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

Group Critical Illness Insurance Limited Benefit 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 Policy Schedule.

Please read it carefully.

The Policyholder as shown on the Policy Schedule 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"). Based on the Master 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.) The Policyholder may add new Insureds from time to time, according to the Plan's terms.

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.

This Plan is a legal contract between the Company and the Policyholder. All material printed by the Company on the following pages is part of the Plan. This Plan is delivered in and governed by the laws of the jurisdiction shown on the Policy Schedule.

In witness whereof, the Company executes this Plan at its home office in Columbia, South Carolina, on the Effective Date.

Signed for the Company at its Home Office,

Teresa White, President

J. Matthew Loudermilk, Secretary

Group Critical Illness Insurance
Non-Participating

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.

Notice of Non-Insured Benefits

The Company may offer or provide goods and/or services that are not related to insurance. These goods and services, which could be offered or provided to some people who apply for CAIC coverage or become insured by CAIC, may include (but are not limited to) the following:

- Enrollment services
- Educational services
- Benefit statement services
- Payroll or plan administration services

The services listed above will fall under the same benefit plan that includes or is related to the applicable CAIC coverage, individual wellness programs, and related services.

In addition, CAIC may arrange for third-party service providers to provide discounted goods and services to people who apply for CAIC coverage or who become insured by CAIC.

Though CAIC has arranged these goods, services, and/or third-party provider discounts, the third-party providers—**not CAIC**—are liable to applicants/insureds for these goods and services. CAIC is not responsible for providing the goods and/or services, nor is CAIC liable to applicants/insureds for the negligent provision of these goods and/or services by third-party service providers.

For information about this notice, call 800.433.3036.

Table of Contents

Section I – Eligibility, Effective Date, and Termination

Eligibility

An Employee is eligible to be covered under this Plan if he is Actively at Work for his 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:

- The Spouse of an Employee, **or**
- The Dependent Child of an Employee or an Employee's Spouse (details included in the **Definitions** section).

Insured means an Employee or 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 Plan coverage are outlined in the Effective Date section.

Effective Date

The Plan's Effective Date is shown on the schedule page. This Plan becomes effective on the Policy Effective Date at 12:01 a.m., as determined by the Policyholder's address.

An eligible Employee must enroll in this Plan and agree to pay the required premiums for coverage to become effective. He may enroll within 31 days of the date he first becomes eligible for coverage. *The first premium must have been paid for coverage to become effective*.

We may require evidence of insurability satisfactory to us if the amount of coverage applied for exceeds the guaranteed-issue amount, if any, or if we do not receive the Application within 31 days after the Employee was first eligible for coverage. Evidence of insurability may also be required based on an agreement between the Policyholder and us.

An Employee's Effective Date is the date his insurance takes effect. After we receive and approve the Application, that date is either:

- The date shown on the Certificate Schedule if the Employee is Actively at Work on that date, **or**
- The date the Employee returns to an Actively-at-Work status if he was 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 60 days' written notice. The written notice requirement does not apply to cancellations for nonpayment of premiums.

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 an Employee's Insurance

An Employee's 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 he no longer belongs 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 the Employee's written request to terminate coverage for his Spouse or all Dependent Children.

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

Portability Privilege

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

To keep his coverage in force, the Employee must:

- Notify the Company in writing within 31 days after the date his coverage would otherwise terminate, **and**
- Pay the required premium to the Company no later than 31 days after the date his 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 the Employee fails to pay any required premium; **or**
- The date the Group Plan is terminated.

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.

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.

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 an Employee's ability to perform his regular employment duties for a full normal workday. The Employee may perform these activities either at his employer's regular place of business or at a location where he is required to travel to perform the regular duties of his 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.

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 an Employee's Spouse or Dependent Child. ***Spouse*** is an Employee's legal wife or husband who is listed on the Employee's Application. ***Dependent Children*** are an Employee's or an Employee's 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 the Insured's 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 the Insured or any of the Insured's Family Members.

