Aflac

Product Reference Guide

GROUP CRITICAL ILLNESS ADVANTAGE INSURANCE

CI 21000

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Underwritten by Continental American Insurance Company
A proud member of the Aflac family of insurers

Aflac®

Why do people purchase GROUP CRITICAL ILLNESS insurance?

REASON NO. 1

IN 2015, AN ESTIMATED **635,000** AMERICANS WILL EXPERIENCE A NEW OR RECURRENT HEART ATTACK[1]

REASON NO. 2

ABOUT EVERY **43 SECONDS** HEART DISEASE STRIKES SOMEONE IN THE UNITED STATES.[1]

REASON NO. 3

ON AVERAGE, EVERY **40 SECONDS** SOMEONE IN THE UNITED STATES HAS A STROKE[1]

REASON NO. 4

IN THE UNITED STATES, MEN HAVE SLIGHTLY LESS THAN A **1-in-2 RISK** OF DEVELOPING CANCER; FOR WOMEN, THE RISK IS A LITTLE MORE THAN 1 IN 3[2]

[1] Heart Disease and Stroke Statistics, American Heart Association, 2015
[2] American Cancer Society, Cancer Facts and Figures 2015

GROUP CRITICAL ILLNESS ADVANTAGE INSURANCE

Policy Series C21000

Product Specifications

FACE AMOUNTS

Employee: $5,000 up to $50,000
Spouse: $5,000 up to $25,000

- In order to apply for spouse coverage, the employee must also apply.
- Spouse coverage is limited to 50% of employee election, up to $25,000 ($5,000 minimum–if an employee elects $5,000, a spouse may elect $5,000 as well). Based on underwriting, spouse coverage will be issued even if employee is declined.

Dependent Children: 50% of primary insured benefit at no additional charge.

ISSUE AGE

- Employee and Spouse: 18 and over
- Dependent Children: All children of the insured who are under age 26.

EFFECTIVE DATE

Coverage is effective on on the billing effective date provided.:

- The insured is actively at work on the date of application and the billing effective date, and
- The applicant is insurable under the underwriting guidelines.

EMPLOYER OPTIONS (Group Level Decision)*

- May be offered with or without a Health Screening Benefit.
- May be offered with or without cancer. An employee can have a maximum of $10k Critical Illness (either with or without cancer) if that employee has an individual Cancer plan or individual Lump Sum Critical Illness and/or individual Critical Care and Recovery.
- Additional Covered Illnesses: Paralysis; Severe Burns; Coma;
  Loss of Speech; Sight, and Hearing pg. 4).†
- Heart Event Rider: Adds 12 surgeries, procedures and techniques (see pg. 4).†
- Optional Benefits Rider: Advanced Alzheimer's Disease, Advanced Parkinson's Disease and Benign Brain Tumor (see pg. 4)
- Occupational HIV Rider: (see pg. 4)
- Progressive Diseases: Amytrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease) and Sustained Multiple Sclerosis (see pg. 4)

PORTABILITY

- Coverage is portable without a change in the premium amount charged (group policy must remain in force). Coverage can be continued through a monthly bank draft or quarterly, semiannual, or annual direct billing (certain stipulations apply). Employees must contact us within 31 days of leaving employment.

UNDERWRITING

Guaranteed-Issue

Available for employee and spouse. Amount and participation requirements vary based on account size and enrollment conditions.

Standard

- 100 - 999 employees: $20,000 employee and $10,000 spouse with the greater of 10% participation or 25 employees applying for Critical Illness coverage
- 1,000+ employees: $30,000 employee and $15,000 spouse with at least 10% of the employees applying for Critical Illness coverage.

Enrollments take place once each 12-month period. Late enrollees cannot enroll outside of an annual enrollment period.

SIMPLIFIED-ISSUE

All applicants are required to answer underwriting questions. The health questions are knockout questions. Any "yes" response will result in a declination or reduction to the guaranteed-issue amount. All applicants must be actively at work on the date of application and billing effective date.

