



CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205

800.433.3036

GROUP SPECIFIED CRITICAL ILLNESS POLICY

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

DEPARTMENT OF ADMINISTRATIVE SERVICES

(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 SPECIFIED CRITICAL ILLNESSES LISTED. IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. PLEASE READ THE POLICY CAREFULLY

If an Insured is eligible for Medicare, review the Guide to Health Insurance For People with Medicare.

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. 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 the state)

Group Policy Number - 6231

Effective Date - January 1, 2014

Jurisdiction - Georgia

Anniversary Date - January 1, 2015

Non-Participating

GROUP POLICY PROVISIONS

- SECTION I** - Eligibility, Effective Date and Termination
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SECTION I - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY

An employee is eligible if he is:

1. Eligible to participate in the Flexible Benefits Program as follows:
 - (a) Regular full-time employees of the State of Georgia or of a state agency who work at least 30 hours a week on a continuing basis and whose employment is expected to last at least nine (9) months;
 - (b) Public school teachers who are employed in a professionally certificated capacity, work half-time (50%) or more, and at least seventeen and one-half (17.5) hours per week, and are not considered “temporary” or “emergency” employees;
 - (c) Employees of a local school system who hold a non-certificated position, are eligible to participate in the Teachers’ Retirement System or its equivalent, and work at least twenty (20) hours per week; or 60% of the time normally required for these positions, if that is more than 20 hours per week;
 - (d) Employees who are eligible to participate in the Public School Employees’ Retirement System and work at least fifteen (15) hours per week or 60% of the time normally required for these positions, if that is more than 15 hours per week;
 - (e) Employees of a county or regional library who works at least seventeen and one-half (17.5) hours per week;
 - (f) Employees who are in active employment and a member of the General Assembly, a constitutional officer, or an employee of an appropriate judicial branch;
 - (g) Other employees deemed eligible by Federal and State of Georgia law.
2. At least 18 years of age at initial eligibility date; and
3. Actively at work.

EFFECTIVE DATE

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

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.

An eligible employee may enroll for coverage or change multiples of coverage during the Annual Enrollment period. An eligible employee may also enroll or increase coverage within thirty (30) days following a life event, if the plan permits a change.

An employee may decrease or terminate coverage within thirty (30) days following a life event, if the plan permits a change.

If an employee enrolls for coverage or increases coverage above the guarantee issue due to a life event, proof of medical insurability is required. The effective date will be the first of the month that follows the change request.

Changes must be on account of and consistent with the life event.

If the employee ends employment and is rehired within 30 days of the same plan year, the employee may be insured on his/her eligibility date for the coverage the employee had under the plan when the employee ended employment. The employee cannot change his coverage until the next Annual Enrollment period or a life event.

LEAVE WITHOUT PAY AND PREMIUM PAYMENTS

Coverage is extended on a month-by-month basis. Normally, premiums are paid through payroll reduction/deduction in the month prior to coverage. When an employee is not in pay status, the employee must pay the monthly premium amount billed by Benefits Administrator by the specified due date.

If the Employee ceases to be Actively at Work due to:

- Suspension without pay, **or**
- Approved leave of absence without pay with respect to which the Employee has a scheduled date of return.

The Employee's insurance may be continued through the twelfth (12th) calendar month through personal premium payments. The exception to this rule is those employees affected by USERRA, who may continue personal premium payments for 24 months.

If the Employee is absent from work without pay for any reason, he should discuss continuing his insurance with his personnel officer. If the Employee's coverage is terminated for failure to pay premium, his re-enrollment will be in accordance with the regulations of the Employee Benefits Plan Council and may include submitting new proof of insurability.

TERMINATION OF THE PLAN

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

Forty-two months after the Plan Effective Date, the Company has the right to cancel the Plan on the day prior to the date any premium is due by giving 60 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 Employee 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 INSURED'S INSURANCE

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

1. The date the Plan is terminated;
2. On the 61st day after the premium due date if the required premium has not been paid;
3. On the date the Insured ceases to meet the definition of an Employee as defined in the Plan;
4. On the date he is no longer a member of the class eligible; **or**
5. On the premium due date following the date an Insured notifies the policyholder in writing.

Insurance for an insured Dependent Child will terminate on the earliest of the following:

1. The date the Plan is terminated;
2. The last day of the month in which a Dependent Child reaches age 26; **or**
3. The premium due date following the date we receive your written request to terminate coverage for all Dependent Children.

