



Thank you for choosing Continental American Insurance Company

1.800.433.3036

www.aflacgroupinsurance.com

Your Group Policy Number is:

CTR0003144810

Product:

Critical Illness

Your Policy is Effective :

09/01/2021

Your State of Issue is:

Texas

(Page 1 of 80)



CITY OF DENTON
215 E MCKINNEY ST
DENTON TX 76201-4229



April 25, 2026

CITY OF DENTON
215 E MCKINNEY ST
DENTON TX 76201-4229

Re: City Of Denton Group Critical Illness Coverage
Policy No.: CTR0003144810

Welcome to the Aflac Family!

Thank you so much for continuing to include Aflac coverage in your employee benefits offering. We take commitments to our accounts very seriously and pledge to be here when you and your employees need us.

Enclosed, you'll find The Aflac group **Critical Illness** Master Policy packet that reflects recent changes made to the existing policy. Your packet includes:

- An updated Master Policy, which indicates your group's coverage effective date and other coverage details,
- A copy of the master application, **and**
- A copy of your employees' updated coverage certificate. **(We'll let employees know they can request copies of their certificates from you, so please be sure to make the coverage documents available. Of course, employees are also welcome to call us directly to request copies of their certificates.)**

If you have any questions about your group plan or your employees' coverage, please reach out to your account manager, or give us a call at 1.866.319.8089 Monday through Friday, from 9 a.m. to 7 p.m. Eastern time.

Again, welcome to the Aflac family!

MPCOVLETA

Continental American Insurance Company • Columbia, South Carolina • 1.800.433.3036 toll-free

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups situated in New York, group coverage is underwritten by American Family Life Assurance Company of New York (22 Corporate Woods Boulevard, Suite 2, Albany, New York 12211), and customer service is administered by CAIC.

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Continental American Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: Continental American Insurance Company at 1-800-433-3036

Toll-free:

1-800-433-3036

Email: cscmail@aflac.com

Mail: Continental American Insurance Company
Post Office Box 427
Columbia, South Carolina 29202

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call: 1-800-252-3439

Online: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Continental American Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Continental American Insurance Company al 1-800-433-3036

Teléfono gratuito:

1-800-433-3036

Correo electrónico: cscmail@aflac.com

Dirección postal: Continental American Insurance Company
Post Office Box 427
Columbia, South Carolina 29202

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame: 1-800-252-3439

En línea: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
 - o Up to \$500,000 for health benefit plans, with some exceptions.
 - o Up to \$300,000 for disability income benefits.
 - o Up to \$300,000 for long-term care insurance benefits.
 - o Up to \$200,000 for all other types of health insurance.
- **Life insurance:**
 - o Up to \$100,000 in net cash surrender or withdrawal value.
 - o Up to \$300,000 in death benefits.
- **Individual annuities:** Up to \$250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to \$300,000 per person, regardless of the number of policies or contracts. A limit of \$500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact: Texas Life and Health Insurance Guaranty Association 1601 Congress Avenue Austin, TX 78701 1-800-982-6362 or www.txlifega.org	For questions about insurance, contact: Texas Department of Insurance P.O. Box 149104 Austin, TX 78714-9104 1-800-252-3439 or www.tdi.texas.gov
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Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.



CONTINENTAL AMERICAN INSURANCE COMPANY
Columbia, South Carolina
800.433.3036

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

Continuation of Coverage Endorsement

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

EFFECTIVE DATE

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

The following provisions are added after the Continuation Privilege provision in your Certificate:

CONTINUATION OF COVERAGE

If the Group Policy is terminated by the Policyholder and is not replaced with another group policy you may apply to continue the coverage you had on the Group Policy termination date. This includes any in-force Spouse or Dependent Child coverage. The Group Policy will be continued as if the Group Policy is in force for those who have applied to continue their coverage under this provision. The members will continue to have coverage, with their Certificates remaining in force.

The Company will apply the same benefits and plan provisions as shown in your Certificate on the date you are eligible to continue coverage under this provision. Your continued coverage is subject to all of the provisions, exclusions and limitations of the Group Policy.

To keep your Certificate in force, you must:

- Apply to the Company in writing under this Continuation of Coverage provision within 31 days after the date your Certificate would terminate, **and**
- Pay the required premium no later than 31 days after the date the Certificate would terminate and on each premium due date thereafter to the Company at our Customer Service Center in Columbus, Georgia.

PREMIUMS

Initial premium rates will be based on the rates in effect at the time you apply to continue your coverage. Premium rates can be changed by the Company at any time upon 60 days written notice to you. Any such change will be applied to all Certificates in your class and will not be based on your or your Spouse and Dependent Children's health or other individual factors.

You may decrease, but not increase, the amount of your coverage, and the amount of your Spouse's coverage, if any.

TERMINATION

Your continued coverage, including any in-force Spouse or Dependent Child coverage, will end:

- 31 days after the date you fail to pay any required premium.

- When coverage is terminated by the Company. We will provide you a 31-day advance written notice of any termination.
- On the date you die (unless your Spouse elects to become the Primary Insured under the Successor Insured provision, if applicable).

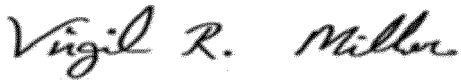
Once continued coverage is cancelled it cannot be reinstated. If your coverage terminates, we will provide benefits for valid claims that arose while your coverage was active.

CONTRACT

This Endorsement is part of the Certificate. It will terminate when:

- The Certificate terminates, or
- Premiums are no longer paid for this Endorsement.

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

Group Critical Illness Insurance Policy

Policyholder Name: City Of Denton
Group Policy Number CTR0003144810
Effective Date September 1, 2021

Jurisdiction Texas
Non-Participating
Anniversary Date September 1, 2022

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

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

Please read it carefully.

