CONTINENTAL AMERICAN INSURANCE COMPANY

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

Columbia, South Carolina
800.433.3036

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

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

Home Office: 2801 Devine Street, Columbia, South Carolina 29205
800.433.3036

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

Certificate of Insurance For Group Supplemental Hospital Indemnity Policy

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

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

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

Your Employer (the "Policyholder") applied for coverage under this Group Supplemental Hospital Indemnity Insurance Policy (the "Plan"). This Plan is issued by Continental American Insurance Company (the "Company," "CAIC," "we," "us," or "our"). For the purposes of this Plan, "you" (including "your" and "yours") refers to you. Based on the application process and the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. (Please note that male pronouns— such as "he," "him," and "his"—are used for both males and females, unless the context clearly shows otherwise.)

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

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

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

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

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SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

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

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

- **Employee Coverage –** We insure only the Employee.
- **Employee and Spouse or Domestic Partner Coverage** – We insure the Employee and spouse or domestic partner (as defined in the applicable rider).
- **Employee and Children Coverage –** We insure the Employee and any dependent children (as defined in the applicable rider).
- **Family Coverage –** We insure the Employee, spouse or domestic partner, and any dependent children (as defined in the applicable rider).

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

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

Effective Date
Your Employee Effective Date is shown on the Certificate Schedule.

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

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

If Employee and Spouse or Domestic Partner, Employee and Children, or Family Coverage is offered:

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

A day begins at 12:01 a.m. standard time at the Employee's place of residence.

Plan Termination

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

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

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

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

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

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

Termination of Your Insurance

Your insurance will terminate on whichever occurs first:

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

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

Continuity of Coverage

When you are no longer a member of an eligible class and your coverage would otherwise end, you may elect to continue your coverage under this Plan if you have been continuously insured under this Plan during the entire 3 months immediately precding termination of eligibility. You may continue the coverage you had on the date your Certificate would otherwise terminate, including any in-force Dependent Spouse Rider or Dependent Child Rider coverage, without any additional underwriting requirements. You may continue the coverage for a period of 12 months following the date of termination of eligibility or until the date the Group Plan is terminated, whichever occurs later.

To keep your coverage in force, you must:

- Make application for the extended coverage within 31 days after the date your coverage would otherwise terminate, and
- Pay the required premium no later than 31 days after the date your coverage would otherwise terminate and on each premium due date thereafter.

Your continued coverage will end on the earliest of the following dates:

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

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

SECTION II – PREMIUM PROVISIONS

Premium Payments

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

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

Premium Changes

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

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

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

Grace Period

This Plan has a 31-day Grace Period. If any premium, except for the first premium, is not paid on or before its due date, the premium may be paid during the next 31 days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of its intention to discontinue the Plan in advance of the date of discontinuance.

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SECTION III – DEFINITIONS

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

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

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

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

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

Dependent means your spouse or domestic partner or dependent children, as defined in the applicable rider, who have been accepted for coverage.

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

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

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

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

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

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

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

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

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

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

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

- A nursing home,
- An extended care facility,
- A skilled nursing facility,
- A rest home or home for the aged,
- A Rehabilitation Facility,

- A facility for the Treatment of alcoholism or drug addiction, or
- An assisted living facility.

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

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

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

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

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

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

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

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

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

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

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

Spouse is your legal wife or husband.

Telemedicine Service means a medical inquiry with a Doctor via audio or video communication that assists with a patient's assessment, diagnosis, and consultation.

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

SECTION IV – BENEFIT PROVISIONS

Hospitalization Benefits

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

We will pay the Hospital Admission Benefit amount shown in the Benefit Schedule. We will not pay benefits for confinement to an observation unit, or for emergency room Treatment or outpatient Treatment.

We will pay this benefit once per period of Hospital Confinement. This benefit is limited to the maximum shown in the Benefit Schedule. We will only pay this benefit once for each Covered Accident or Covered Sickness per Calendar Year. If an Insured is confined to the Hospital because of the same or Related Accidental Injury or Sickness, we will not pay this benefit again in the same Calendar Year.

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

The length of time shown for Hospital Confinement in the Benefit Schedule is the maximum period for which an Insured can collect benefits for Hospital Confinements resulting from Covered Sickness or from Covered Accidental Injuries received in the same Covered Accident.

