Aflac
Group Critical Illness

INSURANCE – PLAN INCLUDES BENEFITS FOR CANCER AND HEALTH SCREENING

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

Coverage is underwritten by Continental American Life Insurance Company.
The Aflac group Critical Illness plan is a supplement to health insurance. It is not a substitute for Hospital or Medical Expense Insurance, a Health Maintenance Organization (HMO) Contract, or Major Medical Expense Insurance.
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.

Understanding the facts can help you decide if the Aflac group Critical Illness plan makes sense for you.

FACT NO. 1
AN ESTIMATED 82.6 MILLION
AMERICAN ADULTS—GREATER THAN 1 IN 3—HAVE ONE OR MORE TYPES OF CARDIOVASCULAR DISEASE (CVD).¹

FACT NO. 2
MORE THAN $44 BILLION
IN EXPENSES MADE CORONARY ARTERY DISEASE THE MOST EXPENSIVE CONDITION TREATED IN 2004.²

¹²http://circ.ahajournals.org/content/125/1/e2.full
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 you choose otherwise.
- 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 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 Amount</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 (Payment of this benefit will reduce your benefit for cancer by 25%)</td>
<td>25%</td>
</tr>
<tr>
<td>CORONARY ARTERY BYPASS SURGERY (Payment of this benefit will reduce your benefit for heart attack by 25%)</td>
<td>25%</td>
</tr>
<tr>
<td>SKIN CANCER</td>
<td>10%</td>
</tr>
</tbody>
</table>

FIRST OCCURRENCE BENEFIT
After the waiting period, a lump sum benefit is payable upon initial diagnosis of a covered critical illness. Employee benefit amount available is $15,000. Spouse benefit amount available is $7,500, not to exceed one half of the employee’s amount.

ADDITIONAL OCCURRENCE BENEFIT
If you collect full benefits for a critical illness under the plan and later are diagnosed with one of the remaining covered critical illnesses, then we will pay the full benefit amount for each additional illness. Occurrences must be separated by at least six months.

REOCURRENCE BENEFIT
If you collect full benefits for a covered condition and are later diagnosed with the same condition, we will pay the full benefit again. The two dates of diagnosis must be separated by at least 12 months, or for cancer 12 months treatment-free. Cancer that has spread (metastasized), even though there is a new tumor, will not be considered an additional occurrence unless you have gone treatment-free for 12 months.

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.

MAMMOGRAPHY BENEFIT
After the waiting period, we will pay a $200 mammography benefit once per calendar year for mammography tests. This benefit is payable for a baseline mammogram for women age 35 to 39, inclusive; a mammogram for women age 40 to 49, inclusive, every two years or more frequently based on the women’s physician’s recommendations; or mammogram every year for women age 50 and over. Payment of this benefit will not reduce the face amount of the certificate.

HEALTH SCREENING BENEFIT
(Employee and Spouse only)
After the waiting period, you may receive a maximum of $50 for any one covered health screening test per calendar year. We will pay this benefit regardless of the results of the test. Payment of this benefit will not reduce the critical illness benefit payable under the plan. There is no limit to the number of years you can receive the Health Screening Benefit; it will be payable as long as coverage remains in force. This benefit is payable for the covered employee and spouse. **This benefit is not paid for dependent children.**

COVERED HEALTH SCREENING TESTS INCLUDE:

- Colonoscopy
- Cervical Cancer Screening
- Breast ultrasound
- Chest X-ray
- PSA (blood test for prostate cancer)
- Stress test on a bicycle or treadmill
- Bone marrow testing
- CA 15-3 (blood test for breast cancer)

- CEA (blood test for colon cancer)
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Serum protein electrophoresis (blood test for myeloma)
- Thermography
- Fasting blood glucose test
- Serum cholesterol test to determine level of HDL and LDL
- Blood test for triglycerides
ADDITIONAL BENEFITS RIDER

PARALYSIS

SEVERE BURNS

COMA

LOSS OF SPEECH / SIGHT / HEARING

HEART EVENT RIDER

OPEN HEART SURGERIES (Category I: Coronary Artery Bypass Surgery (CABS)*, Mitral Valve Replacement or Repair, Aortic Valve Replacement or Repair, Surgical Treatment of Abdominal Aortic Aneurysm). *Payment of this benefit will still reduce the benefit payable for Heart Attack by 25%.

INVASIVE HEART PROCEDURE (Category II: AngiJet Clot Busting, Balloon Angioplasty, Laser Angioplasty, Atherectomy, Stent Implantation, Cardiac Catheterization, Automatic Implantable (or Internal) Cardioverter Defibrillator, Pacemakers)

Benefits from the Heart Event Rider and certificate will not exceed 100% of the maximum applicable benefit. When you purchase the Heart Event Rider, the 25% CABS partial benefit in your certificate is increased to 100%. That means the CABS benefit in the Heart Event Rider, combined with the benefit in your certificate, equal 100% of the maximum benefit—not 125%.

