date which is caused by, contributed to, or resulting from a Pre-existing Condition.

A claim for benefits for loss starting after 12 months from an Insured's Effective Date will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition.

A Critical Illness will no longer be considered Pre-existing at the end of 12 consecutive months starting and ending after an Insured's Effective Date.

EXCEPTIONS

We won't pay for loss due to:

1. Intentionally self-inflicted injury or action.
2. Suicide or attempted suicide while sane or insane.
3. Illegal activities or participation in an illegal occupation.
4. War - declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.
5. Substance Abuse.

Diagnosis must be made and treatment received in the United States.

SECTION VI - CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within sixty (60) days after a covered loss starts, or as soon as reasonably possible. The notice can be given to the Company at P.O. Box 427, Columbia, South Carolina 29202. Notice should include the name of the Insured and the Certificate number. The notice may also be given to an authorized agent of the company.

Claim Forms: When we receive a notice of claim, we will send the claimant forms for filing proof of loss. If the forms are not given within 15 working days, proof of loss requirements can be met by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss Section.

Proof of Loss: Written Proof of Loss must be furnished to the Company at P.O. Box 427, Columbia, South Carolina 29202 within 180 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than one year from the time proof is otherwise required.

Time of Payment of Claims: Benefits payable under this Plan will be paid immediately upon receipt of acceptable Proof of Loss.

Payment of Claims: All benefits will be payable to you unless assigned by them or by operation of law. Any accrued benefit unpaid at the Insured's death may be paid to their estate.

Conformity with State Statutes: Any provision of the Plan which, on its Effective Date, is in conflict with the statutes of the state in which it was issued is hereby amended to conform to the minimum requirements of such statutes.

Additional Coverage with the Company: We will only pay benefits for covered Critical Illness under one Critical Illness Certificate if an Insured is covered by more than one of our Critical Illness Certificates. You may choose which Certificate you wish to keep in force by sending us written notice of your choice. We will return the premiums paid for any of our other Critical Illness Certificates during the period there was more than one Certificate in force.

SECTION VII - GENERAL PROVISIONS

Questions or Comments: If you have any questions about this Plan, its benefits, the filing of claims, a complaint or a compliment, please call us at the toll free number listed on the front of this Plan.

Entire Contract, Changes: The Policy together with the application, endorsements, benefit agreements, certificates and riders, if any, is the Entire Contract of Insurance. No change in the Plan shall be valid until approved in writing by an Executive Officer of the Company. Any change must be noted on or attached hereto. No agent may change the Plan or waive any of its Provisions. Any Rider, Endorsement or Application that modifies, limits, or excludes coverage under the Plan must be signed by the Employee to be valid.

Change of Beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

Physical Examination and Autopsy: We, at our expense, have the right to have an Insured examined as often as reasonable necessary while a claim is pending. In the case of death, we may also have any autopsy done unless prohibited by law.

Legal Action: No legal action may be brought to recover on this Plan within 60 days after written Proof of Loss has been given as required by the Plan. No such action may be brought after 3 years from the time written Proof of Loss is required to be given.

Time Limit on Certain Defenses: After this certificate has been in force for 2 years, it shall become incontestable as to the statements contained in the application.

Misstatement of Age: If an age has been misstated on the application, the benefits will be those the premium paid would have purchased at the correct age.

CERTIFICATE SCHEDULE

Initial Maximum Benefit:	Please see your certificate schedule.
Reduced Maximum Benefit Amount:	Not Applicable
Reduced Benefit Date:	Not Applicable
Waiting Period:	30 Days
Percentage for Partial Benefits:	25% of applicable Maximum Benefit

The applicable Maximum Benefit (Initial or Reduced) is payable for the following Critical Illnesses:

Cancer
Stroke
Kidney Failure
Heart Attack
Major Organ Transplant

PARTIAL BENEFITS

CANCER
Carcinoma in situ - When this Partial Benefit is paid, it will reduce the cancer benefit by 25%.

HEART ATTACK
Coronary Artery Bypass Surgery - When this Partial Benefit is paid, it will reduce the Heart Attack Benefit by 25%.

Maximum Health Screening Benefit Amount: $100 per insured Employee and Spouse per calendar year.

This form is issued to employer groups domiciled in the State of North Carolina ONLY.

CONTINENTAL AMERICAN INSURANCE COMPANY

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

800.433.3036

AMENDMENT
TO CERTIFICATE OF INSURANCE FOR CRITICAL ILLNESS

This rider is a part of the certificate to which it is attached. Unless amended by this rider, Certificate Definitions, other Provisions and terms apply to this rider.

Effective Date - If issued at the same time as the certificate, this rider becomes effective when the certificate becomes effective. If issued after the certificate becomes effective, this rider will have a later Effective Date, which will be shown in the Rider Schedule issued with this rider.

SECTION III – GENERAL DEFINITIONS /BENEFIT DEFINITIONS

The definition of Date of Diagnosis for Cancer and/or carcinoma in situ and Treatment free are deleted and replaced by the following:

Cancer and/or carcinoma in situ: the day the tissue specimen, blood samples and /or titer(s) are taken on which the diagnosis of cancer or carcinoma in situ is based. This includes recurrence of a previously diagnosed cancer provided the Insured is free of any signs or symptoms and is treatment free for that cancer for 12 consecutive months.

Treatment free means a period of time without the consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines. For the purpose of this definition "treatment" does not include maintenance drug therapy or routine follow-up visits to verify if cancer or carcinoma in situ has returned.

The following definition is added:

Maintenance drug therapy means ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer due to primary treatment. It is meant to decrease the risk of cancer recurrence rather than the palliative or suppression of a cancer that is still present.

Symptoms mean the subjective evidence of disease or physical disturbance.

Signs mean the subjective evidence of disease or physical disturbance observed by a physician or other member of the medical profession, acting within the scope of their license.

The Critical Illness Benefit in of SECTION IV - BENEFITS of the form is deleted and replaced by the following:

Critical Illness Benefit

We will pay this benefit when an Insured is diagnosed with one of the Critical Illnesses shown on the Certificate Schedule if:

1. The date of diagnosis is after the Waiting Period;

2. The date of diagnosis is while the his coverage is in force; and

3. It is not excluded by name or specific description in the Certificate.

If the date of diagnosis of a Critical Illness occurs during the Waiting Period, the Certificate may be returned for a full refund of premium.

The Certificate's Initial Maximum Benefit amount is shown in the Schedule. If the Schedule shows a Maximum Benefit Reduction Date, a Certificate's Maximum Benefit will be reduced to the Reduced Maximum Benefit Amount, also shown in the Schedule, on that date. Benefits will be based on the Maximum Benefit amount in effect on the Critical Illness Date of Diagnosis. Any partial benefits paid will be deducted from the appropriate Critical Illness.

Payment of benefits is subject to the following:

1. We will pay benefits for a Critical Illness in the order the events occur.

2. No benefits are payable for each different Critical Illness after the first unless its date of diagnosis is separated from the prior different Critical Illness by at least 6 months (or for cancer at least 6 months treatment free) and it is not caused by or contributed to by a Critical Illness for which benefits have been paid.

3. Once benefits have been paid for a Critical Illness, no additional benefits are payable for that same Critical Illness unless the dates of diagnosis are separated by at least 12 months (or for cancer at least 12 months treatment free). Cancer that has spread (metastasized) even though there is a new tumor, will not be considered an additional occurrence unless you have been treatment free for 12 months.

The Health Screening Benefit in SECTION IV - BENEFITS of the form is deleted and replaced by the following:

Health Screening Benefit (Calendar Year Limit)

We will pay the amount shown in the Benefit Schedule for Health Screening Tests performed after the Waiting Period and while an Insured's coverage is in force. This Benefit is payable once per calendar year up to the Maximum Benefit amount shown in the Benefit Schedule. Payment of this benefit will not reduce the benefit amount payable for Critical Illness.

Health Screening Tests include but are not limited to:

1. Stress test on a bicycle or treadmill,
2. Fasting blood glucose test,
3. Blood test for triglycerides,
4. Serum cholesterol test to determine level of HDL and LDL,
5. Bone marrow testing,
6. Breast ultrasound,
7. CA 15-3 (blood test for breast cancer),
8. CA 125 (blood test for ovarian cancer),
9. CEA (blood test for colon cancer),
10. Chest X-ray,

11. Colonoscopy,
12. Flexible sigmoidoscopy,
13. Hemocult stool analysis,
14. Mammography,
15. Pap smear,
16. PSA (blood test for prostate cancer),
17. Serum Protein Electrophoresis (blood test for myeloma),
18. Thermography.

There is no limit to the number of years an Insured can receive benefits for Health Screening Tests, as long as this Plan is in force. 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.

We will pay this benefit regardless of the results of the test.

The Pre-existing Condition Limitation in Section V is deleted and replaced by the following:

PRE-EXISTING CONDITIONS LIMITATION – NOT APPLICABLE TO CANCER and/or CARCINOMA IN SITU

"Pre-existing conditions" mean those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within the one-year period immediately preceding the effective date of the person's coverage.

We will not pay benefits for any Critical Illness starting within 12 months of an Insured's Effective Date which is caused by, contributed to, or resulting from a Pre-existing Condition.

A claim for benefits for loss starting after 12 months from an Insured's Effective Date will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition.

A Critical Illness will no longer be considered Pre-existing at the end of 12 consecutive months starting and ending after an Insured's Effective Date.

GENERAL PROVISIONS

This Rider is part of the Critical Illness Certificate and will terminate when that Certificate terminates, or when 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 any such items are inconsistent with the terms of this Rider.

Signed for the Company at its Home Office.

Teresa White, President

J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205

800.433.3036

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 31st 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 31st 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,

Teresa White, President **J. Matthew Loudermilk, Secretary**

CONTINENTAL AMERICAN INSURANCE COMPANY

Home Office: 2801 Devine Street, Columbia, South Carolina 29205
(herein called Continental American)

DEPENDENT CHILDREN BENEFIT RIDER
TO CERTIFICATE OF INSURANCE
FOR CRITICAL ILLNESS

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

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

DEFINITIONS

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

YOU, YOUR means the person named in the Certificate Schedule.

DEPENDENT CHILD(REN) means your natural Children, step-Children, children for which petition has been duly filed and who have been placed in your home, legally adopted Children, who are unmarried, chiefly dependent on you or your Spouse for support; and younger than age 25.

A. Your natural Children born after the Effective Date of this Rider will be covered from the moment of live birth. No notice or additional premium is required.

B. However, if any child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, the above age of twenty-five (25) shall not apply. Proof of such incapacity and dependency must be furnished to the Company within thirty-one (31) days following such 25th birthday, and not more frequently than annually from then forward.

C. Newborn Children of an Employee and/or his/her insured spouse and newborn Adopted Children shall automatically be covered from the moment of birth, under the same terms and conditions that apply to the natural, dependent children of covered persons.

D. Other foster children and adopted children shall be treated the same as newborn infants and are eligible for coverage on the same basis upon placement in the Employee's home, under the same terms and conditions that apply to the natural, dependent children of covered persons.