UNDERWRITING QUESTIONS*

1. Have you ever been treated for or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) or ever tested positive for antigens or antibodies to an AIDS virus?
2. In the last seven years, have you been treated for or diagnosed with cancer or any malignancy, which includes carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.
3. Have you ever been treated for or diagnosed with a) a stroke, a heart attack, a heart condition, heart trouble, or any abnormality of the heart (including artery disease), diabetes, or any liver disorder; b) kidney (renal) failure or end-stage kidney (renal) disease; c) organ transplant; d) emphysema; or are you e) now taking three or more medications for high blood pressure?

*May vary by situs state. †Not available in all situs states.

COVERED CRITICAL ILLNESSES

Cancer (Internal or Invasive)	100%	**Bone Marrow Transplant** (Stem Cell Transplant)	100%
Heart Attack (Myocardial Infarction)	100%	**Sudden Cardiac Arrest**	100%
Stroke (Ischemic or Hemorrhagic)	100%	**Non-Invasive Cancer**	25%
Kidney Failure (End-Stage Renal Failure)	100%	**Coronary Artery Bypass Surgery**	25%
Major Organ Transplant	100%		

CRITICAL ILLNESS INSURANCE BENEFITS

INITIAL DIAGNOSIS

We will pay a lump sum benefit upon initial diagnosis of a covered critical illness when such diagnosis is caused by or solely attributed to an underlying disease. Cancer diagnoses are subject to the cancer diagnosis limitation. Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

ADDITIONAL DIAGNOSIS (different conditions separated by at least six months)*

We will pay benefits for each different critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months, and the new critical illness is not contributed to or caused by a critical illness for which benefits have been paid. Cancer diagnoses are subject to the cancer diagnosis limitation.

REOCCURRENCE (same condition separated by at least 6 months)*

We will pay benefits for the same critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months, and the new critical illness is not contributed to or caused by a critical illness for which benefits have been paid. Cancer diagnoses are subject to the cancer diagnosis limitation.

CHILD COVERAGE AT NO ADDITIONAL COST

Each dependent child is covered at 50 percent of the primary insured amount at no additional charge (children-only coverage is not available.).

SPOUSE COVERAGE

Spouse benefit amounts available from $5,000 to $25,000, up to one-half of the employee benefit amount ($5,000 minimum–if an employee elects $5,000, a spouse may elect $5,000, as well). If the employee is deemed ineligible due to a previous medical condition, he/she still retains the ability to purchase coverage for his/her spouse.

WAIVER OF PREMIUM BENEFIT

If you become totally disabled due to a covered critical illness prior to age 65, after 90 continuous days of total disability, we will waive premiums for you and any of your covered dependents. As long as you remain totally disabled, premium will be waived up to 24 months, subject to the terms of the plan.

SUCCESSOR INSURED BENEFIT

If spouse coverage is in force at the time of the primary insured's death, the surviving spouse may elect to continue coverage. Coverage would continue at the existing spouse face amount and would also include any dependent child coverage in force at the time.

$50 HEALTH SCREENING BENEFIT (employee and spouse only)*

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. Covered tests include but are not limited to the following:

- Blood test for triglycerides
- 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
- DNA stool analysis
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test to determine level of HDL and LDL
- Serum protein electrophoresis (blood test for myeloma)
- Spiral CT screening for lung cancer
- Stress test on a bicycle or treadmill
- Thermography

*Not available in all situs states.

BENEFIT PACKAGE OPTIONS (Not Available In All States)

ADDITIONAL COVERED CRITICAL ILLNESSES

Severe Burns*	100%	Loss of Speech**	100%
Paralysis**	100%	Loss of Sight**	100%
Coma**	100%	Loss of Hearing**	100%

*This benefit is only payable for burns due to, caused by, and attributed to, a covered accident.
**These benefits are payable for loss due to a covered underlying disease or a covered accident.

OPTIONAL BENEFITS RIDER

Benign Brain Tumor	100%	Advanced Parkinsons' Disease	25%
Advanced Alzheimer's Disease	25%		

HEART EVENT RIDER

Category 1–Specified Surgeries of the Heart

Coronary artery bypass surgery	75%*
Mitral valve replacement or repair	100%
Aortic valve replacement or repair	100%
Surgical treatment of abdominal aortic aneurysm	100%

*The 75% benefit available in the rider, combined with the partial benefit available in the certificate, equals a 100% benefit for coronary artery bypass surgery.

