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Colonial Life & Accident
Insurance Company
P.O. Box 1365
Columbia, SC 29202-1365

Alamance Community College Fbp
Po Box 8000
Graham, NC 27253-8000

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

1200 Colonial Life Boulevard, P. O. Box 1365, Columbia, South Carolina 29202
1.800.325.4368 coloniallife.com
A Stock Company

CANCER AND SPECIFIED DISEASE GROUP INSURANCE POLICY

Please Read This Policy Carefully

This policy is a legal contract between the policyholder and us. To understand the coverage, this policy must be read as a whole. Throughout this policy, the word **policyholder** refers to the organization shown on the Policy Rate Schedule. **You** or **your** refers to a named insured who is covered under this coverage. **Named insured** refers to the person who is a member of an eligible class as described on the Policy Rate Schedule, who holds a certificate of coverage and for whom the policyholder remits premium. **Covered person** refers to any person covered under this policy as described on the Certificate Schedule. **We, us, our** or **company** refers to Colonial Life & Accident Insurance Company. The male pronoun includes the female whenever used.

This policy is delivered in and is governed by the laws of the governing jurisdiction shown on the Policy Rate Schedule and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the policy, we have discretionary authority to determine the named insured's eligibility for benefits and to interpret the terms and provisions of the policy.

This policy is issued in consideration of the application of the policyholder, a copy of which is attached to and made a part of this policy, and the payment of premium when due. This policy takes effect at 12:01 a.m. Standard Time at the policyholder's address on the Policy Effective Date shown on the Policy Rate Schedule.

We agree to pay, in accordance with the terms of this policy, the benefit amounts of the policy to the named insureds. Details of the benefits are shown in the certificate.

Specified Disease Benefit Reduction

The Face Amount on any coverage in force after the named insured's 75th birthday will be reduced by 50% on the first Policy Anniversary Date following the named insured's 75th birthday. There will be no further increases in the insured's coverage amount.

IMPORTANT CANCELLATION INFORMATION - PLEASE READ THE PROVISION OF THIS POLICY ENTITLED, "TERMINATION OF THIS CONTRACT".

Signed for Colonial Life & Accident Insurance Company:

Secretary

President and Chief Executive Officer

THIS IS A LIMITED POLICY.
PLEASE READ IT CAREFULLY.

THE POLICY IS GUARANTEED RENEWABLE.
PLEASE READ THE "TERMINATION OF THIS CONTRACT" PROVISION.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.
IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THIS GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE WHICH IS AVAILABLE FROM THE COMPANY.

SECTION 2 - POLICY GUIDE

SECTION 1 - FACE PAGE

SECTION 2 - POLICY GUIDE

SECTION 3 - POLICY RATE SCHEDULE

SECTION 4 - POLICYHOLDER PROVISIONS

SECTION 5 - PREMIUM PAYMENTS

SECTION 6 - TERMINATION

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

POLICY RATE SCHEDULE

Policyholder:	Alamance Community College Fbp	Policy Number:	G0022235
Policyholder Address:	Po Box 8000	Billing Control Number:	E9791245
	Graham, NC		
	27253-8000		
Policy Effective Date:	01/01/2016	Governing Jurisdiction:	North Carolina
First Policy Anniversary:	10/01/2017		

Description of Eligible Classes
All employees in active employment working a minimum of 30 hours per week. Temporary and seasonal workers are excluded from coverage.

Active Employment means the named insured is working for the policyholder at the worksite for earnings that are paid regularly, and he is performing the material and substantial duties of his regular occupation. The named insured will not be considered in active employment if employment status is being continued under a severance or termination agreement. The worksite must be:

- the policyholder's usual place of business;
- an alternative work site at the direction of the policyholder; or
- a location to which the named insured's job requires him to travel.

Material and **substantial duties** means duties that are normally required for the performance of the named insured's regular occupation, and cannot be reasonably omitted or modified.

Regular occupation means the occupation the named insured routinely performs on his job.

Policyholder Plan Choice for Specified Disease Benefit:

A member of an eligible class chooses from the following options:

Face Amount for Named Insured in $1,000 increments from a minimum Face Amount of $5,000 up to a maximum Face Amount of $100,000.

Specified Diseases Covered:

Heart Attack (Myocardial Infarction), Stroke, End Stage Renal (Kidney) Failure, Major Organ Failure, Permanent Paralysis Due to a Covered Accident, Coma, Blindness, Occupational HIV or Occupational Infectious Hepatitis B, C or D, Coronary Artery Bypass Graft Surgery, Coronary Artery Disease.

Benefits Payable Upon Subsequent Diagnosis of a Specified Disease

Policyholder Plan Choice for Cancer Benefits:

Diagnosis of Cancer Benefit

A member of an eligible class chooses from the following options:

Face Amount for Named Insured in $1,000 increments from a minimum Face Amount of $5,000 up to a maximum Face Amount of $100,000.

Cancer Treatment and Care Benefit

A member of an eligible class chooses from the following options:

Monthly benefit amount:

$500

Maximum benefit amount for a Cancer Treatment and Care Benefit:

12 monthly payments per covered person per lifetime

Policyholder Plan Choice for Health Screening Benefit:
Health Screening Benefit of $100

This policy may include enrollment, risk management and other support services related to the policyholder's benefit program.

Eligibility Period: 30 days

Initial Monthly Rates/Unit for Specified Disease Benefit and Diagnosis of Cancer Benefit, Diagnosis of Carcinoma In Situ Benefit, Skin Cancer Benefit, and Cancer Vaccine Benefit:

Tobacco Premium Class

Named Insured		Named Insured and Spouse	
Issue Ages	Rates/Unit	Issue Ages	Rates/Unit
16-29	$0.670	16-29	$1.010
30-39	$1.290	30-39	$1.910
40-49	$2.690	40-49	$4.040
50-59	$4.940	50-59	$7.570
60-74	$8.120	60-74	$12.410

One-Parent Family		Two-Parent Family	
Issue Ages	Rates/Unit	Issue Ages	Rates/Unit
16-29	$0.740	16-29	$1.070
30-39	$1.350	30-39	$1.970
40-49	$2.760	40-49	$4.110
50-59	$5.010	50-59	$7.640
60-74	$8.190	60-74	$12.490

Non-Tobacco Premium Class

Named Insured		Named Insured and Spouse	
Issue Ages	Rates/Unit	Issue Ages	Rates/Unit
16-29	$0.420	16-29	$0.630
30-39	$0.820	30-39	$1.230
40-49	$1.700	40-49	$2.550
50-59	$3.120	50-59	$4.760
60-74	$5.020	60-74	$7.660

One-Parent Family		Two-Parent Family	
Issue Ages	Rates/Unit	Issue Ages	Rates/Unit
16-29	$0.480	16-29	$0.680
30-39	$0.880	30-39	$1.290
40-49	$1.770	40-49	$2.620
50-59	$3.190	50-59	$4.830
60-74	$5.090	60-74	$7.730

Unit means $1,000 of Face Amount for named insured.

Initial Monthly Rates for Cancer Treatment and Care Benefit:
Tobacco Premium Class
Rate per $500 for 12 monthly payments

Named Insured	Named Insured and Spouse
$6.300	$12.600
One-Parent Family	Two-Parent Family
$6.580	$12.880

Non-Tobacco Premium Class
Rate per $500 for 12 monthly payments

Named Insured	Named Insured and Spouse
$5.290	$10.580
One-Parent Family	Two-Parent Family
$5.570	$10.860

Initial Monthly Rates for Health Screening Benefit:

Named Insured	Named Insured and Spouse
$6.650	$10.350
One-Parent Family	Two-Parent Family
$6.650	$10.350

Initial Monthly Rates for First Diagnosis Building Benefit Rider:

Tobacco Premium Class

Named Insured		Named Insured and Spouse	
Issue Ages	Rates/Unit	Issue Ages	Rates/Unit
16-29	$	16-29	$
30-39	$	30-39	$
40-49	$	40-49	$
50-59	$	50-59	$
60-74	$	60-74	$

One-Parent Family		Two-Parent Family	
Issue Ages	Rates/Unit	Issue Ages	Rates/Unit
16-29	$	16-29	$
30-39	$	30-39	$
40-49	$	40-49	$
50-59	$	50-59	$
60-74	$	60-74	$

Non-Tobacco Premium Class

Named Insured		Named Insured and Spouse	
Issue Ages	Rates/Unit	Issue Ages	Rates/Unit
16-29	$	16-29	$
30-39	$	30-39	$
40-49	$	40-49	$
50-59	$	50-59	$
60-74	$	60-74	$

One-Parent Family		Two-Parent Family	
Issue Ages	Rates/Unit	Issue Ages	Rates/Unit
16-29	$	16-29	$
30-39	$	30-39	$
40-49	$	40-49	$
50-59	$	50-59	$
60-74	$	60-74	$

Rate Guarantee Period: A change in the premium rate table(s) will not take effect before one year after the policy effective date.

Divisions, subsidiaries or affiliated companies include:

Alamance Community College	Graham, NC
Alamance Community College Fbp	Graham, NC

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
1200 Colonial Life Boulevard, P. O. Box 1365, Columbia, South Carolina 29202
1.800.325.4368 coloniallife.com
A Stock Company

CANCER AND SPECIFIED DISEASE GROUP INSURANCE CERTIFICATE

THIS CERTIFICATE EXPLAINS THE BENEFITS PROVIDED UNDER THE CANCER AND SPECIFIED DISEASE GROUP INSURANCE POLICY.

THIS IS A LIMITED BENEFIT CERTIFICATE.

Please read this certificate carefully.

This is your certificate of coverage as long as you are insured under the policy. You will want to read it carefully and keep it in a safe place.

Throughout this certificate, the word **you** or **your** refers to the named insured shown on the Certificate Schedule, who is a member of an eligible class as described on the Policy Rate Schedule, who holds a certificate of coverage and for whom premiums are remitted. **Covered person** refers to any person covered under the policy as described on the Certificate Schedule. **We, us, our** or **company** refers to Colonial Life & Accident Insurance Company. **Policyholder** refers to the organization shown on the Policy Rate Schedule. It includes any division, subsidiary or affiliated company named in the Policy Rate Schedule. **Policy** means the group contract owned by the policyholder and available for review by you. The male pronoun includes the female whenever used.

If the terms of your certificate of coverage and the policy differ, the policy will govern.

The policy and this certificate may be changed in whole or in part or cancelled as stated in the policy. Such an action may be taken without the consent of or notice to any covered person. Only an executive officer at our home office can approve a change. The approval must be in writing and evidenced by endorsement on the policy or certificate or an amendment signed by the policyholder and one of our executive officers at our home office. No other person, including an agent, may change the policy or certificate or waive any of its provisions. Premiums are subject to periodic changes. This Certificate replaces any and all Certificates previously issued for the eligible classes under the Policy.

The policy and this certificate are delivered in and are governed by the laws of the governing jurisdiction shown on the Policy Rate Schedule and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the policy, we have discretionary authority to determine your eligibility for benefits and to interpret the terms and provisions of the policy.

Specified Disease Benefit Reduction: The Face Amount on any coverage in force after the named insured's 75th birthday will be reduced by 50% on the first Policy Anniversary Date following the named insured's 75th birthday. There will be no further increases in the insured's coverage amount.