This policy is not a Medicare supplement policy.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

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

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

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

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

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary

**Group Critical Illness Insurance
Non-Participating**

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Section I – Eligibility, Effective Date, and Termination

Eligibility

An Employee is eligible to be covered under this Plan if he is Actively at Work for his employer and included in the class that is eligible for coverage, as shown on the Master Application.

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

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

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

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

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

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

Effective Date

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

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

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

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

- The date shown on the Certificate Schedule if the Employee is Actively at Work on that date, or
- The date the Employee returns to an Actively-at-Work status if he was not Actively at Work on the date shown on the Certificate Schedule.

The Effective Date for a Spouse or Dependent Child is:

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

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

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

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

Plan Termination

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

- The premium is not paid before the end of the Grace Period,
- The number of participating Employees is less than the number mutually agreed upon by the Company and the Policyholder in the signed Master Application,
- The Policyholder does not provide timely information or meet any obligations required by this Plan and applicable law, or
- The Company cancels the Plan any time after the end of the first policy year. To do this, the Company must give the Policyholder 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 an Employee's Insurance

An Employee's insurance will terminate on whichever occurs first:

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

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

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

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

Continuation Privilege

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

To keep his coverage in force, the Employee must:

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

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

- 31 days after the date the Employee fails to pay any required premium; or
- The date the Group Plan is terminated.

If an Employee qualifies for this Continuation Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate as shown in his previously issued Certificate.

Section II – Premium Provisions

Premium Payments

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

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

Premium Changes

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

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

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

We will provide the Policyholder a 60-day advance written notice of any change to a premium.

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

Grace Period

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

Section III – Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

- A malignant tumor characterized by:
 - o The uncontrolled growth and spread of malignant cells, and
 - o 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
 - o Clark's Level I or II,
 - o Breslow depth less than 0.77mm, **or**
 - o 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:
 - o Clark's Level I or II,
 - o Breslow depth less than 0.77mm, or
 - o Stage 1A melanomas under TNM Staging

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

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

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

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

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

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

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

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

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

Coma does not include a medically-induced coma.

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

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

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

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

Coronary Artery Bypass Surgery means open heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts and where such narrowing or blockage is attributed to Coronary Artery Disease or Acute Coronary Syndrome. This excludes

any non-surgical procedure, such as, but not limited to, balloon angioplasty, laser relief, or stents.

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

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

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

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

Date of Diagnosis is defined as follows:

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

Dependent means an Employee's Spouse or Dependent Child. **Spouse** is an Employee's legal wife or husband, who is listed on the Employee's Application. **Dependent Children** are an Employee's or an Employee's Spouse's natural children, step-children, 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.

A child is considered to be the child of an Insured if the Insured is a party to a suit in which the Insured seeks to adopt the child.

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 and maintenance. The Employee or the Employee's Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday.

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

- Is made by a Doctor and
- Is based on clinical or laboratory investigations, as supported by the Insured's medical records.

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

Doctor is a person who is:

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

A Doctor does not include the Insured or any of the Insured's Family Members.

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

- | | | |
|------------|----------|-----------|
| • Son | • Mother | • Sister |
| • Daughter | • Father | • Brother |

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

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

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

Heart Attack (Myocardial Infarction) does not include:

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

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

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

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

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

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

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

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

Loss of Sight, Speech, or Hearing

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

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

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

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

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

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

To be considered a Critical Illness, Loss of Speech must be caused solely by or be solely attributed 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 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).

Transient Ischemic Attack (TIA) occurs when blood flow to part of the brain is temporarily blocked or reduced. For a benefit to be payable, the TIA must be caused by one or more of the following diseases:

- Advanced Arteriosclerosis
- Arteriosclerosis of the arteries of the neck or brain
- Vascular embolism
- Hypertension
- Malignant Hypertension
- Brain Aneurysm
- Arteriovenous Malformation.

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

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

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

Section IV - Benefit Provisions

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

Critical Illness Benefit

Initial Diagnosis

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

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

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

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

If the Certificate Schedule shows a Reduced Face Amount Date, your Face Amount will change to the Reduced Face Amount on that date. Benefits will be based on the Face Amount in effect on the Critical Illness Date of Diagnosis.

Additional Diagnosis

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

- The Date of Diagnosis for the new Critical Illness is separated from the prior, different Critical Illness by 6 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.

Additional Benefits

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

Skin Cancer Benefit

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

Health Screening Benefit

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

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

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

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

Accident Benefit

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

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

Waiver of Premium Benefit

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

Total Disability or **Totally Disabled** means the Employee is:

- 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:
 - o During the first 365 days of Total Disability, the Employee is unable to work at the occupation he was performing when his Total Disability began; or
 - o After the first 365 days of Total Disability, the Employee is unable to work at any gainful occupation for which he is suited by education, training, or experience.

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

- The Employee's Total Disability began before the age of 65;
- The Employee's Total Disability has continued without interruption for at least 90 days, during which time the Employee and/or the Policyholder have paid premiums; and
- The Employee provides 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 the claim for this benefit is approved.

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

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

If the Employee is still eligible for coverage when he returns to Active Work, coverage for any Insured may be continued if premium payments are resumed.

Section V - Limitations and Exclusions

Cancer Diagnosis Limitation

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

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

Exclusions

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

- **Self-Inflicted Injuries** - injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured
- **Suicide** - committing or attempting to commit suicide, while sane or insane
- **Illegal Acts** - participating or attempting to participate in an illegal activity, or working at an illegal job
- **Participation in Aggressive Conflict** of any kind, including:
 - o War (declared or undeclared) or military conflicts.
 - o Insurrection or riot
 - o Civil commotion or civil state of belligerence
- **Illegal substance abuse, which includes the following:**
 - o Abuse of legally-obtained prescription medication
 - o Illegal use of non-prescription drugs

Section VI – Claim Provisions

Notice of Claim

Written notice of claim must be given to us:

- Not later than the 20th day after the Date of Diagnosis, or
- As soon as reasonably possible.