Category 2–Invasive Heart Procedures and Techniques

AngioJet clot busting	10%
Balloon angioplasty (or balloon valvuloplasty)	10%
Laser angioplasty	10%
Atherectomy	10%
Stent Implantation	10%
Cardiac Catheterization	10%
Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD)	10%
Pacemakers	10%

These benefits will be paid based on the face amount in effect on the critical illness date of diagnosis. Benefits are payable for the specified surgeries and procedures listed above when caused by a defined underlying disease, treatment is recommended by a doctor, and is not excluded by name or specific description. Benefits from each category are payable once per calendar year, per insured. If multiple procedures are performed at the same time, benefits will be payable only at the highest benefit level and will not exceed the percentage shown above.

OCCUPATIONAL HIV RIDER

100%

This benefit is payable for the initial positive diagnosis of occupational HIV if the diagnosis results from an HIV-specific covered injury. This benefit is payable once, and after the benefit is paid, the rider coverage will terminate.

PROGRESSIVE DISEASES RIDER

Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease)	100%
Sustained Multiple Sclerosis	100%

BUILDING BENEFIT RIDER

For the first 10 years of coverage, the Building Benefit Rider annually increases the Critical Illness benefits payable for the insureds by 5% of the initial face amount. This increase is automatic and requires no medical evidence of insurability. Premiums do not increase each year as the benefit increases.

All options are employer decisions.

WEEKLY RATES – STANDARD

Rates are for illustrative purposes only for groups on 100-999 employees. Rates for groups over 1,000 lives may be obtained via the PIF process.

NON-TOBACCO / Employee

Ages	$10,000	$20,000	$30,000	$40,000	$50,000
25	$1.35	$2.34	$3.34	$4.33	$5.33
35	$2.05	$3.76	$5.46	$7.17	$8.87
45	$3.79	$7.23	$10.67	$14.11	$17.55
55	$7.15	$13.95	$20.76	$27.56	$34.36
60+	$13.51	$26.67	$39.83	$52.99	$66.15

TOBACCO / Employee

Ages	$10,000	$20,000	$30,000	$40,000	$50,000
25	$1.81	$3.26	$4.72	$6.17	$7.63
35	$3.09	$5.83	$8.57	$11.31	$14.04
45	$5.85	$11.36	$16.86	$22.36	$27.86
55	$11.47	$22.59	$33.71	$44.83	$55.95
60+	$21.06	$41.76	$62.47	$83.18	$103.88

NON-TOBACCO / Spouse

Ages	$5,000	$10,000	$15,000	$20,000	$25,000
18-29	$0.85	$1.35	$1.84	$2.34	$2.84
30-39	$1.20	$2.05	$2.91	$3.76	$4.61
40-49	$2.07	$3.79	$5.51	$7.23	$8.95
50-59	$3.75	$7.15	$10.55	$13.95	$17.35
60+	$6.93	$13.51	$20.09	$26.67	$33.25

TOBACCO / Spouse

Ages	$5,000	$10,000	$15,000	$20,000	$25,000
18-29	$1.08	$1.81	$2.53	$3.26	$3.99
30-39	$1.72	$3.09	$4.46	$5.83	$7.20
40-49	$3.10	$5.85	$8.60	$11.36	$14.11
50-59	$5.91	$11.47	$17.03	$22.59	$28.15
60+	$10.70	$21.06	$31.41	$41.76	$52.12

Rates include benefits for Cancer, Additional Occurrence, Reoccurrence, and $50 Health Screening.
Rates vary by situs state.
RE-ENROLLMENTS: If selling increase benefits, separate “buy up” rates apply.

Please Note: Premiums shown are accurate as of publication. They are subject to change.

WEEKLY RATES – OPTIONAL BENEFITS / EMPLOYEE

BASE PLAN / ADDITIONAL COVERED CRITICAL ILLNESSES / NON-TOBACCO

Ages	$10,000	$20,000	$30,000	$40,000	$50,000
25	$1.40	$2.44	$3.49	$4.54	$5.58
35	$2.11	$3.86	$5.62	$7.37	$9.13
45	$3.84	$7.33	$10.82	$14.31	$17.81
55	$7.20	$14.06	$20.91	$27.76	$34.62
60+	$13.56	$26.77	$39.98	$53.19	$66.40

