



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Endorsement to Policy and Certificate of Insurance

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

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

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

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

Premium Payments should be mailed to the Company at:

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

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

Signed for the Company at its Home Office,

Teresa White, President

J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205
800.433.3036

Certificate of Insurance For Group Critical Illness Insurance Policy

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

This Plan provides benefits for the Critical Illnesses listed in the Benefit Schedule.

**The insurance Policy under which this Certificate is issued is limited.
Please read it carefully.**

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

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

We certify that you are insured under the Group Critical Illness Policy (the "Plan"). The Plan was issued to the Policyholder. This coverage provides benefits for loss resulting from Critical Illness. The Certificate is subject to the definitions, exclusions, and other provisions of the Plan.

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

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

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage.

Table of Contents

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

Section I – Eligibility, Effective Date, and Termination

Eligibility

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

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

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

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

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

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

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

Effective Date

Your Certificate Effective Date is shown on the Certificate Schedule.

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

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

The Effective Date for a Spouse or Dependent Child is:

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

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

Newborn children will be covered from the moment of birth, adopted children from the date the petition is filed for adoption, and step-children from the date of the Employee's marriage.

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

Plan Termination

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

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

- The Policyholder does not provide timely information or meet any obligations required by this Plan and applicable law, **or**
- The Company cancels the Plan any time after the end of the first policy year. To do this, the Company must give the Policyholder 31 days' written notice.

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

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

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

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

Termination of Your Insurance

Your insurance will terminate on whichever occurs first:

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

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

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

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

Portability Privilege

When you are no longer a member of an eligible class and your coverage would otherwise end, you may elect to continue your coverage under this Plan. You may continue the coverage you had on the date your Certificate would otherwise terminate, including any in-force Spouse or Dependent Child coverage.

To keep your coverage in force, you must:

- Notify the Company in writing within 31 days after the date your coverage would otherwise terminate, **and**
- Pay the required premium to the Company no later than 31 days after the date your coverage would otherwise terminate and on each premium due date thereafter.

Ported coverage will end on the earliest of the following dates:

- 31 days after the date you fail to pay any required premium; **or**
- The date the Group Plan is terminated.

If you qualify for this Portability Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate as shown in your previously issued Certificate.

Section II – Premium Provisions

Premium Payments

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

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

Premium Changes

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

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

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

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

Premiums on the Policy Anniversary Date are determined by your Attained Age. The Attained Age rates are shown in the Schedule of Premiums.

Grace Period

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

Section III – Definitions

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

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

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

Acute Coronary Syndrome is an obstruction of the coronary arteries that occurs as a result of Myocardial Infarction with or without ST elevation. This is determined by an electrocardiogram (ECG). Acute Coronary Syndrome includes unstable angina but does not include stable angina.

Arteriosclerosis means a disease of the arteries characterized by plaque deposits on the arteries' inner walls, resulting in their abnormal thickening and loss of elasticity.

Arteriovenous Malformation means a congenital disease of the blood vessels in the brain, brain stem, or spinal cord that is characterized by a complex, tangled web of abnormal arteries and veins and may be connected by one or more fistulas.

Atherosclerosis means a disease in which plaque builds up inside a person's arteries.

Attained Age means the Employee's age on his Certificate Effective Date and on each Policy Anniversary Date thereafter.

Bone Marrow Transplant (Stem Cell Transplant) means a procedure to replace damaged or destroyed bone marrow with healthy bone marrow stem cells. For a benefit to be payable, a Bone Marrow Transplant (Stem Cell Transplant) must be caused by at least one of the following diseases:

- Aplastic anemia
- Congenital neutropenia
- Severe immunodeficiency syndromes
- Sickle cell anemia
- Thalassemia
- Fanconi anemia
- Leukemia
- Lymphoma
- Multiple myeloma

The Bone Marrow Transplant (Stem Cell Transplant) benefit is not payable if the Transplant results from a covered Critical Illness for which a benefit has been paid under this Plan.

Brain Aneurysm is a weak area in the wall of a blood vessel of the brain that causes the blood vessel to bulge, balloon out, or rupture.