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

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

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Health Screening Benefit

We will pay the amount shown on the Benefit Schedule for Health Screening Tests performed while an Insured's coverage is in force. This benefit is limited to the Calendar Year Maximum shown in the Benefit Schedule. Benefits are payable for covered dependent children at 100% of the Employee benefit amount.

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

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

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

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Treatment Benefits

Major Diagnostic Exams Benefit
We will pay the daily benefit amount shown in the Benefit Schedule for each day that, due to a Covered Accidental Injury or Covered Sickness, an Insured requires one of the following exams:

- Computerized Tomography (CT/CAT scan)
- Magnetic Resonance Imaging (MRI)
- Electroencephalography (EEG)

This benefit is limited to one payment per Calendar Year for each Covered Accident or Covered Sickness. If an Insured has another covered major diagnostic exam because of the same or a Related Covered Accident or Covered Sickness, we will not pay this benefit again in the same Calendar Year.

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SECTION V – EXCLUSIONS

Exclusions

We will not pay for loss due to:

- War – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the Insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.
- Suicide – committing or attempting to commit suicide, while sane or insane.
- Self-Inflicted Injuries – injuring or attempting to injure oneself intentionally.
- Racing – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semi-professional capacity.
- Illegal Occupation – voluntarily participating in, committing, or attempting to commit a felony or illegal act or activity, or voluntarily working at, or being engaged in, an illegal occupation or job.
- Sports – participating in any organized sport in a professional or semi-professional capacity.
- Custodial Care – this is non-medical care that helps individuals with the basic tasks of everyday life, the preparation of special diets, and the self-administration of medication which does not require the constant attention of medical personnel.
- Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including any resulting complications.
- Services performed by a Family Member.
- Services related to sex or gender change, sterilization, in vitro fertilization, vasectomy or reversal of a vasectomy, or tubal ligation.
- Elective Abortion – an abortion for any reason other than to preserve the life of the person upon whom the abortion is performed.
- Dental Services or Treatment.
- Cosmetic surgery, except when due to:
    - Reconstructive surgery, when the service is related to or follows surgery resulting from a Covered Accidental Injury or a Covered Sickness, or is related to or results from a congenital disease or anomaly of a covered dependent child.
    - Congenital defects in newborns.

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SECTION VI - CLAIM PROVISIONS

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

Notice of Claim

Written Notice of Claim must be given to us:

- Within 60 days after the Covered Accidental Injury or Covered Sickness, or
- As soon as reasonably possible.

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

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

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

Proof of Loss

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

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

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

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

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

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

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

Physical Examination and Autopsy

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

Time of Payment of Claims

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

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

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

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

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

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

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

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

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

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

- Within 60 days after you have sent us written Proof of Loss, or
- More than 3 years from the time written proof is required to be given.

SECTION VII - GENERAL PROVISIONS

Entire Contract Changes
Your insurance is provided under a contract of Group Supplemental Hospital Indemnity insurance with the Policyholder. The Entire Contract of Insurance is made up of:

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

All statements that the Policyholder or an Insured has made in the Application will be considered representations, not warranties. No written statement by an insured person will be used in any contest unless a copy of the statement is furnished to the person, his beneficiary, or his personal representative.

The Company will not void insurance or reduce benefits as a result of statements made on the Application without sending Application copies.

Changes to the Plan:

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

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

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

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

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

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

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

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

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

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

- The coverage (including any limitations, reductions, and exclusions);
- Any family member or dependent coverage;
- To whom benefits will be paid; and
- The rights and privileges under the Plan.

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

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

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

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at: P.O. Box 1157, Richmond, VA 23218, 804-371-9691, (toll free) 1-877-310-6560 or TDD 804-371-9206, fax 804-371-9944.

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

CONTINENTAL AMERICAN INSURANCE COMPANY

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

Columbia, South Carolina
800.433.3036

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

Amendment
to Policy, Certificate of Insurance, and Dependent Child Rider for Group Supplemental Hospital Indemnity

This Amendment is subject to all of the provisions of the Policy and Certificate to which it is attached. Additions or changes have been made to the Policy, Certificate, and Dependent Child Rider and are indicated below.

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

The Plan Termination provision is deleted and replaced with the following:

Plan Termination

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

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

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

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

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

The Policyholder has the sole responsibility of notifying Certificateholders in writing of the Plan's termination no later than 15 days after the receipt of the notice of termination. If the Plan terminates, it—and all Certificates and Riders issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

The definition of Dependent Child or Dependent Children is deleted and replaced with the following:

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

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

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

Your natural Dependent 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.