BASE PLAN / ADDITIONAL COVERED CRITICAL ILLNESSES / TOBACCO

Ages	$10,000	$20,000	$30,000	$40,000	$50,000
25	$1.86	$3.36	$4.87	$6.38	$7.89
35	$3.14	$5.93	$8.72	$11.51	$14.30
45	$5.90	$11.46	$17.01	$22.57	$28.12
55	$11.52	$22.69	$33.86	$45.04	$56.21
60+	$21.11	$41.87	$62.63	$83.38	$104.14

BASE PLAN / BUILDING BENEFIT / NON-TOBACCO

Ages	$10,000	$20,000	$30,000	$40,000	$50,000
25	$1.64	$2.94	$4.23	$5.53	$6.82
35	$2.56	$4.78	$6.99	$9.21	$11.42
45	$4.82	$9.29	$13.76	$18.23	$22.71
55	$9.19	$18.03	$26.88	$35.72	$44.56
60+	$17.46	$34.56	$51.67	$68.78	$85.88

BASE PLAN / BUILDING BENEFIT / TOBACCO

Ages	$10,000	$20,000	$30,000	$40,000	$50,000
25	$2.24	$4.13	$6.03	$7.92	$9.81
35	$3.91	$7.47	$11.03	$14.59	$18.15
45	$7.50	$14.66	$21.81	$28.96	$36.12
55	$14.81	$29.26	$43.72	$58.17	$72.63
60+	$27.27	$54.19	$81.11	$108.02	$134.94

HEART RIDER ONLY / NON-TOBACCO

Ages	$10,000	$20,000	$30,000	$40,000	$50,000
25	$0.31	$0.62	$0.94	$1.25	$1.56
35	$0.37	$0.75	$1.12	$1.49	$1.86
45	$1.04	$2.08	$3.12	$4.16	$5.19
55	$1.47	$2.94	$4.41	$5.89	$7.36
60+	$2.19	$4.37	$6.56	$8.74	$10.93

HEART RIDER ONLY / TOBACCO

Ages	$10,000	$20,000	$30,000	$40,000	$50,000
25	$0.51	$1.02	$1.52	$2.03	$2.54
35	$0.83	$1.67	$2.50	$3.33	$4.17
45	$2.20	$4.39	$6.59	$8.78	$10.98
55	$3.27	$6.53	$9.80	$13.07	$16.33
60+	$5.73	$11.47	$17.20	$22.93	$28.67

HIV RIDER ONLY / NON-TOBACCO

Ages	$10,000	$20,000	$30,000	$40,000	$50,000
18+	$0.03	$0.05	$0.08	$0.11	$0.13

HIV RIDER ONLY / TOBACCO

Ages	$10,000	$20,000	$30,000	$40,000	$50,000
18+	$0.03	$0.05	$0.08	$0.11	$0.13

OPTIONAL BENEFITS ONLY / NON-TOBACCO

Ages	$10,000	$20,000	$30,000	$40,000	$50,000
25	$0.04	$0.07	$0.11	$0.14	$0.18
35	$0.04	$0.09	$0.13	$0.18	$0.22
45	$0.07	$0.15	$0.22	$0.30	$0.37
55	$0.14	$0.28	$0.43	$0.57	$0.71
60+	$0.22	$0.44	$0.66	$0.88	$1.09

OPTIONAL BENEFITS ONLY / TOBACCO

Ages	$10,000	$20,000	$30,000	$40,000	$50,000
25	$0.04	$0.07	$0.11	$0.14	$0.18
35	$0.04	$0.09	$0.13	$0.18	$0.22
45	$0.07	$0.15	$0.22	$0.30	$0.37
55	$0.14	$0.28	$0.43	$0.57	$0.71
60+	$0.22	$0.44	$0.66	$0.88	$1.09

PROGRESSIVE DISEASES ONLY / NON-TOBACCO

Ages	$10,000	$20,000	$30,000	$40,000	$50,000
25	$0.05	$0.09	$0.14	$0.19	$0.23
35	$0.04	$0.09	$0.13	$0.18	$0.22
45	$0.03	$0.07	$0.10	$0.13	$0.17
55	$0.03	$0.06	$0.08	$0.11	$0.14
60+	$0.03	$0.06	$0.10	$0.13	$0.16

PROGRESSIVE DISEASES ONLY / TOBACCO

Ages	$10,000	$20,000	$30,000	$40,000	$50,000
25	$0.05	$0.09	$0.14	$0.19	$0.23
35	$0.04	$0.09	$0.13	$0.18	$0.22
45	$0.03	$0.07	$0.10	$0.13	$0.17
55	$0.03	$0.06	$0.08	$0.11	$0.14
60+	$0.03	$0.06	$0.10	$0.13	$0.16

Rates vary by situs state. **Please Note:** Premiums shown are accurate as of publication. They are subject to change. Optional benefits are not available in all situs states.