Cancer (internal or invasive) is a disease that meets either of the following definitions:

- A malignant tumor characterized by:
 - The uncontrolled growth and spread of malignant cells, **and**
 - The invasion of distant tissue.
- A disease meeting the diagnostic criteria of malignancy, as established by the American Board of Pathology. A Pathologist must have examined and provided a report on the histocytologic architecture or pattern of the tumor, tissue, or specimen.

Cancer (internal or invasive) also includes:

- Melanoma that is Clark's Level III or higher **or** Breslow depth equal to or greater than 0.77mm,
- Myelodysplastic syndrome – RCMD (refractory cytopenia with multilineage dysplasia),
- Myelodysplastic syndrome – RAEB (refractory anemia with excess blasts),
- Myelodysplastic syndrome – RAEB-T (refractory anemia with excess blasts in transformation), **or**
- Myelodysplastic syndrome – CMML (chronic myelomonocytic leukemia).

The following are **not** considered internal or invasive Cancers:

- Pre-malignant tumors or polyps
- Carcinomas in Situ
- Any superficial, non-invasive Skin Cancers including basal cell and squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is Diagnosed as
 - Clark's Level I or II,
 - Breslow depth less than 0.77mm, **or**
 - Stage 1A melanomas under TNM Staging

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

Melanoma in Situ means melanoma cells that occur only on the outer layer of the skin (the epidermis), where there is no invasion of the deeper layer (the dermis).

Non-Invasive Cancer is a Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

For the purposes of this Plan, a Non-Invasive Cancer is:

- Internal Carcinoma in Situ
- Myelodysplastic Syndrome – RA (refractory anemia)
- Myelodysplastic Syndrome – RARS (refractory anemia with ring sideroblasts)

Skin Cancer, as defined in this Plan, is not payable under the Non-Invasive Cancer benefit.

Skin Cancer is a Cancer that forms in the tissues of the skin.

The following are considered Skin Cancers:

- Basal cell carcinoma
- Squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is Diagnosed as
 - Clark's Level I or II,
 - Breslow depth less than 0.77mm, **or**
 - Stage 1A melanomas under TNM Staging

These conditions are not payable under the Cancer (internal or invasive) benefit.

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

1. **Pathological Diagnosis** is a Diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This Diagnosis must be made by a certified Pathologist and conform to the American Board of Pathology standards.
2. **Clinical Diagnosis** is based only on the study of symptoms. The Company will accept a Clinical Diagnosis only if:
 - A Doctor cannot make a Pathological Diagnosis because it is medically inappropriate or life-threatening,
 - Medical evidence exists to support the Diagnosis, **and**
 - A Doctor is treating the Insured for Cancer or Carcinoma in Situ.

Cardiomyopathy means a disease with measurable deterioration of the function of the myocardium, and is typically characterized by breathlessness and swelling of the legs.

Chronic Kidney Disease means a disease characterized by the gradual loss in renal function over time due to diabetes mellitus, Hypertension, glomerulonephritis, polycystic kidney disease, autoimmune disease, or genetic disease.

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

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

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

Coma does not include a medically-induced coma.

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

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

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

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

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

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

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

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

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

Date of Diagnosis is defined as follows:

- **Bone Marrow Transplant (Stem Cell Transplant):** The date the surgery occurs.
- **Cancer:** The day tissue specimens, blood samples, or titer(s) are taken (Diagnosis of Cancer and/or Carcinoma in Situ is based on such specimens).

- **Coma:** The first day of the period for which a Doctor confirms a Coma that is due to one of the underlying diseases and that has lasted for at least seven consecutive days.
- **Coronary Artery Bypass Surgery:** The date the surgery occurs.
- **Heart Attack (Myocardial Infarction):** The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the Heart Attack (Myocardial Infarction) definition.
- **Kidney Failure (End-Stage Renal Failure):** The date a Doctor recommends that an Insured begin renal dialysis.
- **Loss of Sight, Speech, or Hearing:** The date the loss due to one of the underlying diseases is objectively determined by a Doctor to be total and irreversible.
- **Major Organ Transplant:** The date the surgery occurs.
- **Non-Invasive Cancer:** The day tissue specimens, blood samples, or titer(s) are taken (Diagnosis of Cancer and/or Carcinoma in Situ is based on such specimens).
- **Paralysis:** The date a Doctor Diagnoses an Insured with Paralysis due to one of the underlying diseases as specified in this Plan, where such Diagnosis is based on clinical and/or laboratory findings as supported by the Insured's medical records.
- **Skin Cancer:** The date the skin biopsy samples are taken for microscopic examination.
- **Stroke:** The date the Stroke occurs (based on documented neurological deficits and neuroimaging studies).
- **Sudden Cardiac Arrest:** The date the pumping action of the heart fails (based on the Sudden Cardiac Arrest definition).

