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

CERTIFICATE OF INSURANCE FOR CANCER AND SPECIFIED DISEASE POLICY

THIS IS A SPECIFIED DISEASE CERTIFICATE WHICH ONLY PROVIDES BENEFITS AS A RESULT OF LOSS FOR CANCER AND/OR CANCER SCREENING PROCEDURES (AND OTHER SPECIFIED DISEASES IF SHOWN IN THE CERTIFICATE SCHEDULE). SPECIFIED DISEASE COVERAGE PAYS BENEFITS FOR THE DIAGNOSIS AND/OR TREATMENT OF A SPECIFICALLY NAMED DISEASE OR DISEASES OR FOR ANY OTHER CONDITION DIRECTLY CAUSED OR AGGRAVATED BY THE SPECIFIED DISEASE OR THE TREATMENT OF THE SPECIFIED DISEASE.

PLEASE READ YOUR CERTIFICATE CAREFULLY

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from Continental American.

CERTIFICATE INDEX

We certify that you are insured under the Cancer and Specified Disease Policy (herein called the Plan) issued to your employer, the Policyholder, subject to the definitions, exclusions and other provisions of the Plan against loss resulting from cancer.

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 this Certificate.

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

This Certificate is issued in consideration of the payment in advance of the required premium and of your statements and representations in the application. A copy of your application is attached and made a part of this Certificate.

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

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE, ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION

(For insurers declared insolvent or impaired on or after September 1, 2005)

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect policyholders if their life or health insurance company fails. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations and conditions of the Association law. (The law is found in the Texas Insurance Code, Chapter 463.)

It is possible that the Association may not cover your policy in full or in part due to statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- residents of Texas at the time that their (irrespective of the policyholder's residency at policy issue)
- residents of other states, ONLY if the following conditions are met:

    1) The policyholder has a policy with a company domiciled in Texas;
    2) The policyholder's state of residence has a similar guaranty association; and
    3) The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- for each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, and $200,00 for other types of health insurance.

Life Insurance:

- net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on any one life; or
- death benefits up to a total of $3000,000 under one or more policies on any one life; or
- total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- present value of benefits up to a total of $100,000 under one or more contracts on any one life.

Group Annuities:

- present value of allocated benefits up to a total of $100,000 on any one life; or
- present value of unallocated benefits up to a total of $5,000,000 for one contract holder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage.

Texas Life, Accident, Health and Hospital
Service Insurance Guaranty Association
6505 Bridge Point Parkway, Suite 450
Austin, Texas 78730
(800)-982-6362 or www.txlifega.org

Texas Department of Insurance
Post Office Box 149104
Austin, Texas 78714-9104
(800)-252-3439 or www.tdi.state.tx.us

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Continental American Insurance Company's toll free number for information or to make a compliant at:

1-800-433-3036

You may also write to Continental American Insurance Company at:

2801 Devine Street
Post Office Box 427
Columbia, South Carolina 29205

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:
Should you have a dispute concerning your premium or about a claim you should contact Continental American Insurance Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:
This notice is for information only and does not become a part or condition of the attached document

AVISO IMPORANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Continental American Insurance Company para informacion o para someter una queja al:

1-800-433-3036

Usted tambien puede escribir a Continental American Insuance Company at:

2801 Devine Street
Post Office Box 427
Columbia, South Carolina 29205

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS:
Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con Continental American Insurance Company primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:
Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

SECTION I DEFINITIONS

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

You, Your – refer to the person who is shown on the Certificate Schedule.

Insured(s) –

(A) If this is Employee coverage as shown in the Certificate Schedule, Insured includes only to you.

(B) If this is One-Parent coverage as shown in the Certificate Schedule, then Insured includes you and your Dependent Children as defined below.

(C) If this is Two-Parent coverage as shown in the Certificate Schedule, then Insured includes you, your spouse and Dependent Children.

(E) If coverage is offered where the dependent(s) are listed as the primary Insured, then Insured includes the dependent shown on the Certificate Schedule.

(F) If any person who would otherwise be an Insured is specifically excluded from coverage by endorsement to the Plan, a Certificate or by the application, then such person shall not be an Insured.

(G) Any other additions to the Insured class must be added after applying to us.

Dependent Children - All of your children, step-children, grandchildren and adopted who are unmarried and less than twenty-five (25) years of age. However, if any dependent child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, such age of twenty-five (25) shall not apply. Proof of such incapacity and dependency must be furnished to us within thirty-one (31) days following such 25th birthday.

Your and/or your covered spouse's newborn children shall automatically be covered from birth provided you notify us within thirty-one (31) days after the birth of the child.

Dependent Children also includes children for whom a suit of adoption has been filed by you (or for whom adoption proceedings have been instituted by you).

In addition, if you and your lawful Spouse become the legal guardian of a foster child, that child will be treated as an adopted child as long as: a) you continue as the child's legal guardian; b) the child is living with the you; and c) all other requirements of the Plan are met.

Cancer - *Cancer* is defined as a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells, the invasion of tissue, leukemia or Hodgkin's Disease. Pre-malignant conditions or conditions with malignant potential are not to be construed as cancer for the purposes of this Certificate.

Skin Cancer - is defined as cancer on the surface of the body (Skin) that may be a malignant tumor, ulcer, pimple, or mole. Malignant melanomas classified as Clark's Level I and II are included in the definition of skin cancer. Clark's Level I is defined as: lesions involving only the epidermis, not an invasive lesion.
Clark's Level II is defined as: invasion of the papillary dermis, but does not reach the papillary-reticular dermal interface.

Internal Cancer - is defined as cancer which is **not** skin cancer, but includes malignant melanomas of Clark's Level III and higher. Clark's level III is defined as: invasion fills and expands the papillary dermis, but not the reticular dermis. Internal Cancer does not include cancers that the Insured's doctor has determined are not life threatening.

Such cancer must be positively diagnosed by a qualified pathologist, except under the conditions stated immediately below. Diagnosis must be based on a microscopic examination of fixed tissue, or preparations from the hemic system (either during life or postmortem). The pathologist making the diagnosis shall base judgment solely on the criteria of malignancy as accepted by the American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen. Pathological interpretations of the history of skin lesions will be accepted from dermatologists certified by the American Board of Dermatopathology.

