



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

Columbia, South Carolina
(800)433-3036

CERTIFICATE OF INSURANCE FOR CANCER AND SPECIFIED DISEASE POLICY

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

**PLEASE READ YOUR CERTIFICATE CAREFULLY
THIS IS NOT A MEDICARE SUPPLEMENT POLICY.**

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

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

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

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

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

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

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

**IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE
TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION**
(For insurers declared insolvent or impaired on or after September 1, 2011)

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

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

Eligibility for Protection by the Association

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

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

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

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

Life Insurance:

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

Individual Annuities:

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

Group Annuities:

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

Aggregate Limit:

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

These limits are applied for each insolvent insurance company.

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

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

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

IMPORTANT NOTICE

To obtain information or make a complaint:

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

1-800-433-3036

You may also write to Continental American Insurance Company at:

Post Office Box 427
Columbia, South Carolina 29202

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

1-800-252-3439

You may write the Texas Department of Insurance:

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

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de Continental American Insurance Company's para obtener información o para presentar una queja al:

1-800-433-3036

Usted también puede escribir a Continental American Insurance Company:

Post Office Box 427
Columbia, South Carolina 29202

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

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

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:

Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA:

Este aviso es solamente para propósito informativos y no se convierte en parte o en condición del documento adjunto.

SECTION I DEFINITIONS

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

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

Insured(s) –

- (A) If this is Employee coverage as shown in the Certificate Schedule, Insured includes only to you.
- (B) If this is One-Parent coverage as shown in the Certificate Schedule, then Insured includes you and your Dependent Children as defined below.
- (C) If this is Two-Parent coverage as shown in the Certificate Schedule, then Insured includes you, your spouse and Dependent Children.
- (E) If coverage is offered where the dependent(s) are listed as the primary Insured, then Insured includes the dependent shown on the Certificate Schedule.
- (F) If any person who would otherwise be an Insured is specifically excluded from coverage by endorsement to the Plan, a Certificate or by the application, then such person shall not be an Insured.
- (G) Any other additions to the Insured class must be added after applying to us.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Pathologist - A pathologist means a physician, other than the Employee or a family member, who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A pathologist also means an osteopathic pathologist who is certified by the Osteopathic Board of Pathology.

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

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

We, Us or Our – refers to Continental American.

SECTION II PREMIUMS AND INDIVIDUAL TERMINATIONS

PREMIUMS

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

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

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

INDIVIDUAL TERMINATIONS

Your insurance will terminate on the earliest of:

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

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

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

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

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

SECTION III

BENEFITS PROVISIONS

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

ELIGIBILITY FOR BENEFITS

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

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

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

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

BENEFITS

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

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

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

Cancer Screening Test is defined as:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We will not pay this benefit for the following:

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

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

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

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

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

Continuation Privilege

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

1. Coverage may not be continued for any of the following reasons:
 - a. you failed to pay any required premium; or
 - b. the Group Policy terminates.
2. To keep your insurance in force you must:
 - a. make written application to us within 31 days after the date this insurance would otherwise terminate;
 - b. pay the required premium to us no later than 31 days after the date this insurance would otherwise terminate.
3. To keep dependent coverage in force, you must continue coverage.
4. Insurance will cease on the earliest of these dates:
 - a. the date you fail to pay any required premium;
 - b. the date the Group Policy is terminated.

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

SECTION IV

LIMITATIONS AND EXCLUSIONS

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

PRE-EXISTING CONDITIONS LIMITATION

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

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

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

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

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

SECTION V

UNIFORM PROVISIONS

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

Entire Contract - The entire contract consists of:

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

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

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

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

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

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

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

SECTION VI

CLAIM PROVISIONS

Notice of Claim - Written notice of claim must be given within sixty (60) days after a covered loss starts, or as soon as reasonably possible. The notice can be given to us at our Home Office. Notice should include the name of the Insured and the Certificate number.

Claim Forms - When we receive a notice of claim, we will send the claimant forms for filing proof of loss. If the forms are not given to you within 15 working days, you will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss Section.

Proof of Loss - Written proof of loss must be furnished to us at our Home Office within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than one year from the time proof is otherwise required.

Time of Payment of Claims - Benefits payable under this Certificate will be paid immediately upon receipt of written proof of loss.

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

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

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

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

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

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

Option I
SCHEDULE OF OPERATIONS

ABDOMEN

Paracentesi	\$ 95
Exploratory laparotomy	470
Cholecystectomy	625

BLADDER

Cystoscopy	125
TUR bladder tumors	470
Cystectomy	
(partial)	780
(complete)	1,405
(with ureteroileal conduit)	2,800

BRAIN

Burr holes not followed by surgery	525
Ventriculoperitoneal shunt	525
Exploratory craniotomy	1,000
Excision brain tumor	2,000
Hemispherectomy	3,000

BREAST

Needle biopsy	125
Cutting operation biopsy	250
Lumpectomy	310
Mastectomy	
(partial)	470
(simple)	625
(radical)	935
Breast reconstruction	625
Symmetry on non-diseased breast (occurring within five years of breast reconstruction)	325

CERVIX

D & C	155
Colposcopy	155
Vaginal hysterectomy/uterus only	470
Oophorectomy	470
Abdominal hysterectomy/uterus only	780
Uterus, tubes & ovaries	1,250
with exenteration	3,000

CHEST

Thoracentesis	140
Bronchoscopy	300
Mediastinoscopy	300
Thoracostomy	300
Thoracotomy	700
Wedge resection	1,200
Lobectomy	1,500
Pneumonectomy	2,100

