Aflac

Group Insurance Plans:
Critical Illness
Accident
Disability

We help take care of your expenses while you take care of yourself.

If you're interested in increasing your Critical Illness benefit amount, contact your benefits administrator.
Aflac can help ease the financial stress of surviving a critical illness.

Chances are you may know someone who’s been diagnosed with a critical illness. You can’t help but notice the strain it’s placed on the person’s life—both physically and emotionally. What’s not so obvious is the impact a critical illness may have on someone’s personal finances.

That’s because while a major medical plan may pay for a good portion of the costs associated with a critical illness, there are a lot of expenses that just aren’t covered. And, during recovery, having to worry about out-of-pocket expenses is the last thing anyone needs.

That’s the benefit of an Aflac group Critical Illness plan.

It can help with the treatment costs of covered critical illnesses, such as cancer, a heart attack, or a stroke.

More importantly, the plan helps you focus on recuperation instead of the distraction and stress over out-of-pocket costs. With the Critical Illness plan, you receive cash benefits directly (unless otherwise assigned)—giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses.

What you need, when you need it.

Group critical illness insurance pays cash benefits that you can use any way you see fit.
For more than 60 years, Aflac has been dedicated to helping provide individuals and families peace of mind and financial security when they’ve needed it most. The Aflac group Critical Illness plan is just another innovative way to help make sure you’re well protected under our wing.

But it doesn’t stop there. Having group Critical Illness insurance from Aflac means that you may have added financial resources to help with medical costs or ongoing living expenses.

The Aflac group Critical Illness plan benefits include:

- Critical Illness Benefit payable for:
  - Cancer
  - Heart Attack (Myocardial Infarction)
  - Stroke
  - Major Organ Transplant
  - End-Stage Renal Failure
  - Coronary Artery Bypass Surgery
  - Carcinoma In Situ
- Health Screening Benefit

Features:

- Benefits are paid directly to you unless otherwise assigned.
- Coverage is available for you, your spouse, and dependent children.
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire.
- Fast claims payment. Most claims are processed in about four days.

How it works

Aflac group Critical Illness coverage is selected.

You experience chest pains and numbness in the left arm.

You visit the emergency room.

A physician determines that you have had suffered a heart attack.

Aflac group Critical Illness pays a First Occurrence Benefit of $10,000.

Amount payable based on $10,000 First Occurrence Benefit.

The plan has limitations and exclusions that may affect benefits payable. This brochure is for illustrative purposes only. Refer to your certificate for complete details, definitions, limitations, and exclusions.

For more information, ask your insurance agent/producer, call 1.800.433.3036, or visit aflacgroupinsurance.com.
**Benefits Overview**

**COVERED CRITICAL ILLNESSES:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>CANCER (Internal or Invasive)</td>
<td>100%</td>
</tr>
<tr>
<td>HEART ATTACK (Myocardial Infarction)</td>
<td>100%</td>
</tr>
<tr>
<td>STROKE (Apoplexy or Cerebral Vascular Accident)</td>
<td>100%</td>
</tr>
<tr>
<td>MAJOR ORGAN TRANSPLANT</td>
<td>100%</td>
</tr>
<tr>
<td>END-STAGE RENAL FAILURE</td>
<td>100%</td>
</tr>
<tr>
<td>CARCINOMA IN SITU</td>
<td>25%</td>
</tr>
<tr>
<td>(Payment of this benefit will reduce your benefit for cancer by 25%.)</td>
<td></td>
</tr>
<tr>
<td>CORONARY ARTERY BYPASS SURGERY</td>
<td>25%</td>
</tr>
<tr>
<td>(Payment of this benefit will reduce your benefit for heart attack by 25%.)</td>
<td></td>
</tr>
</tbody>
</table>

**FIRST OCCURRENCE BENEFIT**

After the waiting period, an insured may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness; if the date of diagnosis is while coverage is in force, and the certificate does not exclude the illness or condition by name or by specific description. We will pay benefits for a critical illness in the order the events occur. We will deduct any previously-paid partial benefits from the appropriate critical illness benefit.

**SEPARATE DIAGNOSIS BENEFIT**

We will pay benefits for each different critical illness after the first when the following conditions are met: the two dates of diagnosis must be separated by at least 6 months, or if the insured is treatment-free from cancer for at least 6 months, and are not caused by or contributed to by a critical illness for which benefits have been paid.

**REOCCURRENCE BENEFIT**

Once benefits have been paid for a critical illness, we will pay additional benefits for that same critical illness when the dates of diagnosis are separated by at least 12 months, or the insured has been treatment-free from cancer for at least 12 months and is currently treatment-free.

Cancer that has metastasized (spread), even though there is a new tumor, is not considered an additional occurrence unless the insured has been treatment-free for 12 months and is currently treatment-free.

**CHILD COVERAGE AT NO ADDITIONAL COST**

Each dependent child is covered at 50 percent of the primary insured’s benefit amount at no additional charge.

**HEALTH SCREENING BENEFIT**

(Employee and Spouse only)

After the Waiting Period, we will pay $50 for health screening tests performed while an insured’s coverage is in force. We will pay this benefit once per calendar year.

This benefit is only payable for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for the covered employee and spouse. **This benefit is not paid for dependent children.**

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**COVERED HEALTH SCREENING TESTS INCLUDE:**

- Stress test on a bicycle or treadmill
- Fasting blood glucose test, blood test for triglycerides or serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast Cancer)
- CA 125 (blood test for ovarian Cancer)
- CEA (blood test for colon Cancer)
- Chest x-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate Cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Thermograph

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**WAIVER OF PREMIUM**

If a covered critical illness causes an insured to be totally disabled for 90 days, we will waive the premium payments for this coverage for the first 90 days of total disability and for each following day until the earliest of the following:

- The insured is no longer totally disabled,
- We have waived premiums for a total of 24 months of total disability,
- The insured reaches age 65 or is 2 years from the date of total disability, whichever occurs last, or
- Coverage ends according to the termination of coverage provision.

At the end of the waiver period, the insured must resume paying premiums to keep the coverage in force. Premiums waived include those for the employee and those for currently covered dependents or riders that are in force.

- For premiums to be waived, the insured must provide satisfactory proof of total disability at least once every 12 months.