The definition below is added to the Definitions section:

Observation Unit means a unit in which observation services are given through Hospital outpatient services to help the Doctor decide if the patient needs to be admitted as an inpatient or can be discharged. Observation services may be given in the emergency department or another area of the Hospital.

<u>Hospitalization Benefits</u>

The Hospital Admission Benefit is deleted and replaced with the following:

Hospital Admission Benefit

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

We will pay the Hospital Admission Benefit amount shown in the Benefit Schedule. We will not pay benefits for confinement to an Observation Unit, or for emergency room Treatment or outpatient Treatment. We will not pay benefits for Hospital Admission of a newborn child following his birth. However, we will pay for a newborn's admission to a Hospital Intensive Care Unit if, following birth, he is confined as an inpatient as a result of a Covered Accidental Injury or Covered Sickness (including congenital defects, birth abnormalities, and/or premature birth).

We will pay this benefit once per period of Hospital Confinement. This benefit is limited to the maximum shown in the Benefit Schedule. We will only pay this benefit once for each Covered Accident or Covered Sickness per Calendar Year. If an Insured is confined to the Hospital because of the same or Related Accidental Injury or Sickness, we will not pay this benefit again in the same Calendar Year.

The Health Screening Benefit is deleted and replaced with the following:

Health Screening Benefit

We will pay the amount shown on the Benefit Schedule for Health Screening Tests performed while an Insured's coverage is in force. This benefit is limited to the Calendar Year Maximum shown in the Benefit Schedule.

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

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

- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Non-diagnostic vascular screening
- DNA stool analysis
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Immunization
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test to determine level of HDL and LDL
- Serum protein electrophoresis (blood test for myeloma)
- Spiral CT screening for lung cancer
- Stress test on a bicycle or treadmill
- Thermography
- Urinalysis
- Vision screening
- HIV test performed via nucleic acid test (NAT)
- HPV test
- Blood test for chickenpox, mononucleosis, shingles, and other strains of HSV

The Proof of Loss provision is deleted and replaced with the following:

Proof of Loss

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

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

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

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

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

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

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

The Individual Certificates provision is deleted and replaced with the following:

Individual Certificates

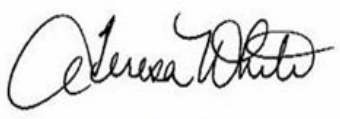
The Company will make available to the Policyholder a Certificate for Employees. The Certificate will set forth:

- The coverage, (including any limitations, reductions and exclusions);
- Any family member or dependent coverage
- To whom benefits will be paid, and
- The rights and privileges under the Plan.

CONTRACT

This Amendment is part of the Policy and Certificate and will terminate when the Policy or Certificate terminates.

Signed for the Company at its Home Office,



Teresa White, President

J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

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

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

Continuation of Coverage Endorsement

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

EFFECTIVE DATE

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

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

CONTINUATION OF COVERAGE

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

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

To keep your Certificate in force, you must:

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

PREMIUMS

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

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

TERMINATION

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

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

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

CONTRACT

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

- The Certificate terminates.

Signed for the Company at its Home Office,

Teresa White, President J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

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

Home Office: 2801 Devine Street, Columbia, South Carolina 29205
800.433.3036

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

Waiver of Premium Rider
To Certificate of Insurance for Group Supplemental Hospital Indemnity Policy

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

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

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

EFFECTIVE DATE

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

DEFINITIONS

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

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

- Not working at any job for pay or benefits,
- Under the care of a Doctor for the Treatment of a Covered Sickness or a Covered Accidental Injury, and
- Unable to Work.

Unable to Work means either:

- You are unable to work at the occupation you were performing when your Total Disability began, which was during the first 365 days of Total Disability; or
- You are unable to work at any gainful occupation for which you are suited by education, training, or experience after the first 365 days of Total Disability.

WAIVER OF PREMIUM BENEFIT

If you, the Employee, become Totally Disabled as defined in this Plan due to a Covered Sickness or Covered Accidental Injury, we will waive premiums for you and for any currently covered Dependents. This includes waiving premiums for any Riders that are in force.

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

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

Pending our approval of a claim for the Waiver of Premium Benefit, premiums should be paid as they are due.