For the purposes of this definition, ***Family Member*** includes the Employee's Spouse as well as the following members of the Employee's 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 physphokinase (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**
- **Poliomyelitis**, 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 Policy 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.

If the Certificate Schedule shows a Reduced Face Amount Date, your Face Amount will change to the Reduced Face Amount on that date. 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 Policy 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 Policy 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 Policy 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
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- DNA stool analysis
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test to determine level of HDL and LDL
- Serum protein electrophoresis (blood test for myeloma)
- Spiral CT screening for lung cancer
- Stress test on a bicycle or treadmill
- Thermography

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.

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 Acts –** participating or attempting to participate in an illegal activity, or working at an illegal job
- **Participation in Aggressive Conflict** of any kind, including:
    - War (declared or undeclared) or military conflicts
    - Insurrection or riot
    - Civil commotion or civil state of belligerence
- **Illegal substance abuse, which includes 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.

When we receive written Notice of Claim, we will send a claim form. If the Claimant does not receive the claim form within 10 working days after the notice is sent, written Proof of Loss can be sent to us without waiting for the form. Notice must include the Employee's name and the Certificate number. Notice can be mailed to the Company at:

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

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 the Employee's legal mental capacity.

The Claimant will be responsible for the cost of obtaining a completed claim form. We may request additional Proof of Loss, such as records from hospitals or Doctors. 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. After receiving the appropriate information, we will pay, deny, or settle all clean claims* within 15 working days for electronic claims and 30 calendar days for paper claims.

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

Payment of Claims

We will pay all benefits to the Employee 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 the Employee's beneficiary,
- To the Employee's surviving Spouse,
- To the Employee's 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 the Employee. Unless otherwise specified by the Employee, 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, the Employee 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—the Employee, 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

The Employee 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

This 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 Certificates 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 or intentionally misrepresented 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 an Employee dies while covered under his Certificate and his Spouse is also insured under this Plan at the time of his death, then his 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, the surviving Spouse must:

- Notify the Company in writing within 31 days after the date of the Employee's death; **and**
- Pay the required premium to the Company no later than 31 days after the date of the Employee's 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 the Employee's death.

Time Limit on Certain Defenses

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

Policy Schedule

Policyholder:	City of Marietta
Jurisdiction:	GA
Policy Number:	24814
Policy Effective Date:	01/01/2019
Policy Anniversary Date:	01/01/2020
Face Amount:	See Certificates
Reduced Face Amount Date:	First Premium Due Date after age 70
Reduced Face Amount:	50% of Employee Face Amount
Spouse Amount:	See Certificates
Covered Dependent Children:	50% of applicable Face Amount
Partial Benefits Percentage:	25% of applicable Face Amount
Additional Benefits:	
Health Screening Benefit Amount:	$75 per Insured per calendar year.
Skin Cancer:	$250
Skin Cancer for Covered Dependent Children:	50% of Skin Cancer Benefit Amount
Accident Benefits:	100% of applicable Face Amount

This Plan is delivered in and governed by the laws of the jurisdiction shown above.

Section VIII – Incorporation of Rider Provisions

The attached listed Certificate Riders are made a part of this Plan.

Rider Name	Form Number
Optional Benefits Rider	C21301GA
Portability Privilege Amendment	CAICCLASSPORT

Benefit Schedule

Critical Illness Benefits

The applicable benefit amount (Face Amount or Reduced Face Amount) is payable for the following Critical Illnesses, provided such Critical Illness meets all applicable definitions contained in the Plan and is caused by an underlying disease as set forth herein:

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

Partial Benefits

Non-Invasive Cancer
Coronary Artery Bypass Surgery

Additional Benefits

Health Screening
Benefit Skin Cancer

Accident Benefits

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

Classifications and Schedule of Premiums

Benefit-eligible employees are classified as such in the Master Application as being **Actively at Work** and **working full-time, a minimum of 30 hours per week**.