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**ADDITIONAL COVERED SPECIFIED CRITICAL ILLNESSES**

<table>
<thead>
<tr>
<th>Illnesses Covered</th>
<th>Percentage of Maximum Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coma</td>
<td>100%</td>
</tr>
<tr>
<td>Paralysis</td>
<td>100%</td>
</tr>
<tr>
<td>Severe Burn</td>
<td>100%</td>
</tr>
<tr>
<td>Loss Sight</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of Hearing</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of Speech</td>
<td>100%</td>
</tr>
<tr>
<td>Benign Brain Tumor</td>
<td>100%</td>
</tr>
<tr>
<td>Advanced Alzheimer’s Disease</td>
<td>25%</td>
</tr>
<tr>
<td>Advanced Parkinson’s Disease</td>
<td>25%</td>
</tr>
</tbody>
</table>

**This benefit is paid based on your selected Critical Illness Benefit amount.**

We will pay the specified critical illness benefit if the insured is diagnosed with one of the specified critical illnesses shown in the rider schedule if the date of diagnosis is after the waiting period, the date of diagnosis occurs while the rider is in force, and the specified critical illness is not excluded by name or specific description in the rider. We will not pay benefits under the rider if these conditions result from another specified critical illness. For benefits to be payable on multiple specified critical illnesses, the date of loss for each illness must be separated by at least 12 months.
Introducing added protection for life’s unexpected moments.

If you’re like most people, you don’t budget for life’s unexpected moments.

But at some point, you may make an unexpected trip to your local emergency room. And that could add a set of unexpected bills into the mix.

That’s the benefit of the Aflac group Accident Advantage Plus plan.

In the event of a covered accident, the plan pays cash benefits fast to help with the costs associated with out-of-pocket expenses and bills—expenses major medical may not take care of, including:

- Ambulance rides.
- Wheelchairs, crutches, and other medical appliances.
- Emergency room visits.
- Surgery and anesthesia.
- Bandages, stitches, and casts.

What you need, when you need it.

Group accident insurance pays cash benefits that you can use any way you see fit.
For more than 60 years, Aflac has been dedicated to helping provide individuals and families peace of mind and financial security when they’ve needed it most. Our group Accident Advantage Plus plan is just another innovative way to help make sure you’re well protected under our wing.

But it doesn’t stop there. The group Accident Advantage Plus plan from Aflac means that your family has access to added financial resources to help with the cost of follow-up care as well.

The Aflac group Accident Advantage Plus plan benefits:

- A Wellness Benefit for covered preventive screenings
- Transportation and Lodging benefits
- An Emergency Room Treatment Benefit
- A Rehabilitation Unit Benefit
- Coverage for certain serious conditions, such as coma and paralysis
- An Accidental-Death Benefit
- A Dismemberment Benefit

Features:

- Coverage is guaranteed-issue (which means you may qualify for coverage without having to answer health questions).
- Benefits are paid directly to you unless otherwise assigned.
- Coverage is available for you, your spouse, and dependent children.
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire.
- Fast claims payment. Most claims are processed in about four business days.

How it works

The Aflac group Accident Advantage Plus High Plan pays:

$2,930

Amount payable was generated based on benefit amounts for: Closed-Reduction Leg Fracture ($2,400), Emergency Room Treatment ($200), one Follow-Up Treatment ($30), Ambulance ($200) and Appliance ($100)

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## HOSPITAL BENEFITS

<table>
<thead>
<tr>
<th><strong>HOSPITAL BENEFITS</strong></th>
<th><strong>EMPLOYEE</strong></th>
<th><strong>SPOUSE</strong></th>
<th><strong>CHILD</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HOSPITAL ADMISSION</strong></td>
<td>We will pay the amount shown, when because of a covered accident, you are injured, require hospital confinement, and are confined to a hospital at least overnight, even if it less than 24 hours within 6 months after the accident. We will pay this benefit once per calendar year. We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>HOSPITAL CONFINEMENT (per day)</strong></td>
<td>We will pay the amount shown when, because of a covered accident, you are injured and those injuries cause confinement to a hospital at least overnight, even if it less than 24 hours within 90 days after the accident. The maximum period for which you can collect the Hospital Confinement Benefit for the same injury is 365 days. This benefit is payable once per hospital confinement even if the confinement is caused by more than one accidental injury. We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.</td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td><strong>HOSPITAL INTENSIVE CARE (per day)</strong></td>
<td>We will pay the amount shown when, because of a covered accident, you are injured, and those injuries cause confinement to a hospital intensive care unit. This benefit is paid up to 30 days per covered accident. Benefits are paid in addition to the Hospital Confinement Benefit.</td>
<td>$400</td>
<td>$400</td>
</tr>
<tr>
<td><strong>MEDICAL FEES (for each accident)</strong></td>
<td>We will pay up to the amount shown for X-rays and doctor services when, because of a covered accident, you are injured and those injuries cause you to receive initial treatment from a doctor within 72 hours after the accident. If you do not exhaust the maximum benefit paid during the initial treatment, we will pay the remainder of this benefit for treatment received due to injuries from a covered accident and for each covered accident up to one year after the accident.</td>
<td>$125</td>
<td>$125</td>
</tr>
<tr>
<td><strong>PARALYSIS (lasting 90 days or more and diagnosed by a physician within 90 days)</strong></td>
<td>Quadruplegia</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td></td>
<td>Paraplegia</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
</tbody>
</table>

*Paralysis* means the permanent loss of movement of two or more limbs. We will pay the appropriate amount shown if, because of a covered accident, you are injured, the injury causes paralysis which lasts more than 90 days, and the paralysis is diagnosed by a doctor within 90 days after the accident.

The amount paid will be based on the number of limbs paralyzed. If this benefit is paid and you later die as a result of the same covered accident, we will pay the appropriate Death Benefit, less any amounts paid under the Paralysis Benefit.

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**Benefits Overview**

The plan has limitations and exclusions that may affect benefits payable.

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### ACCIDENTAL-DEATH AND -DISMEMBERMENT (within 90 days)

<table>
<thead>
<tr>
<th>&quot;accidental-death&quot;</th>
<th>Employee</th>
<th>Spouse</th>
<th>Child</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>accidental-death</strong></td>
<td>$50,000</td>
<td>$25,000</td>
<td>$5,000</td>
</tr>
<tr>
<td><strong>accidental common-carrier death</strong> (plane, train, boat, or ship)</td>
<td>$100,000</td>
<td>$50,000</td>
<td>$15,000</td>
</tr>
<tr>
<td><strong>single dismemberment</strong></td>
<td>$12,500</td>
<td>$5,000</td>
<td>$2,500</td>
</tr>
<tr>
<td><strong>double dismemberment</strong></td>
<td>$25,000</td>
<td>$10,000</td>
<td>$5,000</td>
</tr>
<tr>
<td><strong>loss of one or more fingers or toes</strong></td>
<td>$1,250</td>
<td>$500</td>
<td>$250</td>
</tr>
<tr>
<td><strong>partial amputation of fingers or toes</strong> (including at least one joint)</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
</tr>
</tbody>
</table>

If the Accidental Common-Carrier Death Benefit is paid, we will pay the Accidental-Death Benefit.

**Accidental-Death Benefit**
We will pay the amount shown if, because of a covered accident, you are injured, and the injury causes you to die within 90 days after the accident.

**Accidental Common-Carrier Death Benefit**
We will pay the amount shown if you are a fare-paying passenger on a common carrier, as defined below, are injured in a covered accident, and die within 90 days after the covered accident.