E. If a parent is required by a court or administrative order to provide health benefit plan coverage for a child, and the parent is eligible for family health benefit plan coverage through a health insurer, the health insurer:
    i. Must 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.
    ii. Must 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.

iii. May not disenroll or eliminate coverage of the child unless the health insurer is provided satisfactory written evidence that the court or administrative order is no longer in effect or the child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect not later than the effective date of disenrollment.

iv. Will not impose pre-ex limitations or waiting periods.

F. If Children are covered under the dependent rider, Children born or placed in the Employee's home after the Effective Date of this Rider will also be covered from the moment of birth. No notice or additional premium is required and the enrollment period will be waived. The company will not impose pre-ex limitations or waiting periods for newborn children, foster and adopted children if they are enrolled upon placement or children covered by the court or administrative order.

ACTIVE means a Dependent Child who is not confined in a hospital and who is able to carry on regular activities customary of a person in good health of the same age and sex.

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

BENEFITS

If a Dependent Child contracts a Specified Critical Illness after any applicable Waiting Period and while this Rider is in force, we will provide the benefits contained in the Certificate under the Benefits Section. The appropriate benefit amounts we will pay for the Dependent are shown in the Certificate Schedule.

EXCEPTIONS AND REDUCTIONS

This Rider contains a 30-day "Waiting Period". This means no benefits are payable for any covered Dependent Child who has been diagnosed before coverage has been in force 30 days from his "Effective Date." If a Dependent Child is first diagnosed during the "waiting period", benefits for treatment of that Critical Illness or Specified Procedure will apply only to loss commencing after 12 months from the "Effective Date" of his coverage; or, at your option, you may elect to void his coverage from the beginning and receive a full refund of any applicable premium.

REDUCTIONS

PRE-EXISTING CONDITIONS

"Pre-existing Condition" means a sickness or physical condition which, within the 12-month period prior to a Dependent Child's Effective Date resulted in him receiving medical advice or treatment.

We will not pay benefits for any condition or illness starting within 12 months of a Dependent Child's Effective Date which is caused by, contributed to, or resulting from a Pre-existing Condition.

A claim for benefits for loss starting after 12 months from a Dependent Child's Effective Date will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition.

A condition will no longer be considered Pre-existing at the end of 12 consecutive months starting and ending after a Dependent Child's Effective Date.

EXCEPTIONS

We won't pay for loss due to:

1. Intentionally self inflicted injury or action.
2. Suicide or attempted suicide while sane or insane.
3. Illegal activities or participation in an illegal occupation.
4. War - declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.
5. Substance Abuse.

GENERAL PROVISIONS

If your Dependent Child's coverage is terminated because of marriage or attainment of the limiting age, we will still pay benefits for any covered condition that was diagnosed while the Dependent was covered under this Rider.

TIME LIMIT ON CERTAIN DEFENSES
After this Rider has been in force for a period of two years it shall become incontestable as to the statements contained in the application.

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

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

Signed by the Company at our Home Office.

Teresa White, President **J. Matthew Loudermilk, Secretary**

CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205
800-433-3036

Dependent Children Definition Rider

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

The definition of Dependent Child(ren) is deleted and replaced by the following:

Dependent Child(ren) means your natural children, step-children, foster children, legally adopted children or children placed for adoption, who are under age 26.

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

b. Newborn Children of an Employee and/or his/her insured spouse and newborn Adopted Children shall automatically be covered from the moment of birth, under the same terms and conditions that apply to the natural, dependent children of covered persons.

c. Other foster children and adopted children shall be treated the same as newborn infants and are eligible for coverage on the same basis upon placement in the Employee's home, under the same terms and conditions that apply to the natural, dependent children of covered persons.

d. If a parent is required by a court or administrative order to provide health benefit plan coverage for a child, and the parent is eligible for family health benefit plan coverage through a health insurer, the health insurer:
    i. Must 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.
    ii. Must 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.
    iii. May not disenroll or eliminate coverage of the child unless the health insurer is provided satisfactory written evidence that the court or administrative order is no longer in effect or the child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect not later than the effective date of disenrollment.
    iv. Will not impose pre-ex limitations or waiting periods.

CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205

800.433.3036

ADDITIONAL BENEFITS RIDER
TO CERTIFICATE OF INSURANCE FOR CRITICAL ILLNESS

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

Effective Date - If issued at the same time as the certificate, this Rider becomes effective when the certificate becomes effective. If issued after the certificate becomes effective, this Rider will have a later Effective Date, which will be shown in the Rider Schedule issued with this Rider.

DEFINITIONS

Specified Critical Illness means such illness shown in the Rider Schedule and as defined in this Rider.

Waiting Period means the number of days after the Effective Date before we will pay benefits for loss due to Specified Critical Illness. We won't pay benefits for a Specified Critical Illness which begins during the Waiting Period.

Diagnosed/Diagnosis means a definitive and unequivocal diagnosis made by a Physician: (1) based upon the use of clinical and/or laboratory investigations as supported by the Insured's medical records; and (2) meeting any Diagnostic Requirements set forth in this Rider for the particular Specified Critical Illness being diagnosed.

Actively At Work Requirement
If you are not Actively at Work on the last scheduled work day coincident with or preceding the date your insurance would otherwise become effective, insurance will not be effective until the date you return to and remain Actively at Work.

If an eligible Spouse or Dependent Child is unable to engage in the normal activities of a person in good health of like age and sex on the date this Rider would otherwise become effective, coverage will not be effective until the date such person is able to engage in the normal activities of a person in good health of like age and sex. This will not apply to an eligible Dependent Child who is incapable of self-sustaining employment by reason of mental or physical incapacity, and who is primarily dependent on the Insured for support and maintenance.

BENEFIT DEFINITIONS

Coma means a state of unconsciousness for 30 consecutive days with:

1. no reaction to external stimuli;
2. no reaction to internal needs; and
3. the use of life support systems.

Paralysis/Paralyzed means the permanent, total, and irreversible loss of muscle function or sensation to the whole of at least two limbs as a result of injury or disease and supported by neurological evidence.

Severe Burn/Severely Burned means cosmetic disfigurement of the surface of a body area not less than 35 square inches due to fire, heat, caustics, electricity or radiation that is a full-thickness or third-degree burn, as determined by a Physician. A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possible into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation.

Loss of Sight, Speech or Hearing means:

1. Loss of Speech means the total and permanent loss of the ability to speak as the result of physical injury.
2. Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of Hearing that can be corrected by the use of any hearing aid or device shall not be considered an irrevocable loss.
3. Loss of Sight means the total and irreversible loss of all sight in both eyes

BENEFITS

Specified Critical Illness Benefit

We will pay this benefit if an Insured diagnosed with one of the Specified Critical Illnesses shown on the Rider Schedule if:

1. The Date of Diagnosis is after the Waiting Period;
2. The Date of Diagnosis is while this Rider is in force; and
3. It is not excluded by name or specific description in this Rider.

This Rider pays the indicated percentages of the applicable Maximum Benefit Amount shown in the Certificate Schedule that occurs while this Rider is in force. Benefits are not payable under this Rider for Loss if these conditions result from another Specified Critical Illness. The Dates of Loss for Specified Critical Illnesses must be separated by at least 6 months for benefits to be payable for multiple Specified Critical Illnesses.

Coma

If an Insured is Diagnosed as being Comatose after his Effective Date and any applicable Waiting Period, the Company will pay the Benefit Amount for Coma shown in the Schedule of Benefits.

The Diagnosis of Coma must indicate that permanent neurological deficit is present.

Paralysis

If an Insured is first Diagnosed as being Paralyzed after his Effective Date and any applicable Waiting Period, the Company will pay the Benefit Amount for Paralysis shown in the Schedule of Benefits.

The Diagnosis of Paralysis must include documented evidence of the illness or injury that caused the Paralysis.

Severe Burn

If an Insured is first Diagnosed as having suffered a Severe Burn after his Effective Date and any applicable Waiting Period, the Company will pay the Benefit Amount for Severe Burn shown in the Schedule of Benefits.

Loss of Sight, Speech or Hearing
If an Insured is first Diagnosed as having suffered Loss of Sight, Speech, or Hearing after his Effective Date and any applicable Waiting Period, the Company will pay the Benefit Amount for Loss of Sight, Speech or Hearing shown in the Schedule of Benefits.

EXCEPTIONS AND REDUCTIONS

This Rider contains a 30-day Waiting Period. This means no benefits are payable for any Insured who has been diagnosed before coverage has been in force 30 days from the Insured's Effective Date shown in the Rider Schedule. If an Insured is first diagnosed during the Waiting Period, benefits for treatment of that Specified Critical Illness will apply only to loss commencing after twelve months from the Insured's Effective Date; or, at your option, you may elect to void this rider from the beginning and receive a full refund of premium.

EXCEPTIONS

1. No benefits will be paid if the Specified Critical Illness is a result of:

    a. Intentionally self-inflicted injury or action;
    b. Suicide or attempted suicide while sane or insane;
    c. Illegal activities or participation in an illegal occupation;
    d. War, declared or undeclared, or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence; or
    e. Substance abuse.
2. No benefits will be paid for loss which occurred prior to the effective date of this Rider.
3. No benefits will be paid for diagnosis made outside the United States.

GENERAL PROVISIONS

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

The premium for this Rider is shown in the Rider Schedule. Premiums for this Rider are payable for the number of years shown in the Rider Schedule or until the Rider terminates.

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

Signed for the Company at its Home Office.

Teresa White, President **J. Matthew Loudermilk, Secretary**

RIDER SCHEDULE

BENEFITS

Coma	100% of applicable Maximum Benefit
Paralysis	100% of applicable Maximum Benefit
Severe Burn	100% of applicable Maximum Benefit
Loss of Sight, Speech or Hearing	
Loss of Speech	100% of applicable Maximum Benefit
Loss of Hearing	100% of applicable Maximum Benefit
Loss of Sight	100% of applicable Maximum Benefit

CONTINENTAL AMERICAN INSURANCE COMPANY

Home Office: 2801 Devine Street, Columbia, South Carolina 29205
(herein called Continental American)

HEART EVENT RIDER
TO CERTIFICATE OF INSURANCE FOR SPECIFIED CRITICAL ILLNESS

NO RECOVERY FOR PRE-EXISTING CONDITIONS--READ CAREFULLY. No benefits will be provided during the first twelve months of this Rider for conditions diagnosed within the 12-month period prior to the Effective Date shown in the Rider Schedule.

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

The Benefits provided in this rider amend any benefits shown in the base plan for the same conditions.

Effective Date - If issued at the same time as the certificate, this rider becomes effective when the certificate becomes effective. If issued after the certificate becomes effective, this rider will have a later Effective Date, which will be shown in the Rider Schedule issued with this rider.

DEFINITIONS

Specified Critical Illness means such illness shown in the Schedule and as defined in this rider.

Waiting Period means the number of days after the Effective Date before we will pay benefits for loss due to Specified Critical Illness. We won't pay benefits for a Specified Critical Illness which begins during the Waiting Period.