CRITICAL ILLNESS LIMITATIONS AND EXCLUSIONS

IF DIAGNOSIS OCCURS AFTER THE AGE OF 70, HALF OF THE BENEFIT IS PAYABLE.
The plan contains a 30-day waiting period. This means that no benefits are payable for anyone who has been diagnosed before your coverage has been in force 30 days from the effective date. If you are first diagnosed during the waiting period, benefits for treatment of that critical illness will apply only to loss starting after 12 months from the effective date or the employee can elect to void the coverage and receive a full refund of premium.
The applicable benefit amount will be paid if: the date of diagnosis is after the waiting period; the date of diagnosis occurs while the certificate is in force; and the cause of the illness is not excluded by name or specific description.

EXCLUSIONS
Benefits will not be paid for loss due to:

• Intentionally self-inflicted injury or accident;
• Suicide or attempted suicide while sane or insane;
• Participation in a felony;
• War, whether declared or undeclared or military conflicts, participation in an insurrection or riot;
• Substance abuse; or
• Pre-Existing Conditions (except as stated below).

No benefits will be paid for loss which occurred prior to the effective date.
No benefits will be paid for diagnosis made or treatment received outside of the United States.

PRE-EXISTING CONDITION LIMITATION

Pre-Existing Condition means a sickness or physical condition which, within the 12-month period prior to the effective date, resulted in you receiving medical advice or treatment.

We will not pay benefits for any critical illness starting within 12 months of the effective date which is caused by, contributed to, or resulting from a pre-existing condition. A claim for benefits for loss starting after 12 months from the effective date will not be reduced or denied on the grounds that it is caused by a pre-existing condition. A critical illness will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after the effective date.

TERMS YOU NEED TO KNOW

The Effective Date of your insurance will be the date shown on the certificate schedule.

Employee means the insured as shown on the certificate schedule.

Spouse means your legal wife or husband who is between the ages of 18 and 64, or registered domestic partner (as defined in California Family Code Section 297).

Dependent Children means your natural children, step-children, foster children, legally adopted children or children placed for adoption, who are under age 26. Existing children of a registered domestic partner will be covered the same as stepchildren.

Your natural children born after the effective date of the rider will be covered from the moment of live birth. No notice or additional premium is required.

Coverage on dependent children will terminate on the child's 26th birthday. However, if any child is incapable of self-sustaining employment due to mental or physical handicap and is dependent on his parent(s) for support, the above age 26 shall not apply. Proof of such incapacity and dependency must be furnished to us within 31 days following such 26th birthday.

Treatment means consultation, care, or services provided by a physician, including diagnostic measures and taking prescribed drugs and medicines.

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

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

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

**Stroke** means apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident which begins on or after the coverage effective date. Stroke does not include transient ischemic attacks and attacks of vertebrobasilar ischemia. We will pay for benefit for stroke that produces permanent clinical neurological sequela following an initial diagnosis made after any applicable waiting period. We must receive evidence of the permanent neurological damage provided from computed axial tomography (CAT scan) or magnetic resonance imaging (MRI). Stroke does not mean head injury, transient ischemic attack, or chronic cerebrovascular insufficiency.

**Cancer** means a disease manifested by the uncontrolled growth and spread of malignant cells, the invasion of tissue, leukemia or Hodgkin’s Disease. Pre-malignant conditions or conditions with malignant potential are not to be construed as cancer for the purposes of the plan. In the plan, we pay benefits according to the type of cancer as defined below:

- **Skin Cancer** is cancer on the surface of the body (skin) that may be a malignant tumor, ulcer, pimple or mole. Malignant melanomas classified as Clark’s Level I and II are included in the definition of skin cancer. The diagnosis of skin cancer must be consistent with professional medical standards after a study of the histocytopathologic architecture or pattern of the suspect tumor, tissue, or specimen. **Internal Cancer** is cancer which is not skin cancer or carcinoma in situ, but includes malignant melanomas of Clark’s Level III and higher. **Carcinoma in situ** is cancer whose cells are localized or confined to the site of origin and show no tendency to invade or metastasize to other tissues. Example: should an insured person have a tumor removed from an organ (such as a breast or prostate) and that tumor has not spread, the insured person is eligible for only the limited benefit shown on the benefits schedule. However, if that tumor has spread (metastasized) to other tissue (such as lymph nodes), benefits may be payable for internal cancer.

