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COMPANION LIFE INSURANCE COMPANY
7909 PARKLANE ROAD, SUITE 200, COLUMBIA, SC 29223-5666
PO Box 100102, Columbia, SC 29202-3102
(803) 735-1251
(Herein called Companion Life)

Certifies that it has issued the group insurance policy shown below and, subject to the terms of that policy you, the Insured, are eligible.

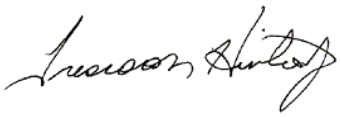
This certificate is merely evidence of your insurance under the Policy, and all matters pertaining to such insurance are subject to the terms and conditions of the Policy. This certificate replaces any certificate previously issued to the employee by Companion Life under the Policy.

Policy Number:	961-25-74817-000
Policyholder:	CHEROKEE CO. SCHOOLS 911 ANDREWS RD MURPHY, North Carolina 28906
Certificate Date:	09/01/2014
Certificate Number:	As Shown on Application
Insured Employee:	As Shown on Application

SCHEDULE OF BENEFITS

Please refer to page 0.2.

PLEASE READ YOUR CERTIFICATE CAREFULLY.



Trescott N. Hinton, Jr.
President

TERM LIFE INSURANCE CERTIFICATE
Renewal at Option of Companion Life
(Non-Participating)

SCHEDULE OF BENEFITS

BASIC TERM LIFE BENEFIT:	$12,000.00
BASIC AD&D PRINCIPAL SUM:	Not Provided
SUPPLEMENTAL TERM LIFE BENEFIT:	Not Provided
SUPPLEMENTAL AD&D PRINCIPAL SUM:	Not Provided
DEPENDENT LIFE BENEFIT:	Not Provided
SHORT TERM DISABILITY TOTAL DISABILITY BENEFIT:	Not Provided
VOLUNTARY SHORT TERM DISABILITY BENEFIT:	Not Provided

The original amount of Term Life insurance and the principal sum for Accidental Death and Dismemberment Insurance, if provided, shall each reduce by 50% at age 70. Benefits terminate at retirement.

If insurance amounts are based on annual earnings, then Companion Life will determine the benefit amounts using the earnings information most recently reported to Companion Life prior to the date of loss.

CERTIFICATE GUIDE

SECTION 1

ACTIVELY AT WORK PROVISION

"Active, Full-Time Employee" means an employee who performs all of the duties of his or her job with the Policyholder. This job may be at either:

1. the Policyholder's normal place of employment; or

2. at some other place to which the regular business operations of the Policyholder require that person to go.

"Full-time", means an employee must be:

1. scheduled to work for the Policyholder at least 30 hours each week; and

2. on the regular payroll of the Policyholder for that work.

"Active work" is work performed as an active, full-time employee. "Actively at work" means being engaged at active work.

SECTION 2

DEFINITIONS

"Earnings" means the Insured's rate of earnings from the Policyholder in effect immediately prior to the date a claim begins. It does not include bonuses, overtime pay and other extra compensation other than commissions. Commissions will be averaged over the 12 month period prior to the date a claim begins.

"Total Disability" or "Totally Disabled" means any disability that:

1. Begins while the Policy is in force as to the Insured.

2. Results from injury or sickness.

3. Prevents the Insured from engaging in any occupation for which he or she is or becomes qualified by education, training, or experience.

4. Requires the Insured to be under the regular care and attendance of a licensed physician.

   NOTE: If there is no doubt that the Insured is permanently disabled and his or her physician feels that the Insured has reached his or her maximum point of recovery and that future or continued treatment would serve no useful purpose, then, the requirement for regular attendance of a physician will be waived.

"Schedule of Benefits" means the description of benefits set forth on the face page of this Certificate.

"Insured" means an eligible employee who is insured under the Policy.

"Insured Dependent" means an Insured's eligible spouse and/or child(ren) who are insured under the Policy, if the Policy provides Dependent Life Insurance.

"The date the Insured retires" or "retirement" means the effective date of the Insured's:

1. retirement pension benefits under any plan of a federal, state, county or municipal retirement systems, if such pension benefits include any credit for employment with the Policyholder;

2. retirement pension benefits under any plan which the Policyholder sponsors, or makes or has made contributions;

3. retirement benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act.