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

SECTION II - PREMIUM PROVISIONS

PREMIUM CALCULATIONS

Premiums payable on any premium due date for insurance on Employees will be calculated in accordance with the Schedule of Premiums. The rates shown in the Schedule of Premiums are guaranteed for 42 months after the Effective Date of this Plan. After the guaranteed period they can be changed annually. The Company will give the policyholder written notice 60 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 60-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 60 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

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

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

Annual Enrollment means a period designated by the Department of Administrative Services during which employees have the opportunity to enroll or change coverage.

Date of Diagnosis is:

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

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.

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

For end stage renal failure: The date an Insured's doctor recommends that he begin renal dialysis.

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

Dependent Children means your natural Children, step-Children, foster Children, legally adopted Children, or Children placed for adoption, who are younger than age 26.

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.

Children for whom a decree of adoption has been entered by you and/or your Spouse (or for whom adoption proceedings have been instituted by you and/or your Spouse), shall be covered automatically from birth. A decree of adoption must be entered within one year from the date proceedings were instituted, unless extended by order of the court, and you and/or your Spouse must continue to have custody pursuant to the decree of the court.

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.

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

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

Hospital - means a place which:

1. Is legally licensed and operated as a hospital;
2. Provides overnight care of injured and sick people;
3. Is supervised by a doctor;
4. Has full-time nurses supervised by a registered nurse;
5. Has on-site or pre-arranged use of X-ray equipment, laboratory and surgical facilities; **and**
6. Maintains permanent medical history records.

A Hospital is not:

1. A nursing home;
2. An extended care facility;
3. A convalescent home;
4. A rest home or a home for the aged;
5. A place for alcoholics or drug addicts; **or**
6. A mental institution.

Insured means an employee of the State of Georgia.

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.

Pathologist means a doctor, other than the 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.

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.

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

Symptoms mean the subjective evidence of disease or physical disturbance.

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. 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.

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

BENEFIT DEFINITIONS

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

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

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

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

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

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

We will pay benefits for a Clinical Diagnosis only if:

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

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

1. New and serial Electrocardiographic (EKG) findings consistent with Myocardial Infarction;
2. Elevation of cardiac enzymes above generally accepted laboratory levels of normal in case of creatine phosphokinase (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, stents 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. 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.

Alzheimer's Disease means a definite clinical diagnosis of a progressive degenerative disease of the brain where an Insured has a significant reduction in mental and social functioning as demonstrated by:

1. A loss of intellectual capacity and cognitive impairment
2. Impaired memory and sense of judgment, and
3. Requiring continuous adult supervision (cannot be left alone) for health and safety, whether medicated or not.

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.

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 while the his coverage is in force; and
2. It is not excluded by name or specific description in the Certificate.

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 amount payable for the applicable 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 3 months 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 3 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.

Spouse Benefit

Spouse is the Insured's legal wife or husband. The coverage amount available to the Insured's spouse will be equal to or less than, but not in excess of, the Insured's benefit amount.

Partial Benefits

Partial Benefits will be paid for Carcinoma in-situ and Coronary Artery Bypass Surgery at the amount shown on the Certificate Schedule. Partial benefits will reduce the maximum benefits paid under the certificate by the amount paid as a partial benefit.

We figure partial benefits by multiplying:

1. The Insured's Maximum Benefit Amount (Initial or Reduced, as the case may be); **LESS**
2. Any benefits previously paid; **TIMES**
3. The Partial Benefit Percentage shown in the "Benefit Percentages By Certificate Year" table in the Certificate Schedule for the applicable Specified Critical Illness and certificate year.

Additional Benefits

Coma: If an Insured is Diagnosed as being Comatose after his Effective Date, 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, 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, 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, the Company will pay the Benefit Amount for Loss of Sight, Speech or Hearing shown in the Schedule of Benefits.

Alzheimer's Disease: If an Insured is first diagnosed as having Alzheimer's Disease after his Effective Date, the Company will pay the Benefit Amount for Alzheimer's shown in the Schedule of Benefits.

The diagnosis must be made by a certified neurologist or psychiatrist licensed and practicing in the United States.

Portability Privilege

When an Insured's coverage would otherwise terminate under this Plan because he ended employment with his Employer, he may elect to continue his coverage. But he must have been continuously insured for at least six months under this Plan and/or the prior plan just before the date his employment terminated. The coverage an Insured may continue is that which he had on the date his employment terminated.

