CONTINENTAL AMERICAN INSURANCE COMPANY

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

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
Yancey County Government
(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.
BENEFIT REDUCTION AT AGE 70
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.

Paul S. Amos II, 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 -12496
Effective Date - 7/1/2012
Anniversary Date - 7/1/2013
Jurisdiction - North Carolina
Non-Participating

GROUP POLICY PROVISIONS

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 rates shown in this Schedule can be changed annually. 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:

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 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.

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 16 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

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.

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 AND REDUCTIONS

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 Certificates
Reduced Maximum Benefit Amount:	50% of Maximum Benefit
Reduced Benefit Date:	First Renewal Date after age 70
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

Stroke
Kidney Failure
Heart Attack
Major Organ Transplant

PARTIAL BENEFITS

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 16 hours per week.**

Rate sheet prepared by Web User on 4/14/2014 7:47:58 PM.
North Carolina Payroll Premium rates are Biweekly.
Aflac Group coverage is underwritten by Continental American Insurance Company (CAIC). 1-800-433-3036

The rates shown on this insert page are for illustration purposes only; they do not imply coverage. For more information about policy/plan benefits and limitations, please refer to the accompanying product brochure for each insurance policy/plan listed below.

CAIC GROUP CRITICAL ILLNESS Series 2800 - Additional Benefits Rider Heart Event Rider NON- TOBACCO for Employee

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$2.47	$3.33	$4.18	$5.04	$5.89	$6.74	$7.60	$8.45	$9.30	$10.16
30-39	$3.03	$4.44	$5.84	$7.25	$8.66	$10.07	$11.47	$12.88	$14.29	$15.70
40-49	$4.48	$7.34	$10.20	$13.07	$15.93	$18.79	$21.65	$24.51	$27.37	$30.24
50-59	$6.21	$10.80	$15.40	$19.99	$24.58	$29.17	$33.77	$38.36	$42.95	$47.54
60-69	$9.00	$16.39	$23.77	$31.16	$38.54	$45.93	$53.31	$60.70	$68.08	$75.47

CAIC GROUP CRITICAL ILLNESS Series 2800 - Additional Benefits Rider Heart Event Rider NON-TOBACCO for Spouse

Age	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$2.47	$2.90	$3.33	$3.75	$4.18	$4.61	$5.04	$5.46	$5.89
30-39	$3.03	$3.73	$4.44	$5.14	$5.84	$6.55	$7.25	$7.95	$8.66
40-49	$4.48	$5.91	$7.34	$8.77	$10.20	$11.64	$13.07	$14.50	$15.93
50-59	$6.21	$8.51	$10.80	$13.10	$15.40	$17.69	$19.99	$22.29	$24.58
60-69	$9.00	$12.70	$16.39	$20.08	$23.77	$27.47	$31.16	$34.85	$38.54

CAIC GROUP CRITICAL ILLNESS Series 2800 - Additional Benefits Rider Heart Event Rider TOBACCO for Employee

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$2.91	$4.20	$5.50	$6.79	$8.08	$9.37	$10.67	$11.96	$13.25	$14.54
30-39	$3.86	$6.10	$8.34	$10.57	$12.81	$15.05	$17.29	$19.53	$21.77	$24.00
40-49	$7.30	$12.97	$18.65	$24.33	$30.00	$35.68	$41.36	$47.04	$52.71	$58.39
50-59	$10.69	$19.76	$28.83	$37.90	$46.97	$56.04	$65.10	$74.17	$83.24	$92.31
60-69	$15.74	$29.87	$43.99	$58.11	$72.24	$86.36	$100.48	$114.60	$128.73	$142.85

CAIC GROUP CRITICAL ILLNESS Series 2800 - Additional Benefits Rider Heart Event Rider TOBACCO for Spouse

Age	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$2.91	$3.56	$4.20	$4.85	$5.50	$6.14	$6.79	$7.44	$8.08
30-39	$3.86	$4.98	$6.10	$7.22	$8.34	$9.45	$10.57	$11.69	$12.81
40-49	$7.30	$10.14	$12.97	$15.81	$18.65	$21.49	$24.33	$27.17	$30.00
50-59	$10.69	$15.22	$19.76	$24.29	$28.83	$33.36	$37.90	$42.43	$46.97
60-69	$15.74	$22.80	$29.87	$36.93	$43.99	$51.05	$58.11	$65.17	$72.24

Rates do not include cancer benefit.