We will pay the Accidental-Death Benefit in addition to the Accidental Common-Carrier Death Benefit.

**Dismemberment Benefit**
We will pay the appropriate amount shown if, because of a covered accident, you are injured and lose a hand, a foot, or sight within 90 days after the accident as a result of the injury. If you lose one hand, one foot, or the sight of one eye in a covered accident, we will pay the single dismemberment benefit shown. If you lose both hands, both feet, the sight of both eyes, or a combination of any two, we will pay the double dismemberment benefit shown. If you lose one or more fingers or toes in a covered accident, we will pay the appropriate benefit shown.

If the Dismemberment Benefit is paid and you later die as a result of the same covered accident, we will pay the appropriate death benefit, less any amounts paid under this benefit.

### MAJOR INJURIES (diagnosis and treatment within 90 days)

<table>
<thead>
<tr>
<th>Fractures (closed reduction)</th>
<th>Employee</th>
<th>Spouse/Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip/Thigh</td>
<td>$4,000</td>
<td></td>
</tr>
<tr>
<td>Vertebrae (except processes)</td>
<td>$3,600</td>
<td></td>
</tr>
<tr>
<td>Pelvis</td>
<td>$3,200</td>
<td></td>
</tr>
<tr>
<td>Skull (depressed)</td>
<td>$3,000</td>
<td></td>
</tr>
<tr>
<td>Leg</td>
<td>$2,400</td>
<td></td>
</tr>
<tr>
<td>Forearm/Hand/Wrist</td>
<td>$2,000</td>
<td></td>
</tr>
<tr>
<td>Foot/Ankle/Kneecap</td>
<td>$2,000</td>
<td></td>
</tr>
<tr>
<td>Shoulder Blade/Collar Bone</td>
<td>$1,600</td>
<td></td>
</tr>
<tr>
<td>Lower Jaw (mandible)</td>
<td>$1,600</td>
<td></td>
</tr>
<tr>
<td>Skull (simple)</td>
<td>$1,400</td>
<td></td>
</tr>
<tr>
<td>Upper Arm/Upper Jaw</td>
<td>$1,400</td>
<td></td>
</tr>
<tr>
<td>Facial Bones (except teeth)</td>
<td>$1,200</td>
<td></td>
</tr>
<tr>
<td>Vertebral Processes</td>
<td>$800</td>
<td></td>
</tr>
<tr>
<td>Coccyx/Rib/Finger/Toe</td>
<td>$320</td>
<td></td>
</tr>
</tbody>
</table>

**Fracture** is a break in the bone that can be seen by X-ray. If a bone is fractured in a covered accident, we will pay the appropriate benefit shown.

**Multiple fractures** means having more than one fracture requiring open or closed reduction. If these fractures occur in any one covered accident, we will pay the appropriate benefits shown for each fracture, but no more than double the amount for the bone fractured that has the highest benefit amount.

**Chip fracture** means a piece of bone that is completely broken off near a joint. If a doctor diagnoses a chip fracture, we will pay 25% of the appropriate benefit shown.

*If a fracture requires open reduction, we will pay double the amount shown.

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**MAJOR INJURIES – continued**

<table>
<thead>
<tr>
<th>DISLOCATIONS  (closed reduction)</th>
<th>EMPLOYEE/ SPOUSE/CHILDREN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip</td>
<td>$3,000</td>
</tr>
<tr>
<td>Knee (not kneecap)</td>
<td>$1,950</td>
</tr>
<tr>
<td>Shoulder</td>
<td>$1,500</td>
</tr>
<tr>
<td>Foot/Ankle</td>
<td>$1,200</td>
</tr>
<tr>
<td>Hand</td>
<td>$1,050</td>
</tr>
<tr>
<td>Lower Jaw</td>
<td>$900</td>
</tr>
<tr>
<td>Wrist</td>
<td>$750</td>
</tr>
<tr>
<td>Elbow</td>
<td>$600</td>
</tr>
<tr>
<td>Finger/Toe</td>
<td>$240</td>
</tr>
</tbody>
</table>

**SPECIFIC INJURIES**

**RUPTURED DISC** (treatment within 60 days; surgical repair within one year)

- Injury occurring during first certificate year: $100
- Injury occurring after first certificate year: $400

**TENDONS/LIGAMENTS** (treatment within 60 days; surgical repair within 90 days)

- Multiple: $600
- Single: $400

If you tear, sever, or rupture a tendon or ligament in a covered accident, we will pay one benefit. We will pay the largest of the scheduled benefit amounts for tendons and ligaments repaired.

**TORN KNEE CARTILAGE** (treatment within 60 days; surgical repair within one year)

- Injury occurring during first certificate year: $100
- Injury occurring after first certificate year: $400

**EYE INJURIES**

- Treatment and surgical repair within 90 days: $250
- Removal of foreign body nonsurgically, with or without anesthesia: $50

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**Dislocation**

- Means a completely separated joint. If a doctor diagnoses and treats the dislocation within 90 days after the covered accident, we will pay the amount shown. If the dislocation requires open reduction, we will pay 200% of the appropriate amount shown.

**Multiple Dislocations**

- Means having more than one dislocation requiring either open or closed reduction. For each dislocation, we will pay the amounts shown. We will not pay more than 200% of the benefit amount for the dislocated joint that has the highest benefit amount.

**Partial dislocation**

- Means the joint is not completely separated. If a doctor diagnoses and treats the partial dislocation, we will pay 25% of the amount shown for the affected joint.

*If a dislocation requires open reduction, we will pay double the amount shown.*

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### SPECIFIC INJURIES

<table>
<thead>
<tr>
<th>Injury</th>
<th>Employee/Spouse/Children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CONCUSSION</strong></td>
<td></td>
</tr>
<tr>
<td>A concussion or mild traumatic brain injury (MTBI) is defined as a disruption of brain function resulting from a traumatic blow to the head.</td>
<td>$200</td>
</tr>
<tr>
<td><strong>COMA</strong></td>
<td></td>
</tr>
<tr>
<td>Coma means a state of profound unconsciousness caused by a covered accident. If you are in a coma lasting 30 days or more as the result of a covered accident, we will pay the benefit shown.</td>
<td>$10,000</td>
</tr>
<tr>
<td><strong>EMERGENCY DENTAL WORK</strong> (per accident; injury to sound, natural teeth)</td>
<td></td>
</tr>
<tr>
<td>Repaired with crown</td>
<td>$150</td>
</tr>
<tr>
<td>Resulting in extraction</td>
<td>$50</td>
</tr>
<tr>
<td><strong>BURNS</strong> (treatment within 72 hours and based on percentage of body surface burned)</td>
<td></td>
</tr>
<tr>
<td><strong>Second-Degree Burns</strong></td>
<td></td>
</tr>
<tr>
<td>Less than 10%</td>
<td>$100</td>
</tr>
<tr>
<td>At least 10%, but less than 25%</td>
<td>$200</td>
</tr>
<tr>
<td>At least 25%, but less than 35%</td>
<td>$500</td>
</tr>
<tr>
<td>35% or more</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Third-Degree Burns</strong></td>
<td></td>
</tr>
<tr>
<td>Less than 10%</td>
<td>$1,000</td>
</tr>
<tr>
<td>At least 10%, but less than 25%</td>
<td>$5,000</td>
</tr>
<tr>
<td>At least 25%, but less than 35%</td>
<td>$10,000</td>
</tr>
<tr>
<td>35% or more</td>
<td>$20,000</td>
</tr>
<tr>
<td>First-degree burns are not covered.</td>
<td></td>
</tr>
<tr>
<td><strong>LACERATIONS</strong> (treatment and repair within 72 hours)</td>
<td></td>
</tr>
<tr>
<td>Under 2&quot; long</td>
<td>$50</td>
</tr>
<tr>
<td>2&quot; to 6&quot; long</td>
<td>$200</td>
</tr>
<tr>
<td>Over 6&quot; long</td>
<td>$400</td>
</tr>
<tr>
<td>Lacerations not requiring stitches</td>
<td>$25</td>
</tr>
</tbody>
</table>