IMPORTANT CANCELLATION INFORMATION - PLEASE READ THE SECTION TITLED - "TERMINATION OF INSURANCE".

Pre-Existing Statement: No benefits will be provided during the first 12 months of the certificate for Cancer and Specified Disease diagnosed before the insured's coverage effective date shown on the Certificate Schedule. Pre-existing condition means those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within the one-year period immediately preceding the effective date of a covered person. NO RECOVERY FOR PRE-EXISTING DIAGNOSED CANCER-READ CAREFULLY. If a covered person is 65 or older when this certificate is issued, pre-existing conditions for that covered person will include only conditions specifically eliminated by rider.

Secretary | President and Chief Executive Officer

Please read this certificate carefully.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

If you are eligible for Medicare, review the Guide To Health Insurance for People with Medicare available from the company.

SECTION 2 – CERTIFICATE GUIDE

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SECTION 2 – CERTIFICATE GUIDE

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SECTION 5 – DEFINITIONS FOR SPECIFIED DISEASE BENEFIT

SECTION 6 – DEFINITIONS FOR CANCER BENEFITS

SECTION 7 – ELIGIBILITY AND EFFECTIVE DATE

SECTION 8 – BENEFIT FOR SPECIFIED DISEASE

SECTION 9 – BENEFITS FOR CANCER

SECTION 10 – HEALTH SCREENING BENEFIT

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SECTION 12 – EXCLUSIONS AND LIMITATIONS FOR CANCER

SECTION 13 – TERMINATION OF INSURANCE

SECTION 14 – PORTABILITY

SECTION 15 – GENERAL PROVISIONS

SECTION 16 – CLAIM PROVISIONS

SECTION 4 - POLICYHOLDER PROVISIONS

Ownership
The policyholder is the owner of this policy and may agree with us to change it without the consent of or notice to the covered persons or their assignees.

Entire Contract
The entire contract consists of:
- this policy;
- the application of the policyholder attached to this policy;
- each named insured's enrollment form and evidence of insurability, if applicable;
- certificates issued under this policy; and
- riders, endorsements or amendments to the policy or certificates.

Changes to the Contract
Riders, endorsements and amendments add provisions to or change the terms of the policy.

Any changes to this policy, other than a change in the premium we charge, must be in writing and evidenced by endorsement on this policy, or by amendment to this policy signed by the policyholder and one of our executive officers at our home office. No agent or anyone else can change this policy or waive any of its provisions.

Furnishing Certificates
The company will provide a certificate for each named insured. The certificate will provide a description of the insurance provided by this policy and will state:
- the benefits provided under the policy;
- to whom benefits are payable;
- the limitations, exclusions and requirements that apply to coverage under the policy; and
- how to file a claim against the coverage.

If there is any discrepancy between the provisions of any certificate and the provisions of this policy, the provisions of this policy govern.

Contestability
After two years from the Policy Effective Date, no statements made by the policyholder in the application will be used to void this policy or to deny a claim for loss incurred after the expiration of the two-year period.

Conformity with State Statutes
Any provision of this policy that is in conflict with the applicable state laws of the state in which the named insured resides when he becomes insured is amended to conform to the minimum requirements of those laws.

Our Right to Change Premiums
We have the right to change the premium we charge after notifying the policyholder in writing at least 60 days in advance. A change in premium rate table(s) will not take effect before the end of the rate guarantee period shown on the Policy Rate Schedule except for reasons which affect the risk assumed, including, but not limited to those reasons shown below:
- a change occurs in this policy;
- a division, subsidiary, or affiliated company is added or deleted;
- the number of insureds changes by 25% or more; or
- a new law or a change in any existing law is enacted which applies to this policy.

After the rate guarantee period, we will not change the premium rates more than once in any six month period based on at least 12 months experience.

New Entrants
Any member of an eligible class, as described on the Policy Rate Schedule, and the eligible dependents of those members will become insured when they satisfy the requirements set forth in the certificate of insurance.

Information to Be Furnished By the Policyholder
The policyholder must keep a record of the named insureds and the particulars of the insurance on each and their covered spouse and dependent children, if applicable. As changes occur, the policyholder should provide us, on forms acceptable to us, information relative to any persons:

- who are eligible to enroll;
- who are insured by the coverage;
- whose status changes; and/or
- whose coverage terminates pursuant to the "Termination of Insurance" provision.

The policyholder should also provide us with any other information about the coverage that may be reasonably required, such as named insureds on leave of absence, including named insureds who are on leave under the Family and Medical Leave Act.

Policyholder records that have a bearing, in our opinion, on this policy will be available for review by us at any reasonable time. We may inspect these records at any time while this policy is in force and within one year after the termination of this policy.

All statements made in any application are considered representations and not warranties (absolute guarantees). No representation by the policyholder in applying for insurance under this policy will make it void unless the representation is contained in the application of the policyholder.

Clerical error or omission by us will not:

- prevent a covered person from receiving coverage;
- affect the amount of a covered person's coverage; or
- cause a covered person's coverage to begin or continue when the coverage would not otherwise be effective.

SECTION 5 - PREMIUM PAYMENTS

Premium Payments
The initial premium for each type of coverage under this policy is based on the initial premium rate table(s) shown on the Policy Rate Schedule.

Premium Amount
To ensure accurate premium calculations, the policyholder is responsible for reporting to us the following information during the stated time periods:

- individuals who are eligible to enroll are to be reported during the month prior to or during the month the coverage becomes effective;
- covered persons whose coverage has terminated are to be reported within a month of the date coverage terminated; and
- changes in named insureds' class are to be reported within a month of the date that the change in insurance class took place.

When and Where to Pay Premiums
The premiums for each certificate must be paid to us at our home office when they are due.

The premium due dates are based on:

- the coverage effective dates shown on the Certificate Schedules; and
- the premium frequency.

The premium frequency is how often the premiums are paid. The policyholder will be liable to us for all unpaid premiums for any period, including the grace period, during which coverage under the policy was in force as to any covered person.

Premium increases or decreases which take effect during an insurance month are due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

Grace Period (If Premiums Are Not Paid When Due)
After the first premium, if the premium is not paid when it is due, it can be paid during the next 31 days. These 31 days are called the grace period. During the grace period this coverage will stay in force. If the premium is not paid before the grace period ends, the coverage provided by this policy will terminate at the end of the grace period. If we agree to reinstate this policy, such reinstatement will not constitute waiver of the "Termination of This Contract" provision.

Reinstatement
If the premium is not paid by the end of the grace period, this policy will no longer be in force. You can ask us or one of our agents about reinstatement. If we accept the premium and do not require a reinstatement application, this policy will be reinstated on the date the premium is received.

If we do require a reinstatement application at the time we accept the premium, a conditional receipt will be given for the premium. If we approve the reinstatement application, this policy will be reinstated on the date we approve it.

If we do not notify you that we have approved or disapproved the reinstatement application, this policy will be reinstated on the 45th day after the date on the conditional receipt.

The reinstated policy will cover:
- specified disease that has a date of diagnosis more than 10 days after the reinstatement date;
- cancer (internal or invasive) that has a date of diagnosis more than 10 days after the reinstatement date;
- skin cancer that has a date of diagnosis more than 10 days after the reinstatement date;
- administration of a covered Cancer Vaccine;
- cancer treatment and care that has a date of diagnosis more than 10 days after the reinstatement date; and
- covered health screening tests that occur more than 10 days after the reinstatement date.

We have the right to make changes in this policy before we reinstate it. Any changes will be made in a rider to be attached to the reinstated policy. In every other way, your rights and our rights will be the same.

SECTION 6 - TERMINATION

Termination of This Contract
This policy can be terminated:
- by the policyholder; or
- by us.

If the premium is not paid when it is due or during the grace period, this policy will terminate automatically at the end of the grace period.

If we cancel this policy for the policyholder's failure to remit premium, a written notice will be delivered to the policyholder by certified mail at least 60 days prior to the cancellation date.

The policyholder may cancel this policy by written notice delivered to us at least 45 days prior to the cancellation date. This policy can be cancelled on an earlier date if we both agree. Coverage will end at 12:00 midnight Standard Time at the policyholder's address on the cancellation date.

If the policy is cancelled, the cancellation will not affect a claim for which we are liable under the terms of this policy.

Policyholder Responsibility to Named Insureds
If this policy terminates for any reason, the policyholder must:
- notify each named insured of the effective date of the termination; and
- refund or otherwise account to each named insured all contributions received or withheld from them for premiums not actually paid to us.

Workers' Compensation
This policy is not in lieu of, and does not affect, any requirement for coverage by workers' compensation insurance.

Injury or loss covered by workers' compensation is not excluded.

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

CERTIFICATE SCHEDULE

Policyholder:	Alamance Community College Fbp	Policy Number:	G0022235
Named Insured:	John Doe	Certificate Number:	99999999999
Coverage Type:	Two-Parent Family	Governing Jurisdiction:	NC
Coverage Effective Date:	01/01/2016	Billing Control Number:	E9791245
Pre-existing Condition Limitation Period:	12 Months	Premium Class:	Tobacco Non-Tobacco

BENEFITS

Face Amount for Named Insured	$100,000
Face Amount for Spouse	$50,000
Face Amount for Dependent Children	$50,000

The Face Amount(s) will reduce by 50% on the first Policy Anniversary Date after the named insured attains age 75.

Specified Disease Benefit	**Percentage of Face Amount**
Heart Attack (Myocardial Infarction)	100%
Stroke	100%
End Stage Renal (Kidney) Failure	100%
Major Organ Failure	100%
Permanent Paralysis due to an Accident	100%
Coma	100%
Blindness	100%
Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D	100%
Coronary Artery Bypass Graft Surgery	25%

Maximum Benefit Amount for Specified Disease: % of the Face Amount per covered person per lifetime.

Cancer Benefit	**Percentage of Face Amount**
Diagnosis of Cancer Benefit	100%
Diagnosis of Carcinoma in Situ Benefit	25%

Maximum Benefit Amount for a Diagnosis of Cancer (internal or invasive) Benefit: 100% of the Face Amount per covered person per lifetime.

Maximum Benefit Amount for a Diagnosis of Carcinoma in Situ Benefit: 25% of the Face Amount per covered person per lifetime.

Cancer Treatment and Care Benefit	$500 per covered person, per calendar month

Maximum Benefit Amount for a Cancer Treatment and Care Benefit: 12 monthly payments per covered person per lifetime.

Skin Cancer Benefit	$500
Cancer Vaccine Benefit	$50
Health Screening Benefit	$100 per covered person, per calendar year

SECTION 4 - GENERAL DEFINITIONS

Additional definitions may be contained in other certificate benefit provisions or any endorsement, amendment or rider.

Calendar Year means the period beginning on the coverage effective date shown on the Certificate Schedule and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

Coverage Effective Date means the date coverage begins as shown in the Certificate Schedule. The coverage effective date of this certificate is not the date you signed the application for coverage.

Dependent Children means your natural children, your step-children, your legally adopted children, foster children, children placed into your custody for adoption or children for whom you are ordered by a court or administrative order to provide coverage regardless of whether you are the custodial or non custodial parent who are under 26 years of age.