"Physician" means a medical doctor or surgeon licensed to render services in accordance with the laws of the state where such services are rendered. The term "physician" will also include a licensed medical practitioner whose services are required by law to be recognized on the same basis as if they had been performed by a licensed medical doctor. Such practitioner must be acting within the scope of his or her license. Physician does not include the Insured; or a member of the Insured's immediate family (spouse, daughter, son, father, mother, sister, or brother).

SECTION 3

TERM LIFE INSURANCE BENEFIT

$12,000.00

If an Insured dies while insured under the Policy, Companion Life will pay the applicable Life Insurance Benefit shown in the Schedule of Benefits.

Part 1

CONTINUATION OF BASIC TERM LIFE INSURANCE BENEFIT DURING TOTAL DISABILITY

EXTENSION OF BASIC TERM LIFE INSURANCE BENEFIT

In the event of termination of employment, a death benefit will be paid if the Insured dies while Totally Disabled provided that the disability:

1. began while the person was both insured under the Policy and under age 60; and
2. has been continuous until death; and
3. began within 12 months of the date of death.

WAIVER OF BASIC TERM LIFE INSURANCE PREMIUM BENEFIT

If an Insured becomes Totally Disabled, prior to age 60, Companion Life will waive premium for the Basic Term Life Insurance Benefit. The waiver of premium will begin on the first of the month following 12 consecutive months of Total Disability. The Insured must file written notice within 12 months after the date of Total Disability to be eligible for this benefit.

With respect to the Insured, this Waiver of Premium Benefit shall end on the earliest of the following:

1. on the date the Insured's Total Disability ends;
2. on the 91st day after Companion Life requests proof of continuous Total Disability, provided the Insured fails to furnish Companion Life with such proof during such 91 day period;
3. on the Premium Due Date immediately prior to the Insured's 65th birthday;
4. on the effective date of any individual life insurance policy obtained in accordance with Part 2, Right to Convert;
5. on the date the Insured retires.

AMOUNT OF BASIC TERM LIFE INSURANCE BENEFIT CONTINUED

The Basic Term Life Insurance Benefit which is continued during Total Disability is the applicable amount of Basic Term Life Insurance in force as to the Insured on the date such Insured's Total Disability begins (subject to any reductions shown in the Schedule of Benefits).

This Continuation of Basic Term Life Insurance Benefit During Total Disability does not apply to the Accidental Death and Dismemberment Benefit.

Part 2

RIGHT TO CONVERT

If an Insured is no longer eligible for part or all of the Life Insurance Benefit provided by the Policy, such Insured is entitled to apply to Companion Life for an individual policy of life insurance, without submitting evidence of insurability provided:

1. The policy applied for:

   A. is a type of individual life policy, other than term, then customarily being issued by Companion Life; and

   B. does not include Accidental Death and Dismemberment, Short Term Disability or other Supplemental benefits; and

2. The amount of life insurance applied for under such individual life policy is in accordance with the **Amount To Convert** provision below; and

3. The Insured agrees to pay the premium for such individual life policy. The premium will be based on the following, as of the effective date of such individual life policy;

   A. Companion Life's usual rate for the amount and type of individual life policy;

   B. the Insured's attained age; and

4. The Insured applies and pays the first premium for such individual life policy within 31 days following termination or reduction of the Life Insurance Benefit under the Policy. Such individual life policy will become effective on the first day following the end of such 31 day period.

AMOUNT TO CONVERT

This conversion privilege is allowed for the Term Life Insurance that ceases as described in items 1. and 2.

1. The Insured may convert all or part of the amount of Life Insurance Benefit the Insured is no longer eligible for due to;

   A. reductions resulting from attainment of a specific age, as shown in the Schedule; or

   B. loss of the individual eligibility.

2. If the Insured has been insured under the Policy for at least 5 years, the lesser of the amounts shown in (i) or (ii) below may be converted if the Insured is no longer eligible due to:

   A. termination of the Policy; or

   B. termination of the class of Insureds to which the Insured belongs; or

   C. reduction of benefits for the class of Insureds to which the Insured is a member:

      (i) $2,000, or

      (ii) All or part of the amount for which the Insured is no longer eligible. This amount will be reduced by the amount of any life insurance for which the Insured becomes eligible to receive under a group policy issued or reinstated by Companion Life or any other insurer during the thirty-one day period immediately following termination of insurance under the Policy.