A clinical diagnosis of cancer will be accepted only when a pathological diagnosis cannot be made because it is medically inappropriate or life threatening, and provided: medical evidence substantially documents the diagnosis of cancer and the Insured receives treatment from a physician for cancer.

Date of Diagnosis - The *date of diagnosis* is the day the tissue specimen, blood samples and/or titer(s) are taken on which the first diagnosis of cancer or specified disease (if applicable) is based.

Hospital - *Hospital* is defined as an institution legally licensed as such and which maintains and uses on its premises or in facilities available to it on a prearranged, written, contractual basis: a laboratory; x-ray equipment; and an operating room. The institution must also have permanent and full-time facilities for the care of overnight resident bed patients under the supervision of one or more licensed physicians and provide 24-hour-a-day nursing service by or under the supervision of a registered professional nurse. The term "Hospital" shall also include Ambulatory Surgical Centers. The term "Hospital" shall **not** include any institution, or part thereof, used as: a hospice unit including any beds designated as a hospice or swing bed; a convalescent home; a rest or nursing facility; an extended care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care or care or treatment for persons suffering from mental disease or disorders, or care for the aged, drug addicts or alcoholics.

Hospital Intensive Care Unit - The specifically designed facility of the hospital that provides the highest level of medical care which is restricted to those patients who are physically and critically ill or injured. Such facilities must be separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement. They must be permanently equipped with special life-saving equipment for the care of the critically ill or injured. They must be under constant and continuous observation by nursing staffs assigned on a full-time basis, exclusively to the Intensive Care Unit.

NCI-Sponsored Cancer Center – a cancer treatment or research facility that currently holds a National Cancer Institute (NCI) sponsorship.

Physician - A physician means a person, other than you or a Family Member, who:

1. is licensed by the state to practice a healing art;
2. performs services which are allowed by his license; and
3. performs services for which benefits are provided by the Plan.

Family Member - *Family Member* means your spouse, son, daughter, grandchildren, mother, father, sister or brother.

Pathologist - A pathologist means a physician, other than the Employee 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.

Specified Disease - Specified Disease is defined to mean one or more of the diseases listed below:

Addison's Disease	Neiman-Pick Disease
Amyotrophic Lateral Sclerosis	Osteomyelitis
Botulism	Poliomyelitis
Brucellosis	Q Fever
Budd-Chiari Syndrome	Rabies
Cystic Fibrosis	Reye's Syndrome
Diphtheria	Rheumatic Fever
Encephalitis	Rocky Mountain Spotted Fever
Hansen's Disease	Scarlet Fever
Histoplasmosis	Sickle Cell Anemia
Legionnaire's Disease	Tay-Sachs Disease
Lupus Erythematosus	Tetanus
Lyme Disease	Toxic Shock Syndrome
Malaria	Trichinosis
Meningitis	Tuberculosis
Multiple Sclerosis	Tularemia
Muscular Dystrophy	Typhoid Fever
Myasthenia Gravis	Whooping Cough

We, Us or Our – refers to Continental American.

SECTION II PREMIUMS AND INDIVIDUAL TERMINATIONS

PREMIUMS

Premiums are not Guaranteed: The initial premium shown in the Certificate Schedule is the premium covering the period from the Effective Date to the next renewal date of this Certificate. Renewal premiums will be in accordance with the schedule of premium rates in effect at the time of renewals as set forth in the Plan.

Certificate Term: The first term of this Certificate starts on the Effective Date in the Certificate Schedule. It ends on the first renewal date also shown. Later terms will be the periods for which renewal premiums are paid when due. All terms will begin and end at 12:01 A.M., Standard Time, at the Policyholder's address. The renewal premium for each term will be due on the day preceding term end, subject to the Grace Period.

Grace Period: This plan has a 31 day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the next 31 days. During the Grace Period, your coverage under the Plan will stay in force.

INDIVIDUAL TERMINATIONS

Your insurance will terminate on the earliest of:

1. the date the Plan is terminated;
2. on the 31st day after the premium due date if the required premium has not been paid;
3. on the date you cease to meet the definition of an Employee as defined in the Plan;
5. on the date he or she is no longer a member of the class eligible.

Insurance for Dependents (Spouse or Children) will terminate the earliest of:

1. The date your insurance terminates;
2. the premium due date following the date a dependent ceases to be a dependent as defined;
3. the premium due date following the date we receive your written request to terminate dependent coverage for all dependents.

If your dependent is the primary insured, their insurance terminates on (1) the 31st day after the premium due date if the required premium has not been paid, or (2) the date they no longer fit the definition of eligible dependent, or the date the Plan is terminated.

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

SECTION III BENEFITS PROVISIONS

The benefit amounts payable under this section are shown in the Benefit Schedule. Coverage terminates according to the provisions stated in the Plan and the Certificate.

ELIGIBILITY FOR BENEFITS

In order to receive benefits an Insured must be eligible (or qualified) for such benefits. This section explains how an Insured is eligible. If an Insured is first diagnosed as having cancer or a specified disease while this Plan and his coverage is in force, we will pay for the diagnosis and treatment of cancer or a specified disease according to this Section, provided that:

1. The date of diagnosis is while this Plan is in force; and
2. All other limitations and exclusions, conditions, and provisions of this Plan apply.

Hospitalization benefits for the treatment of cancer or a specified disease shall accrue as follows:

If cancer or a specified disease is diagnosed while an Insured is hospitalized, benefits shall accrue from the day of admission to the hospital, but not retroactive more than thirty (30) days prior to the date cancer or specified disease was diagnosed. Exception: If skin cancer is diagnosed during hospitalization, benefits shall be limited to the day(s) the Insured actually received treatment for skin cancer (such as a malignant tumor, ulcer, pimple or more that may arise on the surface of the body (skin) including melanomas classified as Clark's Levels I and II). No benefits shall be payable for expenses incurred prior to the 30th day after an Insured's "Effective Date". If cancer is not pathologically or clinically diagnosed until after an Insured dies, we will only pay benefits for the care of cancer received during the forty-five (45) day period before death.