Premium will continue to be waived until the earliest of the following:

- The premium due date following your 65th birthday,
- The date the Company has waived premiums for a total of 24 months of Total Disability,
- The date you refuse to provide proof of continuing Total Disability,
- The date your Total Disability ends, or
- The date coverage ends according to the Termination provisions in **Section I** of your Certificate**.**

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

GENERAL PROVISIONS

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

CONTRACT

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

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

Signed for the Company at its Home Office,

Teresa White, President

J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

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

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

Surgical Benefits Rider
To Certificate of Insurance for Group Supplemental Hospital Indemnity Policy

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

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

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

EFFECTIVE DATE

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

SURGICAL BENEFITS

We will pay the daily benefit amount shown in the Schedule of Operations for each day that, due to a Covered Accidental Injury or Covered Sickness, an Insured has surgery performed by a Doctor. The surgery can be performed in a Hospital (on an inpatient or outpatient basis), in an Ambulatory Surgical Center, or in a Doctor's office.

If an operation is not listed in the Schedule of Operations, we will pay an amount comparable to that which would be payable for the operation listed in the Schedule of Operations which is most nearly similar in severity and complexity.

Only one benefit is payable per 24-hour period for surgery, even though more than one surgical procedure may be performed. If two or more surgical procedures are performed at the same time through the same or different incisions, only one benefit, the largest, will be provided.

ANESTHESIA BENEFITS

When a surgical procedure is performed that is covered under the Surgical Benefits, we will pay 25% of the amount shown in the Schedule of Operations for anesthesia administered by a Doctor in connection with such procedure.

GENERAL PROVISIONS

Time Limit on Certain Defenses

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

CONTRACT

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

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

Signed for the Company at its Home Office,

Teresa White, President

J. Matthew Loudermilk, Secretary

INTEGUMENTARY SYSTEM	Maximum Surgical Benefit			Maximum Surgical Benefit
SKIN			**JOINTS**	
Incision and Drainage of Cyst	$ 7.50		Shoulder or Elbow Arthrotomy	$ 187.50
Acne Surgery	$ 5.63		Arthroplasty	$ 300.00
Biopsy	$ 11.25		Wrist Arthrotomy	$ 150.00
Excision of Benign Tumor	$ 15.00		Arthroplasty	$ 300.00
Excision of Malignant Tumor	$ -		Hip Arthrotomy	$ 262.50
(Trunk, Arms or Legs)	$ 22.50		Arthroplasty	$ 375.00
Excision of Malignant Tumor	$ -		Knee Arthrotomy	$ 187.50
(Face, Scalp, Ears, Neck, Hands	$ -		Arthroplasty	$ 375.00
Feet, Genitalia)	$ 37.50		Ankle Arthrotomy	$ 187.50
Excision of Malignant Tumor	$ -		Arthroplasty	$ 281.25
(Eyelids, Nose, Lips, Mucous	$ -		Hammertoe	$ 75.00
Membrane)	$ 56.25			$ -
Excision of Nail	$ 37.50		**DISLOCATIONS**	$ -
Repair – Simple Wounds	$ 7.50		Jaw	$ 18.75
Repair – Complex Wounds (Linear Repair)	$ 26.25		Collar Bone (requiring reduction)	$ 37.50
Repair – Skin Grafts (Single Stage)	$ 18.75		Shoulder (humerus with anesthesia)	$ -
Repair – Skin Grafts (Multiple Stage)	$ 56.25		Or Elbow	$ 18.75
Electro – surgical destruction of	$ -		Wrist	$ 18.75
Chemocautery	$ 7.50		Fingers or Toes	$ 7.50
Chemosurgery – malignancies of skin	$ 75.00		Hip or Knee	$ 75.00
	$ -		Ankle	$ 37.50
BREAST	$ -			$ -
Biopsy	$ 56.25		**TENDONS**	$ -
Excision of Cyst or Benign Tumor	$ 56.25		Repair or Suture	$ 45.00
Excision of Chest Wall Tumor	$ 262.50		Lengthening or Shortening	$ -
Mastectomy, simple	$ 112.50		(e.g. Achilles tendon)	$ 112.50
Mastectomy, radical	$ 262.50			$ -
Mammoplasty, Reconstructive	$ 562.50		**AMPUTATIONS**	$ -
	$ -		Arm at Shoulder Joint	$ 281.25
MUSCULOSKELETAL SYSTEM	$ -		Arm below Shoulder Joint	$ 131.25
	$ -		Finger	$ 56.25
BONE OR CARTILAGE GRAFT	$ -		Leg at Hip Joint	$ 300.00
Spinal Fusion	$ 300.00		Leg at Knee	$ 150.00
Spinal Fusion with removal of	$ -		Leg above or below knee	$ 187.50
Intervertebral disc	$ 300.00		Toe	$ 37.50
Spinal Fusion of Scoliosis	$ 450.00			$ -
	$ -			$ -
	$ -		**RESPIRATORY SYSTEM**	$ -
FRACTURES (Requiring Reduction)	$ -			$ -
Skull	$ 281.25		**NOSE**	$ -
Nose	$ 18.75		Excision of Nasal Polyps	$ 11.25
Jaw	$ 112.50		Submucous resection, Classic Nasal Sept	$ 112.50
Vertabrae, one or more	$ 112.50			$ -
Collar Bone	$ 56.25		**SINUSES**	$ -
Shoulder blade (Scapula)	$ 206.25		Frontal Sinusotomy – simple	$ 75.00
Upper Arm	$ 93.75		Frontal Sinusotomy – radical	$ 225.00
	$ -			$ -
Lower Arm	$ 56.25		**LARYNX**	$ -
Hand	$ 37.50		Laryngectomy	$ 375.00
Fingers or Toes	$ 18.75		Laryngoscopy	$ 15.00
Upper Leg	$ 150.00			$ -
Lower Leg	$ 56.25			$ -
Ankle	$ 93.75			$ -
Foot	$ 37.50			$ -
	$ -			$ -