If the Insured dies during the conversion period the maximum amount of Term Life Insurance which the Insured would have been entitled to have issued shall be payable as a claim under the Policy; whether or not application for the individual policy or the payment of the first premium has been made.

The rights or benefits granted under this provision are in lieu of any other rights or benefits granted under the Policy.

Part 3

SUICIDE EXCLUSION

With respect to the Life Insurance Benefit, in the event an Insured, while sane or insane (in Missouri while sane), dies from intentionally self-inflicted injuries or any attempts thereat, within two years from the effective date of coverage, Companion Life's liability shall be only to return premiums paid under the Policy as to such Insured.

The Suicide Exclusion will not apply to the Insured who:

1. is actively at work on the effective date of the Policy; and
2. was insured for Group Life Insurance under the prior carrier's policy on its termination date.

Part 4

THE ACCELERATED BENEFITS PROVISION

THE BENEFIT

The Insured with a medically determined terminal condition would be eligible to receive the following accelerated benefit:

Seventy Five percent (75%) of the Basic Term Life Insurance benefit in effect on the Insured's last day of active work up to a maximum insured amount of $133,400. The maximum payable under this benefit is $100,000.

An "Accelerated Benefit" covered under the Policy is a benefit payable;

1. to the Insured. If, during his or her lifetime, the Insured sustains a terminal condition, as defined in this provision, the Insured or his or her legal representative may request a lump-sum accelerated death benefit payable once during the lifetime of the Insured, and
2. which reduces the death benefit otherwise payable under the Policy, and
3. which is payable upon the occurrence of a single qualifying event which results in the payment of a benefit amount fixed at the time of acceleration.

TAX TREATMENT

Benefits paid under this provision may be taxable. The Insured or his or her beneficiary may incur a tax obligation. As with all tax matters, an Insured should consult with his or her personal tax advisor and/or attorney.

DEFINITION OF TERMINAL CONDITION

"Terminal Condition" means that the Insured has a medically determinable condition with no reasonable prospect of cure, which can be expected to result in death within 12 months of the date of disability. The proof of Terminal Condition satisfactory to Companion Life must be certified by the Insured's attending physician and one other physician.

Companion Life reserves the right to have the Insured examined at its expense by one or more physicians of its choice in connection with a request for Accelerated Death Benefit for Terminal Condition.

ELIGIBILITY REQUIREMENTS

All eligible actively at-work full time employees who have been covered under the Basic Term Life Insurance are eligible for the Accelerated Benefit. The benefit terminates at the earliest of:

1. when the Insured's Basic Term Life terminates, or
2. at attained age 70, or
3. at retirement from employment.

In order to be eligible for this benefit, the Insured must have been continuously covered for at least one year under the Policy prior to sustaining a terminal condition, or covered under the Policy from the Policy Effective Date.

EFFECTIVE DATE OF THE ACCELERATED BENEFITS

The Accelerated Benefit provision shall be effective for accidents on the Policy Effective Date. The Accelerated Benefit provision shall be effective for illness thirty (30) days following the Policy Effective Date.

EXCLUSIONS AND LIMITATIONS

The Accelerated Benefit will not apply:

1. to any self-inflicted injuries or suicide attempts;
2. to any Supplemental Term Life Insurance benefits, including Dependent Life, nor to any Accidental Death and Dismemberment benefits;
3. if an Insured is totally disabled on his or her Effective Date of coverage;
4. to a Basic Term Life Insurance benefit that has been assigned;
5. to a Basic Term Life Insurance benefit payable to an irrevocable beneficiary;
6. to a Basic Term Life Insurance benefit with a face amount of less than $10,000;
7. if the required Basic Term Life Insurance premium is due and unpaid.

CONVERSION

The amount of Basic Term Life Insurance that may be converted is the Insured's Basic Term Life Insurance reduced by the Accelerated Benefit amount paid.

REDUCTIONS

If a benefit reduces in accordance with a reduction provision the total amount payable to the Insured will not be affected by the advanced payment.

FREQUENCY

Only one Accelerated Benefit payment will be made to an Insured.