WEEKLY RATES – OPTIONAL BENEFITS / SPOUSE

BASE PLAN / ADDITIONAL COVERED CRITICAL ILLNESSES / NON-TOBACCO

Ages	$5,000	$10,000	$15,000	$20,000	$25,000
25	$0.87	$1.40	$1.92	$2.44	$2.97
35	$1.23	$2.11	$2.98	$3.86	$4.74
45	$2.10	$3.84	$5.59	$7.33	$9.08
55	$3.78	$7.20	$10.63	$14.06	$17.48
60+	$6.96	$13.56	$20.17	$26.77	$33.38

BASE PLAN / ADDITIONAL COVERED CRITICAL ILLNESSES / TOBACCO

Ages	$5,000	$10,000	$15,000	$20,000	$25,000
25	$1.10	$1.86	$2.61	$3.36	$4.12
35	$1.75	$3.14	$4.54	$5.93	$7.33
45	$3.13	$5.90	$8.68	$11.46	$14.24
55	$5.94	$11.52	$17.11	$22.69	$28.28
60+	$10.73	$21.11	$31.49	$41.87	$52.25

BASE PLAN / BUILDING BENEFIT / NON-TOBACCO

Ages	$5,000	$10,000	$15,000	$20,000	$25,000
25	$1.00	$1.64	$2.29	$2.94	$3.58
35	$1.46	$2.56	$3.67	$4.78	$5.89
45	$2.59	$4.82	$7.06	$9.29	$11.53
55	$4.77	$9.19	$13.61	$18.03	$22.46
60+	$8.90	$17.46	$26.01	$34.56	$43.12

BASE PLAN / BUILDING BENEFIT / TOBACCO

Ages	$5,000	$10,000	$15,000	$20,000	$25,000
25	$1.30	$2.24	$3.19	$4.13	$5.08
35	$2.13	$3.91	$5.69	$7.47	$9.25
45	$3.93	$7.50	$11.08	$14.66	$18.23
55	$7.58	$14.81	$22.03	$29.26	$36.49
60+	$13.81	$27.27	$40.73	$54.19	$67.65

HEART RIDER ONLY / NON-TOBACCO

Ages	$5,000	$10,000	$15,000	$20,000	$25,000
25	$0.16	$0.31	$0.47	$0.62	$0.78
35	$0.19	$0.37	$0.56	$0.75	$0.93
45	$0.52	$1.04	$1.56	$2.08	$2.60
55	$0.74	$1.47	$2.21	$2.94	$3.68
60+	$1.09	$2.19	$3.28	$4.37	$5.46

HEART RIDER ONLY / TOBACCO

Ages	$5,000	$10,000	$15,000	$20,000	$25,000
25	$0.25	$0.51	$0.76	$1.02	$1.27
35	$0.42	$0.83	$1.25	$1.67	$2.08
45	$1.10	$2.20	$3.29	$4.39	$5.49
55	$1.63	$3.27	$4.90	$6.53	$8.17
60+	$2.87	$5.73	$8.60	$11.47	$14.33

HIV RIDER ONLY / NON-TOBACCO

Ages	$5,000	$10,000	$15,000	$20,000	$25,000
18+	$0.01	$0.03	$0.04	$0.05	$0.07

HIV RIDER ONLY / TOBACCO

Ages	$5,000	$10,000	$15,000	$20,000	$25,000
18+	$0.01	$0.03	$0.04	$0.05	$0.07

OPTIONAL BENEFITS ONLY / NON-TOBACCO

Ages	$5,000	$10,000	$15,000	$20,000	$25,000
25	$0.02	$0.04	$0.05	$0.07	$0.09
35	$0.02	$0.04	$0.07	$0.09	$0.11
45	$0.04	$0.07	$0.11	$0.15	$0.19
55	$0.07	$0.14	$0.21	$0.28	$0.35
60+	$0.11	$0.22	$0.33	$0.44	$0.55