Rates include $100 Health Screening Benefit.

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.

Paul S. Amos II, 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.

Paul S. Amos II, 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.

f. If Dependent Child(ren) are covered under the plan, Dependent Child(ren) Children Child or 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.

The second paragraph under the provisions **TERMINATION OF AN EMPLOYEE'S INSURANCE** and **TERMINATION OF YOUR INSURANCE** is deleted and replaced by the following:

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

1. the date the Plan is terminated;
2. the date the Spouse or Dependent Child ceases to be a dependent;
3. the premium due date following the date we receive your written request to terminate coverage for your Spouse and/or all Dependent Children.

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

Signed by the Company at its Home Office.

Paul S. Amos II, President

J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205

800.433.3036

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.

Paul S. Amos II, 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.

Paul S. Amos II, President

J. Matthew Loudermilk, Secretary

RIDER SCHEDULE

BENEFITS

Initial Benefit Amount: **See Certificate Schedule**
Benefits reduce by 50% at age 70.

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

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

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

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

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

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

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);

- the insurer was not authorized to do business in this state;

- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

- any policy of reinsurance (unless an assumption certificate was issued);

- interest rate yields that exceed the average rate specified in the law;

- dividends;

- experience or other credits given in connection with the administration of a policy by a group contract holder;

- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);

- unallocated annuity contracts (which give rights to group contract holders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.

- A policy or contract commonly known as Medicare Part C or Part D or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

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

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

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

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

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

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.

NOTICE OF PRIVACY PRACTICES – PROTECTED HEALTH INFORMATION

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

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

DEFINITIONS

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

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

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

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

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

Uses and Disclosures for Health Care Operations – We may use and disclose your PHI as necessary for our health care operations. Examples of health care operations include underwriting, premium rating, or other activities relating to the creation, renewal, or replacement of a Health Plan, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to your Health Plan. Unless permitted by HIPAA, we are prohibited from using or disclosing your PHI that is genetic information for underwriting purposes.

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

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

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

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

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

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

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

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

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

RIGHTS THAT YOU HAVE

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

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

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

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

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

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

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

FOR FURTHER INFORMATION

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

EFFECTIVE DATE

This Notice is effective August 16, 2013.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups sitused in California, coverage is underwritten by Continental American Life Insurance Company. For groups sitused in New York, coverage is underwritten by American Family Life Assurance Company of New York.

Continental American Insurance Company • 2801 Devine Street • Columbia, South Carolina 29205 1-800-433-3036 toll-free

PRIVACY PRACTICES

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

- **We do not sell, rent, lease or otherwise disclose personal information of our customers for purposes unrelated to our products and services.** The personal information of our customers is of paramount importance to us. Therefore, we provide this information only to our employees, agents and third parties as required to allow them to help us develop and provide our insurance and employee benefit products and services.

- **We work to ensure information integrity and security.** We use technology tools and design our business practices to help ensure that the personal information of our customers is properly gathered, stored and processed. We also work to maintain the security of, and internal and external access to, the personal information of our customers through the use of technology and our business practices.

- **We expect our agents and employees to respect the personal information of our customers.** Aflac has business policies and practices in place to help ensure that our employees and agents carry out these practices and otherwise protect personal information about our customers. Both employees and agents are subject to censure, dismissal, or termination for violation of these policies.

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

PRIVACY NOTICE

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

Collection of Information

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

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

Disclosure of Information

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

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

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

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

Confidentiality and Security

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

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

NOTICE OF INFORMATION PRACTICES

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

NOTICE OF PRIVACY PRACTICES - PROTECTED HEALTH INFORMATION

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

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. Aflac is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups sitused in California, coverage is underwritten by Continental American Life Insurance Company. For groups sitused in New York, coverage is underwritten by American Family Life Assurance Company of New York.

Continental American Insurance Company • 2801 Devine Street • Columbia, South Carolina 29205 1-800-433-3036 toll-free