TERMINATION

This provision will terminate for the Insured on the earliest of the following dates:

1. the date the Policyholder terminates coverage under the Policy;
2. the date the Policy terminates;
3. the date the Insured retires;
4. the date the Insured dies;
5. the date the Insured receives an Accelerated Benefit payment; or
6. the date the Insured continues coverage under the Conversion Provisions of the Policy.

SECTION 4

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

NOT PROVIDED

Not Provided

SECTION 5

DEPENDENT LIFE INSURANCE BENEFIT

NOT PROVIDED

Not Provided

SECTION 6

BENEFICIARY AND SETTLEMENT OPTIONS

PART 1

BENEFICIARY DESIGNATION

The beneficiary or beneficiaries of an Insured shall be that person or persons indicated on the Insured's individual application for insurance. This application will be filed with the Policyholder. The beneficiary of an Insured Dependent, if the Policy provides Dependent Life Insurance, shall be the Insured.

PART 2

CHANGE OF BENEFICIARY

Unless the Insured has made an irrevocable assignment of benefits, the beneficiary may be changed by sending a written request to the Home Office of Companion Life. When such request is received by Companion Life, the change of beneficiary shall take effect as of the date of execution of the written request, but without prejudice to Companion Life on account of any payment previously made by Companion Life.

PART 3

CONSENT OF BENEFICIARY

If the Insured does initially name the spouse as beneficiary, Companion Life will require written consent of the spouse to name or change the beneficiary in community property states.

PART 4

PREFERENTIAL BENEFICIARY

If the Insured has died and no beneficiary is living or named, Companion Life may, at its option, pay the benefits to the Insured's estate or to the following surviving relatives of the Insured:

The Insured's:

1. Spouse;
2. Child or children;
3. Parent(s);
4. Brothers and sisters; or
5. Executors or administrators.

Companion Life will not be liable to the extent of any payment so made, unless it receives written notice of a valid claim by some other person before payment is made.

PART 5

MINOR BENEFICIARY

If the beneficiary is a minor or, in the opinion of Companion Life, is not able to give valid release for any payment due, Companion Life may, at its option and until claim is made by the duly appointed guardian, pay the benefit to the person or entity who appears to have assumed the care and support of the beneficiary. Benefits in this event will be made in monthly payments of not more than $50 each.

Companion Life will not be liable to the extent of any payment so made in good faith.

PART 6

MORE THAN ONE BENEFICIARY

If the Insured has named more than one beneficiary, the applicable amount of insurance shall be paid to the beneficiaries who survive the Insured, in equal shares, unless the Insured has specified a different proportion.

PART 7

NO BENEFICIARY

If the beneficiary predeceases the Insured or if the Insured does not designate a beneficiary, then the applicable amount of life insurance will be paid to the estate of the Insured.

PART 8

SETTLEMENT OPTIONS

An Insured may elect or change a settlement option by filing a written request with Companion Life. The settlement options available will be those offered by Companion Life when the option is chosen. If an Insured does not request a settlement option, the beneficiary may do so after the Insured's death.

SECTION 7

ASSIGNMENT

1. The Insured may make an irrevocable assignment of interest under the Policy. The assignment:

   A. must be made in writing on a form approved by Companion Life;

   B. must be an absolute assignment that transfers all rights except those of an irrevocably named beneficiary; and

   C. must not be a collateral assignment.

2. Assignment of interest conveys all rights of ownership. These include the right to change the beneficiary, receive payment of claims and assign the insurance.

3. Companion Life is not responsible for the validity or results of the assignment.

SECTION 9

CHANGE OF CLASS OR EARNINGS

If a change in an Insured's class or earnings would increase the amount of the benefits entitled to be received under the Policy, such increase in benefits will become effective on the Premium Due Date following such change, provided:

1. Notice of the change is given to Companion Life within 30 days of the change.

2. Such increase in benefits does not exceed the Guarantee Issue Amount, stated in the Group Application.

If notice is not given within the required time or the increase in benefits would exceed the Guaranteed Issue Amount, stated in the Group Application, such increase in benefits:

1. Must be approved by Companion Life; and

2. Will become effective on the Premium Due date following Companion Life's approval.

If the Insured is not at work full-time due to injury or sickness on the date an increase in benefits is due to begin, such increase in benefits will not begin until the Insured returns to full-time work.