**Multiple Lacerations:** We will pay for the largest single laceration requiring stitches.

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<table>
<thead>
<tr>
<th>Benefits Overview</th>
<th>ADDITIONAL BENEFITS</th>
<th>EMPLOYEE/ SPOUSE/CHILDREN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EMERGENCY ROOM TREATMENT</strong></td>
<td>We will pay the amount shown for injuries received in a covered accident if you receive treatment in a hospital emergency room and receive initial treatment within 72 hours after the covered accident. This benefit is payable only once per 24-hour period and only once per covered accident.</td>
<td>$200</td>
</tr>
<tr>
<td></td>
<td>We will not pay the Emergency Room Treatment Benefit and the Medical Fees Benefit for the same covered accident. We will pay the highest eligible benefit amount.</td>
<td></td>
</tr>
<tr>
<td><strong>EMERGENCY ROOM OBSERVATION</strong></td>
<td>We will pay the amount shown for injuries received in a covered accident if you receive treatment in a hospital emergency room, are held in a hospital for observation for at least 24 hours, and receive initial treatment within 72 hours after the accident.</td>
<td>$100</td>
</tr>
<tr>
<td></td>
<td>This benefit is payable only once per 24-hour period and only once per covered accident. This benefit is payable in addition to Emergency Room Treatment Benefit.</td>
<td></td>
</tr>
<tr>
<td><strong>MAJOR DIAGNOSTIC TESTING</strong></td>
<td>We will pay the amount shown if, because of injuries sustained in a covered accident, you require one of the following exams, and a charge is incurred: computerized tomography (CT scan); computerized axial tomography (CAT); magnetic resonance imaging (MRI); electroencephalography (EEG).</td>
<td>$200</td>
</tr>
<tr>
<td></td>
<td>These exams must be performed in a hospital or a doctor’s office. This benefit is limited to one payment per covered accident.</td>
<td></td>
</tr>
<tr>
<td><strong>POST TRAUMATIC STRESS DISORDER DIAGNOSIS</strong></td>
<td>Post-traumatic Stress Disorder (PTSD) is a mental health condition triggered by a covered accident.</td>
<td>$200</td>
</tr>
<tr>
<td></td>
<td>We will pay the amount shown if you are diagnosed with post-traumatic stress disorder. You must meet the diagnostic criteria for PTSD, stipulated in the Diagnostic and Statistical Manual of Mental disorders IV (DSM IV-TR), and be under the active care of either a psychiatrist or Ph.D.-level psychologist.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>This benefit is payable only once per covered accident.</td>
<td></td>
</tr>
<tr>
<td><strong>AMBULANCE/AIR AMBULANCE</strong></td>
<td>If you require transportation to a hospital by a professional ambulance or air ambulance service within 90 days after a covered accident, we will pay the amount shown.</td>
<td>$200 ambulance $1,000 air ambulance</td>
</tr>
<tr>
<td><strong>BLOOD/PLASMA</strong></td>
<td>If you are injured, and receive blood or plasma within 90 days after the covered accident, we will pay the benefit shown.</td>
<td>$100</td>
</tr>
<tr>
<td><strong>APPLIANCES</strong></td>
<td>If a doctor advises you to use a medical appliance, we will pay the benefit shown. <em>Medical appliance</em> means crutches, wheelchairs, leg braces, back braces, and walkers.</td>
<td>$100</td>
</tr>
<tr>
<td><strong>INTERNAL INJURIES</strong> (resulting in open abdominal or thoracic surgery)</td>
<td>We will pay the amount shown if a covered accident causes you internal injuries which require open abdominal or thoracic surgery.</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>ACCIDENT FOLLOW-UP TREATMENT</strong></td>
<td>We will pay this benefit for up to six treatments (one per day) per covered accident, per insured for follow-up treatment. You must have received initial treatment within 72 hours of the accident, and the follow-up treatment must begin within 30 days of the covered accident or discharge from the hospital. This benefit is not payable for the same visit that the Physical Therapy Benefit is paid.</td>
<td>$30</td>
</tr>
</tbody>
</table>

The plan has limitations and exclusions that may affect benefits payable.
This brochure is for illustrative purposes only. Refer to your certificate for complete details, definitions, limitations, and exclusions.
## ADDITIONAL BENEFITS