Diagnosed/Diagnosis means a definitive and unequivocal diagnosis made by a Physician: (1) based upon the use of clinical and/or laboratory investigations as supported by the Insured's medical records; and (2) meeting any Diagnostic Requirements set forth in the Certificate for the particular Critical Illness being diagnosed. For Benefit purposes, Date of Diagnosis means both the date the surgery or procedure occurs.

Treatment means consultation, care or services provided by a physician including diagnostic measures and surgical procedures.

Actively At Work Requirement
If an Insured is not actively at work on the last scheduled work day coincident with or preceding the date his insurance would otherwise become effective, insurance will not be effective until the date such Insured returns to and remains actively at work.

If an Eligible Dependent is unable to engage in the normal activities of a person in good health of like age and sex on the date the insurance would otherwise become effective, coverage will not be effective until the date such person is able to engage in the normal activities of a person in good health of like age and sex. This will not apply to an Eligible Dependant Child who is incapable of self-sustaining employment by reason of mental or physical incapacity, and who is primarily dependent on the Insured for support and maintenance.

BENEFIT DEFINITIONS

Category I - Specified Surgeries of the Heart

Specified Surgeries of the Heart "open heart surgery"– means undergoing open chest surgery, where the heart is *exposed* and/or *manipulated* for open cardiothoracic situations.

Benefits are paid for the following Open Heart Surgery procedures only:

1. **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 when the blockages are hard to reach or are too long or hard for angioplasty. A blood vessel, usually taken from the leg or chest, 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.

2. **Mitral valve replacement or repair:** a cardiac surgery procedure in which a patient's mitral valve is repaired or replaced by a different valve.

3. **Aortic valve replacement or repair:** a cardiac surgery procedure in which a patient's aortic valve is repaired or replaced by a different valve.

4. **Surgical Treatment of Abdominal aortic aneurysm:** To prevent aneurysm rupture. The operation consists of opening the abdomen, finding the aorta and removing (excising) the aneurysm. Abdominal aortic aneurysm is a ballooning or widening of the main artery (the aorta) as it courses down through the abdomen. At the point of the aneurysm, the aneurysm generally measures 3 cm or more in diameter.

Category I Benefits exclude all procedures not specifically listed above, including procedures such as, but not limited to, angioplasty, laser relief, stents or other surgical and non-surgical procedures.

Category II - Invasive, Procedures and Techniques of the Heart

A Category II Benefit is paid for the following procedures only:

1. **AngioJet Clot Busting** used to clear 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.

2. **Balloon Angioplasty** (or **Balloon valvuloplasty**) used to open 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.

3. **Laser Angioplasty.** Similar to balloon angioplasty, a laser tip is used to burn/break down plaque in the clogged blood vessel.

4. **Atherectomy** used to open blocked coronary arteries or clear bypass grafts by using a device on the end of a catheter to cut or shave away atherosclerotic plaque.

5. **Stent implantation**. Where a stainless steel mesh coil is implanted in a narrowed part of an artery to keep it propped open.

6. **Cardiac catheterization** (also called heart catheterization) is a diagnostic and occasionally therapeutic procedure that allows a comprehensive examination of the heart and surrounding blood vessels.

7. **Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD).** Means 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.

8. **Pacemakers.** Means the initial placement of a pacemaker. Pacemakers are implanted to send electrical signals to make the heart beat when your heart'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.

Subject to the re-occurrence benefit in the base plan, only one Category II benefit is payable. Benefits will not be paid for multiple procedures listed under the Category II benefit.

Category II Benefits exclude all procedures not specifically listed above.

BENEFITS

We will pay the benefit if you are treated with one of the Specified Surgical Procedures or Interventional Procedures shown on the Rider Schedule if:

1. The Date of Treatment is after the Waiting Period;
2. Treatment is incurred while this Rider is in force;
3. Treatment is recommended by a physician; and
3. It is not excluded by name or specific description in this Rider.

This Rider pays the indicated percentages of the Initial Maximum Benefit Amount shown in the Certificate Schedule that occurs while this Rider is in force. Benefits are not payable under this Rider for Loss if these conditions result from another Specified Critical Illness.

Benefits for Cat II will reduce the benefit amounts payable for Cat I benefits. Benefits will be paid only at the highest benefit level. If a Cat I and II are performed at the same time, benefits are only eligible at the 100% (higher) event and will not exceed the amount Initial Face Amount shown on the Rider Schedule. You are only eligible to receive one payment for each benefit category listed on the schedule page. The Dates of Loss for Covered Procedures must be separated by at least 6 months for benefits to be payable for multiple Covered Procedures.

Payment of initial, re-occurrence, or additional occurrence benefits are subject to the Benefits section of your Certificate.

EXCEPTIONS AND REDUCTIONS

This Rider contains a 30-day Waiting Period. This means no benefits are payable for any Insured who has been diagnosed for a covered condition before coverage has been in force 30 days from the Insured's Effective
Date shown in the Rider Schedule. If an Insured is first diagnosed has a covered procedure during the Waiting Period, benefits for treatment of that Specified Critical Illness will apply only to loss commencing after twelve months from the Insured's Effective Date; or, at your option, you may elect to void this rider from the beginning and receive a full refund of premium.

PRE-EXISTING CONDITIONS EXCEPTION

"Pre-existing Condition" means a sickness or physical condition which, within the 12-month period prior to an Insured's Effective Date resulted in the Insured receiving medical advice or treatment.

We will not pay benefits for any surgical procedure occurring within 12 months of an Insured's Effective Date which is caused by, contributed to, or resulting from a Pre-existing Condition.

A claim for benefits for loss starting after 12 months from an Insured's Effective Date will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition.

A Critical Illness will no longer be considered Pre-existing at the end of 12 consecutive months starting and ending after an Insured's Effective Date.

Any Benefits for Coronary Artery Bypass Surgery denied under this rider due to pre-existing conditions may be paid at the reduced benefit amount under the certificate, subject to the terms of the certificate.

EXCEPTIONS

1. No benefits will be paid if the Specified Critical Illness is a result of:

    a. Intentionally self inflicted injury or action;
    b. Suicide or attempted suicide while sane or insane;
    c. Illegal activities or participation in an illegal occupation;
    d. War, declared or undeclared, or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence; or
    e. an injury sustained while under the influence of alcohol, narcotics or any other controlled substance or drug unless properly administered upon the advice of a physician.

2. No benefits will be paid for loss which occurred prior to the effective date of this Rider.

GENERAL PROVISIONS

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

2. The premium for this Rider is shown in the Rider Schedule. Premiums for this Rider are payable for the number of years shown in the Rider Schedule or until the Rider terminates.

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

Signed for the Company at its Home Office.

Teresa White, President **J. Matthew Loudermilk, Secretary**

RIDER SCHEDULE

BENEFITS

Initial Benefit Amount: **See Certificate Schedule**

Category I
Specified Surgeries of the Heart 100% of Initial Benefit amount

Category II
Invasive Procedures and techniques of the heart 10% of Initial Benefit amount

Benefits for Cat II will reduce the benefit amounts payable for Cat I benefits. Benefits will be paid only at the highest benefit level. If a Cat I and II are performed at the same time, benefits are only eligible at the 100% (higher) event and will not exceed the amount Initial Face Amount shown on the Rider Schedule.

The Dates of Loss for Category I or Category II Covered Procedures must be separated by at least 6 months for benefits to be payable for multiple Covered Procedures.

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 and Health Maintenance Organizations (HMOs) 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 or HMO becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member 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 *in the box* 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 27605-0218
North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 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 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 or HMO. 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 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.

• They acquired rights to receive payments through a structured settlement factoring transaction

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 contractholder;

• 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 contractholders, 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, Medicare Part D, Medicaid or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

(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 a health benefit plan.

(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.

IMPORTANT NOTICE

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.

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Endorsement
to Policy and Certificate of Insurance

This Endorsement alters the Policy and the Certificate to which it is attached. Unless specifically addressed by this Endorsement, all other Policy and Certificate provisions, definitions, and terms continue to apply.

Continental American Insurance Company's mailing addresses for claims and premium payments are changed as listed below.

Notice of Claim and **Proof of Loss** should be mailed to the Company at:

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

Premium Payments should be mailed to the Company at:

P.O. Box 84069, Columbus, Georgia, 31908-4069

If applicable, references to 2801 Devine Street, Columbia, SC 29205 are deleted.

Signed for the Company at its Home Office,

Teresa White, President

J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

Home Office: Columbia, South Carolina

800.433.3036

GROUP CRITICAL ILLNESS POLICY
Lump Sum Single Payment Policy / First Occurrence

Based on the Application for this Group Insurance Policy (herein called the Plan) made by

Onslow Water and Sewer Authority

(herein called the Policyholder)

and based on the payment of the premium when due, the Company agrees to pay the benefits provided on the following pages.

THIS IS A LIMITED POLICY. PLEASE READ IT CAREFULLY
THIS POLICY PROVIDES BENEFITS FOR THE CRITICAL ILLNESSES LISTED.
IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.
THERE MAY BE NO RECOVERY FOR PRE-EXISITING CONDITIONS FOR THE FIRST YEAR.

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

This Plan becomes effective at 12:01 a.m. Standard Time at the Policyholder's address on the Effective Date shown below. It may be continued in effect by the payment of premiums as provided in Section II. The Plan will terminate as provided in the provision titled "Termination of the Plan" in Section I.

The first anniversary of this Plan will be the Anniversary Date shown below. "You" and "your" refer to the Insured or any other Insured under Family Coverage. "We", "us", and "our" refer to the Company. The Policyholder may add new Employees or Dependents from time to time in accordance with the terms of the Plan. Subsequent anniversaries of the Plan will be the same date each year thereafter.

All matter printed or written by the Company on the following pages forms a part of this Plan as if recited over the signature below. This Plan is a legal contract between the Company and the Policyholder. This Plan is delivered in and is governed by the laws of the jurisdiction shown below.

In witness whereof the Company has caused this Plan to be executed at our Home Office in Columbia, South Carolina on the Effective Date.

READ THIS POLICY CAREFULLY.
Signed for the Company at our Home Office.

Teresa White, President — J. Matthew Loudermilk, Secretary

Countersigned by _____
Licensed Resident Agent (if required by your state)

Important Cancellation Information- Please Read The Provision Entitled "Termination of The Plan" on Page 3.

Group Policy Number - 23817
Effective Date 01/01/2019 — **Anniversary Date** - 01/01/2020
Jurisdiction - North Carolina — **Non-Participating**

GROUP POLICY PROVISIONS

SECTION I	-	Eligibility, Effective Date and Termination
SECTION II	-	Premium Provisions
SECTION III	-	General Definitions / Benefit Definitions
SECTION IV	-	Benefit Provisions
SECTION V	-	Exceptions
SECTION VI	-	Claim Provisions
SECTION VII	-	General Provisions
SECTION VIII	-	Benefit Schedules
SECTION IX	-	Occupational Classifications
SECTION X	-	Schedule of Premiums

SECTION I - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY

Employee, as used in this Plan, means a person insured under this Plan who is:

1. An Employee of the Policyholder, or an eligible Spouse of the Employee;
2. Under age 70; **and**
3. Engaged in full-time work; **and**
4. Included in the class of employees eligible for coverage as shown on the application.