If a change in an Insured's class or earnings would decrease the amount of benefits entitled to be received under the Policy, such decrease in benefits will become effective on the Premium Due Date following the change.

SECTION 10

WHEN INDIVIDUAL INSURANCE BEGINS

To become insured, eligible employees must make written application to Companion Life. Coverage will begin on the Premium Due Date, shown in the Group Application for benefits, following the date Companion Life approves the application. Companion Life may require evidence of insurability before approving the application.

If an eligible employee is not at full-time work due to an injury or sickness on the date insurance is due to begin, it will not begin until return to full-time work.

SECTION 11

WHEN INDIVIDUAL INSURANCE ENDS

The insurance will end with respect to an Insured, on the earliest of the following:

1. When the Policy is cancelled;

2. When the insurance is cancelled for the class of insureds to which the Insured belongs;

3. The beginning of the period for which premium is not paid as to the Insured;

4. The date the Insured is no longer actively working on a full-time basis in any class or classes insured under the Policy unless (and only with respect to the Basic Term Life Insurance Benefit, if provided by the Policy) the Continuation of Basic Term Life Insurance Benefit During Total Disability applies.

SECTION 12

CLAIM PROVISIONS

NOTICE OF CLAIM: Written notice of claim must be given within 30 days after a covered loss begins, or as soon as reasonably possible. The notice may be given to Companion Life at PO Box 100102, Columbia, SC 29202-3102. Notice should include information which identifies the Insured or Insured Dependent and the Policy.

CLAIM FORMS: When Companion Life receives notice of claim, forms for filing proof of loss will be sent to the claimant. If these forms are not sent within 15 days, the claimant will meet the proof of loss requirements if, within 90 days after the loss began, he or she gives Companion Life written proof of the nature and extent of the loss.

PROOFS OF LOSS: Written proof of loss must be given to Companion Life within 90 days after the loss begins. Companion Life will not deny nor reduce any claim if it was not reasonably possible to give Companion Life such proof in the time required. In any event, proof must be given to Companion Life within 1 year after it is due, unless the claimant is legally incapable of doing so. Companion Life has the right to require proof of the continuance of total disability at any time during the first two years after receipt of initial proof of total disability; and thereafter, once a year.

PAYMENT OF CLAIMS: Benefits provided by the Policy will be paid to the beneficiary determined in accordance with Section 6 of this Certificate, entitled **BENEFICIARY AND SETTLEMENT OPTIONS**.

TIME OF CLAIM PAYMENTS: Short Term Disability Benefit claims (if this Policy provides a Short Term Disability Benefit) will be paid weekly as of the dates required. Claims for other benefits will be paid not more than 60 days after receipt by Companion Life of written proofs of loss.

PHYSICAL EXAMINATIONS AND AUTOPSY: Companion Life at its own expense will have the right and opportunity to have the Insured examined as often as reasonably necessary while a claim is pending. Companion Life at its own expense may have an autopsy made (during the period of contestability), unless prohibited by law. If the Insured fails to submit proof of continuing Total Disability when required; or fails to be examined medically when required, no further benefit will be provided for that Total Disability.

LEGAL ACTIONS: No legal action may be brought to recover on the Policy before 60 days after written proof of loss has been furnished, as required by the Policy. No such action may be brought after 6 years from the time written proof of loss is required to be furnished.

SECTION 13

GENERAL PROVISIONS

MISSTATEMENT OF AGE: If an Insured's or Insured Dependent's age has been misstated, benefits payable for such Insured or Insured's Dependent will be what the premium paid would have purchased at the correct age. This benefit will be subject to the applicable Policy maximums.

EMPLOYEE ELIGIBILITY: Active full-time Employees of the Policyholder (Employer) who:

1. are in a class of employees determined by conditions of employment, which is agreed upon as eligible by the Policyholder and Companion Life; and

2. have been continuously employed during the minimum service period, as shown in the Group Application, immediately preceding their individual effective dates of insurance.

Full-time means regularly working a minimum of least 30 hours per week at the Policyholder's usual and customary place of business for each employee.