ESOPHAGUS

Esophagoscopy	250
Esophagogastrectomy	1,350
Resection of esophagus	1,295

EYE

P32 uptake	175
Enucleation	350

INTESTINES

Sigmoidoscopy	125
Proctosigmoidoscopy	125
Colonoscopy	250
Cutting operation on rectum for biopsy	250
Colostomy/or revision of	310
ERCP	310
Ileostomy	310
Colectomy	780
Resection small intestine	1,560
Abdominal-perineal approach for removal of cancer of sigmoid colon or rectum	1,875

KIDNEY

Nephrectomy	1,560
Radical	2,800

LIVER

Needle biopsy	125
Wedge biopsy	310
Resection of liver	780

LYMPHATIC

Excision of lymph node	155
Splenectomy	625
Axillary node dissection	625
Lymphadenectomy	
(unilateral)	625
(bilateral)	780

MANDIBLE

Mandibulectomy	1,250
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MISCELLANEOUS

Bone marrow biopsy or aspiration	125
Venous-catheters/venous port for chemotherapy	250
Pathological hip fracture	780

MOUTH

Hemiglossectomy	310
Tonsil/mucous membrane	470
Glossectomy	625
Resection of palate	625

PANCREAS

Jejunostomy	780
Pancreatectomy	1,875
Whipple procedure	2,800

PENIS

Amputation	
(partial)	250
(complete)	470
(radical)	625

PROSTATE

Needle biopsy	125
Cystoscopy	125
TUR prostate	470
Radical prostatectomy	1,250

RADIUM IMPLANTS

Insertion	1,000
Removal	500

SALIVARY GLANDS

Biopsy	310
Parotidectomy	625
Radical neck dissection	1,400

SPINE

Cordotomy	470
Laminectomy	780

STOMACH

Gastroscopy	250
Gastrojejunostomy	780
Partial gastrectomy	780
Gastrectomy	1,225

TESTIS

Orchiectomy	
(unilateral)	310
(bilateral)	450

THROAT

Laryngoscopy	250
Tracheostomy	250
Laryngectomy	
(without neck dissection)	700
(with neck dissection)	400

THYROID

Thyroidectomy	
partial: one lobe)	470
(total: both lobes)	625

VULVA

Vulvectomy	
(partial)	470
(radical)	935

BENEFIT SCHEDULE

OPTION I

<u>BENEFITS</u>	<u>INSURED/SPOUSE/CHILD</u>
FIRST OCCURRENCE	\$1,500
HOSPITAL CONFINEMENT 1-30	\$200 PER DAY
HOSPITAL CONFINEMENT 31+	\$400 PER DAY
SURGERY	SEE SURGICAL SCHEDULE (\$3000 MAXIMUM PER OPERATIVE SESSION)
SKIN CANCER SURGERY	\$100-\$600
SECOND SURGERY OPINION	\$200
RADIATION THERAPY (Radio-Active Isotopes Therapy Chemotherapy or Immunotherapy)	\$200 per day
EXPERIMENTAL TREATMENT	\$200 per day
ANESTHESIA	25% of maximum \$5,000
BONE MARROW TRANSPLANT Incurred charges up to:	\$10,000 in-hospital \$5,000 outpatient \$1,000 donor indemnity
STEM CELL TRANSPLANTATION Incurred charges up to:	\$2,500
OUTPATIENT BLOOD, PLASMA	\$200
PROSTHESIS/ARTIFICIAL LIMB Incurred charges up to:	\$2,500
Prosthesis that does not require surgery:	\$200
NATIONAL CANCER CONSULTATION	\$500

EXTENDED CARE FACILITY

\$100 PER DAY

HOME HEALTH CARE

Incurred charges up to:

\$50 per day

Optional Intensive Care Unit Benefit

\$600 per day up to 30 days

Specified Disease Benefit

\$500 thereafter

\$200 per day for the first 30 days of hospital confinement

BENEFITS

INSURED/SPOUSE/CHILD

AMBULANCE

Incurred CHARGES (Limit two trips per confinement)

HOSPICE CARE

**\$100 PER DAY for the first 60 days
\$50 per day thereafter**

TRANSPORTATION

**\$0.40 PER MILE up to \$1,200
Commercial travel: up to \$1,200 round trip**

FAMILY MEMBER LODGING

\$50 PER DAY

WELLNESS

\$50 PER TEST MAX OF \$100 PER YEAR PER INSURED

ANTI NAUSEA MEDICATION

\$100

WAIVER OF PREMIUM

YES



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

ENHANCED GROUP CONTINUATION RIDER

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

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

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

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

Effective Date

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

Continuation Privilege

When an Employee ends employment with the Employer and his coverage would terminate, that Employee may elect to continue the coverage he had on the date his employment ended, including any in-force Spouse or Dependent Child coverage.

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

When the Group Policy is terminated by the Policyholder and a current Employee's coverage would terminate, that Employee may apply to continue the coverage he had on the date the Group Policy was terminated, including any in-force Spouse or Dependent Child coverage. If an Employee qualifies for this Continuation Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate as shown in his previously issued Certificate.

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

General Provisions

Time Limit on Certain Defenses

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

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

Signed for the Company at its Home Office,



Teresa White, President



J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

WAIVER OF PREMIUM BENEFIT RIDER TO CERTIFICATE OF INSURANCE FOR CANCER

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

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

Effective Date

This Rider becomes effective on the Certificate Effective Date.

Definitions

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

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

Cancer is defined in your certificate of coverage.

Certificate is the certificate to which this Rider is attached.

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

Eligible Medical Expenses will include the following:

BENEFIT

Waiver of Premium

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

Limitations and Exclusions

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

General Provisions

Time Limit on Certain Defenses

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

Contract

This Rider is:

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

This Rider will terminate when:

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

Signed for the Company at its Home Office,



Teresa White, President



J. Matthew Loudermilk, Secretary

Cancer Expense Benefit Rider Schedule

BENEFITS

See Certificate Schedule