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

Home Office: 2801 Devine Street, Columbia, South Carolina 29205

800.433.3036

Certificate of Insurance For
Group Critical Illness Insurance Policy

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

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

Please read it carefully.

You have the right to return this Certificate within ten days of receipt and to have the premium refunded if, upon examination, you are not satisfied for any reason.

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

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

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

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

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

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Section I – Eligibility, Effective Date, and Termination

Eligibility

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

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

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

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

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

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

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

Effective Date

Your Certificate Effective Date is shown on the Certificate Schedule.

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

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

The Effective Date for a Spouse or Dependent Child is:

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

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

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

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

Plan Termination

The Company may not cancel the Plan prior to the first Policy Anniversary Date except for the following reasons:

- Nonpayment of the required premium; **or**
- The failure to meet continued underwriting standards, including the number of participating Employees falling below the number mutually agreed upon by the Company and the Policyholder in the signed Master Application.

After the end of the first policy year, the Company has the right to cancel the Plan on any premium due date. To do this, the Company must give the Policyholder 31 days' written notice.

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

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

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

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

Termination of Your Insurance

Your insurance will terminate on whichever occurs first:

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

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

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

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

Portability Privilege

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

To keep your coverage in force, you must:

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

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

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

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

Section II – Premium Provisions

Premium Payments

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

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

Premium Changes

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

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

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

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

Grace Period

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

Section III – Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

Cancer (internal or invasive) also includes:

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

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

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

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

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

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

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

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

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

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

The following are considered Skin Cancers:

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

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

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

1. ***Pathological Diagnosis*** is a Diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This Diagnosis must be made by a certified Pathologist and conform to the American Board of Pathology standards.

2. ***Clinical Diagnosis*** is based only on the study of symptoms. The Company will accept a Clinical Diagnosis only if:
    - A Doctor cannot make a Pathological Diagnosis because it is medically inappropriate or life-threatening,
    - Medical evidence exists to support the Diagnosis, **and**
    - A Doctor is treating the Insured for Cancer or Carcinoma in Situ.

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

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

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

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

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

Coma does not include a medically-induced coma.

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

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

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

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

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

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

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

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

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

Date of Diagnosis is defined as follows:

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

Dependent means your Spouse or your Dependent Child. ***Spouse*** is your legal wife or husband who is listed on your Application. ***Dependent Children*** are your or your Spouse's natural children, step-children, legally adopted children, or Children Placed for Adoption, who are younger than age 26.

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

There is an exception to the age-26 limit listed above. This limit will not apply to any Dependent Child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. The Employee or the Employee's Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday. We may require at reasonable intervals during the two years following the Dependent Child's attainment of the limiting age subsequent proof of the child's incapacity and dependency. After such two-year period, we may require subsequent proof not more than once each year.

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

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

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

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

Doctor is a person who is:

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

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

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

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

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

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

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

Heart Attack (Myocardial Infarction) does not include:

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

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

- New and serial electrocardiographic (ECG) findings consistent with Heart Attack (Myocardial Infarction), **and**
- Elevation of cardiac enzymes above generally accepted laboratory levels of normal. (In the case of creatine 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 Benefit Schedule. The Company will pay benefits for a Critical Illness in the order the events occur.

Critical Illness Benefit

Initial Diagnosis

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

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

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

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

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

Additional Diagnosis

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

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

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

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

Reoccurrence

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

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

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

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

Partial Benefits

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

Non-Invasive Cancer

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

Coronary Artery Bypass Surgery

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

Additional Benefits

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

Skin Cancer Benefit

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

Accident Benefit

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

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

Waiver of Premium Benefit

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

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

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

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

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

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

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

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

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

Section V – Limitations and Exclusions

Cancer Diagnosis Limitation

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

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

Exclusions

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

- **Self-Inflicted Injuries –** injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured
- **Suicide –** committing or attempting to commit suicide, while sane
- **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. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

Notice must include your name and Certificate number. Notice can be mailed to the Company at:

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

Claim Forms

The Company shall furnish to the person making claim, or to the policyholder for delivery to such person, such forms as are usually furnished by it for filing Proof of Loss. If such forms are not furnished before the expiration of 15 days after we receive notice of any claim under the policy, the person making such claim shall be deemed to have complied with the requirements of the policy as to Proof of Loss upon submitting, within the time fixed in the policy for filing Proof of Loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

Proof of Loss

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

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

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

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

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

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

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

Physical Examination and Autopsy

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

Time of Payment of Claims

Benefits payable under the Certificate will be paid after we receive due Proof of Loss acceptable to us. We will pay, deny, or settle all clean claims* within 30 calendar days after receiving the appropriate information.