Dependent means your Spouse or your Dependent Child. **Spouse** is your legal wife or husband who is listed on your Application. **Dependent Children** are your or your Spouse's natural children, step-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 initiated adoption proceedings. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. You must continue to have custody pursuant to the decree of the court.

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

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

- Is made by a Doctor; **and**
- Is based on clinical or laboratory investigations, as supported by your medical records.

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

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

Doctor is a person who is:

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

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

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

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

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

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

Heart Attack (Myocardial Infarction) is the death of a portion of the heart muscle (myocardium) caused by a blockage of one or more coronary arteries due to Coronary Artery Disease or Acute Coronary Syndrome.

Heart Attack (Myocardial Infarction) does not include:

- Any other disease or injury involving the cardiovascular system.
- Cardiac Arrest not caused by a Heart Attack (Myocardial Infarction).

Diagnosis of a Heart Attack (Myocardial Infarction) must include the following:

- New and serial electrocardiographic (ECG) findings consistent with Heart Attack (Myocardial Infarction), **and**
- Elevation of cardiac enzymes above generally accepted laboratory levels of normal. (In the case of creatine phosphokinase (CPK) a CPK-MB measurement must be used.)

Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms may also be used.

Hypertension means a disease that is characterized by elevated blood pressure in the arteries with a systolic reading of at least 140 mmHg and a diastolic reading of at least 90 mmHg.

Kidney Failure (End-Stage Renal Failure) means end-stage renal failure caused by End-Stage Renal Disease, which results in the chronic, irreversible failure of both kidneys to function.

Kidney Failure (End-Stage Renal Failure) is covered only under the following conditions:

- A Doctor advises that regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) is necessary to treat the Kidney Failure (End-Stage Renal Failure); **or**
- The Kidney Failure (End-Stage Renal Failure) results in kidney transplantation.

Loss of Sight, Speech, or Hearing

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

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

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

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

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

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

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

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

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

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

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

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

Maintenance Drug Therapy is a course of systemic medication given to a patient after a Cancer goes into Complete Remission because of primary Treatment. Maintenance Drug Therapy includes ongoing hormonal therapy, immunotherapy, or chemo-prevention therapy. Maintenance Drug Therapy is meant to decrease the risk of Cancer recurrence; it is not meant to treat a Cancer that is still present.

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

- Bronchiectasis, which is a lung disease state defined by localized, irreversible dilation of the bronchial tree caused by destruction of the muscle and elastic tissue.
- Cardiomyopathy, which is a heart disease characterized by the measurable deterioration of the function of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid.
- Cirrhosis, which is a liver disease characterized by replacement of liver tissue by fibrosis, scar tissue, and regenerative nodules, leading to loss of liver function.
- Chronic obstructive pulmonary disease, which is a lung disease characterized by persistently poor airflow as a result of breakdown of lung tissue and dysfunction of the small airways.

- Congenital Heart Disease, which is heart disease characterized by abnormalities in cardiovascular structures that occur before birth.
- Coronary Artery Disease
- Cystic fibrosis, which is a hereditary disease of the exocrine glands affecting the pancreas, respiratory system, and sweat glands. It is characterized by the production of abnormally viscous mucus by the affected glands.
- Hepatitis, which is a disease caused by the hepatitis A, B, or C virus and is characterized by the inflammation of the liver.
- Interstitial lung disease, which is a lung disease that affects the interstitium of the lungs.
- Lymphangioleiomyomatosis, which is a lung disease characterized by an indolent, progressive growth of smooth muscles cells throughout the lungs, pulmonary blood vessels, lymphatics, and pleurae.
- Polycystic liver disease, which is characterized by multiple variable-sized cysts lined by cuboidal epithelium.
- Pulmonary fibrosis, which is a lung disease where the lung tissue becomes thickened, stiff, and scarred due to chronic inflammation.
- Pulmonary hypertension, which is a disease characterized by increased pressure in the pulmonary artery and results in the thickening of the pulmonary arteries and the narrowing of these blood vessels, which causes the right side of the heart to become enlarged.
- Sarcoidosis, which is a disease characterized by the growth of granulomatous lesions that appear in the body.
- Valvular heart disease, which is a disease of the heart valves.