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Covered for Employee/Spouse/Children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EXPLORATORY SURGERY WITHOUT REPAIR</strong> (i.e., arthroscopy)</td>
<td>$250</td>
</tr>
<tr>
<td>We will pay the amount shown if a covered accident causes you internal injuries which require open abdominal or thoracic surgery.</td>
<td></td>
</tr>
<tr>
<td><strong>WELLNESS BENEFIT</strong> (per 12-month period)</td>
<td>$50</td>
</tr>
<tr>
<td>After 12 months of paid premium and while coverage is in force, we will pay this benefit for preventive testing once each 12-month period. Benefits include and are payable (for each covered person) for annual physical exams, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, PSA tests, ultrasounds, and blood screenings.</td>
<td></td>
</tr>
<tr>
<td><strong>PROSTHESIS</strong></td>
<td>$500</td>
</tr>
<tr>
<td>We will pay this benefit if you require the use of a prosthetic device due to injuries received in a covered accident. We will pay this benefit for each prosthetic device you use. Hearing aids, wigs, dental aids, and false teeth are not covered.</td>
<td></td>
</tr>
<tr>
<td><strong>PHYSICAL THERAPY</strong></td>
<td>$30</td>
</tr>
<tr>
<td>We will pay this benefit for up to six doctor-prescribed physical therapy treatments per covered accident. You must have received initial treatment within 72 hours of the covered accident. The physical therapy treatment must begin within 30 days after the covered accident or discharge from the hospital and must take place within six months of the covered accident. This benefit is not payable for the same visit that the Accident Follow-Up Treatment Benefit is paid.</td>
<td></td>
</tr>
<tr>
<td><strong>TRANSPORTATION</strong></td>
<td>$300 (train/plane) $150 (bus)</td>
</tr>
<tr>
<td>We will pay this benefit if a doctor-recommended hospital treatment or diagnostic study is not available in your resident city. Transportation must begin within 90 days from the date of the covered accident. The distance to the hospital must be greater than 50 miles from your residence.</td>
<td></td>
</tr>
<tr>
<td><strong>FAMILY LODGING BENEFIT</strong> (per night)</td>
<td>$100</td>
</tr>
<tr>
<td>We will pay this benefit for each night’s lodging, up to 30 days, for an adult immediate family member’s lodging if you are required to travel more than 100 miles from your resident home due to confinement in a hospital for treatment of an injury from a covered accident. This benefit is only payable while you remain confined to the hospital, and treatment must be prescribed by your local doctor.</td>
<td></td>
</tr>
<tr>
<td><strong>REHABILITATION UNIT BENEFIT</strong> (per 12-month period)</td>
<td>$75</td>
</tr>
<tr>
<td>We will pay the amount shown for injuries received in a covered accident if you are admitted for a hospital confinement, transferred to a bed in a rehabilitation unit of a hospital, and incur a charge. This benefit is limited to 30 days per period of hospital confinement. This benefit is also limited to a calendar year maximum of 60 days. We will not pay the Rehabilitation Unit Benefit for the same days that the Hospital Confinement Benefit is paid. We will pay the highest eligible benefit.</td>
<td></td>
</tr>
</tbody>
</table>
Aflac can help you protect one of your most important assets. Your income.

All too often when we hear the words disability and insurance together, it conjures up an image of a catastrophic condition that has left an individual in an incapacitated state. Be it an accident or a sickness, that’s the stereotype of a disabling injury that most of us have come to expect.

What most of us don’t realize is that in addition to accidental injuries, conditions such as arthritis, heart disease, diabetes, and even pregnancy are some of the leading causes of disability that can keep you out of work and affect your income.

That’s where Aflac group disability insurance can help.

Our Aflac group disability plan can help protect your income by offering disability benefits to help you make ends meet when you are out of work. Our plan was created with you in mind and includes:

- Off-job only coverage.
- Benefits that help you maintain your standard of living.

What you need, when you need it.

Group disability insurance pays cash benefits that you can use any way you see fit.
Here's why the Aflac group disability plan is right for you.

For more than 60 years, Aflac has been dedicated to helping provide individuals and families peace of mind and financial security when they've needed it most. Our group disability plan is just another innovative way to help make sure you're well protected under our wing.

But it doesn't stop there, having group short-term disability insurance from Aflac means that you will have added financial resources to help with medical costs or ongoing living expenses such as rent, mortgage or car payments.

The Aflac group disability plan benefits:

- Benefits are paid when you are sick or hurt and unable to work, up to 60 percent of your salary (up to 40% in states with state disability).
- Minimum and Maximum Total Monthly Benefit – $300 to $6,000.
- Premium payments are waived after 90 days of total disability (not available on 3 month benefit period).
- Partial Disability Benefit.

Features:

- Benefits are paid directly to you unless otherwise assigned.
- Payroll Deduction – Premiums are paid through convenient payroll deduction.
- Fast claims payment. Most claims are processed in about four days.

How it works

- The certificate holder hurts his back helping his friend move over the weekend.
- The certificateholder visits the doctor.
- A physician determines the certificateholder will be out of work for 1 month while recovering.
- Aflac Group Disability Plan pays the certificate holder 60% of his salary for the length of disability after the elimination period.

Benefits Overview

TOTAL DISABILITY
This convenient, affordable disability income plan will help provide needed income if you become Totally Disabled and are unable to work due to a covered injury or illness. Total disability benefits will be payable monthly once the elimination period has been satisfied.

PARTIAL DISABILITY
The Partial Disability Benefit helps you transition back into full-time work after suffering a disability. If you remain partially disabled and are only able to work earning less than 80 percent of your pre-disability income at any job, this plan will still pay you 50 percent of your selected monthly benefit for up to the maximum partial disability benefit period of 3 months after the elimination period. You do not have to have received the Total Disability benefit to receive the Partial Disability benefit.

WAIVER OF PREMIUM
Premiums are waived after 90 days of Total Disability. After Total Disability benefits end, any premiums which become due must be paid in order to keep your insurance in force. This benefit is not available on plans with a 3-month benefit period.
### AFLAC GROUP CRITICAL ILLNESS

- Current certificateholders use the Buy Up rates when adding additional coverage. If you’re interested in increasing your Critical Illness benefit amount, contact your benefits administrator.

<table>
<thead>
<tr>
<th>AGES</th>
<th>$5,000</th>
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### AFLAC GROUP ACCIDENT

#### Bi-Weekly Rates

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<th>Coverage</th>
<th>Premium</th>
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<tr>
<td>Employee</td>
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<tr>
<td>Employee &amp; Spouse</td>
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<td>Family</td>
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### AFLAC GROUP DISABILITY

<table>
<thead>
<tr>
<th>Age</th>
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<tr>
<td>50-64</td>
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<td>65-74</td>
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Rates per $100 of Monthly Benefit - Weekly (52pp/yr) Premium.
# AFLAC GROUP DISABILITY

<table>
<thead>
<tr>
<th>AGES</th>
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<th>$15,000</th>
<th>$20,000</th>
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<td>$2,461.80</td>
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# AFLAC GROUP CRITICAL ILLNESS

<table>
<thead>
<tr>
<th>Age</th>
<th>Annual Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-49</td>
<td>$30.36</td>
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<td>50-64</td>
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</tr>
<tr>
<td>65-74</td>
<td>$38.40</td>
</tr>
</tbody>
</table>

Contact Information

City and Borough of Juneau  
Natasha Peterson  
Natasha_Peterson@ci.juneau.ak.us  
907.586.0321-CBJ Phone  
907.796.8419-BRH Phone

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# AFLAC GROUP ACCIDENT

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Annual Premium</th>
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</thead>
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<td>Family</td>
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AFLAC GROUP DISABILITY

<table>
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<tr>
<th>Age</th>
<th>Annual Premium</th>
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<tbody>
<tr>
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<td>$38.40</td>
</tr>
</tbody>
</table>

Rates per $100 of Monthly Benefit - Weekly (52pp/yr) Premium.
CRITICAL ILLNESS INSURANCE LIMITATIONS AND EXCLUSIONS

This plan contains a 30-day waiting period. This means that we will not pay benefits to an insured who has been diagnosed or had a health screening test performed before his coverage has been in force 30 days from the effective date. If a critical illness is first diagnosed during the waiting period, we will only pay benefits for loss beginning after coverage has been in force for 12 months. Or, the insured may elect to void the certificate from the beginning and receive a full premium refund.