Doctor or Physician means a person who:

- is licensed by the state to practice a healing art; and
- performs services for a covered person which are allowed by his license.

For purposes of this definition, Doctor or Physician does not include any covered person or anyone related to any covered person by blood or marriage, a business or professional partner of any covered person, or any person who has a financial affiliation or a business interest with any covered person.

Evidence of Insurability means a statement of your medical history which we will use to determine if you are approved for coverage.

Policy Anniversary Date means the date that occurs annually on the same day and in the same month as the First Policy Anniversary shown on the Policy Rate Schedule.

Pre-existing Condition means those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within the one-year period immediately preceding the effective date of a covered person. If a covered person is 65 or older when this certificate is issued, pre-existing conditions for that covered person will include only conditions specifically eliminated by rider.

If additional monthly premiums are required to enroll a new spouse or a new dependent child, you must submit an enrollment application and change form through your group within 90 days of acquiring the new dependent. This applies to a newborn child or an adopted or foster child newly placed in the adoptive/foster home. If no additional monthly premium will be required when you add a dependent child to your plan, you should complete a status change form. A newborn child will be covered from the moment of birth. A foster care or adopted child will be covered from the date of placement in the home provided coverage for that child is put in to effect within 90 days, when additional monthly premium is required.

Spouse means a person who is married to you on the day we issue your certificate.

Temporary Layoff or Leave of Absence means the named insured is temporarily absent from active employment for a period of time that has been agreed to in advance in writing by the employer. Normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

SECTION 5 - DEFINITIONS FOR SPECIFIED DISEASE BENEFIT

Additional definitions may be contained in other certificate benefit provisions or any endorsement, amendment or rider.

Accident means an unintended or unforeseen bodily injury sustained by a covered person, wholly independent of disease, bodily infirmity, illness, infection, or any other abnormal physical condition.

Blindness means clinically proven irreversible reduction of sight in both eyes that has persisted for a period of at least 180 consecutive days. Sight must be reduced to a corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (Snellen or E-Chart Acuity), or visual field restriction to 20° or less in both eyes.
The following are not to be construed as blindness for purposes of this certificate:

- if, in general medical opinion, any procedure, device, or implant could result in the partial or total restoration of sight;
- if the covered person has not attained age three or above on the date of diagnosis, and
- if the covered person's reduction of sight, as defined above, occurs prior to the coverage effective date of the covered person's coverage under this certificate.

Cardiologist means a doctor who is licensed to practice medicine and who is also licensed to practice by the American Board of Internal Medicine in the subspecialty of cardiovascular disease.

Coma means a continuous state of profound unconsciousness resulting from a covered accident or a covered sickness, characterized by the absence of:

- eye opening,
- motor response, and
- verbal response.

The condition must require intubation for respiratory assistance. The term "coma" does not include any medically induced coma.

Coronary Artery Bypass Graft Surgery means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries utilizing venous or arterial grafts, excluding procedures such as, but not limited to, balloon angioplasty, valve replacement surgery, laser relief, stents or other non-surgical procedures.

Covered Accident means an accident which:

- occurs on or after the coverage effective date shown on the Certificate Schedule;
- occurs while this certificate is in force; and
- is not excluded by name or specific description in this certificate.

Covered Sickness means a sickness which:

- occurs on or after the coverage effective date shown on the Certificate Schedule;
- occurs while this certificate is in force; and
- is not excluded by name or specific description in this certificate.

Specified Disease means one of the specified illnesses listed in the Specified Disease Benefit section of the Certificate Schedule.

Date of Diagnosis means the date the covered person receives a diagnosis:

- for *Heart Attack (Myocardial Infarction)*, the date that the ischemic death of a portion of the heart muscle (myocardium) occurred based on the applicable criteria listed under the heart attack (myocardial infarction) definition;
- for *Stroke*, the date a stroke occurred based on neuroimaging or other neurodiagnostic study consistent with an acute or subacute infarction, hemorrhage, embolism, thrombosis and presence of neurological deficits persisting for a period of 30 days or greater;
- for *End Stage Renal (Kidney) Failure*, the date that regular hemodialysis or peritoneal dialysis begins;
- for *Major Organ Failure*, the date that the covered person is placed on the UNOS list for transplantation;
- for *Permanent Paralysis due to a Covered Accident*, the date the doctor confirms the permanent paralysis due to a covered accident continued for a period of 180 consecutive days;
- for *Coma*, the date a doctor confirms a coma resulting from a covered accident or a covered sickness has lasted 7 or more consecutive days;
- for *Blindness*, the date the doctor confirms the irreversible reduction of sight has continued for a period of 180 consecutive days;
- for *Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D*, the date of a positive antibody test for HIV or Hepatitis B, C or D subsequent to a prior negative test for the same condition with a lapse of between 90 and 180 days between the two tests; and
- for *Coronary Artery Bypass Graft Surgery*, the date the covered person undergoes the open heart surgery.

End Stage Renal (Kidney) Failure means chronic irreversible failure of the function of both kidneys such that the covered person must undergo at least weekly hemodialysis or peritoneal dialysis.

Heart Attack (Myocardial Infarction) means the ischemic death of a portion of heart muscle (myocardium) as a result of obstruction of one or more of the coronary arteries. A positive diagnosis of myocardial infarction must occur and must be supported by three or more of the following:

- chest pain;
- electrocardiographic (EKG) changes indicative of myocardial infarction; in the case of myocardial infarction associated with percutaneous coronary intervention (balloon angioplasty, stent implantation, and related procedures to increase the flow of blood through the coronary arteries), evolving ST elevations or new Q wave changes must be documented and included as one of the criteria in establishing a diagnosis;
- elevation of biochemical markers of myocardial necrosis; and
- confirmatory imaging studies.

In the event of death, an autopsy, medical examiner's confirmation or death certificate identifying heart attack (myocardial infarction) as the cause of death will be accepted.

A heart attack (myocardial infarction) is not congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease, cardiac arrest (including arrhythmias), or any other disease, injury or dysfunction of the cardiovascular system.

Major Organ Failure means diagnosis of major organ failure of the heart, kidney, liver, lung, or pancreas resulting in the covered person being placed on the UNOS (United Network for Organ Sharing) list for a transplant.

Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D means diagnosis of Human Immunodeficiency Virus (HIV) infection or Hepatitis B, C or D resulting from exposure to HIV-contaminated or Hepatitis B, C or D contaminated body fluids as the result of a covered accident during the normal course of performing an occupation for which remuneration is earned.
We will pay this benefit if:

- within five days of the covered accident, it is reported and recorded by the appropriate person according to the legislation, regulations, standards or guidelines that apply to the covered person's occupation or profession;
- the covered accident is investigated and a written investigation report is provided to us by the covered person's employer;
- a confirmatory antibody HIV or Hepatitis B, C or D test is taken within five days of the covered accident and HIV or Hepatitis B, C or D is not present;
- all HIV or Hepatitis B, C or D tests are performed by a state certified and licensed laboratory; and
- a follow-up confirmatory antibody HIV or Hepatitis B, C or D test is taken between 90 days and 180 days after the covered accident, and the result is positive.

Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D excludes:

- HIV or Hepatitis B, C or D infection as the result of IV drug use;
- HIV or Hepatitis B, C or D infection as the result of sexual transmission; and
- HIV or Hepatitis B, C or D infection determined not to have been the result of a covered accident.

Permanent Paralysis Due to a Covered Accident means the complete and permanent loss of the use of two or more limbs through paralysis as the result of a covered accident as defined in this certificate for a continuous period of 180 days, as confirmed by a doctor. Loss of use of two or more limbs through paralysis as the result of a stroke will not be construed as permanent paralysis due to a covered accident for purposes of this certificate.

Sickness means an illness, infection, disease or any other abnormal physical condition not caused by an accident. Sickness includes complications of pregnancy.

Stroke means an acute or sub-acute cerebrovascular incident, including infarction of brain tissue, cerebral and subarachnoid hemorrhage, cerebral embolism and cerebral thrombosis. The diagnosis must be supported by:

- evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the event; and
- confirmatory neuroimaging studies consistent with the diagnosis of a new stroke.

The following are not to be construed as a stroke for purposes of this certificate:
- transient ischemic attack;
- brain injury related to trauma or infection;
- brain injury associated with hypoxia/anoxia or hypotension;
- vascular disease affecting the eye or optic nerve; and
- ischemic disorders of the vestibular system.

In the event of death, an autopsy confirmation identifying stroke as the cause of death will be accepted.

SECTION 6 - DEFINITIONS FOR CANCER BENEFITS

Additional definitions may be contained in other certificate benefit provisions or any endorsement, amendment or rider.

Ambulatory Surgical Center means a place which:
- is equipped for surgical procedures performed by qualified physicians;
- provides anesthesia administered by a licensed anesthesiologist or licensed nurse anesthetist; and
- has written agreements with local hospitals to immediately accept patients who develop complications.

Cancer (internal or invasive) means a disease that is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells.

The following are not to be construed as cancer (internal or invasive) for purposes of this certificate:
- pre-malignant conditions or conditions with malignant potential;
- carcinoma in situ;
- basal cell carcinoma and squamous cell carcinoma of the skin; and
- melanoma that is diagnosed as Clark's Level I or II or Breslow less than .75mm.

Clinical diagnosis will be accepted as evidence that cancer exists when a pathological diagnosis cannot be made, provided the medical evidence substantially documents the diagnosis of cancer and the insured received definitive treatment for cancer. If the required pathological or clinical diagnosis can only be made post-mortem, we will pay benefits retroactively beginning with the date of terminal hospital confinement for not less than 45 days before the date of death.

In addition to the required pathological or clinical diagnosis, we may require additional information from the attending physician and hospital.

Carcinoma in Situ means cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue. Skin cancer will not be considered carcinoma in situ for purposes of this certificate.

Chemotherapy means treatment with chemical substances that have a cancericidal effect for the purpose of the destruction of malignant cells during the treatment of cancer (internal or invasive).

Date of Diagnosis for Cancer (internal or invasive) or Carcinoma in Situ means the date the tissue specimen, blood samples or titer(s) are taken upon which a covered person receives diagnosis of cancer (internal or invasive) or carcinoma in situ. If a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening, we will accept a Clinical Diagnosis.

Hospice means an organization that provides care for the terminally ill that:
- is licensed by a governmental agency;
- is accredited by the Joint Commission on Accreditation of Hospitals; or
- is qualified to receive benefit payments from Medicare or Medicaid.

The organization must have on its staff at least one doctor and one registered nurse and must keep complete medical records for each patient.

Hospice does not include:
- food services, meals, and dietary counseling; or

- services related to well-baby care; or
- services provided by volunteers; or
- support for the family after the death of the covered person.

Hospital means a place that:
- is run according to law on a full-time basis;
- provides overnight care of injured and sick people;
- is supervised by a doctor;
- has full-time nurses supervised by a registered nurse; and
- has at its locations or uses on a pre-arranged basis: X-ray equipment, a laboratory and an operating room where surgical operations take place.

Hospital will include a duly licensed State tax-supported institution on a basis no less favorable than the basis which would apply had the medical care been rendered in or by any other public or private institution or provider.