1. Coverage may not be continued for any of the following reasons:
 - a. The insured failed to pay any required premium;
 - b. The insured having attained age 70;
 - c. This Plan terminates.
2. To keep his insurance in force the Insured must:
 - a. Make written application to the Company within 31 days after the date his insurance would otherwise terminate; and
 - b. Pay the required premium to the Company no later than 31 days after the date his insurance would otherwise terminate.
3. Insurance will cease on the earliest of these dates:
 - a. The date the Insured failed to pay any required premium; **or**
 - b. The date this Plan is terminated.

If the Insured qualifies for this Portability Privilege as described, then the same benefits, Plan provisions, and premium rate as shown in his certificate as previously issued will apply.

Health Screening Benefit (Calendar Year Limit)

We will pay this benefit for the following health screening tests performed while an Insured's coverage is in force. We will pay the amount shown in the Schedule for the following health screening tests. This benefit is payable once per calendar year up to the maximum benefit amount shown in the Schedule. Payment of this benefit will not reduce the face amount of a certificate.

Health screening test is defined as:

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

There is no limit to the number of years an Insured can receive benefits for health screening tests, as long as this Plan and his certificate are 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.

SECTION V - LIMITATIONS AND EXCLUSIONS

Diagnosis must be made in the United States.

EXCLUSIONS

We will not 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 civil belligerence; **or**
5. Substance Abuse.

SECTION VI - CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within twenty (20) 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.

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 to an Insured within 10 working days, he will meet the proof of loss requirements 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 ninety (90) 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 written proof of loss. Should Continental American fail to pay any benefits payable upon receipt of written proof of loss, we shall have 15 working days thereafter in which to notify the Insured in writing of the reasons why the claim has not been paid. The notice shall itemize the information needed to process the claim. When all information needed to process the claim is received, we then have 15 working days in which to either deny or pay the claim. If we fail to notify the Insured or pay the claim in the required time, we will pay interest equal to 18 percent per annum on the benefit due under this Plan.

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

SECTION VII - GENERAL PROVISIONS

Entire Contract, Changes: This policy together with the application, endorsements, benefit agreements, certificate and riders, if any, is the entire contract of insurance. No change in the policy 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 policy or waive any of its provisions. Any rider, endorsement or application that modifies, limits or excludes coverage under this policy must be signed by the Insured, to be valid.

Physical Examination and Autopsy: We, at our expense, have the right to have an Insured examined as often as reasonably 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 policy within 60 days after written proof of loss has been given as required by this policy. 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: (1) After two years from the effective date of coverage, no misstatements, except fraudulent misstatements, made by an Insured in the application shall be used to void the coverage or to deny a claim for a covered specified critical illness commencing after the expiration of such two-year period. (2) No claim for loss incurred after two years from the effective date of an Insured's coverage shall be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description, had existed prior to such effective date.

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.

Individual Certificate: Continental American will give the policyholder a certificate for each Employee. The certificate will set forth:

1. The coverage;
2. To whom benefits will be paid; **and**
3. The rights and privileges under the Plan.

Data Required: The policyholder will furnish all information and proofs that Continental American may reasonably require with regard to the Plan.

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 Amount before age 70:	See Certificate Schedule Page
Reduced Benefit Date:	Not Applicable
Reduced Maximum Benefit Amount:	Not Applicable
Percentage for Partial Benefits:	25%

SPECIFIED CRITICAL ILLNESS

BENEFIT PERCENTAGE BY CERTIFICATE YEAR
Certificate Year 1 - Age 70
Initial Maximum Benefit **After Age 70**
Reduced Maximum Benefit

Stroke	100%	N/A
Cancer	100%	N/A
Carcinoma in situ	25%	N/A
Kidney Failure	100%	N/A
Heart Attack	100%	N/A
Major Organ Transplant	100%	N/A
Coronary Artery Bypass Surgery	25%	N/A

Benefits are paid for Covered Dependent Children at 25% of the Employee benefit amount.

PARTIAL BENEFITS

CANCER

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

HEART ATTACK

Coronary Artery Bypass Surgery	25%	N/A
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When this Partial benefit is paid, it will reduce the Heart Attack Benefit by 25%.