The applicable benefit amount will be paid if the date of diagnosis occurs after the waiting period; the date of diagnosis occurs while the insured’s coverage is in force; and the cause of the illness is not excluded by name or specific description.

Pre-existing Condition is a sickness or physical condition that existed within the 12-month period before the insured’s effective date. For this pre-existing condition, a medical professional must have advised, diagnosed, or treated the insured.

We will not pay benefits for any critical illness resulting from or affected by a pre-existing condition if the critical illness was diagnosed within the 12-month period after the insured’s effective date.

We will not reduce or deny a claim for benefits for any critical illness that was diagnosed more than 12 months after the insured’s effective date.

Cancer (internal or invasive) is defined as an illness meeting either of the following definitions:

- A malignant tumor characterized by:
  - The uncontrolled growth and spread of malignant cells
  - The invasion of distant tissue.
- A disease meeting the diagnosis criteria of malignancy, as established by the American Board of Pathology. The doctor must have studied the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen.

Cancer includes leukemia and melanoma.

The following are not internal or invasive cancers:

- Pre-malignant tumors or polyps
- Carcinoma in Situ
- Any skin cancers (except melanomas)
- Basal cell carcinoma and squamous cell carcinoma of the skin
- Melanoma that is diagnosed as:
  - Clark’s Level I or II or
  - Breslow less than .77mm

Carcinoma in Situ is non-invasive cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

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

1. Pathological Diagnosis is a diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This diagnosis must be made by a certified pathologist whose malignancy diagnosis conforms to the American Board of Pathology standards.

2. Clinical Diagnosis is based only on the study of symptoms. The company will accept a clinical diagnosis only if:

- A doctor cannot make a pathological diagnosis because it is medically inappropriate or life-threatening,
- Medical evidence exists to support the diagnosis, and
- A doctor is treating the insured for cancer or carcinoma in situ.

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

Critical Illness is a sickness or disease that first manifests while the insured’s coverage is in force and after any applicable waiting period. Any loss due to critical illness must begin while the insured’s coverage is in force. Critical illness includes only the following:

- Cancer
- Heart Attack due to coronary artery disease or acute coronary syndrome
- Stroke
  - Ischemic Stroke due to advanced arteriosclerosis of the arteries of the neck or brain
  - Hemorrhagic Stroke due to uncontrolled high blood pressure, malignant hypertension, brain aneurysm, or arteriovenous malformation
- Kidney Failure
- Major Organ Transplant

Date of Diagnosis is defined for each critical illness as follows:

- Cancer and/or Carcinoma in Situ: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or carcinoma in situ is based on such specimens). This includes the recurrence of a previously diagnosed cancer as long as the insured:
  - Is free from any signs or symptoms for a consecutive 12-month period before the date of diagnosis (for the
Heart Attack: The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the heart attack definition.

Ischemic or Hemorrhagic Stroke: The date the stroke occurs (based on documented neurological deficits and neuroimaging studies).

Kidney Failure: The date a doctor recommends that an insured begin renal dialysis.

Major Organ Transplant or Coronary Artery Bypass: The date the surgery occurs.

Dependent means the spouse of an employee or the dependent child of an employee.

Dependent Children are an employee’s or an employee’s spouse’s natural children, step-children, legally adopted children, or children placed for adoption who are younger than age 26.

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

There is an exception to the age-26 limit listed above. This limit will not apply to any child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. The employee or the employee’s spouse must furnish proof of this incapacity and dependency to the company within 31 days following the child’s 26th birthday.

Diagnosis (also Diagnosed) refers to the definitive and certain identification of an illness that:
- Is made by a doctor and
- Is based on clinical or laboratory investigations, as supported by the insured’s medical records.

The illness must meet the requirements outlined in this plan for the particular critical illness being diagnosed.

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

Doctor is defined as a person who is:
- Legally qualified to practice medicine,
- Licensed as a doctor by the state where treatment is received, and
- Licensed to treat the type of condition for which a claim is made.

A Doctor does not include the insured or the insured’s family member.

Employee is a person who meets eligibility requirements under Section I – Eligibility of the certificate, and who is covered under this plan. The employee is the primary insured under this plan.

Family Member includes the employee’s spouse (who is defined as an employee’s legal wife or husband) as well as the following members of the insured’s immediate family:
- son
- daughter
- mother
- father
- sister
- brother

This includes step-family members and family members-in-law.

Heart Attack (Myocardial Infarction) is the death of a portion of the heart muscle (myocardium) caused by a blockage of one or more coronary arteries due to coronary artery disease or acute coronary syndrome.

Heart Attack does not include:
- Any other disease or injury involving the cardiovascular system.
- Cardiac Arrest not caused by a myocardial infarction.

Diagnosis of a heart attack must include all of the following:
- New and serial electrocardiographic (EKG) findings consistent with myocardial infarction;
- Elevation of cardiac enzymes above generally accepted laboratory levels of normal (in the case of creatine physphokinase {CPK}, a CPK-MB measurement must be used); and
- Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms.

Kidney Failure (Renal Failure) refers to end-stage renal failure, which is the chronic, irreversible failure of both kidneys to function.

Kidney Failure is covered only if one of the following occurs:
- Regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) are necessary to treat the kidney failure;
- The kidney failure results in kidney transplantation.

The Company will not cover kidney failure caused by a traumatic event, including surgical trauma.

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

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

Pathologist is a doctor who is licensed:
- To practice medicine and
- By the American Board of Pathology to practice pathologic anatomy.

A pathologist also includes an osteopathic pathologist who is certified by the Osteopathic Board of Pathology. Pathologist does not include the insured or a family member.

Signs and/or Symptoms are the evidence of disease or physical disturbance observed by a doctor or other medical professional. The doctor (or other medical professional) must observe these signs while acting within the scope of his license.

Stroke means the death of a portion of the brain producing neurological sequelae, including infarction of brain tissue, hemorrhage, and embolization from an extra-cranial source. There must be evidence of permanent neurological deficit.

Stroke must be either:
Ischemic Stroke due to advanced arteriosclerosis of the arteries of the neck or brain, or
Hemorrhagic Stroke due to uncontrolled high blood pressure, malignant hypertension, brain aneurysm, or arteriovenous malformation.

Stroke does not include:
- Transient ischemic attacks (TIAs).
- Head injury.
- Chronic cerebrovascular insufficiency.
- Reversible ischemic neurological deficits.

Stroke will be covered only if the insured submits evidence of the permanent neurological damage by providing:
- Computed Axial Tomography (CAT scan) images or Magnetic Resonance Imaging (MRI).

Successor Insured means that if an employee dies while covered under a certificate, then his surviving spouse becomes the primary insured if that spouse is also insured under this plan. If the certificate does not cover a surviving spouse, the certificate will terminate on the next premium due date.

Total Disability or Totally Disabled means the insured is:
- Unable to work (defined later in this section),
- Not working at any job for pay or benefits, and
- Under the care of a doctor for the treatment of a covered critical illness.