EFFECTIVE DATE

The Effective Date of this Plan is shown on Page 1 of this form.

The Effective Date for an Employee is as follows:

1. An Employee's insurance will be effective on the date shown on the Certificate Schedule provided the Employee is then actively at work.

2. If an Employee is not actively at work on the date coverage would otherwise become effective, the Effective Date of his coverage will be the date on which such Employee is first thereafter actively at work.

The Effective Date for a Spouse or Dependent Child is the date shown on the Schedule Page subject to the following:

1. The date the Employees insurance is effective for a Spouse or Dependent Child who is eligible on that date; for whom coverage is applied for and premium paid; and who are not hospital confined.

2. At 12:00 a.m. Standard Time, on the day a Spouse or Dependent Child is no longer hospital confined if the Spouse or Dependent Child was otherwise eligible for coverage on the date the Employee's insurance became effective.

3. For a Dependent eligible on or first acquired after the Employee's Effective Date, the Effective Date will be:
   a. For Newborn Children and Adopted Newborn Children, the Effective Date is the date of birth (see Section III, Definitions, Insured).
   b. For other Adopted Children and Foster Children, the Effective Date is the date of placement in the Employee’s home.
   c. For a spouse, the Effective Date is the date we assign after proving that application for his or her coverage.

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 on the day prior to the date any premium is due by giving 45 days written notice. The Plan will terminate when the number of participating Employees is less than the number mutually agreed upon by the Policyholder and the Company in writing.

In these events, this Plan and all certificates issued hereunder 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 as respects any claim arising during the period the Plan is in force.

The Policyholder has the sole responsibility to notify Employees of such termination.

TERMINATION OF AN EMPLOYEE'S INSURANCE

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

1. The date the Plan is terminated;
2. On the 31st day after the premium due date if the required premium has not been paid;
3. On the date he ceases to meet the definition of an Employee as defined in the Plan; **or**
4. On the date he is no longer a member of the class eligible.

Insurance for an insured Spouse or Dependent Child will terminate the earliest of:

1. The date the Plan is terminated;
2. On the 31st day after the premium due date if the required premium has not been paid;
3. The premium due date following the date the Spouse or Dependent Child ceases to be a dependent;
4. The premium due date following the date we receive your written request to terminate coverage for your Spouse and/or all Dependent Children.

Termination of the insurance on any Insured shall be without prejudice to his rights as regarding any claim arising prior thereto.

Portability Privilege

When coverage would otherwise terminate under this Plan because an Employee ends employment with the Employer, they may elect to continue coverage. The coverage that may be continued is that which the Employee had on the date their employment terminated, including Dependent coverage then in effect.

1. Coverage may not be continued for any of the following reasons:
    a. The Employee failed to pay any required premium;
    b. This Group Policy terminates.

2. To keep the Certificate in force the Employee must:
    a. Make written Application to the Company within 31 days after the date their insurance would otherwise terminate;
    b. Pay the required premium to the Company no later than 31 days after the date the Certificate would otherwise terminate.

3. Insurance will cease on the earliest of these dates:
    a. The date the Employee fails to pay any required premium;
    b. The date this Group Policy is terminated.

If an Employee qualifies for this Portability Privilege as described, then the same Benefits, Plan Provisions, and Premium Rate as shown in their Certificate as previously issued will apply.

SECTION II - PREMIUM PROVISIONS

PREMIUM CALCULATIONS

Premiums payable on any premium due date for insurance will be calculated in accordance with the Schedule of Premiums. The Company will give the Policyholder written notice 45 days prior to the date any change in rates is to be effective.

PREMIUM PAYMENTS

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

Aggregate premiums for this Plan are to be paid to the Company at our Home Office in Columbia, South Carolina. 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.

GRACE PERIOD
This Plan has a 31-day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the next 31 days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of discontinuance of the Plan.

SECTION III - GENERAL DEFINITIONS / BENEFIT DEFINITIONS

Whenever a male pronoun is used, it includes the female unless the context clearly shows otherwise.

Actively at Work to be considered "actively at work", an Employee must perform for a full normal workday the regular duties of his employment at the regular place of business or at a location to which he may be required to travel to perform the regular duties of his employment.

Critical Illness means such illness shown in the Schedule and as defined in this Plan.

Date of Diagnosis means for:

Cancer and/or carcinoma in situ: The day the tissue specimen, blood samples and/or titer(s) are taken on which the first diagnosis of cancer or carcinoma in situ is based.

Heart attack: The date that the death (infarction) of a portion of the heart muscle occurred based on the criteria listed under the Heart Attack definition.

Stroke: The date a stroke occurred based on documented neurological deficits and neuroimaging studies.

Kidney failure: The date that a doctor or physician recommends that an Insured begin renal dialysis.

Major organ transplant surgery or coronary artery bypass surgery: The date the surgery occurs for covered transplants or covered coronary artery bypass surgery.

Dependent Child(ren) means your natural children, step-children, legally adopted children or children placed for adoption, who are unmarried, chiefly dependent on you or your Spouse for support; and younger than age 25.

a. However, if any child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, the above age of twenty-five (25) shall not apply. Proof of such incapacity and dependency must be furnished to the Company within thirty-one (31) days following such 25th birthday, and not more frequently than annually from then forward.

b. Newborn Children of an Employee and/or his/her insured spouse and newborn Adopted Children shall automatically be covered from the moment of birth, under the same terms and conditions that apply to the natural, dependent children of covered persons.

c. Other foster children and adopted children shall be treated the same as newborn infants and are eligible for coverage on the same basis upon placement in the Employee's home, under the same terms and conditions that apply to the natural, dependent children of covered persons.

d. If a parent is required by a court or administrative order to provide health benefit plan coverage for a child, and the parent is eligible for family health benefit plan coverage through a health insurer, the health insurer:

i. Must 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.
ii. Must 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.
iii. May not dis-enroll or eliminate coverage of the child unless the health insurer is provided satisfactory written evidence that the court or administrative order is no longer in effect or the child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect not later than the effective date of disenrollment.
iv. Will not impose pre-ex limitations or waiting periods.

f. If Children are covered under the dependent rider, Children born or placed in the Employee's home after the Effective Date of this Rider will also be covered from the moment of birth. No notice or additional premium is required and the enrollment period will be waived. The company will not impose pre-ex limitations or waiting periods for newborn children, foster and adopted children if they are enrolled upon placement or children covered by the court or administrative order.

Doctor or Physician means any licensed practitioner of the healing arts acting within the scope of his license in treating a Critical Illness. It doesn't include an Insured or their family member.

Licensed Health Care Practitioner means an individual who has successfully completed a prescribed program of study in a variety of health fields and who has obtained a license or certificate indicating his or her competence to practice in that field.

Employee means the Insured as shown in the Certificate Schedule.

Family Member means an Insured's spouse, son, daughter, mother, father, sister, or brother.

Full-time Work means an Employee is spending at least 20 hours per week performing his occupational duties.

Illness means sickness or disease which first manifests while the Insured's coverage is in force and after any applicable Waiting Period. Any loss due to illness must begin while the Insured's coverage is in force.

Injury means bodily injury solely due to an accident. It includes all complications of and all injuries from the same accident.

Insured(s) -

1. If Employee coverage is shown in the Certificate Schedule, we insure the Employee.
2. If coverage is for the Spouse of an eligible Employee, we insure the Insured as shown on the Certificate Schedule.
3. Coverage for Dependent Children may be included in an attached rider (if applicable).
4. If any person who would otherwise be an Insured is specifically excluded from coverage by endorsement to the Certificate or by the application, then such person shall not be an Insured.
5. Any other additions to the Insured class must be added by endorsement after applying to the Company.

Pathologist means a doctor, other than an Insured or a family member, who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A Pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Spouse means an Employee's legal wife or husband.

Successor Insured - If an Employee dies while covered under a Certificate, then their surviving Spouse shall become the Insured if such Spouse is an Insured. If there is no surviving Spouse covered under the Certificate, then the Certificate shall terminate on the next premium due date.

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

Treatment free means a period of time without the consultation, care, or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

Waiting Period means the number of days after the Effective Date before we will pay benefits for loss due to a Critical Illness. We won't pay benefits for a Critical Illness that begins during the Waiting Period.

BENEFIT DEFINITIONS

Cancer (internal or invasive) means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes Leukemia. Excluded are Cancers that are non-invasive such as:

1. Pre-malignant tumors or polyps;
2. Carcinoma in Situ;
3. Any skin cancers except melanomas;
4. Basal cell carcinoma and squamous cell carcinoma of the skin; and
5. Melanoma that is diagnosed as Clark's Level I or II or Breslow less than .77mm.

Cancer is also defined as disease which meets the diagnosis criteria of malignancy established by The American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen.

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

Cancer and/or Carcinoma in Situ must be diagnosed in one of two ways:

1. **Pathological Diagnosis** - A Pathological Diagnosis of Cancer or Carcinoma in Situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a Certified Pathologist whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology.

2. **Clinical Diagnosis** - A Clinical Diagnosis of Cancer or Carcinoma in Situ is based on the study of symptoms.

If the requisite pathological clinical diagnosis can only be made postmortem, we will assume liability retroactively for the forty-five (45) day period before death.

We will pay benefits for a Clinical Diagnosis only if:
1. A Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; **and**
2. There is medical evidence to support the diagnosis; **and**
3. A doctor is treating an Insured for Cancer and/or Carcinoma in Situ.

Heart Attack (Myocardial Infarction) means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart Attack does not include any other disease or injury involving the cardiovascular system. Cardiac Arrest not caused by a Myocardial Infarction is not a Heart Attack. The diagnosis must include all of the following criteria:

1. New and serial Electrocardiographic (EKG) findings consistent with Myocardial Infarction;

2. Elevation of cardiac enzymes above generally accepted laboratory levels of normal in case of creatine physphokinase (CPK), a CPK-MB measurement must be used; **and**
3. Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.

Coronary Artery Bypass Surgery means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to balloon angioplasty, laser relief, stints or other non-surgical procedures.

Major Organ Transplant means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas.

Stroke means apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident, which is first manifested on or after an Insured's Effective Date. Stroke does not include Transient Ischemic Attacks and attacks of Verterbrobasilar Ischemia. We will pay a benefit for Stroke which produces permanent clinical neurological sequela following an initial diagnosis made after any applicable Waiting Period. We must receive evidence of the permanent neurological damage provided from Computed Axial Tomography (CAT scan) or magnetic Resonance Imaging (MRI). **Stroke does not mean head injury, transient ischemic attack or chronic cerebrovascular insufficiency.**

Kidney Failure (Renal Failure) means the end stage renal failure presenting as chronic, irreversible failure of both kidneys to function. The Kidney Failure must necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly); or which results in kidney transplantation. Renal failure is covered, provided it is not caused by a traumatic event, including surgical traumas.