BENEFITS

The following benefits will be paid if an Insured is hospitalized for the treatment of a specified disease or cancer, or receives specified outpatient cancer treatment while the Plan and his coverage is in force, and has met the requirements under Eligibility for Benefits.

First Occurrence Benefit: We will pay a First Occurrence Benefit in the amount determined from the Benefit Schedule when an Insured is first diagnosed as having internal cancer. This benefit **is not payable** for any cancer not meeting the definition of internal cancer. This benefit is payable only once for each Insured for the life of the Certificate and will be paid in addition to any other benefit in this Plan. In addition to the diagnosis required by Section III - Definitions, Cancer, we may require additional information from the attending physician and Hospital and we have the right to have a physician or Pathologist of our choice review the medical records to confirm the diagnoses.

Cancer Screening Benefit: We will pay the amount shown in the Certificate Schedule, if an Insured has a cancer screening test performed while this Plan and his coverage is in force.

Cancer Screening Test is defined as:

Bone marrow testing,
Biopsy
Breast Ultrasound
CA 125 (blood test for ovarian cancer),
CA 15-3 (blood test for breast cancer),
CEA (blood test for colon cancer),
Chest X-Ray,
Flexible sigmoidoscopy,
Colonoscopy
Hemocult stool analysis,
Mammography,
Pap Smear,
PSA (blood test for prostate cancer),
Thermography,
Serum Protein Electrophoresis (blood test for myeloma),

We will pay up to the amount shown in the Benefit Schedule for the screening test. We will pay this benefit one time per year per Insured. We will pay this benefit regardless of the results of the tests(s). There is no limit to the number of years an Insured can receive benefits for cancer screening tests.

Hospital Confinement Benefits: We will pay the appropriate daily benefit as shown in the Benefit Schedule when an Insured is confined to a hospital due to cancer or specified disease. We will pay this amount regardless of whether the Insured is actually charged by the hospital or not. If we pay benefits for a period of hospital confinement and an Insured is confined to a hospital again within thirty (30) days for the treatment of cancer or a specified disease we will treat this confinement as a continuation of the prior confinement. If more than thirty (30) days have passed between the periods of hospital confinement, we will treat this confinement as a new confinement.

There is no limit to the number of days an Insured can receive benefits for being confined to a hospital for the treatment.

Radiation and Chemotherapy Benefit: We will pay the amount shown in the Benefit Schedule per day for each day that an Insured receives radioactive or chemical treatments prescribed by a physician for the destruction of abnormal tissue during the treatment of cancer. These treatments must be approved for the treatment of cancer by the United States Food and Drug Administration.

For oral chemotherapy not requiring direct administration by medical personnel we will pay the amount shown in the Benefit Schedule for each prescription not to exceed the per month maximum shown on the Benefit Schedule.

This benefit does not pay for laboratory test, diagnostic X-ray, immunoglobulin or pre-planning procedures related to these therapy treatments.

The radioactive or chemical treatments can be administered in the hospital or at a physician's office, a hospital outpatient department, a clinic or a freestanding surgical center.

Experimental Treatment: We will pay this benefit for each day an Insured receives experimental cancer treatments for the purpose of modification or destruction of abnormal tissue. The treatments must be consistent with one of more National Cancer Institute sponsored protocols. Treatment must be received in the continental United States.

We will not pay this benefit for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors and therapeutic devised or other procedures related to these therapy treatments.

Anti-Nausea Medication Benefit: We will pay up to the amount shown in the Benefit Schedule for anti-nausea medication that is prescribed as a result of radiation/chemotherapy treatments. We will pay this benefit only if an Insured's physician indicates that such medication is prescribed for nausea relating to the radiation/chemotherapy treatments. We will pay this benefit for no more than the number of days the Insured received radiation/chemotherapy treatments. There is no limit to the number of times an Insured can receive benefits for anti-nausea medication other than to the number of days the Insured received Radiation/Chemotherapy treatments.

Nursing Services Benefit: While confined in a Hospital due to cancer or a specified disease, if an Insured requires private nurses, other than those regularly furnished by the Hospital, we will pay the daily amount shown in the Benefit Schedule, for full-time private care and attendance provided by such nurses (registered graduate nurses, licensed practical nurses or licensed vocational nurses). These services must be required and authorized by the attending physician. This benefit is not payable for private nurses who are family members. This benefit is payable only for the number of days the Hospital Confinement Benefit is payable. The daily amount is payable for each 24 hour period. There is no lifetime maximum.

In Hospital Blood and Plasma Benefit: We will pay the amount shown in the Benefit Schedule for each day an Insured receives blood or plasma during a covered hospital confinement due to cancer or specified disease. This benefit **does not pay** for immunoglobulin. There is no lifetime limit.

National Cancer Institute Evaluation/Consultation: We will pay up to the amount shown in the Benefit Schedule when an Insured seeks evaluation or consultation at an NCI-sponsored cancer center after receiving a diagnosis of internal cancer. The purpose of the evaluation/consultation must be to determine the appropriate course of cancer treatment. In addition we will pay $250 for transportation and lodging of the Insured receiving the evaluation or consultation. In order for the transportation and lodging portion of this benefit to be payable, the National Cancer Institute sponsored center must be more that 100 miles from the Insured's residence. This benefit is not payable the same day the Second Surgical Opinion Benefit is payable. This benefit is payable once for each Insured.

Surgical Benefit: We will pay the amount shown in the Surgical Schedule for a surgical operation that is performed on an Insured for a diagnosed cancer or specified disease. If any operation for the treatment of cancer or specified disease is performed other than those listed, we will pay an amount comparable to the amount shown in the Surgical Schedule for the operation most similar in severity and gravity. Two or more surgical procedures performed through the same incision will be considered one operation, and benefits will be paid based upon the most expensive benefit. Benefits are payable in or out of a hospital in accordance with the Surgical Schedule. There is no lifetime maximum on the number of operations.