DUAL COVERAGE PRECLUDED:

No person may be insured under the Policy as:

1. A dependent of more than one employee; or

2. Both an employee and a dependent.

ERISA: If the Policy is an integral part of an employee welfare benefit plan subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA), Companion Life is a claim fiduciary. As claim fiduciary, Companion Life shall have the discretionary authority to determine eligibility for benefits and to construe the terms of that part of the ERISA plan represented by this Contract. Any judicial review of a decision of Companion Life shall be conducted under the arbitrary and capricious standard of review with deference given to the claim fiduciary's decision.

SPENDTHRIFT CLAUSE: To the extent allowed by law, no benefit of the Policy is subject to the claim or legal process of a creditor of an Insured or a beneficiary.

RECORDS AND ESSENTIAL DATA: The Policyholder will keep a record of all Insureds. This record will contain all of the data that is specified by Companion Life.

ALLOCATION OF AUTHORITY: Except for those functions which the Policy specifically reserves to the Policyholder, Companion Life has full and exclusive authority to control and manage the Policy, to administer claims and to interpret the Policy and resolve all questions arising in the administration, interpretation and application of the Policy.

Companion Life's authority includes, but is not limited to:

1. The right to resolve all matters when a review has been requested;

2. The right to establish and enforce rules and procedures for the administration of the group policy and any claim under it; and

3. The right to determine:

   A. eligibility for insurance;

   B. entitlement to benefits;

   C. the amount of benefits payable; and

   D. the sufficiency and the amount of information Companion Life may reasonably require to determine A, B, or C above.

Subject to the review procedures of the group policy, any decision Companion Life makes in the exercise of this authority is conclusive and binding.

NOTICE

THIS NOTICE IS TO BE ISSUED WITH ANY POLICY, CONTRACT, CERTIFICATE, OR EVIDENCE OF COVERAGE OF GROUP HEALTH OR LIFE INSURANCE ISSUED IN THE STATE OF NORTH CAROLINA.

STATE OF NORTH CAROLINA
GENERAL STATUTE SECTION 58-50-40

"UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR HEALTH CARE PLAN PREMIUMS, SHALL:

(1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR HEALTH CARE PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY SUCH PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND

(2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS PRIOR TO THE TERMINATION OF SUCH COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF GENERAL STATUTES CHAPTER 58 AND THEIR RIGHTS UNDER THE FEDERAL CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA).

VIOLATION OF THIS LAW IS A FELONY. ANY PERSONS VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE."

END OF NOTICE

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Issued by:

COMPANION LIFE INSURANCE COMPANY
7909 PARKLANE ROAD, SUITE 200
COLUMBIA, SOUTH CAROLINA 29223-5666
P.O. BOX 100102, COLUMBIA SC 29202-3102
(803) 735-1251

NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE
NORTH CAROLINA LIFE AND HEALTH
INSURANCE GUARANTY ASSOCIATION ACT

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

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The North Carolina Life and Health Insurance Guaranty Association may or may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce the purchase of any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
Post Office Box 10218
Raleigh, North Carolina 27605

North Carolina Department of Insurance, Consumer Division
Post Office Box 26387
Raleigh, North Carolina 27611

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

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate specified in the law;
- dividends;
- experience or other credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out. The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one individual, the association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. For any one group holder of an unallocated annuity contract, the association will pay a maximum of $5,000,000.

STATEMENT OF ERISA RIGHTS
As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

1. Receive Information About Your Plan and Benefits
a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.

c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries
In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

3. Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

4. Assistance with Your Questions
If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200
Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

CLAIM PROCEDURES
The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

Claim Procedures for Claims Requiring a Determination of Disability

Claims for Benefits
If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to our request. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy provisions on which the decision is based, 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, 4) a description of the review procedures and time limits applicable to such procedures, 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal, and 6) (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request, or (B) if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

Appealing Denials of Claims for Benefits
On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to the request.
The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, we will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy provisions on which the decision is based, 3) a statement that you have the right to bring a civil action under section 502(a) of ERISA, 4) a statement that you may request, free of charge, copies of all documents, records, and other information relevant to your claim; 5) (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision on appeal, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the decision on appeal and that a copy will be provided free of charge to you upon request, or (B) if the decision on appeal is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the decision on appeal, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request, and 6) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims for Benefits
If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision. However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision. However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.