When we receive written Notice of Claim, we will send a claim form. If the Claimant does not receive the claim form within 15 days after the notice is sent, written Proof of Loss can be sent to us without waiting for the form. Notice must include the Employee's name and the Certificate number. Notice can be mailed to the Company at:

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

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 84075, Columbus, GA 31993-9103

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

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

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

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

Physical Examination and Autopsy

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

Prompt Payment of Benefits

For benefits other than for loss of time, the Company will, once we receive the required Proof of Loss, pay, deny, or settle each submitted claim not later than the 60th day after the date proof of loss is received. Subject to written Proof of Loss, all accrued benefits payable under the policy for loss of time will be paid at least monthly during the period for which the insurer is liable. Any balance remaining unpaid at the end of that time will be paid as soon as possible after the proof of loss is received.

Payment of Claims

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

1. To the beneficiary designated by the Insured or the beneficiary's assignee;
2. To the Insured's surviving Spouse;
3. To the Insured's estate.

Unpaid Premium

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

Changing of Beneficiary

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

Claim Review

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

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

Appeals Procedure

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

Legal Action

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

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

Section VII – General Provisions

Entire Contract Changes

The *Entire Contract of Insurance* is made up of:

- This Policy
- The Master Application
- Certificates
- Endorsements
- Benefit agreements **and**
- Riders (if any).

In the absence of fraud, a statement made by the Policyholder or an Insured is considered a representation and not a warranty. A statement made by the Policyholder or an Insured may not be used in any contest under the Plan, unless a copy of the written instrument containing the statement is or has been provided to:

- The person making the statement; or
- If the statement was made by the Insured and the Insured has died or become incapacitated, the Insured's beneficiary or personal representative.

Changes to this Plan:

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

Misstatement of Age

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

Successor Insured

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

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

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

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

Time Limit on Certain Defenses

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

Clerical Error

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

Individual Certificates

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

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

Required Information

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

Conformity With State Statutes

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

Section VIII – Incorporation of Rider Provisions

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

<u>Rider Name</u>	<u>Form Number</u>
Specified Disease Rider	C22306TX

Policy Schedule

Policyholder:	CITY OF DENTON
Jurisdiction:	Texas
Policy Number:	CTR0003144810
Policy Effective Date:	September 1, 2021
Policy Anniversary Date:	September 1, 2022
Face Amount:	See Certificates
Spouse Amount:	See Certificates

Additional Benefits:

Health Screening Benefit Amount:	\$50.00 per Insured per calendar year
Skin Cancer:	\$250.00
Accident Benefits:	100.00% of applicable Face Amount

Waiver of Premium:	Yes
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This Plan is delivered in and governed by the laws of the jurisdiction shown above.

This Plan is age-banded. That means Employees' rates may increase on the Policy Anniversary Date. Premiums at the Policy Anniversary Date are determined by the Employee's Attained Age rate, as shown in the Policy Schedule of Premiums.

Benefit Schedule

Critical Illness Benefit

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

- Bone Marrow Transplant (Stem Cell Transplant)
- Cancer
- Coma
- 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

Additional Benefits

Health Screening Benefit

Skin Cancer

Accident Benefits

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

Waiver of Premium

CLASSIFICATIONS AND SCHEDULE OF PREMIUMS

CITY OF DENTON - Monthly

Non Tobacco-Employee					
Issue Age	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000
18- 25	3.87	5.07	6.27	7.48	8.68
26 - 30	4.94	6.67	8.40	10.14	11.87
31 - 35	5.62	7.70	9.78	11.85	13.93
36 - 40	7.14	9.97	12.80	15.63	18.47
41 - 45	8.49	12.00	15.51	19.02	22.53
46 - 50	10.01	14.29	18.56	22.83	27.10
51 - 55	15.17	22.02	28.87	35.72	42.57
56 - 60	14.79	21.45	28.11	34.77	41.43
61 - 65	29.98	44.23	58.49	72.74	87.00
66 +	52.70	78.31	103.92	129.53	155.15

Non Tobacco-Spouse					
Issue Age	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000
18- 25	2.67	3.27	3.87	4.47	5.07
26 - 30	3.20	4.07	4.94	5.80	6.67
31 - 35	3.55	4.58	5.62	6.66	7.70
36 - 40	4.30	5.72	7.14	8.55	9.97
41 - 45	4.98	6.74	8.49	10.25	12.00
46 - 50	5.74	7.88	10.01	12.15	14.29
51 - 55	8.32	11.75	15.17	18.60	22.02
56 - 60	8.13	11.46	14.79	18.12	21.45
61 - 65	15.72	22.85	29.98	37.11	44.23
66 +	27.08	39.89	52.70	65.50	78.31

Tobacco-Employee					
Issue Age	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000
18- 25	5.00	6.77	8.54	10.30	12.07
26 - 30	6.47	8.97	11.47	13.97	16.46
31 - 35	7.95	11.18	14.42	17.66	20.90
36 - 40	10.57	15.12	19.67	24.22	28.77
41 - 45	12.62	18.19	23.77	29.34	34.92
46 - 50	14.98	21.73	28.48	35.23	41.99
51 - 55	23.31	34.22	45.14	56.06	66.98
56 - 60	23.55	34.59	45.63	56.66	67.70
61 - 65	46.66	69.26	91.85	114.45	137.04
66 +	80.26	119.66	159.05	198.45	237.85