ADDITIONAL BENEFITS

Coma	100%	N/A
Burns	100%	N/A
Paralysis	100%	N/A
Loss of Sight	100%	N/A
Loss of Speech	100%	N/A
Loss of Hearing	100%	N/A
Alzheimer's Disease	25%	N/A

Health Screening Benefit Amount: up to \$100 per insured per calendar year.

SECTION IX - SCHEDULE OF PREMIUMS



CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205

800.433.3036

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, foster Children, legally adopted Children or Children placed for adoption, who are younger than age 26.

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.

Children for whom a decree of adoption has been entered by you and/or your Spouse (or for whom adoption proceedings have been instituted by you and/or your Spouse), shall be covered automatically from birth. A decree of adoption must be entered within one year from the date proceedings were instituted, unless extended by order of the court, and you and/or your Spouse must continue to have custody pursuant to the decree of the court.

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 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.

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 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.

EXCLUSIONS

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 two years from the effective date of coverage, no misstatements, except fraudulent misstatements, made by the applicant in the application shall be used to void the coverage or to deny a claim for confinement to a hospital for a covered specified critical illness commencing after the expiration of such two-year period.

No claim for loss incurred after two years from the effective date of coverage shall be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description, had existed prior to such effective date.

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

Portability Privilege Amendment

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

Effective Date

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

Portability Privilege

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

ELIGIBILITY — CLASSES OF COVERAGE

Class I

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

Class II

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

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

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

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

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

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

TERMINATION OF THE PLAN

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

After the end of the first Plan year, the Company has the right to cancel the Plan. To do so, the Company must give 31 days written notice that the plan will end on the date before the next premium due date.

The Policyholder has the right to cancel the Plan on the date before any premium due date by giving 31 days written notice.

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

Class I

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

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

Class II

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

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

TERMINATION OF AN EMPLOYEE'S INSURANCE

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

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

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

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

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

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

PORTABILITY PRIVILEGE

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

The premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least 31 days before any change is to take effect.

The Employee may continue the coverage until the earlier of:

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

Coverage may not be continued:

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

General Provisions

Time Limit on Certain Defenses

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

Contract

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

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

Signed for the Company at its Home Office,



Paul S. Amos II, President



J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205

800.433.3036

ADDITIONAL BENEFITS FOR DEPENDENT CHILDREN RIDER TO CERTIFICATE OF INSURANCE FOR CRITICAL ILLNESS

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

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

Unless amended by this Rider, all Certificate definitions, exclusions, limitations, terms, and other provisions apply. For the purpose of this Rider, “you” (including “your” and “yours”) may refer to the primary Insured or the primary Insured’s Spouse.

Effective Date

If issued at the same time as the Certificate, this Rider becomes effective on the Certificate Effective Date. If issued after the Certificate, this Rider will have a later Effective Date, which is shown in the Rider Schedule following this Rider.

Definitions

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

Dependent Children are your natural children, step-children, foster children, legally adopted children, or children placed for adoption who are younger than age 26.

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

Dependent Child coverage will terminate on that Child’s 26th birthday. If the Child is Diagnosed with a covered Critical Illness **before** his 26th birthday, we will pay this claim (whether the claim is filed before or after the Child’s 26th birthday).

There is an exception to the age-26 limit listed above. This limit will not apply to any Child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. The Employee or Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Child’s 26th birthday.

This Rider will cover Dependent Children from the moment of live birth in the following circumstances:

- Your natural Child is born after this Rider’s Effective Date. You do not have to provide notice or pay any additional premium.
- You enter a decree of adoption for a Child, **or** you and/or your Spouse have initiated adoption proceedings for a Child. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. You or your Spouse must continue to have custody pursuant to the decree of the court.

Diagnosis (also Diagnosed) refers to the definitive and certain identification of an illness that:

- Is made by a Doctor **and**
- Is based on clinical or laboratory investigations, as supported by the Insured's medical records.

The illness **must** meet the requirements outlined in this Rider for the particular Specified Critical Illness being Diagnosed.

Specified Critical Illness is one of the following illnesses defined below and shown in the Rider Schedule:

Cystic Fibrosis is a hereditary chronic disease of the exocrine glands. This disease is characterized by the production of viscid mucus that obstructs the pancreatic ducts and bronchi, leading to infection and fibrosis.

Cerebral Palsy is a disorder of movement, muscle tone, or posture that is caused by injury or abnormal development in the immature brain. Cerebral Palsy can be characterized by stiffness and movement difficulties, involuntary and uncontrolled movements, or a disturbed sense.