	$	-			$ -
LUNGS	$	-		**TRACHEA AND BRONCH**	$ -
Thoracotomy	$	187.50		Tracheotomy	$ 75.00
Pneumonotomy	$	225.00		Bronchoscopy	$ 56.25
Pneumonocentesis	$	18.75		Closure of Tracheotomy	$ 93.75
Thoracentesis	$	11.25			$ -
Pneumonectomy, total	$	375.00			$ -
Wedge Resection of Lung,	$	-		Fistulotomy	$ 37.50
Single or Multiple	$	300.00		Sphincterotomy	$ 18.75
Thoracoscopy (including biopsy)	$	75.00		Fissurectomy or Hemorrhoidectomy	$ 75.00
	$	-		Removal of External Hemorrhoids	$ 11.25
CARDIOVASCULAR SYSTEM	$	-		Aspiration biopsy of liver, pancreas	$ -
	$	-		Or bile duct	$ 18.75
HEART	$	-		Cholecystotomy	$ 187.50
Heart Transplant	$	750.00		Cholecystectomy	$ 225.00
Catheterization of Heart	$	56.25		Pancreatectomy – partial	$ 300.00
Suture of Heart wound or injury	$	375.00		Pancreatectomy – total	$ 525.00
Valvotomy, aortic and pulmonic valve	$	562.50		Laparotomy	$ 150.00
Valvotomy, mitral valve	$	525.00		Hemiotomy	$ 131.25
Valvutoplasty or Replacement	$	-			$ -
Aortic and mitral valve	$	750.00		**URINARY SYSTEM**	$ -
Coronary Bypass, single or multiple	$	750.00		Nephrolithotomy	$ 300.00
Repair of Myocardial Aneurysm	$	750.00		Renal Biopsy	$ 18.75
Repair of Septal Defect	$	675.00		Nephrectomy	$ 300.00
Angioplasty, percutaneous	$	375.00		Lithotripsy	$ 187.50
Pervenous or Transvenous insertion of	$	-		Kidney Transplant	$ 468.75
Pacemaker	$	187.50		Cystetomy	$ 187.50
	$	-		Cystectomy – partial	$ 262.50
ARTERIES	$	-		Cystectomy – complete	$ 375.00
Arterlotomy, extramity	$	225.00		Urethroscopy or Cystoscopy	$ 18.75
Thromboendarterectomy	$	450.00		Cystoplasty	$ 300.00
Carotid endurteractomy	$	450.00		Dilation of Urethra	$ 7.50
Excision and graft, Abdominal Aortic	$	-			$ -
Aneurysm	$	562.50		**GENITAL SYSTEM**	$ -
Injection – Varicose Veins	$	3.75			$ -
	$	-		**MALE**	$ -
HEMIC AND LYPHATIC SYSTEMS	$	-		Circumcision	$ 11.25
Splenectomy	$	225.00		Orchlectomy	$ 75.00
Biopsy of Lymph Node	$	18.75		Reduction of Torsion of Testis	$ 112.50
Radical Lymphadenectomy	$	191.25		Excision of Epididymis, Hydrocele,	$ 37.50
	$	-		Varicocale	$ 112.50
DIGESTIVE SYSTEM	$	-		Vasectomy	$ 56.25
Gastrotomy	$	187.50		Biopsy, Prostate	$ 62.50
Gastrectomy, Total	$	375.00		Prostatectomy – partial	$ 300.00
Gastrectomy, Partial	$	300.00		Prostatectomy – radical	$ 375.00
Gastroscopy	$	56.25			$ -
Gastro Gastrorrhaphy	$	187.50		**FEMALE**	$ -
Enterectathy	$	225.00		Hysterectomy, Vaginal or Abdominal	$ 225.00
Enterectomy	$	262.50		Hysterectomy, radical for cancer	$ -
Colostomy	$	300.00		Including lymph nodes	$ 375.00
Enterostomy	$	187.50		Salpingo – oaphorectomy	$ 168.75
Enterolysis	$	150.00		Repair of cystocele or rectocele	$ 131.25
Diverticulectomy	$	187.50		Repair of cystocele and rectocele	$ 195.00
Appendectomy	$	150.00		Tubal Ligation	$ 150.00
Proctectomy	$	375.00		Biopsy or removal of cervical lesion	$ -
Protosigmoidoscopy	$	11.25		or polyp	$ 112.50
Proctoplasty	$	150.00		Dilation and curettage	$ 56.25
	$	-		Myomectomy	$ 187.50
	$	-		Repair of uterine suspension	$ 150.00
	$	-		Cesarian Section	$ 187.50
	$	-		Obstetrical Delivery	$ 75.00
	$	-		Amniocentesis	$ 18.75
	$	-			