Tobacco-Spouse					
Issue Age	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000
18- 25	3.24	4.12	5.00	5.89	6.77
26 - 30	3.97	5.22	6.47	7.72	8.97
31 - 35	4.71	6.33	7.95	9.57	11.18
36 - 40	6.02	8.30	10.57	12.85	15.12
41 - 45	7.04	9.83	12.62	15.41	18.19
46 - 50	8.22	11.60	14.98	18.35	21.73
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56 - 60	12.51	18.03	23.55	29.07	34.59
61 - 65	24.07	35.36	46.66	57.96	69.26
66 +	40.87	60.56	80.26	99.96	119.66



CONTINENTAL AMERICAN INSURANCE COMPANY
Columbia, South Carolina
800.433.3036

**Amendment
to Policy and Certificate of Insurance for
Group Critical Illness**

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

Effective Date

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

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

Plan Termination

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

- The premium is not paid before the end of the Grace Period,
- The number of participating Employees is less than the number mutually agreed upon by the Company and the Policyholder in the signed Master Application,
- The Policyholder does not provide timely information or meet any obligations required by this Plan and applicable law, or
- The Company cancels the Plan any time after the end of the first policy year. To do this, the Company must give the Policyholder 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 receives premium payments after the Plan terminates, this will not reinstate the Plan.

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

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

Continuation Privilege

When you are no longer a member of an eligible class and your coverage would otherwise end, you may elect to continue your coverage under this Plan. You may continue the coverage you had on the date your Certificate would otherwise terminate, including any in-force Spouse or Dependent Child coverage, without any additional underwriting requirements.

To keep your coverage in force, you must:

- Notify the Company in writing within 31 days after the date your coverage would otherwise terminate. You may notify us by sending written notice to P.O. Box 84079, Columbus, GA 31993-9101 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly to the Company no later than 31 days after the date your coverage would otherwise terminate and on each premium due date thereafter.

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

- 31 days after the premium due date (the last day of the Grace Period), if the premium has not been paid, or
- The date the Group Plan is terminated.

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

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

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

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

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

Additional Diagnosis

Once benefits have been paid for a Critical Illness, the Company will pay benefits for each different Critical Illness when the Date of Diagnosis for the new Critical Illness is separated from the prior, different Critical Illness by at least 6 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.

The Reoccurrence provision is deleted and replaced with the following:

Reoccurrence

Once benefits have been paid for a Critical Illness, benefits are payable for that same Critical Illness when the Date of Diagnosis for the Reoccurrence of that Critical Illness is separated from the prior occurrence of that Critical Illness by at least 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.

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

Health Screening Benefit

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

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

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

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

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

Proof of Loss

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

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

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

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

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

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

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

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

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

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

General Provisions

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

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

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

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

Amendment to Policy and Certificate of Insurance for Group Critical Illness

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

EFFECTIVE DATE

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

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

Termination of Your Insurance

Your insurance will terminate on whichever occurs first:

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

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

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

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

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

Dependent means your Spouse or your Dependent Child. **Spouse** is your legal wife or husband, including a legally-recognized same-sex Spouse, or a person of either gender who is in a legally recognized and registered domestic partnership, civil union, reciprocal beneficiary relationship, or similar relationship with you, who is listed on your Application.

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

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

Employee and Spouse Coverage basis. After such notice, we will arrange for the payment of the appropriate premium due, including returning any unearned premium, if applicable.

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

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

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

- Bronchiectasis, which is a lung disease state defined by localized, irreversible dilation of the bronchial tree caused by destruction of the muscle and elastic tissue.
- Cardiomyopathy, which is a heart disease characterized by the measurable deterioration of the function of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid.
- Cirrhosis, which is a liver disease characterized by replacement of liver tissue by fibrosis, scar tissue, and regenerative nodules, leading to loss of liver function.
- Chronic obstructive pulmonary disease, which is a lung disease characterized by persistently poor airflow as a result of breakdown of lung tissue and dysfunction of the small airways.
- Congenital Heart Disease, which is heart disease characterized by abnormalities in cardiovascular structures that occur before birth.
- Coronary Artery Disease
- Cystic fibrosis, which is a hereditary disease of the exocrine glands affecting the pancreas, respiratory system, and sweat glands. It is characterized by the production of abnormally viscous mucus by the affected glands.
- Hepatitis, which is a disease caused by the hepatitis A, B, or C virus and is characterized by the inflammation of the liver.
- Interstitial lung disease, which is a lung disease that affects the interstitium of the lungs.
- Lymphangioleiomyomatosis, which is a lung disease characterized by an indolent, progressive growth of smooth muscles cells throughout the lungs, pulmonary blood vessels, lymphatics, and pleurae.
- Polycystic liver disease, which is characterized by multiple variable-sized cysts lined by cuboidal epithelium.
- Pulmonary fibrosis, which is a lung disease where the lung tissue becomes thickened, stiff, and scarred due to chronic inflammation.
- Pulmonary hypertension, which is a disease characterized by increased pressure in the pulmonary artery and results in the thickening of the pulmonary arteries and the narrowing of these blood vessels, which causes the right side of the heart to become enlarged.
- Sarcoidosis, which is a disease characterized by the growth of granulomatous lesions that appear in the body.
- Valvular heart disease, which is a disease of the heart valves.

If, while the certificate is in force, the Insured is placed on a transplant list for a Major Organ Transplant due to one of the above-identified diseases, we will pay 25% of the Critical Illness benefit. The remainder of the Critical Illness benefit will become payable on the date the surgery occurs. A Major Organ Transplant benefit is not payable if the Major Organ Transplant results from a covered Critical Illness for which a benefit has been paid.