Cancer must be diagnosed in one of two ways; **pathological diagnosis of cancer** is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a certified pathologist whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology; or **clinical diagnosis of cancer or carcinoma in situ** based on the study of symptoms. A clinical diagnosis of cancer will be accepted when such diagnosis is consistent with professional medical standards, and provided medical evidence substantially documents the diagnosis of cancer or the insured person receives care for cancer from a doctor.

**Cervical Cancer Screening** means conventional Pap test, a human papillomavirus screening test that is approved by the federal Food and Drug Administration, and any cervical cancer screening test approved by the federal Food and Drug Administration.

**Clark Level** is a measurement of the thickness of a melanoma in relation to the layers of the skin. The Clark Level uses a scale of I to V (1-5) to describe which layers of the skin are involved. Example: Clark Level I would only involve the first layer of skin.

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

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

**Doctor or Physician** means any licensed practitioner of the healing arts acting within the scope of his license in treating a critical illness. It doesn’t include an insured or their family member.

**PORTABLE COVERAGE**

When coverage would otherwise terminate because you and 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 then 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 earliest 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.

**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 the insured ceases to meet the definition of an employee as defined in the master policy; or (4) The date the employee is no longer a member of the class eligible.

Coverage for an insured spouse or dependent child will terminate the earliest of: (1) The date the plan is terminated; (2) the date the spouse or dependent child ceases to be a dependent; (3) the premium due date following the date we receive your written request to terminate coverage for his or her spouse and/or all dependent children.

**HEART RIDER**

If diagnosis occurs after the age of 70, half of the benefit is payable. We will pay the indicated percentages of your maximum benefit if you are treated with one of the specified surgical procedures (Category I) or interventional procedures (Category II) shown; if treatment is incurred while coverage is in force; treatment is recommended by a physician; and is not excluded by name or specific description. This benefit is paid based on your selected benefit amount. Benefits are not payable under this coverage for loss if these conditions result from another specified critical illness. Unless amended by the Heart Event Rider, certificate definitions, other provisions and terms apply. Benefits provided by the Heart Event Rider amend any benefits shown in the base plan for the same conditions. Benefits for Category II will reduce the benefit amounts payable for Category I benefits. Benefits will be paid only at the highest benefit level. If Category I and Category II procedures are performed at the same time, benefits are only eligible at the 100% (higher) event and will not exceed the initial face amount shown. The insured is only eligible to receive one payment for each benefit category listed. The dates of loss for covered procedures must be separated by at least 12 months for benefits to be payable for multiple covered procedures. Payment of initial, reoccurrence, or additional occurrence benefits are subject to the benefits section of the base certificate.

**EXCLUSIONS**

(1) No benefits will be paid if the Specified Critical Illness is a result of: (a) Intentionally self-inflicted injury or action; (b) Suicide or attempted suicide while sane or insane; (c) Illegal activities or participation in an illegal occupation; (d) War, declared or undeclared, or military conflicts, participation in an insurrection or riot, civil commotion, or state of belligerence; or (e) an injury sustained while under the influence of alcohol, narcotics, or any other controlled substance or drug, unless properly administered upon the advice of a physician. (2) No benefits will be paid for loss which occurred prior to the effective date of this rider.

**Treatment** means consultation, care, or services provided by a physician, including diagnostic measures and surgical procedures.

**HEART RIDER DEFINITIONS**

**Category I – Specified Surgeries of the Heart**

- **Open Heart Surgery** means undergoing open chest surgery, where the heart is exposed and/or manipulated for open cardiothoracic situations.

Benefits are paid for the following Open Heart Surgery procedures only:

- **Coronary Artery Bypass Surgery** also coronary artery bypass graft surgery, or bypass surgery is a surgical procedure performed to relieve angina and reduce the risk of death from coronary artery disease.

- **Off-Pump Coronary Artery Bypass (OPCAB)** is a form of bypass surgery that does not stop the heart or use the heart-lung machine.

- **Coronary Artery Bypass Grafting (CABG)** is used to treat a narrowing of the coronary arteries when the blockages are hard to reach or are too long or hard for angioplasty. A blood vessel, usually taken from the leg or chest, is grafted onto the blocked artery, creating a bypass around the blockage. If more than one artery is blocked, a bypass can be done on each, but only one benefit is payable under this rider.

- **Mitril Valve Replacement or Repair**: a cardiac surgery procedure in which a patient's mitral valve is replaced by or replaced by a different valve.

- **Aortic Valve Replacement or Repair**: a cardiac surgery procedure in which a patient's aortic valve is repaired or replaced by a different valve.