Anesthesia Benefit: We will pay 25% of the amount shown in the Surgical Schedule opposite the appropriate surgical procedure if an Insured receives anesthesia administered by an anesthesiologist or an anesthetist during a covered surgical procedure.

If an Insured has more than one surgical procedure performed at the same time, we will pay only one Anesthesia Benefit. We will pay the Anesthesia Benefit for the surgical procedure performed which has the highest dollar value. If an Insured has a surgical procedure performed which is not shown in the Surgical Schedule, we will pay an anesthesia benefit amount based on the difficulty of the procedures shown.

We will pay no more than the highest Anesthesia Benefit amount shown in the Surgical Schedule for the administration of anesthesia. There is no lifetime maximum on this benefit.

Second Surgical Opinion Benefit: We will pay the amount shown in the Benefit Schedule, for a second surgical opinion, concerning cancer or specified disease surgery for each positively diagnosed cancer or specified disease, by a licensed physician not related to the Insured. An Insured is **not** required to have a second opinion in order to receive the other benefits under this Plan. This benefit is only payable once for each malignant condition or specified disease. **This benefit is not payable** for reconstructive surgery or for skin cancer treatment. No lifetime maximum.

Skin Cancer Surgery Benefit: We will pay the appropriate amount shown in the Benefit Schedule when an Insured has a surgical operation for a diagnosed skin cancer (with or without anesthesia). No lifetime maximum.

Bone Marrow Transplant: If an Insured undergoes a bone marrow transplant (the harvesting and re-infusion of bone marrow) we will pay up to the appropriate in-hospital or outpatient amount shown in the Benefit Schedule. We will also pay the amount shown in the Benefit Schedule to the bone marrow donor. Bone marrow donor benefits under this provision are not payable if an Insured donates bone marrow to himself. If the donor is also an Insured's family member, he is not eligible for the Lodging Benefit. This benefit is not payable in conjunction with the Stem Cell Transplant Benefit. There is no limit on the number of years an Insured can receive the Bone Marrow Donor benefit.

Stem Cell Transplant: We will up to the amount shown in the Benefit Schedule if an Insured receives a peripheral stem cell transplantation for the treatment of cancer or specified disease. We will only pay this benefit once per Insured. This benefit is not payable in conjunction with the Bone Marrow Transplant Benefit.

Outpatient Blood/Plasma Benefit: We will pay the amount shown in the Benefit Schedule for each day an Insured receives blood or plasma as an outpatient in a physician's office, clinic, hospital or ambulatory surgical center due to cancer or specified disease. This benefit **does not pay** for immunoglobulin. There is no lifetime limit on this benefit.

Ambulance Benefit: We will pay the actual charges incurred if an Insured requires transportation to a Hospital, within 100 miles of the Insured's residence, for overnight confinement for cancer or specified disease treatment. This benefit is limited to two (2) trips per confinement. The ambulance service must be performed by a licensed professional ambulance company. There is no lifetime maximum.

Prosthesis Benefit/Artificial Limb: We will pay the amount shown in the Benefit Schedule for each **surgically implanted** prosthetic device or artificial limb which is prescribed as a direct result of surgery for cancer or specified disease treatment. This benefit is limited to the lifetime maximum as shown in the Benefit Schedule per Insured.

We will pay the charges incurred up to a life time maximum per Insured of $200 for non-surgically implanted prosthetic devises.

Hospice Care Benefit: When an Insured is diagnosed with cancer or a specified disease and therapeutic intervention directed toward the cure of the disease is medically determined to be no longer appropriate, and if the Insured's medical prognosis is one in which there is a life expectancy of six months or less as the direct result of cancer or a specified disease, we will pay the daily benefit shown in the Benefit Schedule up to the lifetime maximum per Insured for each day of hospice care received. The hospice care must be directed and coordinated by the hospice organization primarily in the patient's home, but also on an outpatient or short-term inpatient basis in a hospice unit. For this benefit to be payable, we must be furnished a written statement from the attending physician that an Insured is terminally ill within the terms of this paragraph; and a written statement from the hospice certifying the days on which services were provided.

This benefit does not cover non-terminally ill patients who may be confined in a convalescent home, rest or nursing facility, a skilled nursing facility, a rehabilitation unit or a facility that provides treatment for persons suffering from mental disease or disorders, or care for the aged, drug addicts or alcoholics.

Hospice means a licensed agency, organization, or unit which provides to terminally ill persons and to their families a centrally administered and autonomous continuum of palliative and supportive care.

Extended Care Facility Benefit: If an Insured is hospitalized and receiving benefits under the Hospital Confinement Benefit and are later confined to a section of the Hospital used as an Extended Care Facility, a Skilled Nursing Facility, or any bed designated as a swing bed, we will pay the amount shown in the Benefit Schedule for each day of such continued confinement. Payment will be limited to the same number of days the Insured received benefits under the Hospital Confinement Benefit. For each day this benefit is payable, benefits under the Hospital Confinement Benefit are **not** payable. Rehabilitation units or facilities **are not** covered. Lifetime maximum of the number of days per Insured are shown in the Benefit Schedule.

If more than thirty (30) days separates a stay in an extended care facility, benefits are not payable for the second confinement unless the Insured was again confined to a hospital prior to the second such confinement.

Home Health Care Benefit: We will pay up to the amount shown in the Benefit Schedule if an Insured receives any of the following home health care services, required by his physician for the treatment of cancer or specified disease:

Professional nursing provided by a registered nurse;
Home health aid services provided under the supervision of a registered nurse or qualified therapist;
Physical therapy;
Occupational therapy;
Speech therapy and audiology;
Respiratory and inhalation therapy;
Nutrition counseling by a nutritionist or dietitian;
Medical social services;
Medical supplies;
Prosthesis and orthopedic appliances;
Rental or purchase of durable medical equipment; or
Drugs or medicine

We will pay this benefit per Insured for the maximum number of days per calendar year shown in the Benefit Schedule.