CONTRACT

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

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

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

Specified Disease Rider To Certificate of Insurance for Group Critical Illness

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

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

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

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

EFFECTIVE DATE

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

DEFINITIONS

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

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

- **Adrenal Hypofunction (Addison's Disease):** The date a Doctor Diagnoses an Insured as having Adrenal Hypofunction and where such Diagnosis is supported by medical records.
- **Cerebrospinal Meningitis:** The date a Doctor Diagnoses an Insured as having Cerebrospinal Meningitis and where such Diagnosis is supported by medical records.
- **Diphtheria:** The date a Doctor Diagnoses an Insured as having Diphtheria based on clinical and/or laboratory findings as supported by medical records.
- **Encephalitis:** The date a Doctor Diagnoses an Insured as having Encephalitis and where such Diagnosis is supported by medical records.
- **Human Coronavirus:** The date a Doctor Diagnoses an Insured as having Human Coronavirus based on laboratory findings as supported by viral testing or a blood test.
- **Huntington's Chorea:** The date a Doctor Diagnoses an Insured as having Huntington's Chorea based on clinical findings as supported by medical records.
- **Legionnaire's Disease:** The date a Doctor Diagnoses an Insured as having Legionnaire's Disease by finding *Legionella* bacteria in a clinical specimen taken from the Insured.
- **Lyme Disease:** The date a Doctor Diagnoses an Insured as having Lyme Disease and where such Diagnosis is supported by medical records.
- **Malaria:** The date a Doctor Diagnoses an Insured as having Malaria and where such Diagnosis is supported by medical records.
- **Muscular Dystrophy:** The date a Doctor Diagnoses an Insured as having Muscular Dystrophy and where such Diagnosis is supported by medical records.
- **Myasthenia Gravis:** The date a Doctor Diagnoses an Insured as having Myasthenia Gravis and where such Diagnosis is supported by medical records.
- **Necrotizing Fasciitis:** The date a Doctor Diagnoses an Insured as having Necrotizing Fasciitis and where such Diagnosis is supported by medical records.
- **Osteomyelitis:** The date a Doctor Diagnoses an Insured as having Osteomyelitis and where such Diagnosis is supported by medical records.
- **Poliomyelitis:** The date a Doctor Diagnoses an Insured as having Poliomyelitis and where such Diagnosis is supported by medical records.

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

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

Adrenal Hypofunction does not include secondary and tertiary adrenal insufficiency.

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

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

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

Encephalitis means an inflammation of the brain, usually caused by a direct viral infection or a hyper-sensitivity reaction to a virus or foreign protein.

Hospital means a place that meets all of the following criteria:

- Is legally licensed and operated as a hospital,
- Provides overnight care of injured and sick people,
- Is supervised by a Doctor,
- Has full-time nurses supervised by a registered nurse, and
- Has on-site use of X-ray equipment, laboratory, and surgical facilities.

The term *Hospital* specifically excludes any facility not meeting the definition of Hospital as defined in this Plan, including but not limited to:

- A nursing home,
- An extended-care facility,
- A skilled nursing facility,
- A rest home or home for the aged,
- A rehabilitation facility,
- A facility for the Treatment of alcoholism or drug addiction, or
- An assisted living facility.

Hospital Intensive Care Unit means a place that meets all of the following criteria:

- Is a specifically designated area of the Hospital called a Hospital Intensive Care Unit;
- Provides the highest level of medical care;
- Is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- Is separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement;
- Is permanently equipped with special life-saving equipment for the care of the critically ill or injured;
- Is under close observation by a specially trained nursing staff assigned exclusively to the Hospital Intensive Care Unit 24 hours a day; and

- Has a Doctor assigned to the Hospital Intensive Care Unit on a full-time basis.

The term *Hospital Intensive Care Unit* specifically excludes any type of facility not meeting the definition of Hospital Intensive Care Unit as defined in this Plan, including but not limited to private monitored rooms, surgical recovery rooms, observation units, and the following step-down units:

- A progressive care unit,
- A sub-acute intensive care unit, or
- An intermediate care unit.

Human Coronavirus means a severe type of virus having a lipid envelope studded with club-shaped spike proteins that infects humans, leading to an upper respiratory infection or Pneumonia, and spread through the air by coughing, sneezing, close personal contact, or touching a contaminated object or surface. This does not include the following Human Coronaviruses: 229E, NL63, OC43, and HKU1.

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

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

Lyme Disease means an inflammatory disease caused by bacteria that are transmitted by ticks that is characterized initially by a rash, headache, fever, and chills, and later by possible arthritis and neurological and cardiac disorders.

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

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

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

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

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

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

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

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

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

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

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

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

BENEFIT PROVISIONS

Tier I – Specified Disease Benefit: We will pay the Benefit shown on the Rider Schedule if an Insured is Diagnosed with one of the Tier I Specified Diseases listed below, and if the Date of Diagnosis is while this Rider is in force:

- Adrenal Hypofunction
- Cerebrospinal Meningitis
- Diphtheria
- Encephalitis
- Huntington's Chorea
- Legionnaire's Disease
- Lyme Disease
- Malaria
- Muscular Dystrophy
- Myasthenia Gravis
- Necrotizing Fasciitis
- Osteomyelitis
- Poliomyelitis
- Rabies
- Sickle Cell Anemia
- Systemic Lupus
- Systemic Sclerosis (Scleroderma)
- Tetanus
- Tuberculosis

For any subsequent Tier I Specified Disease to be covered, the Date of Diagnosis of the subsequent Tier I Specified Disease must be 6 Months or more after the date the Insured first qualified for any previously paid Tier I Specified Disease Benefit.