RATES TABLE FOR: CITY OF MARIETTA - GP-7664 / GROUP CRITICAL ILLNESS - PLAN-42010

DEDUCTION FREQUENCY : Weekly (52pp / yr)

Employee - Non-Tobacco

	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
18-29	$0.96	$1.40	$1.85	$2.29	$2.74	$3.19
30-39	$0.96	$1.40	$1.85	$2.29	$2.74	$3.19
40-49	$1.98	$3.45	$4.91	$6.38	$7.85	$9.32
50-59	$3.20	$5.92	$8.65	$11.37	$14.09	$16.81
60-69	$4.94	$9.45	$13.97	$18.48	$23.00	$27.51

Employee - Tobacco

	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
18-29	$1.15	$1.78	$2.42	$3.05	$3.69	$4.32
30-39	$1.68	$2.84	$4.01	$5.18	$6.35	$7.51
40-49	$2.83	$5.15	$7.46	$9.78	$12.10	$14.42
50-59	$4.88	$9.29	$13.69	$18.09	$22.49	$26.90
60-69	$7.47	$14.53	$21.58	$28.63	$35.68	$42.74

Spouse - Non-Tobacco

	$5,000	$7,500	$10,000	$12,500	$15,000
18-29	$0.96	$1.18	$1.40	$1.63	$1.85
30-39	$1.25	$1.62	$1.99	$2.36	$2.73
40-49	$1.98	$2.71	$3.45	$4.18	$4.91
50-59	$3.20	$4.56	$5.92	$7.29	$8.65
60-69	$4.94	$7.19	$9.45	$11.71	$13.97

Spouse - Tobacco

	$5,000	$7,500	$10,000	$12,500	$15,000
18-29	$1.15	$1.46	$1.78	$2.10	$2.42
30-39	$1.68	$2.26	$2.84	$3.43	$4.01
40-49	$2.83	$3.99	$5.15	$6.31	$7.46
50-59	$4.88	$7.08	$9.29	$11.49	$13.69
60-69	$7.47	$11.00	$14.53	$18.05	$21.58

CONTINENTAL AMERICAN INSURANCE COMPANY

P.O. Box 427, Columbia, South Carolina 29202
800.433.3036

Amendment
to Policy and Certificate of Insurance for
Group Critical Illness

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

Effective Date

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

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

Plan Termination

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

- The premium is not paid 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 60 days' written notice. The written notice requirement does not apply to cancellations for nonpayment of premiums.

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 receives premium payments after the Plan terminates, this will not reinstate the Plan.

The Policyholder has the sole responsibility of notifying Certificateholders in writing of the Plan's termination 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.

The Portability Privilege provision is deleted and replaced with the following:

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, without any additional underwriting requirements.

To keep your coverage in force, you must:

- Notify the Company in writing within 31 days after the date your coverage would otherwise terminate. You may notify us by sending written notice to P.O. Box 427, Columbia, South Carolina, 29202 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly 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 premium due date (the last day of the Grace Period), if the premium has not been paid, or
- The date the Group Plan is terminated.

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

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

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

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.

The Additional Diagnosis provision is deleted and replaced with the following:

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.

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.

The Reoccurrence provision is deleted and replaced with the following:

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 six consecutive months.

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.

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

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

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

Proof of Loss

Proof of Loss refers to documentation that supports a claim. (This information is often found in standardized medical documents, such as hospital bills and operative reports. It 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 the Claimant's legal mental capacity.

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

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

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

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

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

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

General Provisions

This Amendment is part of the Policy and Certificate and will terminate when that Policy or Certificate terminates, or when premiums are no longer paid for this Amendment.

This Amendment is subject to all of the terms of the Group Critical Illness Policy and Certificate to which it is attached unless any such items are inconsistent with the terms of this Amendment.

Signed for the Company at its Home Office,

Teresa White, President

J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

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

Amendment
to Policy and Certificate of Insurance for
Group Critical Illness

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

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

The Termination of Your Insurance provision is deleted and replaced with the following:

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.

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

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

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

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.

The definition of Major Organ Transplant is deleted and replaced with the following:

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.