Notwithstanding the above, a hospital is not:
- a nursing home;
- an extended care facility;
- a skilled nursing facility;
- a rest home or home for the aged;
- a rehabilitation center;
- a place for alcoholics or drug addicts; or
- an assisted living facility.

Oral Chemotherapy means chemotherapy taken by mouth.

Pathologist means a doctor who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Radiation means the following treatments for the purpose of the destruction of malignant cells during the treatment of internal or invasive (not skin) cancer:
- teleradiotherapy, using either natural or artificially propagated radiation; or
- interstitial or intracavitary application of radium or radioisotopes in sealed or non-sealed sources.

Office visits, laboratory tests, diagnostic X-rays, treatment planning, simulation, treatment devices, dosimetry, radiation physics, teletherapy, laser surgery or other procedures related to these treatments will not be considered radiation.

Skin Cancer means melanoma of Clark's Level I or II (Breslow less than .75mm); basal cell carcinoma; or squamous cell carcinoma of the skin.

Supportive or Protective Care Drugs and Colony Stimulating Factors means:
- bone marrow growth factors;
- radiation and chemotherapy protectants; and
- medications that promote bone growth.

Supportive or Protective Care Drugs must be approved for the treatment of cancer (internal or invasive) by the United States Food and Drug Administration and must be prescribed by a physician.

Surgery means the cutting into the skin or other organ to accomplish any of the following goals:
- take a biopsy of a suspicious lump that results in a diagnosis of cancer (internal or invasive) or carcinoma in situ;
- remove diseased tissues or organs;
- remove an obstruction;
- reposition structures to their normal position;
- redirect channels;
- transplant tissue or whole organs;

- implant mechanical or electronic devices;
- reconstruct anatomic defects that result from treatment of cancer (internal or invasive) or carcinoma in situ; or
- restore proper function.

The following will not be considered a surgical procedure for the purposes of this certificate:
- venipuncture (drawing blood);
- lumbar puncture;
- epidural steroid injections;
- removal of skin tags;
- catherization; or
- scopes not requiring biopsy or removal of tissue.

Topical Chemotherapy means a chemotherapy drug placed directly onto the skin.

SECTION 7 - ELIGIBILITY AND EFFECTIVE DATE

Coverage Effective Date
Your coverage under the policy will start at 12:01 a.m. Standard Time in the time zone where you live on the coverage effective date shown on your Certificate Schedule.

Enrollment
An individual who is a member of an eligible class may enroll in coverage during the eligibility period, as shown on the Policy Rate Schedule, that follows the later of:
- the policy effective date as shown on the Policy Rate Schedule;
- the date the individual first becomes a member of an eligible class;
- the date the individual completes the policyholder probationary period shown on the application of the policyholder, if applicable;
- the date the individual meets evidence of insurability requirements, if any.

An individual who fails to enroll during the eligibility period may enroll only during an open enrollment period. Evidence of insurability may be required. The policyholder and the company will determine when an open enrollment period begins and ends.

After the coverage effective date, the named insured cannot make any changes to the coverage type under the certificate until an open enrollment period, unless the named insured has a qualifying event. A qualifying event, for the purposes of this provision, means:
- birth or adoption of a child;
- issuance of a court order requiring coverage of a child;
- marriage;
- divorce; or
- death of a covered person.

The named insured will have 31 days from the date of occurrence of a qualifying event in which to:
- notify us he wishes to make a change;
- complete any required enrollment form; and
- pay any additional premium, if applicable.

Delayed Coverage Effective Date
The effective date of your coverage will be delayed if you are not a member of an eligible class on the coverage effective date shown on the Certificate Schedule. The coverage will be effective on the date that you return to status as a member of an eligible class. If this is named insured and spouse coverage, one-parent family or two-parent family coverage, coverage on the spouse and/or dependent children will be effective on the date that you return to status as a member of an eligible class.

Who is Covered By This Certificate
If this is named insured coverage as shown on the Certificate Schedule, we insure you, the named insured.

If this is named insured and spouse coverage as shown on the Certificate Schedule, we insure you and your spouse.

If this is one-parent family coverage as shown on the Certificate Schedule, we insure you and your dependent children.

If this is two-parent family coverage as shown on the Certificate Schedule, we insure you, your spouse and your dependent children.

You may not apply for coverage for your spouse if your spouse is covered as a named insured.

Coverage on newborn children begins from the moment of live birth. Coverage for adopted children begins with the date of placement into your custody for adoption. Coverage for foster children begins with the date of placement into the foster home. Coverage for a child for whom you are ordered by a court to provide coverage begins on the date specified in the order. If the coverage is named insured coverage or named insured and spouse coverage, the coverage on the newborn or newly adopted child will end 31 days later if you do not request a change in coverage type as provided in the Enrollment provision above.

The 31-day enrollment period will not apply if you are ordered by a court to provide coverage for a child and the child meets all conditions for eligibility under the policy.

If this is a one-parent or two parent family coverage, no additional premium is due for the newborn, foster child or newly adopted child. We may not deny coverage for a child due to your failure to timely notify us of the birth of the child.

SECTION 8 - BENEFIT FOR SPECIFIED DISEASE

Specified Disease Benefit
We will pay this benefit if a covered person is diagnosed with a specified disease, as defined in this Certificate, and:
- the date of diagnosis is while this certificate is in force; and
- the specified disease is not excluded by name or specific description in this certificate.

We will pay the percentage of the covered person's face amount shown on the Certificate Schedule for the specified disease diagnosed, up to the Maximum Benefit Amount for Specified Disease shown on the Certificate Schedule.

We will pay the benefit for only once per lifetime per covered person. If a covered person receives a benefit for Coronary Artery Bypass Graft Surgery and is later diagnosed with a different specified disease, we will pay the face amount less the amount received for Coronary Artery Bypass Graft Surgery.

If, on the same day, a covered person is placed on the UNOS list for a transplant of two or more major organs listed above in the definition of major organ failure (example: heart and lungs), a single benefit will be paid.

We will pay the benefit for Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D only once per lifetime per covered person.

If the date of diagnosis of two or more specified diseases is the same day, we will pay only one specified disease benefit. We will pay the larger of the specified disease benefit.

The Specified Disease Benefit is not payable for conditions other than the specified diseases defined in this certificate.

Benefit Payable Upon Subsequent Diagnosis of a Specified Disease
If a covered person has been diagnosed with and received a benefit for a specified disease and is subsequently diagnosed with a **different** specified disease, we will pay the percentage of the covered person's face amount as shown on the Certificate Schedule for the specified disease diagnosed, if:
- the date of diagnosis of the subsequent specified disease is more than 180 days after any previous date of diagnosis for a specified disease;
- the subsequent date of diagnosis is while coverage under this certificate is in force; and
- the specified disease is not excluded by name or specific description in this certificate.

If a covered person has been diagnosed with and received a benefit for a specified disease and is subsequently diagnosed with the **same** specified disease (other than Coronary Artery Bypass Graft Surgery and Occupational Infectious HIV or Occupational

Infectious Hepatitis B, C or D), we will pay an amount equal to 25 percent of the Face Amount for the covered person as shown on the Certificate Schedule, if:

- the date of diagnosis of the subsequent specified disease is more than 180 days after any previous date of diagnosis for the same specified disease;
- the covered person has not received treatment during the 180 days between the dates of diagnosis for the same specified disease. For purposes of the preceding sentence, treatment does not include medications and follow-up visits to the covered person's doctor;
- the subsequent date of diagnosis is while coverage under this certificate is in force; and
- the specified disease is not excluded by name or specific description in this certificate.

Benefit Reduction

The Face Amount(s) will reduce by 50 percent on the first policy anniversary date after the named insured attains age 75. All specified disease benefits payable after that date will be based on the reduced Face Amount.

SECTION 9 - BENEFITS FOR CANCER

Diagnosis of Cancer Benefit

We will pay this benefit when you are diagnosed as having cancer (internal or invasive) if:

- the date of diagnosis is while this certificate is in force;
- for a cancer (internal or invasive) diagnosed during the 12 months following the coverage effective date, the cancer (internal or invasive) is not a pre-existing condition; and
- the cancer (internal or invasive) is not excluded by name or specific description in the certificate.

We will pay the percentage of the covered person's face amount shown on the Certificate Schedule. We will pay no more than the Maximum Benefit Amount for the Diagnosis of Cancer shown on the Certificate Schedule per covered person per lifetime.

We will not pay the Diagnosis of Cancer Benefit for any cancer (internal or invasive) diagnosed during the 12 months following the coverage effective date if the cancer (internal or invasive) is a pre-existing condition.

Cancer (internal or invasive) must be diagnosed in one of two ways:

1. Pathological Diagnosis

A *pathological diagnosis* of cancer (internal or invasive) 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 pathologist whose diagnosis of malignancy is in keeping with the standards established by the American Board of Pathology. A pathological diagnosis of cancer (internal or invasive) can be made before or after death.

2. Clinical Diagnosis

A *clinical diagnosis* of cancer (internal or invasive) is based on the study of symptoms. We will pay benefits for a clinical diagnosis only if:

- a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening;
- there is medical evidence to support the diagnosis; and
- a doctor is treating the covered person for cancer (internal or invasive).

In addition to the pathological or clinical diagnosis required, we may require additional information from the attending doctor and hospital.

If a covered person has been diagnosed with and received a benefit for carcinoma in situ and is subsequently diagnosed with cancer (internal or invasive), we will pay the Diagnosis of Cancer Benefit for the covered person as shown on the Certificate Schedule, up to the Maximum Benefit Amount for a Diagnosis of Cancer Benefit and subject to the provisions of this certificate, if the date of diagnosis of the cancer (internal or invasive) is more than 180 days after the date of diagnosis for the carcinoma in situ.

Diagnosis of Carcinoma In Situ Benefit

We will pay this benefit when you are diagnosed as having carcinoma in situ, if:

- the date of diagnosis is while this certificate is in force;

- for a carcinoma in situ diagnosed during the 12 months following the coverage effective date, the carcinoma in situ is not a pre-existing condition; and
- the carcinoma in situ is not excluded by name or specific description in the certificate.

We will pay the percentage of the covered person's face amount shown on the Certificate Schedule. We will pay no more than the Maximum Benefit Amount for the Diagnosis of Carcinoma In Situ shown on the Certificate Schedule per covered person per lifetime.

We will not pay the Diagnosis of Carcinoma In Situ Benefit for any carcinoma in situ diagnosed during the 12 months following the coverage effective date if the carcinoma in situ is a pre-existing condition.

Carcinoma in situ must be diagnosed in one of two ways:

1. Pathological Diagnosis

A *pathological diagnosis* of 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 pathologist whose diagnosis of malignancy is in keeping with the standards established by the American Board of Pathology. A pathological diagnosis of carcinoma in situ can be made before or after death.

2. Clinical Diagnosis

A *clinical diagnosis* of carcinoma in situ is based on the study of symptoms. We will pay benefits for a clinical diagnosis only if:

- a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening;
- there is medical evidence to support the diagnosis; and
- a doctor is treating the covered person for carcinoma in situ.

In addition to the pathological or clinical diagnosis required, we may require additional information from the attending doctor and hospital.