Tier II – Specified Disease Benefit: We will pay the Benefit shown on the Rider Schedule if an Insured is Diagnosed with one of the Tier II Specified Diseases listed below, and such Diagnosis results in either a period of Hospital confinement or a period of Hospital Intensive Care Unit confinement as a direct result of the Tier II Specified Disease. Furthermore, the Date of Diagnosis must be while this Rider is in force.

In order to receive a Tier II Specified Disease Benefit the Insured must be confined to a Hospital or confined to a Hospital Intensive Care Unit as a direct result of a Tier II Specified Disease. In addition, the Insured must be receiving Treatment for the Tier II Specified Disease for the minimum number of days shown in the Rider Schedule. Only the highest eligible benefit amount shown on the Rider Schedule will be payable under these benefits. In the event a lower benefit amount was previously paid under these benefits for any period of Hospital confinement and that confinement is extended or the Insured is moved to an Intensive Care Unit triggering a higher payment, the difference between the previous paid benefit amount and the new benefit amount will be provided:

- Human Coronavirus

For any subsequent Tier II Specified Disease to be covered, the Date of Diagnosis of the subsequent Tier II Specified Disease must be 6 Months or more after the date the Insured first qualified for any previously paid Tier II Specified Disease Benefit.

This benefit is limited to the maximum shown in the Rider Schedule.

GENERAL PROVISIONS

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.

CONTRACT

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

- That Certificate terminates, or
- Premiums are no longer paid for this Rider, subject to the Grace Period.

This Rider is subject to all of the terms of the Critical Illness Certificate to which it is attached unless those terms are inconsistent with this Rider.

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary

Benefits

Tier I Specified Disease Benefit:

Adrenal Hypofunction (Addison's Disease)	25.00% of Applicable Face Amount
Cerebrospinal Meningitis	25.00% of Applicable Face Amount
Diphtheria	25.00% of Applicable Face Amount
Encephalitis	25.00% of Applicable Face Amount
Huntington's Chorea	25.00% of Applicable Face Amount
Legionnaire's Disease	25.00% of Applicable Face Amount
Lyme Disease	25.00% of Applicable Face Amount
Malaria	25.00% of Applicable Face Amount
Muscular Dystrophy	25.00% of Applicable Face Amount
Myasthenia Gravis	25.00% of Applicable Face Amount
Necrotizing Fasciitis	25.00% of Applicable Face Amount
Osteomyelitis	25.00% of Applicable Face Amount
Poliomyelitis (Polio)	25.00% of Applicable Face Amount
Rabies	25.00% of Applicable Face Amount
Sickle Cell Anemia	25.00% of Applicable Face Amount
Systemic Lupus	25.00% of Applicable Face Amount
Systemic Sclerosis (Scleroderma)	25.00% of Applicable Face Amount
Tetanus	25.00% of Applicable Face Amount
Tuberculosis	25.00% of Applicable Face Amount

Tier II Specified Disease Benefit:

Human Coronavirus	10.00% of Applicable Face Amount if confined to a Hospital for 4-9 days
	25.00% of Applicable Face Amount if confined to a Hospital for 10 or more days
	40.00% of Applicable Face Amount if confined to an Intensive Care Unit
Maximum per Insured per Lifetime	1 time

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CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina

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.

This certificate is not a Medicare supplement policy.

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.

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.

The Certificate Effective Date is shown in the Certificate Schedule. The Certificate will terminate as provided in the provision titled "Termination of an Employee's Insurance" in Section I. 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, on its Effective Date, automatically replaces any Certificate or Certificates previously issued to you under the Plan.

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SECTION VI	-	Claim Provisions
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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.
- **Family Coverage** - We insure the Employee, Spouse, and any Dependent Children.

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

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

Effective Date

Your Certificate Effective Date is shown on the Certificate Schedule.

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

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

The Effective Date for a Spouse or Dependent Child is:

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

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

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

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

Plan Termination

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

- The premium is not paid before the end of the Grace Period,
- The number of participating Employees is less than the number mutually agreed upon by the Company and the Policyholder in the signed Master Application,
- The Policyholder does not provide timely information or meet any obligations required by this Plan and applicable law, or

- The Company cancels the Plan any time after the end of the first policy year. To do this, the Company must give the Policyholder 31 days' written notice.

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

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

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

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

Termination of Your Insurance

Your insurance will terminate on whichever occurs first:

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

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

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

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

Continuation 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 Continuation 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 60-day advance written notice of any change to a premium.

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

Grace Period

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

Section III – Definitions

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

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

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

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

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

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

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

Attained Age means your age on your Certificate Effective Date and on each Policy Anniversary Date thereafter.

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

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

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

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

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

- A malignant tumor characterized by:
 - o The uncontrolled growth and spread of malignant cells, and
 - o 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
 - o Clark's Level I or II,
 - o Breslow depth less than 0.77mm, **or**
 - o 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:
 - o Clark's Level I or II,
 - o Breslow depth less than 0.77mm, or
 - o 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, 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.

A child is considered to be the child of an Insured if the Insured is a party to a suit in which the Insured seeks to adopt the child.

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 and maintenance. 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.

Dependent Children may also include grandchildren, who are (1) unmarried; (2) under age 26; and (3) if they are the Member's dependents for federal income tax purposes, or (4) if the Employee must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in this state.

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.