- **Spastic Cerebral Palsy** is characterized by stiffness and movement difficulties.
- **Athetoid Cerebral Palsy** is characterized by involuntary and uncontrolled movements.
- **Ataxic Cerebral Palsy** is characterized by a disturbed sense of balance and depth perception.

Cleft Lip occurs when there is an opening (one or two vertical fissures) in the lip. A **Cleft Palate** occurs when the two sides of a palate do not join, resulting in an opening in the roof of the mouth or soft tissue in the back of the mouth. Sometimes, an opening in the bones of the upper jaw or upper gum accompanies a Cleft Palate.

A Cleft Lip or Palate can occur on one or both sides of the face. If a Child has both a Cleft Lip and Cleft Palate or has one on each side of the face, we will pay this benefit only once.

Down Syndrome is a chromosomal condition characterized by the presence of an extra copy of genetic material on the 21st chromosome, either in whole or part.

Spina Bifida refers to any birth defect involving incomplete closure of the spine. This includes:

- **Spina Bifida Cystica**, which is a condition where a cyst protrudes through the defect in the vertebral arch.
- **Spina Bifida Occulta**, which is a condition where the bones of the spine do not close, but the spinal cord and meninges remain in place. Skin usually covers the defect.
- **Meningocele**, which is a condition where the tissue covering the spinal cord sticks out of the spinal defect, but the spinal cord remains in place.
- **Myelomeningocele**, which is a condition where the unfused portion of the spinal column allows the spinal cord to protrude through an opening. The meningeal membranes that cover the spinal cord form a sac enclosing the spinal elements.

Benefit Provisions

While this Rider is in force, if a Dependent Child is Diagnosed with a covered Critical Illness or Specified Critical Illness after any applicable Waiting Period, we will pay the benefit amounts shown in the Dependent Child Benefit Rider Schedule.

Exclusions

Exclusions

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

- **Self-Inflicted Injuries** – injuring or attempting to injure yourself intentionally or taking action that causes you to become injured
- **Suicide** – committing or attempting to commit suicide, while sane or insane
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job
- **Participation in Aggressive Conflict** of any kind, including:
 - War (declared or undeclared) or military conflicts
 - Insurrection or riot
 - Civil commotion or civil state of belligerence
- **Illegal substance abuse, which includes:**
 - Abuse of legally-obtained prescription medication
 - Illegal use of non-prescription drugs

General Provisions

Time Limit on Certain Defenses

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

Contract

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

- The Certificate terminates,
- Premiums are no longer paid for this Rider, or
- The covered Dependent Child reaches age 26 (details in the **Definitions** section under *Dependent Children*).

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

Signed for the Company at its Home Office,



Paul S. Amos II, President



J. Matthew Loudermilk, Secretary

BENEFITS

Cystic Fibrosis	100% of applicable Face Amount
Cerebral Palsy	100% of applicable Face Amount
Cleft Lip or Cleft Palate	100% of applicable Face Amount
Down Syndrome	100% of applicable Face Amount
Spina Bifida	100% of applicable Face Amount



CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205

800.433.3036

SPECIFIED CRITICAL ILLNESS RIDER TO CERTIFICATE OF INSURANCE FOR CRITICAL ILLNESS

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

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

Unless amended by this Rider, all Certificate definitions, exclusions, limitations, terms, and other provisions apply. For the purpose of this Rider, “you” (including “your” and “yours”) may refer to the primary Insured or the primary Insured’s covered Dependents.

Effective Date

If issued at the same time as the Certificate, this Rider becomes effective on the Certificate Effective Date. If issued after the Certificate, this Rider will have a later Effective Date, which is shown in the Rider Schedule following this Rider.

Definitions

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

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

- **Maintaining continence** – controlling urination and bowel movements, including the ability to use ostomy supplies or other devices (such as catheters).
- **Transferring** – moving between a bed and a chair or a bed and a wheelchair.
- **Dressing** – putting on and taking off all necessary items of clothing.
- **Toileting** – getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene.
- **Eating** – performing all major tasks of getting food into the body.
- **Bathing** – washing oneself by sponge bath or in either a tub or shower, including getting into or out of the tub or shower.

Covered Accident means an unforeseen and unexpected traumatic event resulting in bodily injury. An event meets the qualifications of Covered Accident if it:

- Occurs on or after the Plan’s Effective Date,
- Occurs while coverage is in force, **and**
- Is not specifically excluded.