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

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

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

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

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

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

The Diagnosis of Paralysis must be supported by neurological evidence.

Pathologist is a Doctor who is licensed:

- To practice medicine, **and**
- By the American Board of Pathology to practice pathologic anatomy.

A Pathologist also includes an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

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

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

Signs and/or Symptoms are the evidence of disease or physical disturbance observed by a Doctor or other medical professional. The Doctor (or other medical professional) must observe these Signs while acting within the scope of his license.

Stroke means apoplexy due to rupture or acute occlusion of a cerebral artery. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. Stroke must be either:

- **Ischemic:** Due to advanced Arteriosclerosis or Arteriosclerosis of the arteries of the neck or brain, or vascular embolism, **or**
- **Hemorrhagic:** Due to uncontrolled Hypertension, Malignant Hypertension, Brain Aneurysm, or Arteriovenous Malformation.

The Stroke must be positively Diagnosed by a Doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

Stroke does not include:

- Transient Ischemic Attacks (TIAs)
- Head injury
- Chronic cerebrovascular insufficiency
- Reversible ischemic neurological deficits unless brain tissue damage is confirmed by neurological imaging

Stroke will be covered only if the Insured submits evidence of the neurological damage by providing:

- Computed Axial Tomography (CAT scan) images, **or**
- Magnetic Resonance Imaging (MRI).

Sudden Cardiac Arrest is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to Coronary Artery Disease, Cardiomyopathy, or Hypertension.

Sudden Cardiac Arrest is not a Heart Attack (Myocardial Infarction). A Sudden Cardiac Arrest benefit is not payable if the Sudden Cardiac Arrest is caused by or contributed to by a Heart Attack (Myocardial Infarction).

Treatment or **Medical Treatment** is the consultation, care, or services provided by a Doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

Treatment-Free From Cancer refers to the period of time without the consultation, care, or services provided by a Doctor. This includes receiving diagnostic measures and taking prescribed drugs and medicines. Treatment does not include Maintenance Drug Therapy or routine follow-up visits to verify whether Cancer or Carcinoma in Situ has returned.

Section IV – Benefit Provisions

The benefit amounts payable under this section are shown in the Benefit Schedule. The Company will pay benefits for a Critical Illness in the order the events occur.

Critical Illness Benefit

Initial Diagnosis

We will pay the Critical Illness benefit when an Insured is Diagnosed with one of the Critical Illnesses shown in the Certificate Schedule, and when such Diagnosis is caused by or solely attributed to an underlying disease as identified herein. We will pay this benefit if:

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

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

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

Benefits will be based on the Face Amount in effect on the Critical Illness Date of Diagnosis.

Additional Diagnosis

Once benefits have been paid for a Critical Illness, the Company will pay benefits for each different Critical Illness when:

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

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

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

Reoccurrence

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

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

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

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

Partial Benefits

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

Non-Invasive Cancer

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

Coronary Artery Bypass Surgery

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

Additional Benefits

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

Skin Cancer Benefit

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

Health Screening Benefit

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

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

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

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

Accident Benefit

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

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

Waiver of Premium Benefit

If you become Totally Disabled as defined in this Plan due to a covered Critical Illness, we will waive premiums for you and any currently covered Dependents (this includes any Riders that are in force).

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

- Not working at any job for pay or benefits,
- Under the care of a Doctor for the Treatment of a covered Critical Illness, and
- **Unable to Work**, which means either:
 - During the first 365 days of Total Disability, you are unable to work at the occupation you were performing when your Total Disability began; **or**
 - After the first 365 days of Total Disability, you are unable to work at any gainful occupation for which you are suited by education, training, or experience.

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

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

Pending our approval of a claim for the Waiver of Premium Benefit, premiums should be paid as they are due. Premiums that were paid for the first 90 days of Total Disability will be refunded after your claim for this benefit is approved.