ENDOCRINE SYSTEM	$	-			
Incision and drainage of	$	-			
Thyroid Gland	$	11.25			
Local excision of thyroid cyst	$	-			
Or adenoma	$	150.00			
Thyroidectomy or parathyroidectomy	$	262.50			
Adrenalectomy	$	300.00			
	$	-			
NERVOUS SYSTEM	$	-			
Burr Holes	$	112.50			
Carnioplasty	$	375.00			
Craniotomy or Craniectomy	$	150.00			
Laminectomy	$	375.00			
Spinal Puncture	$	7.50			
Paravertebral block, lumbar,	$	-			
Or thoracic nerve	$	18.75			
Median nerve decompression	$	-			
(Carpal Tunnel)	$	112.50			
	$	-			
EYE	$	-			
Removal of eye	$	150.00			
Excision of pteryglum	$	93.75			
Sclerotomy – anterior	$	187.50			
Sclerotomy – posterior	$	112.50			
Iridectomy	$	187.50			
Extraction of lens (including	$	-			
Cataract extraction)	$	300.00			
Reattachment of retina	$	375.00			
Muscle operation (one or more muscles)	$	225.00			
Excision of lacrimal gland or sac	$	187.50			
	$	-			
EAR	$	-			
Drainage of abscess	$	7.50			
Otoscopy	$	7.50			
Myringotomy	$	11.25			
Tympanotomy (diagnostic)	$	187.50			
Tympanotomy with insertion of	$	-			
Collar Button Tube	$	93.75			
Mastoidectomy – simple	$	187.50			
Tympanoplasty	$	375.00			
Labyrinthotomy or Labyrinthactomy	$	375.00			

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

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

This notice provides a **brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.
The Association was established to provide protection in the unlikely event that a life, annuity or health insurance company licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - o $300,000 in death benefits
  - o $100,000 in cash surrender or withdrawal values

- Health Insurance
  - o $500,000 in hospital, medical and surgical insurance benefits
  - o $300,000 in disability income insurance benefits
  - o $300,000 in long-term care insurance benefits
  - o $100,000 in other types of health insurance benefits

- Annuities
  - o $250,000 in withdrawal and cash values

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

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

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

VIRGINA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.
1503 Santa Rosa Road, Suite 101
Henrico, VA 23229-5105
804-282-2240

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

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

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

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

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