A Covered Accident **must** occur while you are covered by this Rider.

Date of Diagnosis is defined for each Specified Critical Illness as follows:

- **Advanced Alzheimer's Disease** – The date a Doctor Diagnoses you as incapacitated due to Alzheimer's disease.

Diagnosis (also Diagnosed) refers to the definitive and certain identification of an illness that:

- Is made by a Doctor **and**
- Is based on clinical or laboratory investigations, as supported by the Insured's medical records.

The illness **must** meet the requirements outlined in this Rider for the particular Specified Critical Illness being Diagnosed.

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

Specified Critical Illness is one of the illnesses defined below and shown in the Rider Schedule:

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

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

Benefit Provisions

Specified Critical Illness Benefit

We will pay the Specified Critical Illness Benefit if you are Diagnosed with one of the Specified Critical Illnesses shown in the Rider Schedule **if**:

- The Date of Diagnosis is after the Waiting Period,
- The Date of Diagnosis is while this Rider is in force, **and**
- The Specified Critical Illness is not excluded by name or by specific description in this Rider.

We will pay the indicated percentages of the applicable benefit amount shown in the Rider Schedule for loss occurring while this Rider is in force. We will not pay benefits under this Rider if these conditions result from another Specified Critical Illness. For benefits to be payable on multiple Specified Critical Illnesses, the date of loss for each Illness must be separated by at least 12 months.

Exclusions

Exclusions

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

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured
- **Suicide** – committing or attempting to commit suicide, while sane or insane
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job
- **Participation in Aggressive Conflict** of any kind, including:
 - War (declared or undeclared) or military conflicts
 - Insurrection or riot
 - Civil commotion or civil state of belligerence
- **Illegal substance abuse, which includes:**
 - Abuse of legally-obtained prescription medication
 - Illegal use of non-prescription drugs

General Provisions

Time Limit on Certain Defenses

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

Contract

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

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

The Rider Schedule shows the premium amount. Premiums for this Rider must be paid 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 those terms are inconsistent with this Rider.

Signed for the Company at its Home Office,



Paul S. Amos II, President



J. Matthew Loudermilk, Secretary

BENEFITS

Advanced Alzheimer's Disease 25% of applicable Face Amount



CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205

800.433.3036

WAIVER OF PREMIUM BENEFIT RIDER TO CERTIFICATE OF INSURANCE FOR CRITICAL ILLNESS

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

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

Unless amended by this Rider, all Certificate definitions, exclusions, limitations, terms, and other provisions apply. For the purpose of this Rider, “you” refers to the primary Insured.

Effective Date

If issued at the same time as the Certificate, this Rider becomes effective on the Certificate Effective Date. If issued after the Certificate, this Rider will have a later Effective Date, which is shown in the Rider Schedule following this Rider.

Definitions

Total Disability or *Totally Disabled* means you are:

- Unable to Work (defined later in this section),
- Not working at any job for pay or benefits, **and**
- Under the care of a Doctor for the treatment of a covered Critical Illness.

Unable to Work means either:

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

Benefit Provisions

Waiver of Premium Benefit

A Critical Illness may result in more than 90 days of Total Disability for an Insured. If a covered Critical Illness causes an Insured to be Totally Disabled for 90 days, the Company will waive the premium payments for this coverage for the first 90 days of Total Disability and for each following day until the earliest of the following:

- The Insured is no longer Totally Disabled,
- The Company has waived premiums for a total of 24 months of Total Disability,
- The Insured reaches age 65 or is 2 years from the date of Total Disability, whichever occurs last, **or**
- Coverage ends according to the Termination of Coverage provision.

At the end of the waiver period, the Insured must resume paying premiums to keep this coverage in force. Premiums waived include those for the Employee and those for currently covered Dependents or Riders that are in force.

For premiums to be waived, the Insured must provide satisfactory proof of Total Disability at least once every 12 months.

General Provisions

Time Limit on Certain Defenses

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

Contract

This Rider is:

- Part of the Critical Illness Certificate to which it is attached **and**
- Subject to all of the terms of the Certificate unless those terms are inconsistent with this Rider.

This Rider will terminate when:

- The Critical Illness Certificate to which it is attached terminates, **or**
- Premiums are no longer paid for this Rider.

Signed for the Company at its Home Office,



Paul S. Amos II, President



J. Matthew Loudermilk, Secretary

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

Continental American Insurance Company • 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.

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