If a covered person has been diagnosed with and received a benefit for cancer (internal or invasive) and is subsequently diagnosed with carcinoma in situ, we will pay the Diagnosis of Carcinoma In Situ Benefit for the covered person as shown on the Certificate Schedule, up to the Maximum Benefit Amount for a Diagnosis of Carcinoma In Situ Benefit and subject to the provisions of this certificate, if the date of diagnosis of the carcinoma in situ is more than 180 days after the date of diagnosis for the cancer (internal or invasive).

Skin Cancer Benefit

We will pay this benefit if a covered person is diagnosed with skin cancer if:

- the date of diagnosis is while this certificate is in force;
- for a skin cancer diagnosed during the 12 months following the coverage effective date, the skin cancer is not a pre-existing condition; and
- the skin cancer is not excluded by name or specific description in this certificate.

We will pay the amount shown on the Certificate Schedule.

We will pay this benefit only once per covered person per lifetime.

Cancer Treatment and Care Benefit

We will pay benefits for Cancer Treatment and Care if:

- a covered person receives a covered treatment for cancer (internal or invasive) or carcinoma in situ while this certificate is in force;
- a covered person receives a covered treatment for cancer (internal or invasive) or carcinoma in situ within the United States;
- the cancer (internal or invasive) or carcinoma in situ is not excluded by name or specific description in the certificate; and
- the covered treatment is not excluded by name or specific description in the certificate.

We will pay the amount shown on the Certificate Schedule for each calendar month during which a covered person incurs charges for and receives one or more of the covered treatments listed below as a result of cancer (internal or invasive) or carcinoma in situ, up to the Maximum Benefit Amount for Cancer Treatment and Care Benefit shown on the Certificate Schedule.

We will pay no more than one Cancer Treatment and Care Benefit per calendar month per covered person.

Covered Treatments consist of the following:

- **Chemotherapy**, consisting of one or more of the following:
  - chemotherapy treatments injected by medical personnel in a doctor's office, clinic or hospital;
  - a prescription filled for oral chemotherapy;
  - a prescription filled for topical chemotherapy;
  - a pump for chemotherapy initially filled or refilled;
  - a prescription filled for chemotherapy to be injected by yourself or anyone other than personnel in a doctor's office, clinic or hospital; or
  - a prescription filled for supportive and protective care drugs and colony stimulating factors.
- **Radiation** delivered by medical personnel in a doctor's office, clinic or hospital.
- **Confinement** to a bed as a resident inpatient in a hospital (including intensive care) on the advice of a doctor or confinement in an observation unit within a hospital for a period of no less than 20 continuous hours on the advice of a doctor.
- **Surgery** performed by a doctor in a hospital or ambulatory surgical center.
- **Hospice Care,** consisting of one or more of the following services received by a covered person for whom a doctor determines that cancer treatments are no longer of benefit and that he is expected to live for only six months or less:
  - a visit from a representative of a hospice care team at home;
  - the services of a hospital on an outpatient basis under the direction of a hospice;
  - a visit to a hospice on an outpatient basis for treatment or services; and
  - confinement to a hospice care facility.

If the covered person's cancer (internal or invasive) or carcinoma in situ is a pre-existing condition, coverage for that cancer (internal or invasive) or carcinoma in situ will apply only to treatment of cancer (internal or invasive) or carcinoma in situ commencing after this certificate has been in force for 12 months, unless the cancer (internal or invasive) or carcinoma in situ is excluded by name or specific description in this certificate. In the alternative, you may elect to void the certificate and receive a full refund of premium.

Unrelated Cancer Diagnosis
Benefits will be provided for an unrelated cancer diagnosed after the effective date of this certificate.

Cancer Vaccine Benefit
We will pay this benefit if a covered person incurs a charge for and receives any cancer vaccine that is FDA approved for the prevention of cancer. The vaccine must be administered by licensed medical personnel while coverage under this certificate is in force. We will pay the amount shown on the Certificate Schedule. This benefit is limited to one payment per covered person, per lifetime.

Benefit Reduction
The Face Amount(s) and the Maximum Benefit Amount for a Diagnosis of Cancer Benefit and the Maximum Benefit Amount for a Diagnosis of Carcinoma In Situ will reduce by 50% on the policy anniversary date after the named insured attains age 75. All Diagnosis of Cancer Benefits and Diagnosis of Carcinoma In Situ Benefits payable after that date will be based on the reduced Face Amount and the reduced Maximum Benefit Amount.

SECTION 10 - HEALTH SCREENING BENEFIT

Health Screening Benefit
We will pay this benefit if any covered person incurs charges for and has one of the health screening tests listed below performed while this certificate is in force. We will pay the amount shown on the Certificate Schedule for one of the following screening tests:

Stress test on a bicycle or treadmill Fasting blood glucose test Blood test for triglycerides Serum Cholesterol test to determine level of HDL and LDL Bone marrow testing Carotid Doppler Electrocardiogram (EKG, ECG) Echocardiogram (ECHO)	Skin cancer biopsy 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 Flexible sigmoidoscopy	Hemoccult stool analysis Mammography Pap smear PSA (blood test for prostate cancer) Serum protein electrophoresis(blood test for myeloma) Thermography ThinPrep pap test Virtual colonoscopy

We will pay a maximum of one Health Screening Benefit per covered person per calendar year.

SECTION 11 - EXCLUSIONS AND LIMITATIONS FOR SPECIFIED DISEASE

We will not pay benefits for a critical illness that occurs as a result of a covered person's:

Alcoholism or Drug Addiction
Addiction to alcohol or drugs, except for drugs taken as prescribed by his doctor.

Felonies or Illegal Occupations
Committing or attempting to commit a felony or engaging in an illegal occupation.

Intoxicants and Narcotics
Being intoxicated or under the influence of any narcotic unless administered on the advice of his doctor.

Psychiatric or Psychological Conditions
Having a psychiatric or psychological condition, including but not limited to affective disorders, neuroses, anxiety, stress and adjustment reactions. However, Alzheimer's Disease and other organic senile dementias are covered under this certificate.

Suicide or Injuries Which Any Covered Person Intentionally Does to Himself
Committing or trying to commit suicide or his injuring himself intentionally, whether he is sane or not.

War or Armed Conflict
Being exposed to war or any act of war, declared or undeclared, or serving in the armed forces of any country or authority.

Pre-Existing Condition Limitation
We will not pay the Specified Disease Benefit or Benefits Payable Upon Subsequent Diagnosis of a Specified Disease for any covered person when the specified disease is a pre-existing condition as defined in this certificate, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is diagnosed with a specified disease. If a covered person is 65 or older when this certificate is issued, the pre-existing conditions for that covered person will include only conditions specifically eliminated by rider.

SECTION 12 - EXCLUSIONS AND LIMITATIONS FOR CANCER

We will not pay the Diagnosis of Cancer Benefit, Diagnosis of Carcinoma In Situ Benefit , the Cancer Treatment and Care Benefit or the Skin Cancer Benefit for a covered person's cancer (internal or invasive), carcinoma in situ or skin cancer that:

Pre-Existing Condition Limitation
Is a pre-existing condition, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is initially diagnosed as having cancer (internal or invasive), carcinoma in situ or skin cancer. No Pre-existing Condition Limitation will be applied for dependent children who are born or adopted while you are covered under this policy, and who are continuously covered from the date of birth or adoption. If a covered person is 65 or older when this certificate is issued, the pre-existing conditions for that covered person will include only conditions specifically eliminated by rider.

Geographical Limitation
Is diagnosed or treated outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico.

SECTION 13 - TERMINATION OF INSURANCE

Termination of The Named Insured's Coverage
The coverage on a named insured under the policy will terminate on the earliest of the following dates:
- the date the policy terminates; or
- the end of the grace period following the premium due date we fail to receive the required premium for the named insured; or
- the date the named insured is no longer in an eligible class; or
- the date the named insured's class is no longer included for insurance; or
- the date the next premium is due after the named insured asks us to end his coverage.

We will provide coverage for a claim for which we are liable under the terms of this certificate if the loss occurs while you are covered.

When Coverage Ends on Your Spouse and Dependent Children
If this is a named insured and spouse coverage or two-parent family coverage, coverage on your spouse will end on the earliest of the following dates:
- the date your coverage under the policy terminates; or
- the end of the grace period following the premium due date we fail to receive the required premium for your spouse; or
- the date the next premium is due after you ask us to end your spouse's coverage; or
- the date you die; or
- the date the next premium is due after you divorce your spouse or your marriage is annulled.

If this is a one-parent family or two-parent family coverage, coverage on your dependent children will end on the earliest of the following dates:
- the date your coverage under the policy terminates; or
- the end of the grace period following the premium due date we fail to receive the required premium for your dependent children; or
- the date the next premium is due after you ask us to end your dependent children's coverage; or
- the date you die.

We will provide coverage for a claim for which we are liable under the terms of this certificate if the loss occurs while your spouse and/or dependent child is covered.

Coverage will end on each child when he no longer qualifies as a dependent child as defined in this certificate. A dependent child who reaches age 26 may remain covered if that child is and continues to be mentally or physically handicapped and is dependent on you for support and maintenance. You must submit satisfactory proof of incapacity and dependency to us within 31 days of the termination date and subsequently as we may require, but not more frequently than annually following the termination date. We will continue to charge any appropriate premium for that child as long as he meets the definition of a dependent child. It is your responsibility to notify us if any dependent child no longer qualifies as an eligible dependent. If this is one-parent family or two-parent family coverage and all of your dependent children no longer qualify as eligible dependents and you do not notify us, the extent of our liability will be to refund premium paid for the time period for which they did not qualify.

Leave of Absence Under the Family and Medical Leave Act
A named insured may continue his coverage during absences for family or medical leave. If a named insured is on a family or medical leave of absence, coverage will continue under this certificate as if the named insured were in active employment, if the following conditions are met:
- the premiums are paid in accordance with the policy's provisions; and
- the policyholder has approved the named insured's leave in writing.

Coverage will be continued for up to the greater of:
- the leave period required by the federal Family and Medical Leave Act of 1993, and any amendments; or
- the leave period required by applicable state law.

If coverage is not continued during a family or medical leave of absence, upon the named insured's return to active employment:

- no new pre-existing condition limitation will be applied; and
- no new evidence of insurability will be required to reinstate the coverage which was in effect before the leave began.

In order for these conditions to apply, the policyholder must notify us and commence paying premiums for the named insured's coverage within 31 days following a named insured's return to active employment following a leave of absence for family or medical leave.

The time period in the pre-existing condition limitation period will continue to run through a named insured's family or medical leave of absence.

Leave of Absence - Other
If the named insured is on a temporary layoff or leave of absence other than for family or medical leave and premium is paid in accordance with the policy's provisions, he will be covered through the premium due date immediately following the date the temporary layoff or leave of absence begins.

If premium is remitted beyond the premium due date referenced above, our only liability will be to return the premium.

SECTION 14 - PORTABILITY

Portability Privilege
We will provide specified disease insurance portability coverage, subject to these provisions.
Such coverage will not be available for a named insured, unless:

- we receive a written request by the named insured and payment of all premiums due for the portability coverage not later than 63 days after such termination; and
- the request is made on a form we furnish or approve for that purpose.