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

Treatment-Free From Cancer refers to the period of time without the consultation, care, or services provided by a doctor. This includes receiving diagnostic measures and taking prescribed drugs and medicines. Treatment does not include maintenance drug therapy or routine follow-up visits to verify whether cancer or carcinoma in situ has returned.

Unable to Work means either:
- During the first 365 days of total disability, the insured is unable to work at the occupation he was performing when his total disability began; or
- After the first 365 days of total disability, the insured is unable to work at any gainful occupation for which he is suited by education, training, or experience.

Waiting Period is the number of days after the effective date before we will pay benefits for a critical illness. We will not pay benefits for a critical illness whose date of diagnosis begins during the waiting period.

ADDITIONAL SPECIFIED CRITICAL ILLNESS RIDER LIMITATIONS AND EXCLUSIONS

All limitations and exclusions that apply to the critical illness plan also apply to this rider unless amended by the rider. The waiting period and pre-existing condition limitation apply from the date of this rider is effective.

No benefits will be paid for loss which occurred prior to the effective date of the rider.

Benefits are not payable for loss if these conditions result from another specified critical illness.

Activities of Daily Living (ADLs) are activities used in measuring levels of personal functioning capacity. These activities are normally performed without assistance, allowing personal independence in everyday living.

For the purposes of this policy, ADLs include the following:
- Maintaining continence – controlling urination and bowel movements, including the ability to use ostomy supplies or other devices (such as catheters).
- Transferring – moving between a bed and a chair or a bed and a wheelchair.
- Dressing – putting on and taking off all necessary items of clothing.
- Toileting – getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene.
- Eating – performing all major tasks of getting food into the body.
- Bathing – washing oneself by sponge bath or in either a tub or shower, including getting into or out of the tub or shower.

Covered Accident means an unforeseen and unexpected traumatic event resulting in bodily injury. An event meets the qualifications of covered accident if it:
- Occurs on or after the plan’s effective date,
- Occurs while coverage is in force, and
- Is not specifically excluded.

Date of Diagnosis is defined for each specified critical illness as follows:
- Benign Brain Tumor: The date a doctor determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.
- Coma: The first day of the period for which a doctor confirms a coma has lasted for 7 consecutive days.
- Loss of Sight, Speech, or Hearing: The date the loss is objectively determined by a doctor to be total and irreversible.
- Paralysis: The date a doctor establishes the diagnosis of paralysis on clinical and/or laboratory findings as supported by medical records (based on the paralysis definition).
- Severe Burn: The date the burn takes place.
- Advanced Alzheimer’s Disease: The date a doctor diagnoses you as incapacitated due to Alzheimer’s disease.
- Advanced Parkinson’s Disease: The date a doctor diagnoses you
as incapacitated due to Parkinson’s disease.

**Specified Critical Illness** is one of the illnesses defined below and shown in the rider schedule:

**Advanced Alzheimer’s Disease** means Alzheimer’s Disease that causes the insured to be incapacitated. Alzheimer’s Disease is a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer’s Disease.

**To be incapacitated due to Alzheimer’s Disease,** the insured must:

- Exhibit the loss of intellectual capacity involving impairment of memory and judgment, resulting in a significant reduction in mental and social functioning, and
- Require substantial physical assistance from another adult to perform at least three ADLs.

**Advanced Parkinson’s Disease** means Parkinson’s Disease that causes the insured to be incapacitated. Parkinson’s Disease is a brain disorder that is diagnosed by a psychiatrist or neurologist as Parkinson’s Disease. To be incapacitated due to Parkinson’s Disease, the insured must:

- Exhibit at least two of the following clinical manifestations:
  - Muscle rigidity
  - Tremor
  - Bradykinesia (abnormal slowness of movement,
- Require substantial physical assistance from another adult to perform at least three ADLs.

**Benign Brain Tumor** is a mass or growth of abnormal, noncancerous cells in the brain. The tumor is composed of similar cells that do not follow normal cell division and growth patterns and develop into a mass of cells that microscopically do not have the characteristic appearance of a cancer.

**Coma** means a state of unconsciousness for 7 consecutive days with:

- No reaction to external stimuli,
- No reaction to internal needs, and

**Loss of Sight, Speech, or Hearing**

- Loss of Sight means the total and irreversible loss of all sight in both eyes.
- Loss of Speech means the total and permanent loss of the ability to speak.
- Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of hearing does not include hearing loss that can be corrected by the use of a hearing aid or device.

**Paralysis or Paralyzed** means the permanent, total, and irreversible loss of muscle function to the whole of at least two limbs as a result of a covered accident or disease. This must be supported by neurological evidence.

**Severe Burn or Severely Burned** means a burn resulting from fire, heat, caustics, electricity, or radiation. The burn must:

- Be a full-thickness or third-degree burn, as determined by a doctor. A Full-Thickness Burn or Third-Degree Burn is the destruction of the skin through the entire thickness or depth of the dermis (or possibly into underlying tissues). This results in loss of fluid and sometimes shock.
- Cause cosmetic disfigurement to the body’s surface area of at least 35 square inches.

**ACCIDENT INSURANCE LIMITATIONS AND EXCLUSIONS**

**WE WILL NOT PAY BENEFITS FOR INJURY, TOTAL DISABILITY, OR DEATH CONTRIBUTED TO, CAUSED BY, OR RESULTING FROM:**

- War – participating in war or any act of war, declared or not; participating in the armed forces of, or contracting with, any country or international authority. We will return the prorated premium for any period not covered by this certificate when you are in such service.
- Suicide – committing or attempting to commit suicide, while sane or insane.
- Sickness – having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness.
- Self-Inflicted Injuries – injuring or attempting to injure yourself intentionally.
- Racing – riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.
- Intoxication – being legally intoxicated, or being under the influence of any narcotic, unless taken under the direction of a doctor. Legally intoxicated means that condition as defined by the law of the jurisdiction in which the accident occurred.
- Illegal Acts – participating or attempting to participate in an illegal activity, or working at an illegal job.
- Sports – participating in any organized sport—professional or semi-professional.
- Cosmetic Surgery – having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of a covered accident.
- An injury arising from any employment.
- An injury or sickness covered by Worker’s Compensation.

**Terms You Need to Know**

**Accidental injury or injuries** means bodily injury or injuries resulting from an unforeseen and unexpected traumatic event that meets the definition of covered accident.

**Common carrier** means an airline carrier that is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports; a railroad train that is licensed and operated for passenger service only; or a boat or ship that is licensed for passenger service and operated on a regular schedule between established ports.

**Covered accident** means an unforeseen and unexpected traumatic event resulting in bodily injury. An event meets the qualifications of covered accident if it occurs on or after the plan’s effective date, occurs while coverage is in force, and is not specifically excluded.

**Dependent children** are your or your spouse’s natural children, step-children, legally adopted children, or children placed for adoption who are younger than age 26.