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 | • Mother | • Sister |
| • Daughter | • Father | • Brother |

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

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

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

Heart Attack (Myocardial Infarction) does not include:

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

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

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

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

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

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

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

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

Loss of Sight, Speech, or Hearing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Bronchiectasis, which is a lung disease state defined by localized, irreversible dilation of the bronchial tree caused by destruction of the muscle and elastic tissue.
- Cardiomyopathy, which is a heart disease characterized by the measurable deterioration of the function of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid.
- Cirrhosis, which is a liver disease characterized by replacement of liver tissue by fibrosis, scar tissue, and regenerative nodules, leading to loss of liver function.
- Chronic obstructive pulmonary disease, which is a lung disease characterized by persistently poor airflow as a result of breakdown of lung tissue and dysfunction of the small airways.
- Congenital Heart Disease, which is heart disease characterized by abnormalities in cardiovascular structures that occur before birth.
- Coronary Artery Disease
- Cystic fibrosis, which is a hereditary disease of the exocrine glands affecting the pancreas, respiratory system, and sweat glands. It is characterized by the production of abnormally viscous mucus by the affected glands.
- Hepatitis, which is a disease caused by the hepatitis A, B, or C virus and is characterized by the inflammation of the liver.

- Interstitial lung disease, which is a lung disease that affects the interstitium of the lungs.
- Lymphangioleiomyomatosis, which is a lung disease characterized by an indolent, progressive growth of smooth muscles cells throughout the lungs, pulmonary blood vessels, lymphatics, and pleurae.
- Polycystic liver disease, which is characterized by multiple variable-sized cysts lined by cuboidal epithelium.
- Pulmonary fibrosis, which is a lung disease where the lung tissue becomes thickened, stiff, and scarred due to chronic inflammation.
- Pulmonary hypertension, which is a disease characterized by increased pressure in the pulmonary artery and results in the thickening of the pulmonary arteries and the narrowing of these blood vessels, which causes the right side of the heart to become enlarged.
- Sarcoidosis, which is a disease characterized by the growth of granulomatous lesions that appear in the body.
- Valvular heart disease, which is a disease of the heart valves.

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

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

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

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

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

- **Amyotrophic Lateral Sclerosis**, which is a progressive degeneration of the motor neurons of the central nervous system, leading to wasting of the muscles and paralysis;
- **Cerebral Palsy**, which is a disorder of movement, muscle tone, or posture that is caused by injury or abnormal development in the immature brain. Cerebral Palsy can be characterized by stiffness and movement difficulties, or by involuntary and uncontrolled movements;
- **Parkinson's disease**, which is a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement; or
- **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).

Transient Ischemic Attack (TIA) occurs when blood flow to part of the brain is temporarily blocked or reduced. For a benefit to be payable, the TIA must be caused by one or more of the following diseases:

- Advanced Arteriosclerosis
- Arteriosclerosis of the arteries of the neck or brain
- Vascular embolism
- Hypertension
- Malignant Hypertension
- Brain Aneurysm
- Arteriovenous Malformation.

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

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

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

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

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

If the Certificate Schedule shows a Reduced Face Amount Date, your Face Amount will change to the Reduced Face Amount on that date. Benefits will be based on the Face Amount in effect on the Critical Illness Date of Diagnosis.

Additional Diagnosis

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

- The Date of Diagnosis for the new Critical Illness is separated from the prior, different Critical Illness by 6 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.

Additional Benefits

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

Skin Cancer Benefit

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

Health Screening Benefit

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

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

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

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

Accident Benefit

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

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

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:
 - o During the first 365 days of Total Disability, you are unable to work at the occupation he was performing when his Total Disability began; or
 - o After the first 365 days of Total Disability, you are unable to work at any gainful occupation for which he is 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 the Employee 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 the claim for this benefit is approved.

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

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

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

Section V - Limitations and Exclusions

Cancer Diagnosis Limitation

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

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

Exclusions

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

- **Self-Inflicted Injuries** - injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured
- **Suicide** - committing or attempting to commit suicide, while sane or insane
- **Illegal Acts** - participating or attempting to participate in an illegal activity, or working at an illegal job
- **Participation in Aggressive Conflict** of any kind, including:
 - o War (declared or undeclared) or military conflicts.
 - o Insurrection or riot
 - o Civil commotion or civil state of belligerence
- **Illegal substance abuse, which includes the following:**
 - o Abuse of legally-obtained prescription medication
 - o Illegal use of non-prescription drugs

Section VI – Claim Provisions

Notice of Claim

Written notice of claim must be given to us:

- Not later than the 20th day after the Date of Diagnosis, or
- As soon as reasonably possible.

When we receive written Notice of Claim, we will send a claim form. If the Claimant does not receive the claim form within 15 days after the notice is sent, written Proof of Loss can be sent to us without waiting for the form. Notice must include your name and Certificate number. Notice can be mailed to the Company at:

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

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 84075, Columbus, GA 31993-9103

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 mental capacity.

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

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

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

Physical Examination and Autopsy

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

Prompt Payment of Benefits

For benefits other than for loss of time, the Company will, once we receive the required Proof of Loss, pay, deny, or settle each submitted claim not later than the 60th day after the date proof of loss is received. Subject to written Proof of Loss, all accrued benefits payable under the policy for loss of time will be paid at least monthly during the period for which the insurer is liable. Any balance remaining unpaid at the end of that time will be paid as soon as possible after the proof of loss is received.

Payment of Claims

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

1. To your beneficiary or the beneficiary's assignee;
2. To your surviving spouse;
3. 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 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 Certificates of insurance;
- The Application of the Policyholder, a copy of which is attached to and made part of the Policy when issued;
- The Applications, if any, of each Employee; and
- Any Riders, Endorsements, or Amendments to the Policy or Certificate.

In the absence of fraud, a statement made by the Policyholder or an Insured is considered a representation and not a warranty. A statement made by the Policyholder or an Insured may not be used in any contest under the Plan, unless a copy of the written instrument containing the statement is or has been provided to:

- The person making the statement; or
- If the statement was made by the Insured and the Insured has died or become incapacitated, the Insured's beneficiary or personal representative.

