



CONTINENTAL AMERICAN INSURANCE COMPANY

PO Box 427, Columbia, South Carolina 29202
800.433.3036

CRITICAL ILLNESS COVERAGE ONLY

OUTLINE OF COVERAGE

This certificate is part of a group policy. This certificate provides critical illness coverage ONLY. This certificate does NOT provide comprehensive medical or hospital insurance, Medicare supplement insurance, long-term care insurance, nursing home insurance only, home health care insurance only, or nursing home and home care insurance. You may also contact your local social security office or this company and obtain a copy of the Guide to Health Insurance for People with Medicare.

BENEFIT DEFINITIONS

Cancer (internal or invasive) means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes Leukemia. Excluded are Cancers that are non-invasive such as:

1. Pre-malignant tumors or polyps;
2. Carcinoma in Situ;
3. Any skin cancers except melanomas;
4. Basal cell carcinoma and squamous cell carcinoma of the skin; and
5. Melanoma that is diagnosed as Clark's Level I or II or Breslow less than .77mm.

Cancer is also defined as a disease which meets the diagnosis criteria of malignancy established by The American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen.

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

Cancer and/or Carcinoma in Situ must be diagnosed in one of two ways:

1. **Pathological Diagnosis** - A Pathological Diagnosis of Cancer or Carcinoma in Situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a Certified Pathologist whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology.
2. **Clinical Diagnosis** - A Clinical Diagnosis of Cancer or Carcinoma in Situ is based on the study of symptoms.

We will pay benefits for a Clinical Diagnosis only if:

1. A Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; and
2. there is medical evidence to support the diagnosis; and
3. a doctor is treating an Insured for Cancer and/or Carcinoma in Situ.

Heart Attack (Myocardial Infarction) means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart Attack does not include any other disease or injury involving the cardiovascular system. Cardiac Arrest not caused by a Myocardial Infarction is not a Heart Attack. The diagnosis must include all of the following criteria:

1. New and serial Electrocardiographic (EKG) findings consistent with Myocardial Infarction;
2. Elevation of cardiac enzymes above generally accepted laboratory levels of normal in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used; and
3. Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.

Coronary Artery Bypass Surgery means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to balloon angioplasty, laser relief, stints or other non-surgical procedures.

Major Organ Transplant means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas.

Stroke means apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident. Stroke does not include Transient Ischemic Attacks and attacks of Vertebrobasilar Ischemia. We will pay a benefit for Stroke which produces permanent clinical neurological sequela following an initial diagnosis. We must receive evidence of the permanent neurological damage provided from Computed Axial Tomography (CAT scan) or magnetic Resonance Imaging (MRI). **Stroke does not mean head injury, transient ischemic attack or chronic cerebrovascular insufficiency.**

Kidney Failure (Renal Failure) means the end stage renal failure presenting as chronic, irreversible failure of both kidneys to function. The Kidney Failure must necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly); or which results in kidney transplantation. Renal failure is covered, provided it is not caused by a traumatic event, including surgical traumas.

BENEFITS

Critical Illness Benefit

We will pay this benefit when an Insured is diagnosed with one of the Critical Illnesses shown on the Certificate Schedule if:

1. The date of diagnosis is while the his coverage is in force; and
2. It is not excluded by name or specific description in the Certificate.

The Certificate's Maximum Benefit amount is shown in the Schedule. Any partial benefits paid will be deducted from the appropriate Specified Disease.

Payment of benefits is subject to the following:

1. We will pay benefits for a Critical Illness in the order the events occur.

2. No benefits are payable for each different Critical Illness after the first unless its date of diagnosis is separated from the prior different Critical Illness by at least 6 months and it is not caused by or contributed to by a Critical Illness for which benefits have been paid.
3. Once benefits have been paid for a Critical Illness, no additional benefits are payable for that same Critical Illness unless the dates of diagnosis are separated by at least 12 months or for cancer 12 months treatment free) Cancer that has spread (metastasized) even though there is a new tumor, will not be considered an additional occurrence unless you have been treatment free for 12 months.

Health Screening Benefit (Calendar Year Limit)

We will pay the amount shown in the Benefit Schedule for Health Screening Tests performed while an Insured's coverage is in force. This Benefit is payable once per calendar year up to the Maximum Benefit amount shown in the Benefit Schedule. Payment of this benefit will not reduce the Critical Illness benefit available under this Certificate.

Health Screening Tests include but are not limited to:

1. Stress test on a bicycle or treadmill,
2. Fasting blood glucose test,
3. Blood test for triglycerides,
4. Serum cholesterol test to determine level of HDL and LDL,
5. Bone marrow testing,
6. Breast ultrasound,
7. CA 15-3 (blood test for breast cancer),
8. CA 125 (blood test for ovarian cancer),
9. CEA (blood test for colon cancer),
10. Chest X-ray,
11. Colonoscopy,
12. Flexible sigmoidoscopy,
13. Hemocult stool analysis,
14. Mammography,
15. Pap smear,
16. PSA (blood test for prostate cancer),
17. Serum Protein Electrophoresis (blood test for myeloma),
18. Thermography.

There is no limit to the number of years an Insured can receive benefits for Health Screening Tests, as long as this Plan is in force.

We will pay this benefit regardless of the results of the test.

Portability Privilege

When coverage would otherwise terminate under this Plan because an Employee ends employment with the Employer, they may elect to continue coverage. The coverage that may be continued is that which the Employee had on the date their employment terminated, including Dependent coverage then in effect.

1. Coverage may not be continued for any of the following reasons:
 - a. the Employee failed to pay any required premium;
 - b. this Group Policy terminates.

2. To keep the Certificate in force the Employee must:
 - a. make written Application to the Company within 31 days after the date their insurance would otherwise terminate;
 - b. pay the required premium to the Company no later than 31 days after the date the Certificate would otherwise terminate.
3. Insurance will cease on the earliest of these dates:
 - a. the date the Employee fails to pay any required premium;
 - b. the date this Group Policy is terminated.

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

LIMITATIONS AND EXCLUSIONS

PRE-EXISTING CONDITIONS LIMITATION

"Pre-existing Condition" means a sickness or physical condition for which, within the 6-month period prior to an Insured Person's Effective Date, medical advice was given or treatment was recommended or treatment was received from a licensed health care provider.

We will not pay benefits for any Pre-existing Condition starting within 6 months after the Insured Person's Effective Date.

A claim for benefits for loss starting after 6 months from an Insured's Effective Date will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition.

A Critical Illness will no longer be considered Pre-existing at the end of 6 consecutive months starting and ending after an Insured's Effective Date.

EXCLUSIONS

We won't pay for loss due to:

1. Intentionally self inflicted injury or action.
2. Suicide or attempted suicide while sane or insane.
3. Illegal activities or participation in an illegal occupation.
4. War - declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.
5. Substance Abuse.

Diagnosis must be made and treatment received in the United States.

This outline of coverage is a very brief summary of your certificate.

The certificate itself sets forth the rights and obligations of both you and the insurance company. It is therefore imperative that you READ YOUR CERTIFICATE carefully.

The anticipated loss ratio for this policy or certificate is 75 percent. This ratio is the portion of future premiums which the company expects to return as benefits, when averaged over all people with this policy or certificate.