Waiver of Premium will continue until the earliest of the following:

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

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

Section V – Limitations and Exclusions

Cancer Diagnosis Limitation

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

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

Exclusions

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

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured
- **Suicide** – committing or attempting to commit suicide, while sane or insane
- **Illegal Occupation** – committing or attempting to commit a felony, or being engaged in an illegal occupation
- **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 the following:**
 - Abuse of legally-obtained prescription medication
 - Illegal use of non-prescription drugs

Section VI – Claim Provisions

Notice of Claim

Written notice of claim must be given to us:

- Within 60 days after the Date of Diagnosis, **or**
- As soon as reasonably possible.

Notice must include your name and Certificate number. Notice can be mailed to the Company at the below address or it can be given to any authorized agent of the Company:

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

Claim Forms

When the Company receives Notice of Claim, we will furnish to the claimant such forms as are usually furnished by us for filing Proof of Loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to Proof of Loss upon submitting, within the time fixed in the policy for filing Proof of Loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss

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

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

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

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

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

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

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

Physical Examination and Autopsy

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

Time of Payment of Claims

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

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

Payment of Claims

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

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

Unpaid Premium

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

Changing of Beneficiary

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

Claim Review

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

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

Appeals Procedure

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

Legal Action

You cannot take legal action against us for benefits under this Plan:

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

Section VII – General Provisions

Entire Contract Changes

Your insurance is provided under a contract of Group Critical Illness insurance with the Policyholder. The entire Contract of Insurance is made up of:

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

All statements (excluding fraudulent ones) that the Policyholder or an Insured has made in the Application will be considered representations, not warranties. The Company will not void insurance or reduce benefits as a result of statements made on the Application without sending Application copies.

Changes to this Plan:

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

Misstatement of Age

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

Successor Insured

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

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

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

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

Time Limit on Certain Defenses

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

Clerical Error

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

Individual Certificates

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

- The coverage,
- To whom benefits will be paid, **and**
- The rights and privileges under the Plan.

Required Information

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

Conformity with State Statutes

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



CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205
800.433.3036

Optional Benefits Rider To Certificate of Insurance for Group Critical Illness

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

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

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

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

Effective Date

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

Definitions

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

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

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

Date of Diagnosis is defined as follows:

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

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

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

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

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

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

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

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

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

Benefit Provisions

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

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

General Provisions

Time Limit on Certain Defenses

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

Contract

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

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

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

Signed for the Company at its Home Office,



Teresa White, President



J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205
800.433.3036

ENHANCED GROUP PORTABILITY RIDER

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

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

The Portability Privilege—as well as any other references to portability—in the Certificate and previously attached Rider(s), if applicable, are deleted and replaced by this Rider.

Unless amended by this Rider, all Certificate definitions, exclusions, limitations, terms, and other provisions apply.

Effective Date

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date provided that you are actively at work on that date.

Portability Privilege

When an Employee, including an Employee who is a resident of Florida or New Hampshire, ends employment with the Employer and his coverage would terminate, that Employee may elect to continue the coverage he had on the date his employment ended, including any in-force Spouse or Dependent Child coverage. If an Employee qualifies for this Portability Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate as shown in his previously issued Certificate.

- To keep his Certificate in force, the Employee must:
 - Apply to the Company in writing within 31 days after the date his Certificate would terminate, **and**
 - Pay the required premium to the Company no later than 31 days after the date the Certificate would terminate and on each premium due date thereafter.
- Continued coverage will end on the earlier of these dates:
 - 31 days after the date the Employee fails to pay any required premium, **or**
 - When the Group Policy is terminated.

When the Group Policy is terminated by the Policyholder and an Employee's coverage would terminate, current Employees and former Employees who have previously continued coverage, not including Employees who are residents of Florida or New Hampshire, may apply to continue coverage under a trust policy. The trust policy will allow the Employee to continue coverage beyond the termination of the Group Policy. If the Employee qualifies for this Portability Privilege, he will be issued a new Certificate, which will be subject to the terms and conditions of the trust policy. Different Benefits, Plan Provisions, and Premium Rates may apply. To apply for the trust policy, this Rider, as issued to the Policyholder, must be in force for one year.

- To keep his coverage in force, the Employee must:
 - Apply to the Company in writing within 31 days after the date his coverage would terminate, **and**
 - Pay the required premium to the Company no later than 31 days after the date the coverage would terminate and on each premium due date thereafter.