- **Surgical Treatment of Abdominal Aortic Aneurysm**: To prevent aneurysm rupture. The operation consists of opening the abdomen, finding the aorta, and removing (excising) the aneurysm. Abdominal Aortic Aneurysm is a ballooning or widening of the main artery (the aorta) as it courses down through the abdomen. At the point of the aneurysm, the aneurysm generally measures 3 cm or more in diameter.
Category I Benefits exclude all procedures not specifically listed above, including procedures such as but not limited to, angioplasty, laser relief, stents, or other surgical and nonsurgical procedures.

Category II - Invasive, Procedures and Techniques of the Heart

A Category II Benefit is paid for the following procedures only:

AngioJet Clot Busting is used to clear blood clots from coronary arteries before angioplasty and stenting. The device delivers a high pressure saline solution through the artery to the clot, breaking it up and simultaneously drawing it out.

Balloon Angioplasty (or Balloon Valvuloplasty) is used to open a clogged blood vessel. A thin tube is threaded through an artery to the narrowed heart vessel, where a small balloon at its tip is inflated. A balloon opens the narrowing by compressing atherosclerotic plaque against the vessel wall. The balloon is then deflated and removed.

Laser Angioplasty. Similar to Balloon Angioplasty, a laser tip is used to burn/break down plaque in the clogged blood vessel.

Atherectomy is used to open blocked coronary arteries or clear bypass grafts by using a device on the end of a catheter to cut or shave away atherosclerotic plaque.

Stent Implantation is where a stainless steel mesh coil is implanted in a narrowed part of an artery to keep it propped open.

Cardiac Catheterization (also called heart catheterization) is a diagnostic and occasionally therapeutic procedure that allows a comprehensive examination of the heart and surrounding blood vessels.

Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD). Means the initial placement of the AICD. AICDs are used for treating irregular heartbeats. The defibrillator is surgically placed inside the patient’s chest, where it monitors the heart’s rhythm. When it identifies a serious arrhythmia, it produces an electrical shock to disrupt the arrhythmia.

Pacemakers means the initial placement of a pacemaker. Pacemakers are implanted to send electrical signals to make the heart beat when your heart’s natural pacemaker is not working properly. This electrical device is placed under the skin. A lead extends from the device to the right side of the heart. Most pacemakers are used to correct a slow heart rate.

Subject to the occurrence of an event in the base plan, only one Category II benefit is payable. Benefits will not be paid for multiple procedures listed under the Category II benefit.

Category II Benefits exclude all procedures not specifically listed above.

ADDITIONAL BENEFITS RIDER

If diagnosis occurs after the age of 70, half of the benefit is payable.

The date of diagnosis of a Specified Critical Illness must be separated from the date of diagnosis of a subsequent different Critical Illness by at least 6 months.

The applicable benefit amount will be paid if the date of diagnosis occurs while the rider is in force and the cause of the illness is not excluded by name or specific description.

Benefits will not be paid for loss due to: (1) Intentionally self-inflicted injury or action; (2) Suicide or attempted suicide while sane or insane; (3) Illegal activities or participation in an illegal occupation; (4) War, whether declared or undeclared, or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence; (5) Substance abuse; or (6) No benefits will be paid for diagnosis made outside the United States; (7) No benefits will be paid for loss which occurred prior to the Effective Date of this rider.

DEFINITIONS

Coma means a state of unconsciousness for 30 consecutive days with: (1) no reaction to external stimuli; (2) no reaction to internal stimuli; and (3) the use of life support systems.

Paralysis/Paralyzed means the permanent, total, and irreversible loss of muscle function or sensation to the whole of at least two limbs as a result of injury or disease and supported by neurological evidence.

Severe Burn/Severely Burned means cosmetic disfigurement of the surface of a body area not less than 35 square inches due to fire, heat, caustics, electricity, or radiation that is a full-thickness or third-degree burn, as determined by a physician. A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissue, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity, or radiation.)

Loss of Sight, Speech, or Hearing means: (1) Loss of Speech means the total and permanent loss of the ability to speak as the result of physical injury. (2) Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of Hearing that can be corrected by the use of any hearing aid or device shall not be considered an irrevocable loss. (3) Loss of Sight means the total and irreversible loss of all sight in both eyes.

Treatment means consultation, care, or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

Continental American Life Insurance Company is not aware of whether you receive benefits from Medicare, Medicaid, or a state variation. If you or a dependent are subject to Medicare, Medicaid, or a state variation, any and all benefits under the plan could be assigned. This means that you may not receive any of the benefits outlined in the plan. Please check the coverage in all health insurance plans you already have or may have before you purchase the insurance outlined in this summary to verify the absence of any assignments or liens.

Notice to Consumer: The coverages provided by Continental American Life Insurance Company (CALIC) 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. CALIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.
We’ve got you under our wing.

aflacgroupinsurance.com  1.800.433.3036

Please contact the California Department of Insurance if you have an issue that cannot be solved with Continental American Life Insurance Company.

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
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