CONTRACT

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

Signed for the Company at its Home Office,

Teresa White, President

J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

P.O. Box 427, Columbia, South Carolina 29202
800.433.3036

Portability Privilege Amendment

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

Effective Date

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

Portability Privilege

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

ELIGIBILITY — CLASSES OF COVERAGE

Class I

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

Class II

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

- Was previously insured under Class I; **and**
- Is no longer employed by the Policyholder.

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

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

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

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

TERMINATION OF THE PLAN

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

After the end of the first Plan year, the Company has the right to cancel the Plan. To do so, the Company must give 31-60 days written notice that the plan will end on the date before the next premium due date.
The Policyholder has the right to cancel the Plan on the date before any premium due date by giving 31 days written notice.

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

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

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

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

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

TERMINATION OF AN EMPLOYEE'S INSURANCE
An Employee's insurance will terminate on the earliest of the following:

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

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

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

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

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

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

The premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least 31-60 days before any change is to take effect.

The Employee may continue the coverage until the earlier of:

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

Coverage may not be continued:

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

General Provisions

Time Limit on Certain Defenses

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

Contract

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

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

Signed for the Company at its Home Office,

Teresa White, President **J. Matthew Loudermilk, Secretary**

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
    - Bradykinesis (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 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 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

OPTIONAL BENEFITS RIDER SCHEDULE

Benefits

Advanced Alzheimer's Disease	25% of applicable Face Amount
Advanced Parkinson's Disease	25% of applicable Face Amount
Benign Brain Tumor	100% of applicable Face Amount

AFLAC CUSTOMER PRIVACY POLICY

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, and Continental American Insurance Company (collectively, "Aflac"). Accordingly, Aflac has developed and adopted this "Customer Privacy Policy" which is designed to ensure that our collection and use of customer information complies with the following commitments:

- **Aflac does not sell, rent, lease or otherwise disclose nonpublic personal information (NPI) of its customers for purposes unrelated to Aflac products and services.** Our customers' NPI is of paramount importance to us. Therefore, we provide your NPI only to our affiliates, employees, agents and third parties as necessary to facilitate the development and delivery of our insurance and employee benefit products and services. Aflac may also provide your NPI to its affiliates for marketing purposes consistent with the terms disclosed herein (see *Sharing Information*, below).
- **Aflac works to ensure information integrity and security.** We use technology tools and design our business practices to help ensure that our customers' NPI is properly gathered, stored and processed. We also work to maintain the security of our customers' NPI through the use of technology and our business practices.
- **Aflac expects its agents and employees to respect customer NPI.** Aflac has adopted internal policies and procedures designed to ensure that employees and agents adhere to Aflac's privacy policies and otherwise protect our customers' NPI. Both employees and agents are subject to censure, dismissal, or termination for violation of these policies.

  This Customer Privacy Policy applies to those individuals who receive our products and services, as well as to individuals who provide us with NPI in the course of submitting an application to us for our products and services. .

PRIVACY NOTICE

Aflac provides this notice to let you know about our current privacy practices with respect to the collection, sharing and protection of your NPI. **You do not need to do anything in response to this notice, unless you would like to prohibit the use of your NPI by our affiliates to market products and services to you, as described below.**

Collecting 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 NPI about Aflac's customers, including:

- Information from our customers (including names, addresses, and financial and health information).
- Information about our customers' transactions with Aflac or our agents (including claims and payment information).
- Information from or about your transactions with nonaffiliated third parties (including, but not limited to, accident reports, claims, health and insurance application histories, health history, and salary data).

Sharing Information

- Aflac shares the NPI it collects about you, as described above, among Aflac and its affiliates so that Aflac and its affiliates may perform their everyday business functions, such as processing your transactions and claims, or otherwise maintaining your policies. Aflac also reserves the right to share your NPI with its affiliates to enable Aflac affiliates to market their products and services directly to you. You can prevent the use of your NPI for this purpose by following the "opt-out" procedure described below, "*Opting Out of Information Sharing*."
- Aflac does not share, and does not reserve the right to share, customer NPI with nonaffiliated third parties except as permitted or required by applicable law.
- Aflac agents will share your NPI only while acting on Aflac's behalf and, furthermore, will share your NPI only to the extent Aflac itself is permitted to do so.
- Neither Aflac nor its agents will disclose the NPI of former customers unless the disclosure is authorized by or at the request of the former customer, or is otherwise permitted or required by law.