Home health care Benefit means one of the services listed above when it is required by the Insured's physician instead of confinement in a hospital. Prior confinement in a hospital is not required. The service must be rendered by a home health agency as part of a plan of care established by the physician and the home health agency.

Home health agency means an agency that is certified by the state government. Its main purpose is to arrange and provide nursing services, home health aide services, and other related services.

We will not pay this benefit for the following:

Services or supplies for personal comfort or convenience, including housekeeping services;
Child care; or
Food Services or meals other than dietary counseling.

There is no limit to the number of times an Insured can receive benefits for Home Health Care other than the calendar year limit.

Lodging Benefit: We will pay the daily amount shown in the Benefit Schedule, for each night's lodging in a motel/hotel room for an Employee or any one adult Family member when an Insured is confined to a Hospital for internal cancer or specified disease treatment. The Hospital and motel/hotel must be more than 100 miles from the Insured's residence. The special cancer or specified disease treatment must be prescribed by the Insured's local attending physician. The lifetime maximum of the number of days per Insured is shown in the Benefit Schedule.

Transportation Benefit: If an Insured requires special treatment for internal cancer or specified disease which has been prescribed by his local attending physician and which cannot be obtained locally, we will pay the amount shown in the Benefit Schedule for commercial travel or travel in an automobile. We will pay the amount per mile shown in the Benefit Schedule for commercial or automobile transportation from an Insured legal residence to the hospital that is providing treatment for such cancer or specified disease. This benefit will be paid only for the Insured for whom the special treatment is prescribed, unless the treatment is for an insured dependent child, then the child's parent or legal guardian who travels with the child will also received this benefit. Only one person will be paid to travel with the insured child. **This benefit is only payable** for transportation to a hospital located outside the 100-mile radius of the Insured's residence. No lifetime maximum.

Waiver of Premium Benefit (Applies to the Named Insured Only): If the Employee is diagnosed as having internal cancer or a specified disease and/or the treatment thereof results in 90 continuous days of total disability, we will waive, from month to month, the payment of any premium due for as long as the employee is totally disabled due to such cancer or specified disease. After total disability ends, any premium that becomes due must be paid in order to keep the insurance in force. For premiums to be waived, an Employer's statement (if applicable) and a physician's statement of the Employee's inability to perform his duties or activities. We may each month during a continuing disability require a physician's statement that total disability continues.

Continuation Privilege

When coverage would otherwise terminate under this Certificate because you end employment with the Employer, you may elect to continue this cancer coverage. But you must have been continuously covered for at least six months under the Plan and/or the prior plan just before the date your employment terminated. The coverage you may continue is that which you had on the date your employment terminated, including dependent coverage then in effect.

1. Coverage may not be continued for any of the following reasons:

    a. you failed to pay any required premium; or
    b. the Group Policy terminates.

2. To keep your insurance in force you must:

    a. make written application to us within 31 days after the date this insurance would otherwise terminate;
    b. pay the required premium to us no later than 31 days after the date this insurance would otherwise terminate.

3. To keep dependent coverage in force, you must continue coverage.

4. Insurance will cease on the earliest of these dates:

    a. the date you fail to pay any required premium;
    b. the date the Group Policy is terminated.

If you qualify for this Continuation Privilege as described, then the same benefits, Plan provisions, and premium rate as shown in the Certificate as previously issued will apply.

SECTION IV LIMITATIONS AND EXCLUSIONS

This Certificate provides only for cancer diagnosis and cancer screening, or for loss resulting from definitive cancer treatment including the direct extension, metastatic spread or recurrence and other diseases and conditions caused by or resulting from cancer or cancer treatment. Pathologic proof thereof must be submitted. Clinical diagnosis of cancer will be accepted under the conditions specified in Section III - Cancer Defined. Benefits are not provided for any other disease, sickness or incapacity. No benefits are payable for cancer diagnosis, screening, or treatment received outside the United States.

PRE-EXISTING CONDITIONS LIMITATION

"Pre-existing Condition" means a sickness or physical condition for which medical advice or treatment was recommended or received within the 12-month period prior to the Insured's Effective Date.

We will not pay benefits for any condition or illness starting within 12 months of the Insured Effective Date that is caused by, contributed to, or results from a Pre-existing Condition.

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

A condition will no longer be considered preexisting at the end of 12 consecutive months starting and ending after the Insured's Effective Date.

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

SECTION V UNIFORM PROVISIONS

Questions or Comments - We want to hear from you. If you have any questions about this Certificate, its benefits, the filing of claims, a complaint or a compliment, please call us at the toll free number listed (or write to us) on the front of this Certificate. Thank you for your loyal patronage.

Entire Contract - The entire contract consists of:

1. the Plan;
2. the application of the Policy holder; and
3. your application(s).

All statements made in such application(s) shall, in the absence of fraud, be deemed representations and not warranties. No statement will be used in defense of a claim under the Plan unless:

1. the statement is in writing signed by the Policyholder or by you; and
2. a copy of that statement is given to the Policyholder or to you or to your beneficiary.

Contract Changes - No change in this Certificate is valid unless approved by our Home Office and unless such approval is endorsed by an officer and attached to this Certificate. No agent has the authority to change this Certificate or to waive any of its provisions.

Misstatements of Age - If you incorrectly stated your age or the ages of your dependents, if any, in the application, the benefits will be such as the premium paid would have purchased at the correct age. If, based on the correct ages, we would not have issued this Certificate or insured certain dependents under this Certificate, then our responsibility will be to refund all premiums paid, if any.

Time Limit On Certain Defenses - We rely on the statements you made in the application when issuing this Certificate. After this Certificate has been in force for two years, we cannot cancel it or refuse to pay benefits because of any misstatements in the application unless you fraudulently made them.

Conformity With State Statutes - Any provision of this Certificate which, on the Effective Date, is in conflict with the laws of the state, in which your Certificate was issued, will be amended to conform to the minimum requirements of those laws.

SECTION VI CLAIM PROVISIONS

Notice of Claim - Written notice of claim must be given within sixty (60) days after a covered loss starts, or as soon as reasonably possible. The notice can be given to us at our Home Office. 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 you within 15 working days, you 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 us at our Home Office 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 Certificate will be paid immediately upon receipt of written proof of loss.