Coverage
The benefits, terms and conditions of the portability coverage will be the same as those provided under the policy for specified disease insurance when the named insured's insurance terminated. We will allow you to decrease the face amount at the time portability is requested; provided that the face amount cannot be decreased below a Face Amount for Named Insured of $5,000. Portability coverage may include any eligible family members who were covered under the policy. Any change made to the policy after a named insured is insured under the portability privilege will not apply to that named insured unless it is required by law.

Portability coverage will be effective on the day after coverage under the policy terminates.

Premiums
Premiums are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The premium rates are based on the portability rates in effect on any premium due date. We have the right to change the portability premium we charge on any premium due date. Written notice will be given at least 45 days before the change is to take effect.

Grace Period
The grace period provision of the policy will apply to each certificateholder of portability coverage as if such certificateholder is the policyholder.

If we agree to reinstate this certificate, such reinstatement will not constitute waiver of the "Termination of This Contract" provision.

Termination of Insurance
Insurance under this portability privilege will automatically end on the earliest of the following dates:

- The date the named insured again becomes eligible for specified disease insurance under the policy.
- The last day for which premiums have been paid, if the named insured fails to pay premiums when due, subject to the Grace Period provision.
- The date insurance under this portability provision is cancelled by us for any reason upon 45-days notice.

With respect to insurance for your spouse and dependent children, insurance under this portability privilege will automatically end on the earliest of the following dates:

- the date the named insured's insurance terminates; or
- as to your dependent children, the date the dependent child ceases to qualify as a dependent child as defined in this certificate; or
- as to your spouse, the date the next premium is due after you divorce your spouse or your marriage is annulled.

Once insurance under this portability provision is cancelled, it can not be reinstated.

Termination of the Policy
Portability coverage may continue beyond the termination date of the policy, subject to the timely payment of premiums. Benefits, terms and conditions for portability coverage will be determined as if the policy had remained in full force and effect.

SECTION 15 - GENERAL PROVISIONS

Misstatement of Age
If the age of the named insured has been misstated, we will make any equitable adjustment of premiums. We will refund any excess premium payment over the amount due based on your correct age. We will request payment for any overdue premium based on your correct age. If the misstatement is discovered after a payment is due and payable, we will reduce or increase the benefit amount payable by the amount of excess or overdue premium due to the misstatement. If a named insured is not eligible because of age we will refund all premiums paid.

Misstatement of Tobacco Status
If there is a misstatement in the application of the named insured's tobacco status, we will adjust the benefits payable to the amounts which would have been purchased at the correct tobacco status in consideration of the most recent premium. We will not make such an adjustment after this policy has been in force for two years from the coverage effective date.

Contestability
No statement made by any named insured relating to his insurability or the insurability of his dependents shall be used to contest the validity of the insurance after the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made.

Contest means that we question the validity of coverage under this policy through a letter to the policyholder or the named insured. This contest is effective on the date we mail the letter and refund premiums.

All statements made by the policyholder or any named insured shall be deemed representations and not warranties. No written statement made by the policyholder or any named insured shall be used in any contest unless a copy of the statement is furnished to the policyholder or the named insured.

After this certificate has been in force for 12 months from the coverage effective date, we will pay benefits for any pre-existing condition not excluded by name or specific description if the date of diagnosis is more than 12 months after the coverage effective date. If a covered person is 65 or older when this certificate is issued, the pre-existing conditions for that covered person will include only conditions specifically eliminated by rider.

Policyholder as Agent
For purposes of the policy and this certificate, the policyholder acts on its own behalf or as your agent. Under no circumstances will the policyholder be deemed our agent.

SECTION 16 - CLAIM PROVISIONS

Notice of Claim
If a covered person has an injury or sickness that may result in a claim for benefits under the policy, written notice must be given to us at our home office or to any authorized agent of the insurer. This must be done within 90 days after a covered loss begins. If notice cannot be given within that time, it must be given as soon as is reasonably possible. The notice must contain enough information to identify the covered person.

Claim Forms
When we receive written or verbal notice of a claim, claim forms will be sent with which to file Proof of Loss. If these forms are not given to you within 15 days, you will be excused from filing the forms as long as you send us Proof of Loss as described below.

Proof of Loss
We must receive a written proof of loss within 180 days after the covered loss begins. If you are not able to give us written proof of loss within 180 days, it will not have a bearing on this claim if proof is given to us as soon as it is reasonably possible. In any event, proof must be given no later than one year from the time stated unless you are legally unable to do so.

Written proof of loss must include one or more of the following: a doctor's bill, a hospital bill or other proof of charges.

Time of Payment of Claim
After we receive written proof of loss and process your claim, we will immediately pay any benefits due.

Payment of Claim
Benefits will be paid to you unless we receive a written authorization to pay them elsewhere, such as to a hospital or a doctor's office. This is called assignment.

If we still owe you benefits at your death, benefits due will be paid in this order to your:
- spouse; or
- children; or
- parents; or
- brothers and sisters; or
- estate.

If benefits are payable to your estate or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, we can pay benefits up to an amount not exceeding $3,000 to someone related to you by blood or connection by marriage or beneficiary who we feel is fairly entitled to them. If we do this, we will have no responsibility for this payment because we made it in good faith.

Unpaid Premium
When a claim is paid under the policy, any premium then due and unpaid may be deducted by us from the claim payment.

Overpaid Claim
We have the right to recover any overpayments due to:
- fraud; and
- any error we make in processing a claim.

You must reimburse us in full. We will work with you to develop a reasonable method of repayment if you are financially unable to repay us in a lump sum.

We will not recover more money than the amount we overpaid.

Questions Concerning the Named Insured's Claim
If you have questions concerning your claim, you can call us at our home office. We are open Monday through Friday from 8:30 a.m. until 5:00 p.m. Eastern Time.

Physical Exam and Autopsy
We can require that any covered person be examined by a doctor of our choice as often as it is reasonably necessary while his claim is pending. We can also require an autopsy in the event of the death of any covered person in those states where this is allowed. Either or both of these will be done at our expense.

Legal Action
We cannot be sued for benefits under the policy:
- until 60 days after we are sent written proof of loss; or

- more than three years after the time has passed in which we require written proof of loss.

Claim Review
If a claim is denied, we will give written notice of:
- the reason for denial; and
- the policy provision that relates to the denial;
- the right to ask for a review of the claims; and
- the right to submit any additional information that might allow us to change our decision.

You may, upon written request, read any reports that are not confidential. For a small fee, we will make copies of those reports.

Change of Beneficiary
Unless you make an irrevocable designation of beneficiary, the right to change a beneficiary is reserved to you and the consent of the beneficiary or beneficiaries shall not be requisite to assignment of this certificate or to change of beneficiary or beneficiaries, or to any changes in this certificate. A change of beneficiary will not have a bearing on any payment we make before we receive it.

Appeals Procedure
Prior to filing any lawsuit and within 60 days after denial of a claim, you or your estate must appeal any denial of benefits under the policy by making a written request for review of the denial.

Workers' Compensation Not Affected
The policy does not replace or change any requirement for coverage under Workers' Compensation insurance.

Injury or loss covered by workers' compensation is not excluded.

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

1200 Colonial Life Boulevard, P. O. Box 1365, Columbia, South Carolina 29202
1.800.325.4368 coloniallife.com

CANCER AND SPECIFIED DISEASE GROUP INSURANCE CERTIFICATE
THE CERTIFICATE PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

Outline of Coverage
(Applicable to policy form GCC1.0-P-GR-NC and certificate form GCC1.0-C-GR-NC)

Pre-Existing Statement: No benefits will be provided during the first 12 months of the certificate for diagnosed before the insured's coverage effective date. Pre-existing condition means those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within the one-year period immediately preceding the effective date of a covered person. If a covered person is 65 or older when this policy is issued, pre-existing conditions for that covered person will include only conditions specifically eliminated by rider.

Specified Disease Benefit Reduction: The Face Amount on any coverage in force after the named insured's 75th birthday will be reduced by 50% on the first Policy Anniversary Date following the named insured's 75th birthday. There will be no further increases in the insured's coverage amount.

IMPORTANT CANCELLATION INFORMATION - PLEASE READ THE SECTION TITLED - "TERMINATION ".

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

Please Read Your Certificate Carefully. This outline provides a very brief description of the important features of the Group Policy. This is not an insurance contract and only the actual policy provisions will control. The policy sets forth in detail the rights and obligations of the policyholder, you and us. The certificate describes the features of the coverage, lists any limitations or exclusions on coverage and explains how to file a claim against the coverage. It is, therefore, important that you **READ YOUR CERTIFICATE CAREFULLY**.

Coverage Provided by The Certificate. The certificate is designed to provide coverage ONLY for specified diseases and for certain health screening tests, subject to any limitations or exclusions in your certificate. It does not provide coverage for basic hospital, basic medical-surgical or major medical expenses.

BENEFITS

Face Amount for Named Insured	$100,000
Face Amount for Spouse (if covered)	50% of face amount for Named Insured
Face Amount for Dependent Children (if covered)	50% of face amount for Named Insured

The Face Amount(s) will reduce by 50% on the first Policy Anniversary Date after the named insured attains age 75.

BENEFIT FOR SPECIFIED DISEASE
We will pay this benefit if a covered person is diagnosed with a specified disease, as shown below and:
the date of diagnosis is while the certificate is in force; and the specified disease is not excluded by name or specific description in the certificate.

Specified Disease Benefit	Percentage of Face Amount
Heart Attack (Myocardial Infarction)	100%
Stroke	100%
End Stage Renal (Kidney) Failure	100%
Major Organ Failure	100%
Permanent Paralysis due to an Accident	100%
Coma	100%
Blindness	100%
Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D	100%
Coronary Artery Bypass Graft Surgery	25%

Maximum Benefit Amount for Specified Disease: % of the Face Amount per covered person per lifetime.

We will pay the percentage of the covered person's face amount shown above for the specified disease diagnosed .

We will pay the benefit for Coronary Artery Bypass Graft Surgery only once per lifetime per covered person.

If, on the same day, a covered person is placed on the UNOS list for a transplant of two or more major organs listed above in the definition of major organ failure (example: heart and lungs), a single benefit will be paid.

We will pay the benefit for Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D only once per lifetime per covered person.

If the date of diagnosis of two or more specified diseases is the same day, we will pay only one specified disease benefit. We will pay the larger of the specified disease benefits.

The Specified Disease Benefit is not payable for conditions other than the specified illnesses listed in the Specified Disease Benefit section of the Certificate Schedule.

Benefits Payable Upon Subsequent Diagnosis of a Specified Disease
If a covered person has been diagnosed with and received a benefit for a specified disease and is subsequently diagnosed with a **different** specified disease, we will pay the percentage of the covered person's face amount as shown above for the specified disease diagnosed, if:

- the date of diagnosis of the subsequent specified disease is more than 180 days after any previous date of diagnosis for a
- specified disease;
- the subsequent date of diagnosis is while coverage under the certificate is in force; and
- the specified disease is not excluded by name or specific description in the certificate.