OPTIONAL BENEFITS ONLY / TOBACCO

Ages	$5,000	$10,000	$15,000	$20,000	$25,000
25	$0.02	$0.04	$0.05	$0.07	$0.09
35	$0.02	$0.04	$0.07	$0.09	$0.11
45	$0.04	$0.07	$0.11	$0.15	$0.19
55	$0.07	$0.14	$0.21	$0.28	$0.35
60+	$0.11	$0.22	$0.33	$0.44	$0.55

PROGRESSIVE DISEASES ONLY / NON-TOBACCO

Ages	$5,000	$10,000	$15,000	$20,000	$25,000
25	$0.02	$0.05	$0.07	$0.09	$0.12
35	$0.02	$0.04	$0.07	$0.09	$0.11
45	$0.02	$0.03	$0.05	$0.07	$0.08
55	$0.01	$0.03	$0.04	$0.06	$0.07
60+	$0.02	$0.03	$0.05	$0.06	$0.08

PROGRESSIVE DISEASES ONLY / TOBACCO

Ages	$5,000	$10,000	$15,000	$20,000	$25,000
25	$0.02	$0.05	$0.07	$0.09	$0.12
35	$0.02	$0.04	$0.07	$0.09	$0.11
45	$0.02	$0.03	$0.05	$0.07	$0.08
55	$0.01	$0.03	$0.04	$0.06	$0.07
60+	$0.02	$0.03	$0.05	$0.06	$0.08

Rates vary by situs state. **Please Note:** Premiums shown are accurate as of publication. They are subject to change. Optional benefits are not available in all situs states.

LICENSING AND ENROLLMENT METHODS

AFLAC GROUP PRODUCTS

(underwritten by Continental American Insurance Company – accounts situsted outside of New York)

All enrollers must be properly licensed and appointed with CAIC in the solicitation state (or state of enrollment) of the account prior to the enrollment. All commissioned agents must be properly licensed and appointed in the situs state prior to the effective date of the group.

One-On-One Paper Enrollment*

- Wet signatures are acceptable in all states of enrollment, except New York, Puerto Rico, Guam, and the Virgin Islands.
- Aflac Group will provide state-specific enrollment forms.
- State of enrollment is physical location.

One-On-One Laptop Enrollment*

- PIN code signatures are accepted in all states of enrollment, except New York, Puerto Rico, Guam, and the Virgin Islands.
- State of enrollment is physical location.

Web Enrollment Self-Enrollment

- PIN code signatures are accepted in all states of enrollment.
- State of enrollment is employee's state of residence.

Call Center Enrollment*

- Voice recording signatures are accepted in all states of enrollment, except New York, Puerto Rico, Guam, and the Virgin Islands.
- PIN code signatures are accepted in all states except FL, GA, NJ, VT, WV, New York, Puerto Rico, Guam, and the Virgin Islands.
- State of enrollment is employee's state of residence.

Applications can not be solicited by an agent in New York, Puerto Rico, Guam or the Virgin Islands. Direct mail or applications taken by the Human Resources department are accepted in these states.

AFLAC NEW YORK GROUP PRODUCTS

(accounts situsted in state of New York)

All agents must be properly licensed and appointed with Aflac New York, including the amendment, to sell group products in the situs state (NY) and the state of enrollment (based on list below). Agents cannot solicit applications outside of NY, MA, VT, CT, NJ, or ND. Direct mail or applications taken by the Human Resources department are accepted in all other states of enrollment.

One-On-One Paper Enrollment*

- Wet signatures are acceptable if the state of enrollment is NY, MA, VT, CT, NJ, or ND.
- Aflac Group will provide state-specific enrollment forms.
- State of enrollment is physical location.

One-On-One Laptop Enrollment*

- PIN code signatures are accepted if the state of enrollment is NY, MA, VT, CT, NJ, or ND.
- State of enrollment is physical location.

Web Enrollment Self-Enrollment

- PIN code signatures are accepted in all states of enrollment.
- State of enrollment is employee's state of residence.