SECTION IV - BENEFITS

Critical Illness Benefit

We will pay this benefit when an Insured is diagnosed with one of the Critical Illnesses shown on the Certificate Schedule if:

1. The date of diagnosis is after the Waiting Period;
2. The date of diagnosis is while the his coverage is in force; **and**
3. It is not excluded by name or specific description in the Certificate.

If the date of diagnosis of a Critical Illness occurs during the Waiting Period, the Certificate may be returned for a full refund of premium.

The Certificate's Initial Maximum Benefit amount is shown in the Schedule. If the Schedule shows a Maximum Benefit Reduction Date, a Certificate's Maximum Benefit will be reduced to the Reduced Maximum Benefit Amount, also shown in the Schedule, on that date. Benefits will be based on the Maximum Benefit amount in effect on the Critical Illness Date of Diagnosis. Any partial benefits paid will be deducted from the appropriate Critical Illness.

Payment of benefits is subject to the following:

1. We will pay benefits for each different Critical Illness in the order the events occur. We will pay benefits for any one Critical Illness once every six months. Therefore, no benefits are payable for each different Critical Illness after the first unless its date of diagnosis is separated from the prior Critical Illness by at least 6 months.

2. Re-Occurrence Benefits - We will pay benefits for the re-occurrence any Critical Illness once every twelve months. Therefore, once benefits have been paid for Critical Illness, no additional benefits are payable for that same Critical Illness unless the dates of diagnosis are separated by at least 12 months (Cancer benefits must be medically unrelated to any cancer for which benefits have already been paid).

Health Screening Benefit (Calendar Year Limit)

We will pay the amount shown in the Benefit Schedule for Health Screening Tests performed after the Waiting Period and while an Insured's coverage is in force. This Benefit is payable once per calendar year up to the Maximum Benefit amount shown in the Benefit Schedule. Payment of this benefit will not reduce the benefit amount payable for Critical Illness.

Health Screening Tests include but are not limited to:

1. Stress test on a bicycle or treadmill,
2. Fasting blood glucose test,
3. Blood test for triglycerides,
4. Serum cholesterol test to determine level of HDL and LDL,
5. Bone marrow testing,
6. Breast ultrasound,
7. CA 15-3 (blood test for breast cancer),
8. CA 125 (blood test for ovarian cancer),
9. CEA (blood test for colon cancer),
10. Chest X-ray,
11. Colonoscopy,
12. Flexible sigmoidoscopy,
13. Hemocult stool analysis,
14. Mammography,
15. Pap smear,
16. PSA (blood test for prostate cancer),
17. Serum Protein Electrophoresis (blood test for myeloma),
18. Thermography.

There is no limit to the number of years an Insured can receive benefits for Health Screening Tests, as long as this Plan is in force.

We will pay this benefit regardless of the results of the test.

SECTION V - EXCEPTIONS

This Plan contains a 30-day "Waiting Period". This means no benefits are payable for any Insured who has been diagnosed before their coverage has been in force 30 days from their Effective Date. If an Insured is first diagnosed during the "Waiting Period", benefits for treatment of that Critical Illness will apply only to loss commencing after 12 months from their Effective Date; or, at the Employee's option, they may elect to void the Certificate from the beginning and receive a full refund of premium.

PRE-EXISTING CONDITIONS LIMITATION & EXCEPTIONS

"Pre-existing Condition" means a sickness or physical condition which, within the 12-month period prior to an Insured's Effective Date resulted in the Insured receiving medical advice or treatment.

We will not pay benefits for any Critical Illness starting within 12 months of an Insured's Effective Date which is caused by, contributed to, or resulting from a Pre-existing Condition.

A claim for benefits for loss starting after 12 months from an Insured's Effective Date will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition.

A Critical Illness will no longer be considered Pre-existing at the end of 12 consecutive months starting and ending after an Insured's Effective Date.

EXCEPTIONS

We won't pay for loss due to:

1. Intentionally self-inflicted injury or action.
2. Suicide or attempted suicide while sane or insane.
3. Illegal activities or participation in an illegal occupation.
4. War -declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.
5. Substance Abuse.

Diagnosis must be made and treatment received in the United States.

SECTION VI - CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within sixty (60) days after a covered loss starts, or as soon as reasonably possible. The notice can be given to the Company at P.O. Box 427, Columbia, South Carolina 29202. Notice should include the name of the Insured and the Certificate number. The notice may also be given to an authorized agent of the company.

Claim Forms: When we receive a notice of claim, we will send the Claimant forms for filing proof of loss. If the forms are not given within 15 working days, proof of loss requirements can be met by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss Section.

Proof of Loss: Written Proof of Loss must be furnished to the Company at P.O. Box 427, Columbia, South Carolina 29202 within 180 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than one year from the time proof is otherwise required.

Time of Payment of Claims: Benefits payable under this Plan will be paid immediately upon receipt of acceptable Proof of Loss.

Payment of Claims: All benefits will be payable to the employee unless assigned by them or by operation of law. Any accrued benefit unpaid at the Insured's death may be paid to their estate.

Conformity with State Statutes: Any provision of this Plan which, on its Effective Date, is in conflict with the statutes of the state in which it was issued is hereby amended to conform to the minimum requirements of such statutes.

Additional Coverage with the Company: We will only pay benefits for covered Critical Illness under one Critical Illness Certificate if an Insured is covered by more than one of our Critical Illness Certificates. An Insured may choose which Certificate they wish to keep in force by sending us written notice of their choice. We will return the premiums paid for any of our other Critical Illness Certificates during the period there was more than one Certificate in force.

SECTION VII - GENERAL PROVISIONS

Questions or Comments: If you have any questions about this Plan, its benefits, the filing of claims, a complaint or a compliment, please call us at the toll free number listed on the front of this Plan.

Entire Contract, Changes: This Policy together with the application, endorsements, benefit agreements, certificates and riders, if any, is the Entire Contract of Insurance. No change in this Plan shall be valid until approved in writing by an Executive Officer of the Company. Any change must be noted on or attached hereto. No agent may change this Plan or waive any of its Provisions. Any Rider, Endorsement or Application that modifies, limits, or excludes coverage under this Plan must be signed by the Employee to be valid.

Change of Beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

Physical Examination and Autopsy: We, at our expense, have the right to have an Insured examined as often as reasonable necessary while a claim is pending. In the case of death, we may also have any autopsy done unless prohibited by law.

Legal Action: No legal action may be brought to recover on this Plan within 60 days after written Proof of Loss has been given as required by this Plan. No such action may be brought after 3 years from the time written Proof of Loss is required to be given.

Time Limit on Certain Defenses: After this Policy has been in force for a period of 2 years, it shall become incontestable as to the statements contained in the application.

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

Misstatement of Age: If an age has been misstated on the application, the benefits will be those the premium paid would have purchased at the correct age.

SECTION VIII - BENEFIT SCHEDULE

Initial Maximum Benefit:	See Certificate
Reduced Maximum Benefit Amount:	Not Applicable
Reduced Benefit Date:	Not Applicable
Waiting Period:	30 Days
Percentage for Partial Benefits:	25% of applicable Maximum Benefit

The applicable Maximum Benefit (Initial or Reduced) is payable for the following Critical Illnesses:

Cancer (internal or invasive)
Stroke
Kidney Failure
Heart Attack
Major Organ Transplant

PARTIAL BENEFITS

CANCER (internal or invasive)
Carcinoma in situ - When this Partial Benefit is paid, it will reduce the cancer benefit by 25%.

HEART ATTACK
Coronary Artery Bypass Surgery - When this Partial Benefit is paid, it will reduce the Heart Attack Benefit by 25%.

Maximum Health Screening Benefit Amount: $100 per insured Employee and Spouse per calendar year.

This form will be issued to employer groups domiciled in the State of North Carolina ONLY.

SECTION IX - OCCUPATIONAL CLASSIFICATIONS

Benefit-eligible employees are classified as such in the Master Application as being **Actively at Work and working full-time, a minimum of 20 hours per week.**

SECTION X - SCHEDULE OF PREMIUMS

GROUP CRITICAL ILLNESS

CI[G]

North Carolina - Monthly (12pp/yr)

NONTOBACCO - Employee

Issue Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$ 6.25	$ 9.00	$ 11.75	$ 14.50	$ 17.25	$ 20.00	$ 22.75	$ 25.50	$ 28.25	$ 31.00
30-39	$ 7.95	$ 12.40	$ 16.85	$ 21.30	$ 25.75	$ 30.20	$ 34.65	$ 39.10	$ 43.55	$ 48.00
40-49	$ 12.85	$ 22.20	$ 31.55	$ 40.90	$ 50.25	$ 59.60	$ 68.95	$ 78.30	$ 87.65	$ 97.00
50-59	$ 19.17	$ 34.83	$ 50.50	$ 66.17	$ 81.83	$ 97.50	$ 113.17	$ 128.83	$ 144.50	$ 160.17
60-69	$ 28.50	$ 53.50	$ 78.50	$ 103.50	$ 128.50	$ 153.50	$ 178.50	$ 203.50	$ 228.50	$ 253.50

NONTOBACCO - Spouse

Issue Age	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$ 6.25	$ 7.63	$ 9.00	$ 10.38	$ 11.75	$ 13.13	$ 14.50	$ 15.88	$ 17.25
30-39	$ 7.95	$ 10.18	$ 12.40	$ 14.63	$ 16.85	$ 19.08	$ 21.30	$ 23.53	$ 25.75
40-49	$ 12.85	$ 17.53	$ 22.20	$ 26.88	$ 31.55	$ 36.23	$ 40.90	$ 45.58	$ 50.25
50-59	$ 19.17	$ 27.00	$ 34.83	$ 42.67	$ 50.50	$ 58.33	$ 66.17	$ 74.00	$ 81.83
60-69	$ 28.50	$ 41.00	$ 53.50	$ 66.00	$ 78.50	$ 91.00	$ 103.50	$ 116.00	$ 128.50

TOBACCO - Employee

Issue Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$ 7.85	$ 12.20	$ 16.55	$ 20.90	$ 25.25	$ 29.60	$ 33.95	$ 38.30	$ 42.65	$ 47.00
30-39	$ 10.95	$ 18.40	$ 25.85	$ 33.30	$ 40.75	$ 48.20	$ 55.65	$ 63.10	$ 70.55	$ 78.00
40-49	$ 22.80	$ 42.10	$ 61.40	$ 80.70	$ 100.00	$ 119.30	$ 138.60	$ 157.90	$ 177.20	$ 196.50
50-59	$ 34.40	$ 65.30	$ 96.20	$ 127.10	$ 158.00	$ 188.90	$ 219.80	$ 250.70	$ 281.60	$ 312.50
60-69	$ 52.85	$ 102.20	$ 151.55	$ 200.90	$ 250.25	$ 299.60	$ 348.95	$ 398.30	$ 447.65	$ 497.00

TOBACCO - Spouse

Issue Age	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$ 7.85	$ 10.03	$ 12.20	$ 14.38	$ 16.55	$ 18.73	$ 20.90	$ 23.08	$ 25.25
30-39	$ 10.95	$ 14.68	$ 18.40	$ 22.13	$ 25.85	$ 29.58	$ 33.30	$ 37.03	$ 40.75
40-49	$ 22.80	$ 32.45	$ 42.10	$ 51.75	$ 61.40	$ 71.05	$ 80.70	$ 90.35	$ 100.00
50-59	$ 34.40	$ 49.85	$ 65.30	$ 80.75	$ 96.20	$ 111.65	$ 127.10	$ 142.55	$ 158.00
60-69	$ 52.85	$ 77.53	$ 102.20	$ 126.88	$ 151.55	$ 176.23	$ 200.90	$ 225.58	$ 250.25

Rates include cancer benefit.