Changes to this Plan:

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

Misstatement of Age

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

Successor Insured

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

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

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

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

Time Limit on Certain Defenses

After 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.

Benefit Schedule

Critical Illness Benefit

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

- Bone Marrow Transplant (Stem Cell Transplant)
- Cancer
- Coma
- 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

Additional Benefits

Health Screening Benefit

Skin Cancer

Accident Benefits

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

Waiver of Premium



CONTINENTAL AMERICAN INSURANCE COMPANY
Columbia, South Carolina
800.433.3036

**Amendment
to Policy and Certificate of Insurance for
Group Critical Illness**

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

Effective Date

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

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

Plan Termination

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

- The premium is not paid before the end of the Grace Period,
- The number of participating Employees is less than the number mutually agreed upon by the Company and the Policyholder in the signed Master Application,
- The Policyholder does not provide timely information or meet any obligations required by this Plan and applicable law, or
- The Company cancels the Plan any time after the end of the first policy year. To do this, the Company must give the Policyholder 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 receives premium payments after the Plan terminates, this will not reinstate the Plan.

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

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

Continuation Privilege

When you are no longer a member of an eligible class and your coverage would otherwise end, you may elect to continue your coverage under this Plan. You may continue the coverage you had on the date your Certificate would otherwise terminate, including any in-force Spouse or Dependent Child coverage, without any additional underwriting requirements.

To keep your coverage in force, you must:

- Notify the Company in writing within 31 days after the date your coverage would otherwise terminate. You may notify us by sending written notice to P.O. Box 84079, Columbus, GA 31993-9101 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly to the Company no later than 31 days after the date your coverage would otherwise terminate and on each premium due date thereafter.

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

- 31 days after the premium due date (the last day of the Grace Period), if the premium has not been paid, or
- The date the Group Plan is terminated.

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

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

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

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

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

Additional Diagnosis

Once benefits have been paid for a Critical Illness, the Company will pay benefits for each different Critical Illness when the Date of Diagnosis for the new Critical Illness is separated from the prior, different Critical Illness by at least 6 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.

The Reoccurrence provision is deleted and replaced with the following:

Reoccurrence

Once benefits have been paid for a Critical Illness, benefits are payable for that same Critical Illness when the Date of Diagnosis for the Reoccurrence of that Critical Illness is separated from the prior occurrence of that Critical Illness by at least 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.

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

Health Screening Benefit

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

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

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

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

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

Proof of Loss

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

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

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

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

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

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

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

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

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

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

General Provisions

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

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

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

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

Amendment to Policy and Certificate of Insurance for Group Critical Illness

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

EFFECTIVE DATE

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

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

Termination of Your Insurance

Your insurance will terminate on whichever occurs first:

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

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

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

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

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

Dependent means your Spouse or your Dependent Child. **Spouse** is your legal wife or husband, including a legally-recognized same-sex Spouse, or a person of either gender who is in a legally recognized and registered domestic partnership, civil union, reciprocal beneficiary relationship, or similar relationship with you, who is listed on your Application.

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

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

Employee and Spouse Coverage basis. After such notice, we will arrange for the payment of the appropriate premium due, including returning any unearned premium, if applicable.

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

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

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

- Bronchiectasis, which is a lung disease state defined by localized, irreversible dilation of the bronchial tree caused by destruction of the muscle and elastic tissue.
- Cardiomyopathy, which is a heart disease characterized by the measurable deterioration of the function of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid.
- Cirrhosis, which is a liver disease characterized by replacement of liver tissue by fibrosis, scar tissue, and regenerative nodules, leading to loss of liver function.
- Chronic obstructive pulmonary disease, which is a lung disease characterized by persistently poor airflow as a result of breakdown of lung tissue and dysfunction of the small airways.
- Congenital Heart Disease, which is heart disease characterized by abnormalities in cardiovascular structures that occur before birth.
- Coronary Artery Disease
- Cystic fibrosis, which is a hereditary disease of the exocrine glands affecting the pancreas, respiratory system, and sweat glands. It is characterized by the production of abnormally viscous mucus by the affected glands.
- Hepatitis, which is a disease caused by the hepatitis A, B, or C virus and is characterized by the inflammation of the liver.
- Interstitial lung disease, which is a lung disease that affects the interstitium of the lungs.
- Lymphangioleiomyomatosis, which is a lung disease characterized by an indolent, progressive growth of smooth muscles cells throughout the lungs, pulmonary blood vessels, lymphatics, and pleurae.
- Polycystic liver disease, which is characterized by multiple variable-sized cysts lined by cuboidal epithelium.
- Pulmonary fibrosis, which is a lung disease where the lung tissue becomes thickened, stiff, and scarred due to chronic inflammation.
- Pulmonary hypertension, which is a disease characterized by increased pressure in the pulmonary artery and results in the thickening of the pulmonary arteries and the narrowing of these blood vessels, which causes the right side of the heart to become enlarged.
- Sarcoidosis, which is a disease characterized by the growth of granulomatous lesions that appear in the body.
- Valvular heart disease, which is a disease of the heart valves.

If, while the certificate is in force, the Insured is placed on a transplant list for a Major Organ Transplant due to one of the above-identified diseases, we will pay 25% of the Critical Illness benefit. The remainder of the Critical Illness benefit will become payable on the date the surgery occurs. A Major Organ Transplant benefit is not payable if the Major Organ Transplant results from a covered Critical Illness for which a benefit has been paid.

CONTRACT

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

Signed for the Company at its Home Office,

A handwritten signature in cursive script that reads "Virgil R. Miller".

Virgil R. Miller, President

A handwritten signature in cursive script that reads "J. Matthew Loudermilk".

J. Matthew Loudermilk, Secretary