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

Payment of Claims

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

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

Unpaid Premium

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

Changing of Beneficiary

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

Claim Review

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

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

Appeals Procedure

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

Legal Action

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

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

Section VII – General Provisions

Entire Contract Changes

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

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

All statements 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.

Conversion Privilege (Successor Insured)

If you die while covered under this Certificate and your Spouse is also insured under this Plan at the time of your death, then your surviving Spouse may elect to become the primary Insured at the current Spouse Face Amount. This would include continuation of any Dependent Child coverage that is in force at that time. This coverage will be effective immediately. The surviving Spouse will not need to provide medical evidence of insurability.

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

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

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

Time Limit on Certain Defenses

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

Clerical Error

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

Individual Certificates

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

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

Required Information

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

Conformity with State Statutes

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

CONTINENTAL AMERICAN INSURANCE COMPANY

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

APPENDIX ONE
NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE LIFE AND
HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Missouri Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Missouri Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Missouri. You should not rely on coverage by the Missouri Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy. Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. Insurance companies or their insurance producers are required by law to give or send you this notice. However, insurance companies and their insurance producers are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy. YOU MAY CONTACT EITHER THE ASSOCIATION OR THE MISSOURI DEPARTMENT OF INSURANCE AT THE FOLLOWING ADDRESSES SHOULD YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE.

The Missouri Life and Health Insurance Guaranty Association
994 Diamond Ridge, Suite 102
Jefferson City, MO 65109

Missouri Department of Insurance
PO Box 690
Jefferson City, MO 65102-0690

The state law that provides for this safety-net coverage is called the Missouri Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the guaranty association.

Generally, persons will be covered if they live in this state, and hold a life or health insurance contract or annuity, or a certificate under a group policy or contract. However, not all individuals with a right to recover under life or health insurance policies or annuities are protected by the Act. A person is not protected when—

1. The person is eligible for protection under the laws of another state;
2. The person purchased the insurance from a company that was not authorized to do business in this state;
3. The policy is issued by an organization which is not a member insurer of the association; or
4. The person does not live in this state, except under limited circumstances.

Additionally, the Association may not provide coverage for the entire amount a person expects to receive from the policy. The Association does not provide coverage for any portion of the policy where the person has assumed the risk, for any policy of reinsurance (unless an assumption certificate was issued), for interest rates that exceed a specified average rate, for employers' plans that are self-funded, for parts of plans that provide dividends or credits in connection with the administration of policy, or for unallocated annuity contracts (which are generally issued to pension plan trustees). The Act also limits the amount the Association is obligated to pay persons on various policies. The Association does not pay more than the amount of the contractual obligation of the insurance company. The Association does not have to pay more than three hundred thousand dollars ($300,000) in death benefits for any one life regardless of the number of policies that insure that life. The Association does not have to pay amounts over one hundred thousand dollars ($100,000) in cash surrender or withdrawal benefits on one life regardless of the number of policies insuring that individual. For health insurance benefits, the Association is not obligated to pay over one hundred thousand dollars ($100,000) including net cash surrender and withdrawal benefits. On an annuity contract, the Association is not liable for over one hundred thousand dollars ($100,000) in present value. Finally, the Association is never obligated to pay more than a total of three hundred thousand dollars ($300,000) for any one insured for any combination of insurance benefits.

APPENDIX TWO
NOTICE

This policy or contract is not covered by the Missouri Life and Health Insurance Guaranty Association. If the company providing this policy or contract is unable to meet its obligation by reason of insolvency or financial impairment, the fund(s) of the Missouri Life and Health Insurance Guaranty Association will not be available to protect the policy or contract holder or his/her beneficiaries, payees or assignees.