Rates include: $100 Health Screening Benefit, Additional Benefits Rider, Heart Rider, and no additional riders.

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

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GROUP CRITICAL ILLNESS

CI G

North Carolina - Monthly (12pp/yr) Buy Up Rates

NONTOBACCO - Employee

Issue Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000
18-29	$ 2.75	$ 5.50	$ 8.25	$ 11.00	$ 13.75	$ 16.50	$ 19.25	$ 22.00	$ 24.75
30-39	$ 4.45	$ 8.90	$ 13.35	$ 17.80	$ 22.25	$ 26.70	$ 31.15	$ 35.60	$ 40.05
40-49	$ 9.35	$ 18.70	$ 28.05	$ 37.40	$ 46.75	$ 56.10	$ 65.45	$ 74.80	$ 84.15
50-59	$ 15.67	$ 31.33	$ 47.00	$ 62.67	$ 78.33	$ 94.00	$ 109.67	$ 125.33	$ 141.00
60-69	$ 25.00	$ 50.00	$ 75.00	$ 100.00	$ 125.00	$ 150.00	$ 175.00	$ 200.00	$ 225.00

NONTOBACCO - Spouse

Issue Age	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$ 2.75	$ 4.13	$ 5.50	$ 6.88	$ 8.25	$ 9.63	$ 11.00	$ 12.38	$ 13.75
30-39	$ 4.45	$ 6.68	$ 8.90	$ 11.13	$ 13.35	$ 15.58	$ 17.80	$ 20.03	$ 22.25
40-49	$ 9.35	$ 14.03	$ 18.70	$ 23.38	$ 28.05	$ 32.73	$ 37.40	$ 42.08	$ 46.75
50-59	$ 15.67	$ 23.50	$ 31.33	$ 39.17	$ 47.00	$ 54.83	$ 62.67	$ 70.50	$ 78.33
60-69	$ 25.00	$ 37.50	$ 50.00	$ 62.50	$ 75.00	$ 87.50	$ 100.00	$ 112.50	$ 125.00

TOBACCO - Employee

Issue Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000
18-29	$ 4.35	$ 8.70	$ 13.05	$ 17.40	$ 21.75	$ 26.10	$ 30.45	$ 34.80	$ 39.15
30-39	$ 7.45	$ 14.90	$ 22.35	$ 29.80	$ 37.25	$ 44.70	$ 52.15	$ 59.60	$ 67.05
40-49	$ 19.30	$ 38.60	$ 57.90	$ 77.20	$ 96.50	$ 115.80	$ 135.10	$ 154.40	$ 173.70
50-59	$ 30.90	$ 61.80	$ 92.70	$ 123.60	$ 154.50	$ 185.40	$ 216.30	$ 247.20	$ 278.10
60-69	$ 49.35	$ 98.70	$ 148.05	$ 197.40	$ 246.75	$ 296.10	$ 345.45	$ 394.80	$ 444.15

TOBACCO - Spouse

Issue Age	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$ 4.35	$ 6.53	$ 8.70	$ 10.88	$ 13.05	$ 15.23	$ 17.40	$ 19.58	$ 21.75
30-39	$ 7.45	$ 11.18	$ 14.90	$ 18.63	$ 22.35	$ 26.08	$ 29.80	$ 33.53	$ 37.25
40-49	$ 19.30	$ 28.95	$ 38.60	$ 48.25	$ 57.90	$ 67.55	$ 77.20	$ 86.85	$ 96.50
50-59	$ 30.90	$ 46.35	$ 61.80	$ 77.25	$ 92.70	$ 108.15	$ 123.60	$ 139.05	$ 154.50
60-69	$ 49.35	$ 74.03	$ 98.70	$ 123.38	$ 148.05	$ 172.73	$ 197.40	$ 222.08	$ 246.75

Rates include cancer benefit.

Rates include: No Health Screening Benefit, Additional Benefits Rider, Heart Rider, and no additional riders.

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

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Underwritten by:
Continental American Insurance Company
2801 Devine Street | Columbia, South Carolina 29205

CONTINENTAL AMERICAN INSURANCE COMPANY

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

800.433.3036

AMENDMENT
TO CERTIFICATE OF INSURANCE FOR CRITICAL ILLNESS

This rider is a part of the certificate to which it is attached. Unless amended by this rider, Certificate Definitions, other Provisions and terms apply to this rider.

Effective Date - If issued at the same time as the certificate, this rider becomes effective when the certificate becomes effective. If issued after the certificate becomes effective, this rider will have a later Effective Date, which will be shown in the Rider Schedule issued with this rider.

SECTION III – GENERAL DEFINITIONS /BENEFIT DEFINITIONS

The definition of Date of Diagnosis for Cancer and/or carcinoma in situ and Treatment free are deleted and replaced by the following:

Cancer and/or carcinoma in situ: the day the tissue specimen, blood samples and /or titer(s) are taken on which the diagnosis of cancer or carcinoma in situ is based. This includes recurrence of a previously diagnosed cancer provided the Insured is free of any signs or symptoms and is treatment free for that cancer for 12 consecutive months.

Treatment free means a period of time without the consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines. For the purpose of this definition "treatment" does not include maintenance drug therapy or routine follow-up visits to verify if cancer or carcinoma in situ has returned.

The following definition is added:

Maintenance drug therapy means ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer due to primary treatment. It is meant to decrease the risk of cancer recurrence rather than the palliative or suppression of a cancer that is still present.

Symptoms mean the subjective evidence of disease or physical disturbance.

Signs mean the subjective evidence of disease or physical disturbance observed by a physician or other member of the medical profession, acting within the scope of their license.

The Critical Illness Benefit in of SECTION IV - BENEFITS of the form is deleted and replaced by the following:

Critical Illness Benefit

We will pay this benefit when an Insured is diagnosed with one of the Critical Illnesses shown on the Certificate Schedule if:

1. The date of diagnosis is after the Waiting Period;

2. The date of diagnosis is while the his coverage is in force; and

3. It is not excluded by name or specific description in the Certificate.

If the date of diagnosis of a Critical Illness occurs during the Waiting Period, the Certificate may be returned for a full refund of premium.

The Certificate's Initial Maximum Benefit amount is shown in the Schedule. If the Schedule shows a Maximum Benefit Reduction Date, a Certificate's Maximum Benefit will be reduced to the Reduced Maximum Benefit Amount, also shown in the Schedule, on that date. Benefits will be based on the Maximum Benefit amount in effect on the Critical Illness Date of Diagnosis. Any partial benefits paid will be deducted from the appropriate Critical Illness.

Payment of benefits is subject to the following:

1. We will pay benefits for a Critical Illness in the order the events occur.

2. No benefits are payable for each different Critical Illness after the first unless its date of diagnosis is separated from the prior different Critical Illness by at least 6 months (or for cancer at least 6 months treatment free) and it is not caused by or contributed to by a Critical Illness for which benefits have been paid.

3. Once benefits have been paid for a Critical Illness, no additional benefits are payable for that same Critical Illness unless the dates of diagnosis are separated by at least 12 months (or for cancer at least 12 months treatment free). Cancer that has spread (metastasized) even though there is a new tumor, will not be considered an additional occurrence unless you have been treatment free for 12 months.

The Health Screening Benefit in SECTION IV - BENEFITS of the form is deleted and replaced by the following:

Health Screening Benefit (Calendar Year Limit)

We will pay the amount shown in the Benefit Schedule for Health Screening Tests performed after the Waiting Period and while an Insured's coverage is in force. This Benefit is payable once per calendar year up to the Maximum Benefit amount shown in the Benefit Schedule. Payment of this benefit will not reduce the benefit amount payable for Critical Illness.

Health Screening Tests include but are not limited to:

1. Stress test on a bicycle or treadmill,
2. Fasting blood glucose test,
3. Blood test for triglycerides,
4. Serum cholesterol test to determine level of HDL and LDL,
5. Bone marrow testing,
6. Breast ultrasound,
7. CA 15-3 (blood test for breast cancer),
8. CA 125 (blood test for ovarian cancer),
9. CEA (blood test for colon cancer),
10. Chest X-ray,

11. Colonoscopy,
12. Flexible sigmoidoscopy,
13. Hemocult stool analysis,
14. Mammography,
15. Pap smear,
16. PSA (blood test for prostate cancer),
17. Serum Protein Electrophoresis (blood test for myeloma),
18. Thermography.

There is no limit to the number of years an Insured can receive benefits for Health Screening Tests, as long as this Plan is in force. 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.

We will pay this benefit regardless of the results of the test.

The Pre-existing Condition Limitation in Section V is deleted and replaced by the following:

PRE-EXISTING CONDITIONS LIMITATION – NOT APPLICABLE TO CANCER and/or CARCINOMA IN SITU

"Pre-existing conditions" mean those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within the one-year period immediately preceding the effective date of the person's coverage.

We will not pay benefits for any Critical Illness starting within 12 months of an Insured's Effective Date which is caused by, contributed to, or resulting from a Pre-existing Condition.

A claim for benefits for loss starting after 12 months from an Insured's Effective Date will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition.

A Critical Illness will no longer be considered Pre-existing at the end of 12 consecutive months starting and ending after an Insured's Effective Date.

GENERAL PROVISIONS

This Rider is part of the Critical Illness Certificate and will terminate when that Certificate terminates, or when 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 any such items are inconsistent with the terms of this Rider.

Signed for the Company at its Home Office.

Teresa White, President

J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205

800.433.3036

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 31st 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 31st 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,

Teresa White, President **J. Matthew Loudermilk, Secretary**

CONTINENTAL AMERICAN INSURANCE COMPANY

Home Office: 2801 Devine Street, Columbia, South Carolina 29205
(herein called Continental American)

DEPENDENT CHILDREN BENEFIT RIDER
TO CERTIFICATE OF INSURANCE
FOR CRITICAL ILLNESS

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

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

DEFINITIONS

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

YOU, YOUR means the person named in the Certificate Schedule.

DEPENDENT CHILD(REN) means your natural Children, step-Children, children for which petition has been duly filed and who have been placed in your home, legally adopted Children, who are unmarried, chiefly dependent on you or your Spouse for support; and younger than age 25.

A. Your natural Children born after the Effective Date of this Rider will be covered from the moment of live birth. No notice or additional premium is required.