Payment Of Claims - Benefits will be paid to you. All of the benefits due will be paid to you unless you assign them elsewhere. Any benefits unpaid at the time of your death will be paid in the following order:

1. to any approved assignee;
2. your beneficiary;
3. your surviving spouse.

Unpaid Premium - when a claim is paid, any premium due and unpaid may be deducted from the claim payment.

Legal Actions - No action at law or equity shall be brought to recover on this Certificate prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirement of this Certificate. No such action shall be brought after the expiration of six years from the time written proof of loss is required to be furnished.

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

Additional Policies with Us - We will only pay benefits for the treatment of cancer under one cancer Certificate if An Insured is covered by more than one of our cancer Certificates. You may choose which Certificate you wish to keep in force by sending us written notice of your choice. We will return the premiums you paid for any of our other cancer policies during the period you had more than one Certificate in force.

Option II

SCHEDULE OF OPERATIONS

ABDOMEN	
Paracentesi	$100
Exploratory laparotomy	525
Cholecystectomy	700
BLADDER	
Cystoscopy	140
TUR bladder tumors	525
Cystectomy	
(partial)	900
(complete)	1,800
(with ureteroileal conduit)	3,600
BRAIN	
Burr holes not followed by surgery	700
Ventriculoperitoneal shunt	700
Exploratory craniotomy	1,500
Excision brain tumor	3,500
Hemispherectomy	5,000
BREAST	
Needle biopsy	140
Cutting operation biopsy	250
Lumpectomy	350
Mastectomy	
(partial)	525
(simple)	700
(radical)	1,050
Breast reconstruction	700
Symmetry on non-diseased breast (occurring within five years of breast reconstruction)	350
CERVIX	
D & C	175
Colposcopy	175
Vaginal hysterectomy/uterus only	525
Oophorectomy	525
Abdominal hysterectomy/uterus only	900
Uterus, tubes & ovaries	1,750
with exenteration	5,000
CHEST	
Thoracentesis	140
Bronchoscopy	300
Mediastinoscopy	300
Thoracostomy	300
Thoracotomy	700
Wedge resection	1,200
Lobectomy	1,500
Pneumonectomy	2,100
ESOPHAGUS	
Esophagoscopy	280
Esophagogastrectomy	1,500
Resection of esophagus	2,000
EYE	
P32 uptake	250
Enucleation	500
INTESTINES	
Sigmoidoscopy	140
Proctosigmoidoscopy	140
Colonoscopy	280
Cutting operation on rectum for biopsy	280
Colostomy/or revision of	350
ERCP	350
Ileostomy	310
Colectomy	900
Resection small intestine	2,100
Abdominal-perineal approach for removal of cancer of sigmoid colon or rectum	2,500
KIDNEY	
Nephrectomy	2,100
Radical	3,600
LIVER	
Needle biopsy	140
Wedge biopsy	350
Resection of liver	1,000
LYMPHATIC	
Excision of lymph node	175
Splenectomy	700
Axillary node dissection	700
Lymphadenectomy	
(unilateral)	700
(bilateral)	900
MANDIBLE	
Mandibulectomy	1,400
MISCELLANEOUS	
Bone marrow biopsy or aspiration	140
Venous-catheters/venous port for chemotherapy	280
Pathological hip fracture	875

MOUTH	
Hemiglossectomy	310
Tonsil/mucous membrane	525
Glossectomy	700
Resection of palate	700
PANCREAS	
Jejunostomy	900
Pancreatectomy	2,100
Whipple procedure	3,600
PENIS	
Amputation	
(partial)	350
(complete)	700
(radical)	900
PROSTATE	
Needle biopsy	140
Cystoscopy	140
TUR prostate	525
Radical prostatectomy	1,400
RADIUM IMPLANTS	
Insertion	1,000
Removal	500
SALIVARY GLANDS	
Biopsy	350
Parotidectomy	700
Radical neck dissection	1,800
SPINE	
Cordotomy	525
Laminectomy	900
STOMACH	
Gastroscopy	300
Gastrojejunostomy	900
Partial gastrectomy	900
Gastrectomy	1,400
TESTIS	
Orchiectomy	
(unilateral)	350
(bilateral)	490
THROAT	
Laryngoscopy	300
Tracheostomy	300
Laryngectomy	
(without neck dissection)	900
(with neck dissection)	1,800
THYROID	
Thyroidectomy	
(partial: one lobe)	525
(total: both lobes)	700
VULVA	
Vulvectomy	
(partial)	525
(radical)	1,050

CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205
800.433.3036

ENHANCED GROUP CONTINUATION 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 Continuation Privilege—as well as any other references to continuation—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.

Continuation Privilege

When an Employee 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.

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

When the Group Policy is terminated by the Policyholder and a current Employee's coverage would terminate, that Employee may apply to continue the coverage he had on the date the Group Policy was terminated, including any in-force Spouse or Dependent Child coverage. If an Employee qualifies for this Continuation 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:
  - 31 days after the date the Employee fails to pay any required premium, **or**
  - When coverage is terminated by the Company.

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,

Paul S. Amos II, President

J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205
800.433.3036

WAIVER OF PREMIUM BENEFIT RIDER TO CERTIFICATE OF INSURANCE FOR CANCER

This Rider is part of the Certificate to which it is attached.

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
This Rider becomes effective on the Certificate 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):

Calendar Year means the time period beginning January 1st and ending December 31st.

Cancer is defined in your certificate of coverage.

Certificate is the certificate to which this Rider is attached.

Eligible Medical Expenses means medically necessary expenses for services and supplies required by a Physician incurred by an Insured as a result of treatment of Cancer or Skin Cancer. An expense is incurred on the date the service is performed or supplies are furnished.

Eligible Medical Expenses will include the following:

BENEFIT

Waiver of Premium
If the insured, due to having internal cancer, is completely unable to do all of the usual and customary duties of his occupation for a period of 90 continuous days, we will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, we will require an employer's statement (if applicable) and a physician's statement of the insured's inability to perform said duties or activities, and may each month thereafter require a physician's statement that total inability continues.