If a covered person has been diagnosed with and received a benefit for a specified disease and is subsequently diagnosed with the **same** specified disease (other than and Occupational
Infectious HIV or Occupational Infectious Hepatitis B, C or D), we will pay an amount equal to 25 percent of the Face Amount for the covered person, if:

- the date of diagnosis of the subsequent specified disease is more than 180 days after any previous date of diagnosis for the
- same specified disease;
- the covered person has not received treatment during the 180 days between the dates of diagnosis for the same specified
- disease;
- the subsequent date of diagnosis is while coverage under the certificate is in force; and
- the specified disease is not excluded by name or specific description in the certificate.

Benefit Reduction
The Face Amount(s) will reduce by 50 percent on the first policy anniversary date after the named insured attains age 75. All specified disease benefits payable after that date will be based on the reduced Face Amount.

BENEFITS FOR CANCER

	Percentage of Face Amount
Diagnosis of Cancer Benefit	100%
Diagnosis of Carcinoma in Situ Benefit	25%

Diagnosis of Cancer Benefit
We will pay this benefit when you are diagnosed as having cancer (internal or invasive) if:
- the date of diagnosis is while this certificate is in force;
- for a cancer (internal or invasive) diagnosed during the 12 months following the coverage effective date, the cancer (internal or invasive) is not a pre-existing condition; and
- the cancer (internal or invasive) is not excluded by name or specific description in the certificate.

We will pay the percentage of the covered person's face amount shown on the Certificate Schedule. We will pay no more than the Maximum Benefit Amount for the Diagnosis of Cancer shown on the Certificate Schedule per covered person per lifetime.

We will not pay the Diagnosis of Cancer Benefit for any cancer (internal or invasive) diagnosed during the 12 months following the coverage effective date if the cancer (internal or invasive) is a pre-existing condition.

Cancer (internal or invasive) must be diagnosed by either pathological diagnosis or clinical diagnosis. In addition to the pathological or clinical diagnosis required, we may require additional information from the attending doctor and hospital.

If a covered person has been diagnosed with and received a benefit for carcinoma in situ and is subsequently diagnosed with cancer (internal or invasive), we will pay the Diagnosis of Cancer Benefit for the covered person as shown on the Certificate Schedule, up to the Maximum Benefit Amount for a Diagnosis of Cancer Benefit and subject to the provisions of this certificate, if the date of diagnosis of the cancer (internal or invasive) is more than 180 days after the date of diagnosis for the carcinoma in situ.

Diagnosis of Carcinoma In Situ Benefit
We will pay this benefit when you are diagnosed as having carcinoma in situ, if:
- the date of diagnosis is while the certificate is in force;
- for a carcinoma in situ diagnosed during the 12 months following the coverage effective date, the carcinoma in situ is not a pre-existing condition; and
- the carcinoma in situ is not excluded by name or specific description in the certificate.

We will pay the percentage of the covered person's face amount as shown above. We will pay no more than 25% of the Face Amount per covered person per lifetime.

We will not pay the Diagnosis of Carcinoma In Situ Benefit for any carcinoma in situ diagnosed during the 12 months following the coverage effective date if the carcinoma in situ is a pre-existing condition.

Carcinoma in situ must be diagnosed by either pathological diagnosis or clinical diagnosis. In addition to the pathological or clinical diagnosis required, we may require additional information from the attending doctor and hospital.

If a covered person has been diagnosed with and received a benefit for cancer (internal or invasive) and is subsequently diagnosed with carcinoma in situ, we will pay the Diagnosis of Carcinoma In Situ Benefit for the covered person as shown above, up to the Maximum Benefit Amount for a Diagnosis of Carcinoma In Situ Benefit and subject to the provisions of the certificate, if the date of diagnosis of the carcinoma in situ is more than 180 days after the date of diagnosis for the cancer (internal or invasive).

Cancer Treatment and Care Benefit $500 per covered person, per calendar month
Maximum Benefit Amount for a Cancer Treatment and Care Benefit: 12 monthly payments per covered person per lifetime.
We will pay benefits for Cancer Treatment and Care if:
- a covered person receives a covered treatment for cancer (internal or invasive) or carcinoma in situ while the certificate is in force;
- a covered person receives a covered treatment for cancer (internal or invasive) or carcinoma in situ within the United States;
- the cancer (internal or invasive) or carcinoma in situ is not excluded by name or specific description in the certificate; and

- the covered treatment is not excluded by name or specific description in the certificate.

We will pay the amount shown above for each calendar month during which a covered person incurs charges for and receives one or more of the covered treatments listed below as a result of cancer (internal or invasive) or carcinoma in situ, up to the Maximum Benefit Amount for Cancer Treatment and Care Benefit as shown above.

We will pay no more than one Cancer Treatment and Care Benefit per calendar month per covered person.

Covered Treatments consist of the following:

- Chemotherapy, consisting of one or more of the following:
  - chemotherapy treatments injected by medical personnel in a doctor's office, clinic or hospital;
  - a prescription filled for oral chemotherapy;
  - a prescription filled for topical chemotherapy;
  - a pump for chemotherapy initially filled or refilled;
  - a prescription filled for chemotherapy to be injected by yourself or anyone other than personnel in a doctor's office, clinic or hospital; or
  - a prescription filled for supportive and protective care drugs and colony stimulating factors.
- Radiation delivered by medical personnel in a doctor's office, clinic or hospital.
- Confinement to a bed as a resident inpatient in a hospital (including intensive care) on the advice of a doctor or confinement in an observation unit within a hospital for a period of no less than 20 continuous hours on the advice of a doctor.
- Surgery performed by a doctor in a hospital or ambulatory surgical center.
- Hospice Care, consisting of one or more of the following services received by a covered person for whom a doctor determines that cancer treatments are no longer of benefit and that he is expected to live for only six months or less:
  - a visit from a representative of a hospice care team at home;
  - the services of a hospital on an outpatient basis under the direction of a hospice;
  - a visit to a hospice on an outpatient basis for treatment or services; and
  - confinement to a hospice care facility.

If the covered person's cancer (internal or invasive) or carcinoma in situ is a pre-existing condition, coverage for that cancer (internal or invasive) or carcinoma in situ will apply only to treatment of cancer (internal or invasive) or carcinoma in situ commencing after the certificate has been in force for 12 months, unless the cancer (internal or invasive) or carcinoma in situ is excluded by name or specific description in the certificate. In the alternative, you may elect to void the certificate and receive a full refund of premium.

Unrelated Cancer Diagnosis
Benefits will be provided for an unrelated cancer diagnosed after the effective date of this certificate.

Cancer Vaccine Benefit **$50 per covered person, per lifetime**
We will pay this benefit if a covered person incurs a charge for and receives any cancer vaccine that is FDA approved for the prevention of cancer. The vaccine must be administered by licensed medical personnel while coverage under the certificate is in force. We will pay the amount shown above. This benefit is limited to one payment per covered person, per lifetime.

Benefit Reduction
The Face Amount(s) and the Maximum Benefit Amount for a Diagnosis of Cancer Benefit and the Maximum Benefit Amount for a Diagnosis of Carcinoma In Situ will reduce by 50% on the policy anniversary date after the named insured attains age 75. All Diagnosis of Cancer Benefits and Diagnosis of Carcinoma In Situ Benefits payable after that date will be based on the reduced Face Amount and the reduced Maximum Benefit Amount.

Health Screening Benefit **$100 per covered person, per calendar year**
We will pay this benefit if any covered person incurs charges for and has one of the health screening tests listed below performed while the certificate is in force. We will pay the amount shown above for one of the following screening tests:

Stress test on a bicycle or treadmill	Skin cancer biopsy	Hemoccult stool analysis
Fasting blood glucose test	Breast ultrasound	Mammography
Blood test for triglycerides	CA 15-3 (blood test for breast cancer)	Pap smear
Serum Cholesterol test to determine level of HDL and LDL	CA 125 (blood test for ovarian cancer)	PSA (blood test for prostate cancer)
Bone marrow testing	CEA (blood test for colon cancer)	Serum protein electrophoresis(blood test for myeloma)
Carotid Doppler	Chest x-ray	Thermography
Electrocardiogram (EKG, ECG)	Colonoscopy	ThinPrep pap test
Echocardiogram (ECHO)	Flexible sigmoidoscopy	Virtual colonoscopy

We will pay a maximum of one Health Screening Benefit per covered person per calendar year.

EXCLUSIONS AND LIMITATIONS FOR SPECIFIED DISEASE

We will not pay benefits for a specified disease that occurs as a result of a covered person's:

- Addiction to alcohol or drugs, except for drugs taken as prescribed by his doctor.
- Committing or attempting to commit a felony or engaging in an illegal occupation.
- Being intoxicated or under the influence of any narcotic unless administered on the advice of his doctor.
- Having a psychiatric or psychological condition, including but not limited to affective disorders, neuroses, anxiety, stress and adjustment reactions. However, Alzheimer's Disease and other organic senile dementias are covered under this certificate.
- Committing or trying to commit suicide or his injuring himself intentionally, whether he is sane or not.
- Being exposed to war or any act of war, declared or undeclared, or serving in the armed forces of any country or authority.

Pre-Existing Condition Limitation

We will not pay the Specified Disease Benefit or Benefits Payable Upon Subsequent Diagnosis of a Specified Disease for any covered person when the specified disease is a pre-existing condition as defined in the certificate, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is diagnosed with a specified disease. If a covered person is 65 or older when this certificate is issued, the pre-existing conditions for that covered person will include only conditions specifically eliminated by rider.

EXCLUSIONS AND LIMITATIONS FOR CANCER

We will not pay the Diagnosis of Cancer Benefit, Diagnosis of Carcinoma In Situ Benefit , the Cancer Treatment and Care Benefit or the Skin Cancer Benefit for a covered person's cancer (internal or invasive), carcinoma in situ or skin cancer that:

Pre-Existing Condition Limitation

Is a pre-existing condition, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is initially diagnosed as having cancer (internal or invasive), carcinoma in situ or skin cancer. No Pre-existing Condition Limitation will be applied for dependent children who are born or adopted while you are covered under the policy, and who are continuously covered from the date of birth or adoption. If a covered person is 65 or older when this certificate is issued, the pre-existing conditions for that covered person will include only conditions specifically eliminated by rider.

Geographical Limitation

Is diagnosed or treated outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico.

TERMINATION

The policy can be cancelled by the policyholder or us. Your coverage will terminate if the policy terminates, if your premium is not paid, if you are no longer in an eligible class, your class is no longer included for insurance, or if you ask us to end your coverage.

For named insured and spouse or named insured, spouse and dependents coverage, coverage on your spouse will terminate on the earliest of the following dates: the date your coverage under the policy terminates, the required premium for your spouse is not paid, if you ask us to end your spouse's coverage, if you die, or if you divorce your spouse or your marriage is annulled.

For named insured and dependents or named insured, spouse and dependents coverage, the dependent children's coverage will terminate on the earliest of the following dates: the date your coverage under the policy terminates, the required premium for your

dependent children is not paid, if you ask us to end your dependent children's coverage, or if you die. Coverage will end on each child when he no longer qualifies as a dependent child as defined in the certificate.