B. However, if any child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, the above age of twenty-five (25) shall not apply. Proof of such incapacity and dependency must be furnished to the Company within thirty-one (31) days following such 25th birthday, and not more frequently than annually from then forward.

C. Newborn Children of an Employee and/or his/her insured spouse and newborn Adopted Children shall automatically be covered from the moment of birth, under the same terms and conditions that apply to the natural, dependent children of covered persons.

D. Other foster children and adopted children shall be treated the same as newborn infants and are eligible for coverage on the same basis upon placement in the Employee's home, under the same terms and conditions that apply to the natural, dependent children of covered persons.

E. If a parent is required by a court or administrative order to provide health benefit plan coverage for a child, and the parent is eligible for family health benefit plan coverage through a health insurer, the health insurer:
    i. Must 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.
    ii. Must 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.

iii. May not disenroll or eliminate coverage of the child unless the health insurer is provided satisfactory written evidence that the court or administrative order is no longer in effect or the child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect not later than the effective date of disenrollment.

iv. Will not impose pre-ex limitations or waiting periods.

F. If Children are covered under the dependent rider, Children born or placed in the Employee's home after the Effective Date of this Rider will also be covered from the moment of birth. No notice or additional premium is required and the enrollment period will be waived. The company will not impose pre-ex limitations or waiting periods for newborn children, foster and adopted children if they are enrolled upon placement or children covered by the court or administrative order.

ACTIVE means a Dependent Child who is not confined in a hospital and who is able to carry on regular activities customary of a person in good health of the same age and sex.

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

BENEFITS

If a Dependent Child contracts a Specified Critical Illness after any applicable Waiting Period and while this Rider is in force, we will provide the benefits contained in the Certificate under the Benefits Section. The appropriate benefit amounts we will pay for the Dependent are shown in the Certificate Schedule.

EXCEPTIONS AND REDUCTIONS

This Rider contains a 30-day "Waiting Period". This means no benefits are payable for any covered Dependent Child who has been diagnosed before coverage has been in force 30 days from his "Effective Date." If a Dependent Child is first diagnosed during the "waiting period", benefits for treatment of that Critical Illness or Specified Procedure will apply only to loss commencing after 12 months from the "Effective Date" of his coverage; or, at your option, you may elect to void his coverage from the beginning and receive a full refund of any applicable premium.

REDUCTIONS

PRE-EXISTING CONDITIONS

"Pre-existing Condition" means a sickness or physical condition which, within the 12-month period prior to a Dependent Child's Effective Date resulted in him receiving medical advice or treatment.

We will not pay benefits for any condition or illness starting within 12 months of a Dependent Child's Effective Date which is caused by, contributed to, or resulting from a Pre-existing Condition.

A claim for benefits for loss starting after 12 months from a Dependent Child's Effective Date will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition.

A condition will no longer be considered Pre-existing at the end of 12 consecutive months starting and ending after a Dependent Child's Effective Date.

EXCEPTIONS

We won't pay for loss due to:

1. Intentionally self inflicted injury or action.
2. Suicide or attempted suicide while sane or insane.
3. Illegal activities or participation in an illegal occupation.
4. War - declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.
5. Substance Abuse.

GENERAL PROVISIONS

If your Dependent Child's coverage is terminated because of marriage or attainment of the limiting age, we will still pay benefits for any covered condition that was diagnosed while the Dependent was covered under this Rider.

TIME LIMIT ON CERTAIN DEFENSES
After this Rider has been in force for a period of two years it shall become incontestable as to the statements contained in the application.

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

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

Signed by the Company at our Home Office.

Teresa White, President **J. Matthew Loudermilk, Secretary**

CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205
800-433-3036

Dependent Children Definition Rider

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

The definition of Dependent Child(ren) is deleted and replaced by the following:

Dependent Child(ren) means your natural children, step-children, foster children, legally adopted children or children placed for adoption, who are under age 26.

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

b. Newborn Children of an Employee and/or his/her insured spouse and newborn Adopted Children shall automatically be covered from the moment of birth, under the same terms and conditions that apply to the natural, dependent children of covered persons.

c. Other foster children and adopted children shall be treated the same as newborn infants and are eligible for coverage on the same basis upon placement in the Employee's home, under the same terms and conditions that apply to the natural, dependent children of covered persons.

d. If a parent is required by a court or administrative order to provide health benefit plan coverage for a child, and the parent is eligible for family health benefit plan coverage through a health insurer, the health insurer:
    i. Must 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.
    ii. Must 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.
    iii. May not disenroll or eliminate coverage of the child unless the health insurer is provided satisfactory written evidence that the court or administrative order is no longer in effect or the child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect not later than the effective date of disenrollment.
    iv. Will not impose pre-ex limitations or waiting periods.

CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205

800.433.3036

ADDITIONAL BENEFITS RIDER
TO CERTIFICATE OF INSURANCE FOR CRITICAL ILLNESS

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

Effective Date - If issued at the same time as the certificate, this Rider becomes effective when the certificate becomes effective. If issued after the certificate becomes effective, this Rider will have a later Effective Date, which will be shown in the Rider Schedule issued with this Rider.

DEFINITIONS

Specified Critical Illness means such illness shown in the Rider Schedule and as defined in this Rider.

Waiting Period means the number of days after the Effective Date before we will pay benefits for loss due to Specified Critical Illness. We won't pay benefits for a Specified Critical Illness which begins during the Waiting Period.

Diagnosed/Diagnosis means a definitive and unequivocal diagnosis made by a Physician: (1) based upon the use of clinical and/or laboratory investigations as supported by the Insured's medical records; and (2) meeting any Diagnostic Requirements set forth in this Rider for the particular Specified Critical Illness being diagnosed.

Actively At Work Requirement
If you are not Actively at Work on the last scheduled work day coincident with or preceding the date your insurance would otherwise become effective, insurance will not be effective until the date you return to and remain Actively at Work.

If an eligible Spouse or Dependent Child is unable to engage in the normal activities of a person in good health of like age and sex on the date this Rider would otherwise become effective, coverage will not be effective until the date such person is able to engage in the normal activities of a person in good health of like age and sex. This will not apply to an eligible Dependent Child who is incapable of self-sustaining employment by reason of mental or physical incapacity, and who is primarily dependent on the Insured for support and maintenance.

BENEFIT DEFINITIONS

Coma means a state of unconsciousness for 30 consecutive days with:

1. no reaction to external stimuli;
2. no reaction to internal needs; and
3. the use of life support systems.

Paralysis/Paralyzed means the permanent, total, and irreversible loss of muscle function or sensation to the whole of at least two limbs as a result of injury or disease and supported by neurological evidence.

Severe Burn/Severely Burned means cosmetic disfigurement of the surface of a body area not less than 35 square inches due to fire, heat, caustics, electricity or radiation that is a full-thickness or third-degree burn, as determined by a Physician. A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possible into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation.

Loss of Sight, Speech or Hearing means:

1. Loss of Speech means the total and permanent loss of the ability to speak as the result of physical injury.
2. Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of Hearing that can be corrected by the use of any hearing aid or device shall not be considered an irrevocable loss.
3. Loss of Sight means the total and irreversible loss of all sight in both eyes

BENEFITS

Specified Critical Illness Benefit

We will pay this benefit if an Insured diagnosed with one of the Specified Critical Illnesses shown on the Rider Schedule if:

1. The Date of Diagnosis is after the Waiting Period;
2. The Date of Diagnosis is while this Rider is in force; and
3. It is not excluded by name or specific description in this Rider.

This Rider pays the indicated percentages of the applicable Maximum Benefit Amount shown in the Certificate Schedule that occurs while this Rider is in force. Benefits are not payable under this Rider for Loss if these conditions result from another Specified Critical Illness. The Dates of Loss for Specified Critical Illnesses must be separated by at least 6 months for benefits to be payable for multiple Specified Critical Illnesses.

Coma

If an Insured is Diagnosed as being Comatose after his Effective Date and any applicable Waiting Period, the Company will pay the Benefit Amount for Coma shown in the Schedule of Benefits.

The Diagnosis of Coma must indicate that permanent neurological deficit is present.

Paralysis

If an Insured is first Diagnosed as being Paralyzed after his Effective Date and any applicable Waiting Period, the Company will pay the Benefit Amount for Paralysis shown in the Schedule of Benefits.

The Diagnosis of Paralysis must include documented evidence of the illness or injury that caused the Paralysis.

Severe Burn

If an Insured is first Diagnosed as having suffered a Severe Burn after his Effective Date and any applicable Waiting Period, the Company will pay the Benefit Amount for Severe Burn shown in the Schedule of Benefits.

Loss of Sight, Speech or Hearing
If an Insured is first Diagnosed as having suffered Loss of Sight, Speech, or Hearing after his Effective Date and any applicable Waiting Period, the Company will pay the Benefit Amount for Loss of Sight, Speech or Hearing shown in the Schedule of Benefits.

EXCEPTIONS AND REDUCTIONS

This Rider contains a 30-day Waiting Period. This means no benefits are payable for any Insured who has been diagnosed before coverage has been in force 30 days from the Insured's Effective Date shown in the Rider Schedule. If an Insured is first diagnosed during the Waiting Period, benefits for treatment of that Specified Critical Illness will apply only to loss commencing after twelve months from the Insured's Effective Date; or, at your option, you may elect to void this rider from the beginning and receive a full refund of premium.

EXCEPTIONS

1. No benefits will be paid if the Specified Critical Illness is a result of:

    a. Intentionally self-inflicted injury or action;
    b. Suicide or attempted suicide while sane or insane;
    c. Illegal activities or participation in an illegal occupation;
    d. War, declared or undeclared, or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence; or
    e. Substance abuse.
2. No benefits will be paid for loss which occurred prior to the effective date of this Rider.
3. No benefits will be paid for diagnosis made outside the United States.

GENERAL PROVISIONS

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

The premium for this Rider is shown in the Rider Schedule. Premiums for this Rider are payable for the number of years shown in the Rider Schedule or until the Rider terminates.

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

Signed for the Company at its Home Office.

Teresa White, President **J. Matthew Loudermilk, Secretary**

RIDER SCHEDULE

BENEFITS

Coma	100% of applicable Maximum Benefit
Paralysis	100% of applicable Maximum Benefit
Severe Burn	100% of applicable Maximum Benefit
Loss of Sight, Speech or Hearing	
Loss of Speech	100% of applicable Maximum Benefit
Loss of Hearing	100% of applicable Maximum Benefit
Loss of Sight	100% of applicable Maximum Benefit

CONTINENTAL AMERICAN INSURANCE COMPANY

Home Office: 2801 Devine Street, Columbia, South Carolina 29205
(herein called Continental American)

HEART EVENT RIDER
TO CERTIFICATE OF INSURANCE FOR SPECIFIED CRITICAL ILLNESS

NO RECOVERY FOR PRE-EXISTING CONDITIONS--READ CAREFULLY. No benefits will be provided during the first twelve months of this Rider for conditions diagnosed within the 12-month period prior to the Effective Date shown in the Rider Schedule.