Limitations and Exclusions

All Exclusions provisions in the Certificate apply to this Rider and are incorporated by reference herein.

General Provisions

Time Limit on Certain Defenses
After two years from the Insured's Effective Date of coverage, the Company may not contest 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

Cancer Expense Benefit Rider Schedule

BENEFITS

See Certificate Schedule

CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205
800.433.3036

SPECIFIED DISEASE RIDER
TO CERTIFICATE OF INSURANCE FOR GROUP CANCER

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 apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

Date of Diagnosis is defined for each Specified Disease as follows:

- ***Adrenal Hypofunction (Addison's Disease):*** The date a Doctor Diagnoses an Insured as having Adrenal Hypofunction and where such Diagnosis is supported by medical records.
- ***Cerebrospinal Meningitis:*** The date a Doctor Diagnoses an Insured as having Cerebrospinal Meningitis and where such Diagnosis is supported by medical records.
- ***Cystic Fibrosis:*** The date a doctor diagnoses an insured as having cystic fibrosis and where such diagnosis is supported by medical records.
- ***Cerebral Palsy:*** The date a doctor diagnoses an insured as having cerebral palsy and where such diagnosis is supported by medical records.
- ***Diphtheria*****:** The date a Doctor Diagnoses an Insured as having Diphtheria based on clinical and/or laboratory findings as supported by medical records.
- ***Encephalitis:*** The date a doctor diagnoses an insured as having encephalitis and where such diagnosis is supported by medical records.
- ***Huntington's Chorea:*** The date a Doctor Diagnoses an Insured as having Huntington's Chorea based on clinical findings as supported by medical records.
- ***Legionnaire's Disease:*** The date a Doctor Diagnoses an Insured as having Legionnaire's Disease by finding *Legionella* bacteria in a clinical specimen taken from the Insured.
- ***Malaria*****:** The date a Doctor Diagnoses an Insured as having Malaria and where such Diagnosis is supported by medical records.

- ***Muscular Dystrophy:*** The date a Doctor Diagnoses an Insured as having Muscular Dystrophy and where such Diagnosis is supported by medical records.
- ***Myasthenia Gravis:*** The date a Doctor Diagnoses an Insured as having Myasthenia Gravis and where such Diagnosis is supported by medical records.
- ***Necrotizing Fasciitis:*** The date a Doctor Diagnoses an Insured as having Necrotizing Fasciitis and where such Diagnosis is supported by medical records.
- ***Osteomyelitis*****:** The date a Doctor Diagnoses an Insured as having Osteomyelitis and where such Diagnosis is supported by medical records.
- ***Poliomyelitis*****:** The date a Doctor Diagnoses an Insured as having Poliomyelitis and where such Diagnosis is supported by medical records.
- ***Rabies*****:** The date a Doctor Diagnoses an Insured as having Rabies and where such Diagnosis is supported by medical records.
- ***Sickle Cell Anemia:*** The date a Doctor Diagnoses an Insured as having Sickle Cell Anemia and where such Diagnosis is supported by medical records.
- ***Systemic Lupus:*** The date a Doctor Diagnoses an Insured as having Systemic Lupus and where such Diagnosis is supported by medical records.
- ***Systemic Sclerosis (Scleroderma):*** The date a Doctor Diagnoses an Insured as having Systemic Sclerosis and where such Diagnosis is supported by medical records.
- ***Tetanus:*** The date a Doctor Diagnoses an Insured as having Tetanus by finding Clostridium tetani bacteria in a clinical specimen taken from the Insured.
- ***Tuberculosis:*** The date a Doctor Diagnoses an Insured as having Tuberculosis by finding Mycobacterium tuberculosis bacteria in a clinical specimen taken from the Insured.

Adrenal Hypofunction (Addison's Disease) means a disease occurring when the body's adrenal glands do not produce sufficient steroid hormones.

Adrenal Hypofunction does not include secondary and tertiary adrenal insufficiency.

Cerebrospinal Meningitis means a disease resulting in the inflammation of the meninges of both the brain and spinal cord caused by infection from viruses, bacteria, or other microorganisms or from Cancer.

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 disturbed sensation.

- ***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.

Diphtheria means an infectious disease caused by the bacterium *Corynebacterium diphtheriae* and characterized by the production of a systemic toxin and the formation of a false membrane lining of the mucous membrane of the throat and other respiratory passages, causing difficulty in breathing, high fever, and/or weakness.

Diphtheria can be Diagnosed either through laboratory tests that confirm Diphtheria through a culture obtained from the infected area or through clinical observation of visible symptoms.

Encephalitis means 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.

Huntington's Chorea means a hereditary disease characterized by gradual loss of brain function and voluntary movement due to degenerative changes in the cerebral cortex and basal ganglia.

Legionnaire's Disease means an infectious lung disease caused by species of the aerobic bacteria belonging to the genus *Legionella*.

Malaria means an infectious disease characterized by cycles of chills, fever, and sweating, caused by the bite of an anopheles mosquito infected with a protozoan of the genus *Plasmodium*.

Muscular Dystrophy means a genetic disease that causes progressive weakness and degeneration in the musculoskeletal system and where such muscles are replaced by scar tissue and fat. Muscular Dystrophy is characterized by progressive skeletal muscle weakness, defects in muscle proteins, and the death of muscle cells and tissues.

Myasthenia Gravis means a disease characterized by progressive weakness and exhaustibility of voluntary muscles without atrophy or sensory disturbance and caused by an autoimmune attack on acetylcholine receptors at the neuromuscular junction.

Necrotizing Fasciitis means a severe soft tissue infection by bacteria that is marked by edema and necrosis of subcutaneous tissues with involvement of adjacent fascia and by painful red swollen skin over the affected areas.

Osteomyelitis means an infectious inflammatory disease of the bone that typically results from a bacterial infection and may result in the death of bone tissue.