However, there is an exception to the age-26 limit listed above. This limit will not apply to any child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. You or your spouse must furnish proof of this incapacity and dependency to the company within 31 days following the child’s 26th birthday.
**Dismemberment** means: loss of a hand — The hand is removed at or above the wrist joint; loss of a foot — The foot is removed at or above the ankle; or loss of sight — At least 80% of the vision in one eye is lost (such loss of sight must be permanent and irrecoverable); or loss of a finger/toe — The finger or toe is removed at or above the joint where it is attached to the hand or foot.

**Doctor** is defined as a person who is a legally qualified to practice medicine, licensed as a physician by the state where treatment is received, and licensed to treat the type of condition for which a claim is made. A doctor does not include you or your family member.

**Employee** means a person who is actively at work with the master policyholder, engaged in full-time work, and is included in the class of employees eligible for coverage.

**Family member** includes your spouse (who is defined as your legal wife or husband) as well as the following members of your immediate family: son, daughter; mother; father; sister, or brother. This includes step-family members and family-members-in-law.

**Hospital** refers to a place that is legally licensed and operated as a hospital; provides overnight care of injured and sick people; is supervised by a doctor; has full-time nurses supervised by a registered nurse; has on-site or pre-arranged use of X-ray equipment, laboratory, and surgical facilities; and maintains permanent medical history records.

A hospital is not a nursing home; an extended-care facility; a convalescent home; a rest home or a home for the aged; a place for alcoholics or drug addicts; or a mental institution.

**Hospital Intensive Care Unit** refers to a specifically designed hospital facility that provides the highest level of medical care and is restricted to patients who are critically ill or injured. Hospital Intensive Care Units must be separate and apart from the surgical recovery room; separate and apart from rooms, beds, and wards customarily used for patient confinement; permanently equipped with special life-saving equipment to care for the critically ill or injured; and under constant and continuous observation by nursing staffs assigned to the Intensive Care Unit on an exclusive, full-time basis.

**Rehabilitation Unit** is a unit of a hospital providing coordinated multidisciplinary physical restorative services. These services must be provided to inpatients under a doctor’s direction. The doctor must be knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit specifically designated for this service.

**You** and **Your** refer to an employee as defined in the plan.

**We** refers to Continental American Insurance Company.

**Spouse** means your legal wife or husband. Coverage may only be issued to your spouse if your spouse is over 18.

**PORTABLE COVERAGE**

When coverage is effective and would otherwise terminate because you end employment with the employer, coverage may be continued. You may continue the coverage that is in force on the date employment ends, including dependent coverage that is in effect. You must apply to us in writing within 31 days after the date that the insurance would terminate. You may be allowed to continue the coverage until the earlier of the date you fail to pay the required premium, or the date the group master policy is terminated. Coverage may not be continued if you fail to pay any required premium or the group master policy terminates. Premium for portable coverage is paid directly by you.

**TERMINATION**

Your insurance will terminate on the date we terminate the plan, the 31st day after the premium due date, if the premium has not been paid, the date you no longer meet the plan’s definition of an employee, or the date you no longer belong to an eligible class.

If the master policy and/or certificate terminates, we will provide coverage for claims arising from covered accidents that occurred while the plan was in force.

**EFFECTIVE DATE**

The effective date for you, the employee, is as follows: (1) Your insurance will be effective on the date shown on the certificate schedule, provided you are then actively at work. (2) If you are not actively at work on the date coverage would otherwise become effective, the effective date of your coverage will be the date on which you are first thereafter actively at work.
weeks for noncearean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames due to Complications of Pregnancy.

**TERMS YOU NEED TO KNOW**

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

**Benefit Period** is the maximum number of days after the Elimination Period, if any, for which you can be paid benefits for any period of disability. Each new Benefit Period is subject to a new Elimination Period.

**Complications of Pregnancy refers to:**
Conditions requiring Medical Treatment that comes before or comes after the termination of a pregnancy. The diagnoses for this Medical Treatment must be distinct from pregnancy but either adversely affected by pregnancy or caused by pregnancy. For a condition to be a Complication of Pregnancy, it must constitute a classifiably distinct pregnancy complication. Examples of such Complications of Pregnancy are: 1. Acute nephritis; 2. Nephrosis; 3. Cardiac decompensation; 4. Missed abortion; 5. Disease of the vascular, hemopoietic, nervous, or endocrine systems; and 6. Similar medical and surgical conditions of comparable severity.

**Further Complications of Pregnancy include:**
1. Hyperemesis gravidarum and pre-eclampsia requiring hospital confinement; 2. Ectopic pregnancy that is terminated; and 3. Spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

**Complications of Pregnancy do not include the following conditions:**
1. Multiple gestation pregnancy; 2. false labor; 3. occasional spotting; and 4. morning sickness.

Other similar conditions associated with the management of a difficult pregnancy are not considered Complications of Pregnancy. Cesarean deliveries are not considered Complications of Pregnancy.

**Effective Date** is the date shown on the Certificate Schedule, provided you are actively at work, or if not, it is the date you are actively at work as an eligible employee.

**Elimination Period** is the number of continuous days at the beginning of your Period of Disability for which no benefits are payable. Each new Benefit Period is subject to a new Elimination Period.

**Injury** refers to a bodily injury not otherwise excluded that is directly caused by a covered accident, is not caused by Sickness, disease, bodily infirmity, or any other cause, and occurs while coverage is in force.

**Mental Illness** is defined as a Total Disability resulting from psychiatric or psychological conditions, regardless of cause. Mental Illnesses and Emotional Disorders includes but are not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, post-partum depression, personality disorders and adjustment disorders or other condition usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the above conditions.

**Partial Disability** refers to your being under the care and attendance of a Doctor due to a condition that causes your inability to perform the material and substantial duties of your Full-Time Job. To qualify as Partial Disability, you are able to work at any job earning less than 80 percent of the Annual Income of your Full-Time Job at the time you became disabled.

**Sickness** refers to a covered illness, disease, infection, or any other abnormal physical condition that is not caused by an Injury, first manifested and first treated after the Effective Date of coverage, and occurs while coverage is in force.

**Termination Coverage** will terminate on the earliest of: (1) the date the master policy is terminated, (2) the 31st day after the premium due date if the required premium has not been paid, (3) the date you cease to meet the definition of an employee as defined in the master policy, (4) the date you no longer belong to an eligible class, (5) age 75.

**Total Disability** refers to your being under the care and attendance of a Doctor due to a condition that causes your inability to perform the material and substantial duties of your Full-Time Job. To qualify as Total Disability, you may not be working at any job.

**You and Your** refers to an employee as defined in the Plan.

**NOTICES**

If this coverage will replace any existing individual policy, please be aware that it may be in your employees’ best interest to maintain their individual guaranteed-renewable policy.

**Notice to Consumer:** The coverages provided by Continental American Insurance Company (CAIC) represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. CAIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.
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