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

The Benefits provided in this rider amend any benefits shown in the base plan for the same conditions.

Effective Date - If issued at the same time as the certificate, this rider becomes effective when the certificate becomes effective. If issued after the certificate becomes effective, this rider will have a later Effective Date, which will be shown in the Rider Schedule issued with this rider.

DEFINITIONS

Specified Critical Illness means such illness shown in the Schedule and as defined in this rider.

Waiting Period means the number of days after the Effective Date before we will pay benefits for loss due to Specified Critical Illness. We won't pay benefits for a Specified Critical Illness which begins during the Waiting Period.

Diagnosed/Diagnosis means a definitive and unequivocal diagnosis made by a Physician: (1) based upon the use of clinical and/or laboratory investigations as supported by the Insured's medical records; and (2) meeting any Diagnostic Requirements set forth in the Certificate for the particular Critical Illness being diagnosed. For Benefit purposes, Date of Diagnosis means both the date the surgery or procedure occurs.

Treatment means consultation, care or services provided by a physician including diagnostic measures and surgical procedures.

Actively At Work Requirement
If an Insured is not actively at work on the last scheduled work day coincident with or preceding the date his insurance would otherwise become effective, insurance will not be effective until the date such Insured returns to and remains actively at work.

If an Eligible Dependent is unable to engage in the normal activities of a person in good health of like age and sex on the date the insurance would otherwise become effective, coverage will not be effective until the date such person is able to engage in the normal activities of a person in good health of like age and sex. This will not apply to an Eligible Dependant Child who is incapable of self-sustaining employment by reason of mental or physical incapacity, and who is primarily dependent on the Insured for support and maintenance.

BENEFIT DEFINITIONS

Category I - Specified Surgeries of the Heart

Specified Surgeries of the Heart "open heart surgery"– means undergoing open chest surgery, where the heart is *exposed* and/or *manipulated* for open cardiothoracic situations.

Benefits are paid for the following Open Heart Surgery procedures only:

1. **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 when the blockages are hard to reach or are too long or hard for angioplasty. A blood vessel, usually taken from the leg or chest, 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.

2. **Mitral valve replacement or repair:** a cardiac surgery procedure in which a patient's mitral valve is repaired or replaced by a different valve.

3. **Aortic valve replacement or repair:** a cardiac surgery procedure in which a patient's aortic valve is repaired or replaced by a different valve.

4. **Surgical Treatment of Abdominal aortic aneurysm:** To prevent aneurysm rupture. The operation consists of opening the abdomen, finding the aorta and removing (excising) the aneurysm. Abdominal aortic aneurysm is a ballooning or widening of the main artery (the aorta) as it courses down through the abdomen. At the point of the aneurysm, the aneurysm generally measures 3 cm or more in diameter.

Category I Benefits exclude all procedures not specifically listed above, including procedures such as, but not limited to, angioplasty, laser relief, stents or other surgical and non-surgical procedures.

Category II - Invasive, Procedures and Techniques of the Heart

A Category II Benefit is paid for the following procedures only:

1. **AngioJet Clot Busting** used to clear 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.

2. **Balloon Angioplasty** (or **Balloon valvuloplasty**) used to open 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.

3. **Laser Angioplasty.** Similar to balloon angioplasty, a laser tip is used to burn/break down plaque in the clogged blood vessel.

4. **Atherectomy** used to open blocked coronary arteries or clear bypass grafts by using a device on the end of a catheter to cut or shave away atherosclerotic plaque.

5. **Stent implantation**. Where a stainless steel mesh coil is implanted in a narrowed part of an artery to keep it propped open.

6. **Cardiac catheterization** (also called heart catheterization) is a diagnostic and occasionally therapeutic procedure that allows a comprehensive examination of the heart and surrounding blood vessels.

7. **Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD).** Means 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.

8. **Pacemakers.** Means the initial placement of a pacemaker. Pacemakers are implanted to send electrical signals to make the heart beat when your heart'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.

Subject to the re-occurrence benefit in the base plan, only one Category II benefit is payable. Benefits will not be paid for multiple procedures listed under the Category II benefit.

Category II Benefits exclude all procedures not specifically listed above.

BENEFITS

We will pay the benefit if you are treated with one of the Specified Surgical Procedures or Interventional Procedures shown on the Rider Schedule if:

1. The Date of Treatment is after the Waiting Period;
2. Treatment is incurred while this Rider is in force;
3. Treatment is recommended by a physician; and
3. It is not excluded by name or specific description in this Rider.

This Rider pays the indicated percentages of the Initial Maximum Benefit Amount shown in the Certificate Schedule that occurs while this Rider is in force. Benefits are not payable under this Rider for Loss if these conditions result from another Specified Critical Illness.

Benefits for Cat II will reduce the benefit amounts payable for Cat I benefits. Benefits will be paid only at the highest benefit level. If a Cat I and II are performed at the same time, benefits are only eligible at the 100% (higher) event and will not exceed the amount Initial Face Amount shown on the Rider Schedule. You are only eligible to receive one payment for each benefit category listed on the schedule page. The Dates of Loss for Covered Procedures must be separated by at least 6 months for benefits to be payable for multiple Covered Procedures.

Payment of initial, re-occurrence, or additional occurrence benefits are subject to the Benefits section of your Certificate.

EXCEPTIONS AND REDUCTIONS

This Rider contains a 30-day Waiting Period. This means no benefits are payable for any Insured who has been diagnosed for a covered condition before coverage has been in force 30 days from the Insured's Effective
Date shown in the Rider Schedule. If an Insured is first diagnosed has a covered procedure during the Waiting Period, benefits for treatment of that Specified Critical Illness will apply only to loss commencing after twelve months from the Insured's Effective Date; or, at your option, you may elect to void this rider from the beginning and receive a full refund of premium.

PRE-EXISTING CONDITIONS EXCEPTION

"Pre-existing Condition" means a sickness or physical condition which, within the 12-month period prior to an Insured's Effective Date resulted in the Insured receiving medical advice or treatment.

We will not pay benefits for any surgical procedure occurring within 12 months of an Insured's Effective Date which is caused by, contributed to, or resulting from a Pre-existing Condition.

A claim for benefits for loss starting after 12 months from an Insured's Effective Date will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition.

A Critical Illness will no longer be considered Pre-existing at the end of 12 consecutive months starting and ending after an Insured's Effective Date.

Any Benefits for Coronary Artery Bypass Surgery denied under this rider due to pre-existing conditions may be paid at the reduced benefit amount under the certificate, subject to the terms of the certificate.

EXCEPTIONS

1. No benefits will be paid if the Specified Critical Illness is a result of:

    a. Intentionally self inflicted injury or action;
    b. Suicide or attempted suicide while sane or insane;
    c. Illegal activities or participation in an illegal occupation;
    d. War, declared or undeclared, or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence; or
    e. an injury sustained while under the influence of alcohol, narcotics or any other controlled substance or drug unless properly administered upon the advice of a physician.

2. No benefits will be paid for loss which occurred prior to the effective date of this Rider.

GENERAL PROVISIONS

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

2. The premium for this Rider is shown in the Rider Schedule. Premiums for this Rider are payable for the number of years shown in the Rider Schedule or until the Rider terminates.

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

Signed for the Company at its Home Office.

Teresa White, President **J. Matthew Loudermilk, Secretary**

RIDER SCHEDULE

BENEFITS

Initial Benefit Amount: **See Certificate Schedule**

Category I
Specified Surgeries of the Heart 100% of Initial Benefit amount

Category II
Invasive Procedures and techniques of the heart 10% of Initial Benefit amount

Benefits for Cat II will reduce the benefit amounts payable for Cat I benefits. Benefits will be paid only at the highest benefit level. If a Cat I and II are performed at the same time, benefits are only eligible at the 100% (higher) event and will not exceed the amount Initial Face Amount shown on the Rider Schedule.

The Dates of Loss for Category I or Category II Covered Procedures must be separated by at least 6 months for benefits to be payable for multiple Covered Procedures.

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

NOTICE OF NON-INSURANCE BENEFITS ENDORSEMENT

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

From time to time, Continental American Insurance Company (CAIC) may offer or provide goods and/or services that are not related to insurance. These goods and services, which could be offered or provided to some people who apply for CAIC coverage or become insured by CAIC, may include (but are not limited to) the following:

- Enrollment services
- Educational services
- Benefit statement services
- Payroll or plan administration services

The services listed above will fall under the same benefit plan that includes or is related to the applicable CAIC coverage, individual wellness programs, and related services.

In addition, CAIC may arrange for third-party service providers to provide discounted goods and services to people who apply for CAIC coverage or who become insured by CAIC.

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

Signed for the Company at its Home Office,

Teresa White, President

J. Matthew Loudermilk, Secretary

For assistance or information about this notice, call 800.433.3036.

CAI0039NNB.1NC

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 and Health Maintenance Organizations (HMOs) 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 or HMO becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member 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 *in the box* 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 27605-0218
North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 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 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 or HMO. 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 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.

• They acquired rights to receive payments through a structured settlement factoring transaction

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 contractholder;

• 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 contractholders, 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, Medicare Part D, Medicaid or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

(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 a health benefit plan.

(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.

IMPORTANT NOTICE

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.

AFLAC CUSTOMER PRIVACY POLICY

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

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

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

PRIVACY NOTICE

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

Collecting Information

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

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

Sharing Information

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

Opting Out of Information Sharing

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

Affiliate Marketing Opt Out

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

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

Confidentiality and Security

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

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

NOTICE OF INFORMATION PRACTICES

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

STATE SPECIFIC DISCLOSURES

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

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

NOTICE OF PRIVACY PRACTICES - PROTECTED HEALTH INFORMATION

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

NOTICE OF PRIVACY PRACTICES – PROTECTED HEALTH INFORMATION

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

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

DEFINITIONS

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

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

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

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

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

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

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

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

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

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

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

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

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

- The following are examples of when your authorization would be required prior to use and disclosure:

- Most uses and disclosures of your psychotherapy notes.
- Uses and disclosures of your PHI for marketing purposes.
- Uses and disclosures that constitute a sale of PHI.

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

RIGHTS THAT YOU HAVE

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

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

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

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

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

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

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

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

FOR FURTHER INFORMATION

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

EFFECTIVE DATE

This Notice is effective January 6, 2017.

ONSLOW WATER AND SEWER AUTHORITY

CRITICAL ILLNESS CERTIFICATE SCHEDULE

INSURED «ISNAMF» «ISNAML»	**GROUP POLICY NUMBER** 23817
EFFECTIVE DATE «ISPHEF»	**CERTIFICATE NUMBER** «ISCERT»
INITIAL PREMIUM («ISBLMD») «ISPREM»	**FIRST RENEWAL DATE** «ISPHRN»

BENEFITS:

Initial Benefit Amount: «BENEFIT»

Spouse Face Amount: «SPOUSE_»

This Certificate includes coverage for children as shown in the Dependent Benefit Rider- 50% of the primary insured's benefit.

****Benefits are available for any covered loss after the date you enrolled for coverage as shown on your approved application.****