Call Center Enrollment*

- Voice recording signatures are accepted if the state of enrollment is NY, MA, VT, CT, NJ, or ND.
- State of enrollment is employee's state of residence.

*All applications must be submitted with a Transmittal or Electronic File in the required file layout.

ENROLLMENT AND SALES

PRODUCT NOTES*

- **Employee Eligibility:** Employees are eligible to apply once they have reached the required length of employment (set by the employer) and work at least 16 hours per week or more, as set by the employer.
- **Actively At Work:** Employees must be actively at work at the time of election, and he/she must answer the "actively at work" question on the enrollment form. If he/she answers "no," coverage will not be issued.
- **Spouse Eligibility:** If an employee elects spouse coverage, he/she must answer the spouse eligibility question. If the answer to this question is "yes," spouse coverage will not be issued.
- **Enrollment Forms Due:** All paper applications are due 5 days after the enrollment end date. All electronic enrollment files are due 10 days after the enrollment end date.
- **Billing Effective Date:** Billing effective dates are always the first of the month.
- **Group Eligibility:** A minimum of 25 payors are needed to establish group billing. Product only available through payroll deduction.

REQUESTING A PROPOSAL

When a potential client is interested in this plan, please submit a Prospect Information Form (PIF) to Aflac Group. The PIF will provide the necessary information for Aflac Group to prepare a proposal.

- Name of Group
- Type of Business
- Number of Eligible Employees
- Domicile State
- Employer Contribution
- Other

REQUIRED DOCUMENTS FOR SOLD CASES

The following documents are required at least 30 days prior to the start of the enrollment:

1. Master Application
2. Payroll Account Set up form (G0138)
3. Licensing and contracting paperwork

*May vary by situs state.

LIMITATIONS AND EXCLUSIONS*

Cancer Diagnosis Limitation Benefits are payable for cancer and/or non-invasive cancer as long as the insured:

- Is treatment-free from cancer for at least 12 months before the diagnosis date; and
- Is in complete remission prior to the date of a subsequent diagnosis, as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the cancer.

EXCLUSIONS

We will not pay for loss due to:

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured;
  - In Alaska: injuring or attempting to injure oneself intentionally
- **Suicide** – committing or attempting to commit suicide, while sane or insane;
  - In Missouri: committing or attempting to commit suicide, while sane
  - In Illinois: this exclusion does not apply
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job:
  - In Arizona: participating in or attempting to commit a felony, or being engaged in an illegal occupation;
  - In Florida: participating or attempting to participate in an illegal activity, or working at an illegal occupation;
  - In Illinois and Pennsylvania: Illegal Occupation - committing or attempting to commit a felony or being engaged in an illegal occupation;
  - In Michigan: Illegal Occupation – the commission of or attempt to commit a felony, or being engaged in an illegal occupation;
  - In Nebraska: being engaged in an illegal occupation, or commission of or attempting to commit a felony;
  - In Ohio: committing or attempting to commit a felony, or working at an illegal job
- **Participation in Aggressive Conflict:**
  - War (declared or undeclared) or military conflicts;
    - -In Florida: War does not include acts of terrorism
    - -In Oklahoma: War, or act of war, declared or undeclared when serving in the military service or an auxiliary unit thereto
  - Insurrection or riot
  - Civil commotion or civil state of belligerence
- **Illegal Substance Abuse:**
  - Abuse of legally-obtained prescription medication
  - Illegal use of non-prescription drugs

- In Arizona: Being intoxicated or under the influence of any narcotic unless administered on the advice of a physician
- In Michigan, Nevada, and South Dakota: this exclusion does not apply

Diagnosis, treatment, testing, and confinement must be in the United States or its territories.

All benefits under the plan, including benefits for diagnoses, treatment, confinement and covered tests, are payable only while coverage is in force.

TERMS YOU NEED TO KNOW

Bone Marrow Transplant (Stem Cell Transplant) means a procedure to replace damaged or destroyed bone marrow with healthy bone marrow stem cells. For a benefit to be payable, a Bone Marrow Transplant (Stem Cell Transplant) must be caused by at least one of the following diseases:

- Aplastic anemia
- Congenital neutropenia
- Severe immunodeficiency syndromes
- Sickle cell anemia
- Thalassemia
- Fanconi anemia
- Leukemia
- Lymphoma
- Multiple myeloma

The Bone Marrow Transplant (Stem Cell Transplant) benefit is not payable if the transplant results from a covered critical illness for which a benefit has been paid under this plan.