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COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

FIRST DIAGNOSIS BUILDING BENEFIT RIDER TO GROUP INSURANCE CERTIFICATE

RIDER SCHEDULE

Policyholder: Alamance Community College Fbp

Group Policy Number: G0022235

Named Insured: John A. Doe

Certificate Number: 9999999999

Coverage Type: Two-Parent Family

Rider Effective Date: January 1, 2016

Rider Year: 01/01 - 12/30 of each year this rider is in effect

3SN1G0022235000285

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
1200 Colonial Life Boulevard, P. O. Box 1365, Columbia, South Carolina 29202
1.800.325.4368 coloniallife.com
A Stock Company

FIRST DIAGNOSIS BUILDING BENEFIT RIDER

THIS IS A LIMITED RIDER - READ IT CAREFULLY.

THIS RIDER IS NOT ATTACHED TO A MEDICARE SUPPLEMENT POLICY.
If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from us.

All terms, definitions of terms, conditions, exclusions and limitations stated in the certificate will also apply to this rider unless we state otherwise in this rider.

Coverage Provided by This Rider
We provide the benefit stated in this rider as a part of the certificate to which it is attached for the person(s) shown on the Rider Schedule, subject to any limitations in the rider or the certificate.

First Diagnosis Building Benefit
Amount for Named Insured: $ for each rider year this rider is in force after the rider effective date, up to a maximum of 10 rider years

Amount for Spouse: $ for each year coverage for the spouse under this rider is in force, up to a maximum of 10 years

Amount for Dependent Children: $ for each year coverage for the dependent children under this rider is in force, up to a maximum of 10 years

We will pay the First Diagnosis Building Benefit if a covered person is diagnosed with a specified disease (other than or cancer (internal or invasive), as defined in the Certificate to which this rider is attached, and:

- the date of diagnosis is while this rider is in force;
- for a date of diagnosis during the 12 months following the rider effective date, the specified disease or cancer (internal or invasive) is not a pre-existing condition; and
- the specified disease or cancer (internal or invasive) is not excluded by name or specific description in the certificate.

We will pay the First Diagnosis Building Benefit amount for the covered person, as shown above, for each rider year this rider has been in force after the rider effective date and before the covered person's diagnosis is made, up to a maximum of 10 rider years or, in case of spouse or dependent children, each year coverage for the spouse or dependent children under this rider is in force and before the covered person's diagnosis is made, up to a maximum of 10 years . **Rider Year** means the period shown on the Rider Schedule. **Year** means 12 calendar months. In the event the covered person's diagnosis occurs before the end of the first rider year following the rider effective date, the First Diagnosis Building Benefit amount for that covered person will be $500 if the covered person is the named insured and $250 if the covered person is the named insured's covered spouse or dependent child, if applicable.

We will pay this benefit only once for each covered person insured by this rider.

We will not pay this benefit for skin cancer or carcinoma in situ, as defined in the Certificate to which the rider is attached, or any specified disease or cancer (internal or invasive) diagnosed during the 12 months following the rider effective date if the specified disease or cancer (internal or invasive) is a pre-existing condition.

Termination of the Named Insured's Coverage
The coverage on a named insured under this rider will terminate on the earliest of the following dates:

- the date coverage terminates under the certificate to which this rider is attached; or

- the end of the grace period following the premium due date we fail to receive the required premium for the named insured; or
- the date the next premium is due after the named insured asks us to end his coverage.

We will provide coverage for a claim for which we are liable under the terms of this rider if the loss occurs while you are covered.

When Coverage Ends on Your Spouse and Dependent Children

If this is a named insured and spouse coverage or two-parent family coverage, coverage on your spouse will end on the earliest of the following dates:

- the date your coverage under the certificate terminates; or
- the end of the grace period following the premium due date we fail to receive the required premium for your spouse; or
- the date the next premium is due after you ask us to end your spouse's coverage; or
- the date you die; or
- the date the next premium is due after you divorce your spouse or your marriage is annulled.

If this is a one-parent family or two-parent family coverage, coverage on your dependent children will end on the earliest of the following dates:

- the date your coverage under the certificate terminates; or
- the end of the grace period following the premium due date we fail to receive the required premium for your dependent children; or
- the date the next premium is due after you ask us to end your dependent children's coverage; or
- the date you die.

Coverage will end on each child when he no longer qualifies as a dependent child as defined in the certificate to which this rider is attached. A dependent child who reaches age 26 may remain covered if that child is and continues to be mentally or physically handicapped and is dependent on you for support and maintenance. You must submit satisfactory proof of incapacity and dependency to us within 31 days of the termination date and subsequently as we may require, but not more frequently than annually following the termination date. We will continue to charge any appropriate premium for that child as long as he meets the definition of a dependent child. It is your responsibility to notify us if any dependent child no longer qualifies as an eligible dependent. If this is one-parent family or two-parent family coverage and all of your dependent children no longer qualify as eligible dependents and you do not notify us, the extent of our liability will be to refund premium paid for the time period for which they did not qualify.

We will provide coverage for a claim for which we are liable under the terms of this rider if the loss occurs while your spouse and/or dependent child is covered.

Secretary

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COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

1200 Colonial Life Boulevard, P. O. Box 1365, Columbia, South Carolina 29202
1.800.325.4368 coloniallife.com
A Stock Company

FIRST DIAGNOSIS BUILDING BENEFIT RIDER
OUTLINE OF COVERAGE
(Applicable to Rider Form R-GGC1.0-BB-GR-NC)

THE RIDER IS NOT ATTACHED TO A MEDICARE SUPPLEMENT POLICY.
If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

Read your rider carefully. This outline provides a very brief description of the important features of your rider. This is not an insurance contract and only the actual policy and rider provisions will control. The policy and rider set forth in detail the rights and obligations of both you and us. It is, therefore, important that you READ YOUR RIDER CAREFULLY.

Coverage Provided by the Rider. Your rider is designed to provide coverage ONLY for specified diseases, subject to any limitations in your rider. The rider does not provide coverage for basic hospital, basic medical-surgical or major medical expenses.

First Diagnosis Building Benefit Rider
Amount: $ for each rider year the rider is in force after the rider effective date, up to a maximum of 10 rider years

Amount for Spouse: $ for each year coverage for the spouse under the rider is in force, up to a maximum of 10 years

Amount for Dependent Children: $ for each year coverage for the dependent children under the rider is in force, up to a maximum of 10 years

We will pay the First Diagnosis Building Benefit if a covered person is diagnosed with a specified disease (other than Coronary Artery Bypass Graft Surgery or cancer (internal or invasive), as defined in the Certificate to which the rider is attached, and:

- the date of diagnosis is while the rider is in force;
- for a date of diagnosis during the 12 months following the rider effective date, the is not a pre-existing condition; and
- the specified disease or cancer (internal or invasive) is not excluded by name or specific description in the certificate.

We will pay the First Diagnosis Building Benefit amount for the covered person, as shown above, for each rider year the rider has been in force after the rider effective date and before the covered person's diagnosis is made, up to a maximum of 10 rider years or in the case of spouse or dependent children, each year coverage for the spouse or dependent children under this rider is in force and before the covered person's diagnosis is made, up to a maximum of 10 years. **Rider Year** means the period shown on the Rider Schedule. **Year** means 12 calendar months. In the event the covered person's diagnosis occurs before the end of the first rider year following the rider effective date, the First Diagnosis Building Benefit amount for that covered person will be $500 if the covered person is the named insured and $250 if the covered person is the named insured's covered spouse or dependent child, if applicable.

We will pay this benefit only once for each covered person insured by the rider.

We will not pay this benefit for skin cancer or carcinoma in situ, as defined in the Certificate to which the rider is attached, or any diagnosed during the 12 months following the rider effective date if the is a pre-existing condition.

Cancer (internal or invasive) must be diagnosed by either pathological diagnosis or clinical diagnosis. In addition to the pathological or clinical diagnosis required, we may require additional information from the attending doctor and hospital.

Termination of the Named Insured's Coverage
The coverage on a named insured under the rider will terminate on the earliest of the following dates:

- the date coverage terminates under the certificate to which the rider is attached; or
- the end of the grace period following the premium due date we fail to receive the required premium for the named insured; or

- the date the next premium is due after the named insured asks us to end his coverage.

When Coverage Ends on Your Spouse and Dependent Children

If this is a named insured and spouse coverage or two-parent family coverage, coverage on your spouse will end on the earliest of the following dates:

- the date your coverage under the certificate terminates; or
- the end of the grace period following the premium due date we fail to receive the required premium for your spouse; or
- the date the next premium is due after you ask us to end your spouse's coverage; or
- the date you die; or
- the date the next premium is due after you divorce your spouse or your marriage is annulled.

If this is a one-parent family or two-parent family coverage, coverage on your dependent children will end on the earliest of the following dates:

- the date your coverage under the certificate terminates; or
- the end of the grace period following the premium due date we fail to receive the required premium for your dependent children; or
- the date the next premium is due after you ask us to end your dependent children's coverage; or
- the date you die.

Coverage will end on each child when he no longer qualifies as a dependent child as defined in the certificate to which the rider is attached.

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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 the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted *in the box* below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in 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 you to purchase 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 Services Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

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

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 the 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.
- a policy or contract commonly known as Medicare Part C or Part D or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

(1) The guaranty association cannot pay out more than what the insurance company would owe under the policy or contract.
(2) Except as provided in (3) (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.
(3) The guaranty association will pay a maximum of $500,000 with respect to basic hospital, medical and surgical insurance and major medical insurance.
(4) The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.
(5) The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.

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COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

1200 Colonial Life Boulevard, P.O. Box 1365, Columbia, South Carolina 29202
1-800-325-4368 www.coloniallife.com
A Stock Company

ENDORSEMENT

This endorsement is added to and made a part of the policy/certificate to which it is attached.

From time to time, Colonial Life & Accident Insurance Company ("Company") may offer or provide to persons who apply for coverage with the Company or become insureds/enrollees with the Company, or to their employers or membership organizations, certain consultative or administrative services incident to a comprehensive employee benefits program, including but not limited to, flexible spending account (Flex) administration services; Internal Revenue Code Section 125 cafeteria plan premium conversion services; benefits statements; access to human resources advisory websites; or other services or goods incident to a comprehensive employee benefits program. Such services or goods may be offered by the Company directly or through third-party vendors.

In addition, the Company may arrange for third-party health care providers, including but not limited to physicians, pharmacies, dentists, and optometrists, to furnish discounted goods or services to persons who apply for coverage with the Company or who become insureds/enrollees with the Company, or to their employers or membership organizations, as part of a comprehensive employee benefits program.

The Company may discontinue the furnishing of any or all of the above-referenced services, goods, or discounts at any time. In addition, any of said services, goods or discounts furnished through a third-party vendor or provider shall be the sole responsibility of such third-party vendor or provider. The Company shall not be liable for the furnishing of, or the failure to furnish, services, goods, or discounts arranged through a third-party vendor or provider.

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

Secretary

NOTICE REQUIRED BY NORTH CAROLINA INSURANCE LAW

WILLFUL FAILURE BY FIDUCIARY TO PAY GROUP INSURANCE PREMIUM

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 GROUP HEALTH PLAN PREMIUMS, SHALL:

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

2. WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THAT PERON'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 CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES.

VIOLATION OF THIS LAW IS A FELONY. ANY PERSON 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.