If an Employee files a claim for loss occurring *after* the Group Policy terminates but *before* the new coverage is in force, any payable **benefits will be processed under the provisions of the new coverage** (as long as the Employee meets the requirements to keep his coverage in force).

- Trust coverage will end:
 - 31 days after the date the Employee fails to pay any required premium, **or**
 - When the trust policy is terminated by the Company.

When an Employee is a resident of Florida or New Hampshire and the Group Policy is terminated, that Employee may apply to convert his coverage to an individual policy. If the Employee qualifies for this Portability Privilege, he will be issued an individual policy. Different Benefits, Plan Provisions, and Individual Premium Rates may apply.

- To keep his coverage in force, the Employee must:
 - Apply in writing within 31 days after the date his coverage would terminate, **and**
 - Pay the required premium no later than 31 days after the date the coverage would terminate and on each premium due date thereafter.

If an Employee files a claim for loss occurring *after* the Group Policy terminates but *before* the new coverage is in force, any payable **benefits will be processed under the provisions of the new coverage** (as long as the Employee meets the requirements to keep his coverage in force).

- Converted individual coverage will end 31 days after the date the Employee fails to pay any required premium.

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.

- This Rider is part of the Certificate to which it is attached and will terminate when that Certificate terminates, or when premiums are no longer paid for this Rider.
- This Rider is subject to all the terms of the Certificate to which it is attached unless any such items are inconsistent with the terms of this Rider.

Signed for the Company at its Home Office,



Teresa White, President



J. Matthew Loudermilk, Secretary


CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205
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***SUMMARY OF THE LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT
AND
NOTICE CONCERNING LIMITATIONS AND EXCLUSIONS***

INTRODUCTION

Residents of Pennsylvania 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 Pennsylvania Life and Health Insurance Guaranty Association (PLHIGA). 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 Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in Pennsylvania and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Association is limited, however. As noted below, this protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable. Insurance companies and their agents are prohibited by law from using the existence of the association to induce you to purchase any kind of insurance policy.

This Information is Provided By:

Pennsylvania Life and Health Insurance Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, PA 19087
(610) 975-0572

SUMMARY

The state law that provides for this safety-net coverage is called the Pennsylvania Life and Health Insurance Guaranty Association Act. Below is a brief summary of the law's coverages, exclusions and limits. This summary does not cover all provisions of the law; not does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Association.

Coverage. Generally, individuals will be protected by the Pennsylvania 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 hold certificates under a group life or health insurance contract or annuity, 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. Persons holding such policies or contracts are not protected by this Association if:

- they are not residents of the State of Pennsylvania, except under certain very specific circumstances;
- the insurer was not authorized or licensed to do business in Pennsylvania at the time the policy or contract was issued;
- their policy was issued by a nonprofit hospital or health service corporation (e.g., a blue cross or blue shield plan), 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;
- any policy of reinsurance (unless an assumption certificate was issued);
- plans of employers, associations or similar entities to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
- interest rate yields that exceed an average rate;
- dividends;
- experience rating credits;
- credits given in connection with the administration of a policy or contract;
- annuity contracts or group annuity certificates used by nonprofit insurance companies to provide retirement benefits for nonprofit educational institutions and their employees;
- policies, contracts, certificates or subscriber agreements issued by a prepaid dental care plan;
- sickness and accident insurance when written by a property and casualty insurer as part of an automobile insurance contract;
- unallocated annuity contracts issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
- financial guarantees, funding agreements or guaranteed investment contracts not containing mortality guarantees and not issued to or in connection with a specific employee benefit plan or governmental lottery;
- any kind of insurance or annuity, the benefits of which are exclusively payable or determined by a separate account required by the terms of such insurance policy or annuity maintained by the insurer or by a separate entity.

Limits On Amount of Coverage. The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of \$300,000 – no matter how many policies and contracts there were with the same company, even if they provided different types of coverages.

Subject to the over-all \$300,000 limit, the Association will pay up to \$300,000 in life insurance death benefits, but not more than \$100,000 in net cash surrender or withdrawal values. For annuities, the Association will pay up to \$300,000 in annuity benefits, or \$100,000 in net cash surrender or withdrawal benefits. For health insurance, the Association will pay up to \$300,000, including any net cash surrender or withdrawal benefits.