Opting Out of Information Sharing

As described above, Aflac shares your NPI when permitted or required by law. You are not able to limit Aflac's ability to share your NPI for these purposes.

Affiliate Marketing Opt Out

If you would prefer not to receive marketing materials from Aflac's affiliates about their products or services, you can opt out of such affiliate marketing by either (1) calling 1.800.433.3036; or (2) visiting www.aflacgroupinsurance.com and downloading, completing, and returning the Affiliate Marketing Opt-Out Form to Aflac at the referenced address. If you opt-out and later change your mind, please let Aflac know and we will change your choice. Your opt out does not prevent Aflac

from sending you information about products or services offered by Aflac or its affiliates. Similarly, your opt out will not prevent an Aflac affiliate from using NPI received from Aflac to market affiliate products and services to you if (a) you have a pre-existing relationship with such affiliate, or (b) you contact such affiliate directly and request information about such affiliate's products or services.

Confidentiality and Security

Aflac and its agents safeguard customer (and former customer) NPI by maintaining administrative, technical, and physical safeguards to ensure the security and confidentiality of such NPI. This includes having security practices in place to protect against anticipated threats or hazards, and to protect against unauthorized access to or use of customer and former customer NPI.

Aflac limits access to NPI to only those employees who need access to such information to perform their job functions. Employees who misuse NPI are subject to disciplinary actions. Aflac provides privacy training and awareness to all of its employees.

NOTICE OF INFORMATION PRACTICES

California, Connecticut, Georgia, Illinois, Kansas, Maine, Massachusetts, Minnesota, Montana, 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 Aflac, ATTN: Privacy Office, P.O. Box 427, Columbia, SC 29202.

STATE SPECIFIC DISCLOSURES

Customer NPI shall be collected, used and stored in accordance with applicable federal privacy laws. To the extent that the privacy laws of a Customer's state of residence are more protective of the Customer's NPI than federal privacy laws, Aflac will protect the Customer's NPI in accordance with such state law.

Attention Washington Residents: You have the right to limit disclosures of your nonpublic personal information under the circumstances described in WAC 284-04-510. For instance, you may request in writing that Aflac limit the disclosure of nonpublic personal information to specified individuals if the disclosure of the information to those individuals could jeopardize your safety. In addition, you may also request, in writing, that Aflac limit certain disclosures of information regarding reproductive health, sexually transmitted diseases, chemical dependency and mental health. For more information or if you wish to submit a request, please write to: Aflac, 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 Health Insurance Portability and Accountability Act of 1996 (HIPAA), copies are available by visiting Aflac's website, www.aflacgroupinsurance.com, or sending a written request to: Aflac, ATTN: Privacy Office, P.O. Box 427, Columbia, SC 29202.

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 and Continental American Life Insurance Company (collectively, "we," "our," or "Aflac") [1]. This Notice describes how Aflac 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 Aflac 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 Aflac: 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 Aflac 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).

[1] *With respect to its Health Plans, American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York and Continental American Insurance Company are affiliated covered entities (see 45 CFR 164.105).*

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 Aflac to share PHI with your spouse or others, you may exercise your right to request a restriction on Aflac'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, Aflac 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 Aflac or a Business Associate of Aflac 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 Aflac Access request forms are available from Aflac 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 Aflac 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 Aflac 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 Aflac 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 Aflac 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 Aflac at the telephone number or address below.

Complaints – If you believe your privacy rights have been violated, you can file a complaint with Aflac 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 Aflac's Privacy Office by writing to: Aflac, Attn: Privacy Office, P.O. Box 427, Columbia, SC 29202, or by calling 1-800-433-3036.

EFFECTIVE DATE

This Notice is effective January 6, 2017.