Poliomyelitis (Polio) means an acute infectious disease caused by the poliovirus and characterized by fever, motor paralysis, and atrophy of skeletal muscles. It often results in permanent disability and deformity, and marked by inflammation of nerve cells in the anterior gray matter in each lateral half of the spinal cord.

Rabies means an acute viral disease of the nervous system caused by a rhabdovirus, which is usually transmitted through the bite of a rabid animal. It is typically characterized by increased salivation, abnormal behavior, and eventual paralysis.

Sickle Cell Anemia means a hereditary disease caused by a genetic blood disorder. It is characterized by red blood cells that assume an abnormal, rigid, sickle shape due to a mutation on the hemoglobin gene.

Systemic Lupus means an autoimmune disease where the body's immune system attacks healthy tissue, leading to long-term inflammation. This disease is primarily characterized by joint pain and swelling.

Systemic Sclerosis (Scleroderma) means a progressive autoimmune disease characterized by the hardening and tightening of the skin and connective tissues.

Tetanus means a disease marked by rigidity and spasms of the voluntary muscles, caused by the bacterium Clostridium tetani.

Tuberculosis means an infectious disease caused by Mycobacterium tuberculosis bacteria. It is characterized by the growth of nodules in the bodily tissues, as well as by fever, cough, difficulty breathing, caseation, pleural effusions, and fibrosis.

BENEFIT PROVISIONS

We will pay the Benefit shown if an Insured is Diagnosed with one of the diseases listed in the Rider Schedule, and 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.

LIMITATIONS

Pre-Existing Conditions Limitation
Pre-existing Condition is a sickness or physical condition that existed within the 12-month period before the Insured's Effective Date. A medical professional must have advised, Diagnosed, or treated the Insured for the condition to be considered Pre-Existing.

We will not pay benefits for any disease resulting from or affected by a Pre-existing Condition if the disease was Diagnosed within the 12-month period after the Insured's Effective Date.

GENERAL PROVISIONS

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

Contract
This Rider is part of the 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 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

Adrenal Hypofunction (Addison's Disease)	25% of applicable Face Amount
Cerebral Palsy	25% of applicable Face Amount
Cerebrospinal Meningitis	25% of applicable Face Amount
Cystic Fibrosis	25% of applicable Face Amount
Diphtheria	25% of applicable Face Amount
Encephalitis	25% of applicable Face Amount
Huntington's Chorea	25% of applicable Face Amount
Legionnaire's Disease	25% of applicable Face Amount
Malaria	25% of applicable Face Amount
Muscular Dystrophy	25% of applicable Face Amount
Myasthenia Gravis	25% of applicable Face Amount
Necrotizing Fasciitis	25% of applicable Face Amount
Osteomyelitis	25% of applicable Face Amount
Poliomyelitis (Polio)	25% of applicable Face Amount
Rabies	25% of applicable Face Amount
Sickle Cell Anemia	25% of applicable Face Amount
Systemic Lupus	25% of applicable Face Amount
Systemic Sclerosis (Scleroderma)	25% of applicable Face Amount
Tetanus	25% of applicable Face Amount
Tuberculosis	25% of applicable Face Amount

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Continental American Insurance Company's toll free number for information or to make a complaint at:

1-800-433-3036

You may also write to Continental American Insurance Company at:

2801 Devine Street
Post Office Box 1807
Columbia, South Carolina 29205

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Web: http://www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:
Should you have a dispute concerning your premium or about a claim you should contact Continental American Insurance Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:
This notice is for information only and does not become a part or condition of the attached document

AVISO IMPORANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Continental American Insurance Company para informacion o para someter una queja al:

1-800-433-3036

Usted tambien puede escribir a Continental American Insuance Company at:

2801 Devine Street
Post Office Box 1807
Columbia, South Carolina 29205

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Web: http://www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS SOBRE PRIMAS O RECLAMOS:
Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con Continental American Insurance Company primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:
Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

(For insurers declared insolvent or impaired on or after September 1, 2011)

Texas law establishes a system to protect Texas Policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association (the "Association") administers this protection system. Only the policyholders of insurance companies that are members of the Association are eligible for this protection which is subject to the terms, limitations and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas **(regardless of where the policyholder lived when the policy was issued)**
- Residents of other states, ONLY if the following conditions are met:
    1. The policyholder has a policy with a company domiciled in Texas;
    2. The policyholder's state of residence has a similar guaranty association; and
    3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, and $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on a single life; or
- Death benefits up to a total of $300,000 under one or more policies on a single life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $250,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $250,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contract holder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limits, and the $5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life, Accident, Health and Hospital
Service Insurance Guaranty Association
6505 Bridge Point Parkway, Suite 450
Austin, Texas 78730
(800)-982-6362 or www.txlifega.org

Texas Department of Insurance
Post Office Box 149104
Austin, Texas 78714-9104
(800)-252-3439 or www.tdi.texas.gov

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. Although underwriting falls within the definition of health care operations, we will not use or disclose genetic information for purposes of underwriting. Genetic information is defined under the Genetic Information Nondiscrimination Act (GINA).

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. Specifically, most uses and disclosures of psychotherapy notes, uses or disclosures for marketing purposes and disclosures that constitute a sale of PHI require an authorization. You have the right to revoke that authorization in writing except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining insurance, and we have the right, under other law, to contest a claim under the plan itself.

- The following are examples of when your authorization would be required prior to use and disclosure:
  - Most uses and disclosures of your psychotherapy notes.
  - Uses and disclosures of your PHI for marketing purposes.
  - Uses and disclosures that constitute a sale of PHI.

Breach of Unsecured PHI – If 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. We may deny your request for access in certain very limited circumstances, such as request to access psychotherapy notes.

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

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

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

PRIVACY PRACTICES

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

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

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

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

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

PRIVACY NOTICE

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

Collection of Information

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

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

Disclosure of Information

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

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

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

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

Confidentiality and Security

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

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

NOTICE OF INFORMATION PRACTICES

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

NOTICE OF PRIVACY PRACTICES - PROTECTED HEALTH INFORMATION

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

Continental American Insurance Company • P.O. Box 427 • Columbia, South Carolina 29202 1-800-433-3036 toll-free