Cancer (internal or invasive) is a disease that meets either of the following definitions:

A malignant tumor characterized by:

- The uncontrolled growth and spread of malignant cells, and
- The invasion of distant tissue.

A disease meeting the diagnostic criteria of malignancy, as established by the American Board of Pathology. A pathologist must have examined and provided a report on the histocytologic architecture or pattern of the tumor, tissue, or specimen.

Cancer (internal or invasive) also includes:

- Melanoma that is Clark's Level III or higher or Breslow depth equal to or greater than 0.77mm,
- Myelodysplastic syndrome – RCMD (refractory cytopenia with multilineage dysplasia),
- Myelodysplastic syndrome – RAEB (refractory anemia with excess blasts),
- Myelodysplastic syndrome – RAEB-T (refractory anemia with excess blasts in transformation), or
- Myelodysplastic syndrome – CMML (chronic myelomonocytic leukemia).

The following are not considered internal or invasive cancers:

- Pre-malignant tumors or polyps
- Carcinomas in Situ
- Any superficial, non-invasive skin cancers including basal cell and squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is diagnosed as
  - Clark's Level I or II,
  - Breslow depth less than 0.77mm, or
  - Stage 1A melanomas under TNM Staging

Non-Invasive Cancer is a cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

For the purposes of the plan, a Non-Invasive Cancer is:

- Internal Carcinoma in Situ
- Myelodysplastic Syndrome – RA (refractory anemia)
- Myelodysplastic Syndrome – RARS (refractory anemia with ring sideroblasts)

Skin Cancer, as defined in this plan, is not payable under the Non-Invasive Cancer Benefit.

Skin Cancer is a cancer that forms in the tissues of the skin. The following are considered skin cancers:

- Basal cell carcinoma
- Squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is diagnosed as
  - Clark's Level I or II,
  - Breslow depth less than 0.77mm, or
  - Stage 1A melanomas under TNM Staging

These conditions are not payable under the Cancer (internal or invasive) Benefit.

Cancer, non-invasive cancer, or skin cancer 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 and conform to the American Board of Pathology standards.
2. Clinical Diagnosis is based only on the study of symptoms. A clinical diagnosis will be accepted 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 you for cancer or carcinoma in situ

Complete Remission is defined as having no symptoms and no signs that can be identified to indicate the presence of cancer.

Civil Union: In Washington DC, Civil Union is defined as a relationship similar to marriage that is recognized by law. In Illinois, a Civil Union is defined as a legal relationship between two persons, of either the same or opposite sex, established pursuant to the Illinois Religious Freedom Protection and Civil Union Act.

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

Critical Illness is a disease or a sickness as defined in the plan that first manifests while your coverage is in force. In Illinois, critical illness is a sickness or disease that began while the insured's coverage is in force. In South Dakota, critical illness is a disease or a sickness that manifests while your coverage is in force.

Date of Diagnosis is defined as follows:

- Bone Marrow Transplant (Stem Cell Transplant): The date the surgery occurs.
- Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or carcinoma in situ is based on such specimens).
- Coronary Artery Bypass Surgery: The date the surgery occurs.
- Heart Attack (Myocardial Infarction): The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the heart attack (myocardial

Infarction) definition.

- Kidney Failure (End-Stage Renal Failure): The date a doctor recommends that an insured begin renal dialysis.
- Major Organ Transplant: The date the surgery occurs.
- Non-Invasive Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or carcinoma in situ is based on such specimens).
- Skin Cancer: The date the skin biopsy samples are taken for microscopic examination.
- Stroke: The date the stroke occurs (based on documented neurological deficits and neuroimaging studies).
- Sudden Cardiac Arrest: The date the pumping action of the heart fails (based on the sudden cardiac arrest definition).

Dependent means your spouse or your dependent child. Spouse is your legal wife or husband, (In Delaware, Illinois, Nevada, Oregon, or Washington DC - or a person who is in a legally recognized domestic partnership, civil union, or similar relationship with you), who is listed on your application. 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 (in Indiana, this includes children subject to legal guardianship). Newborn children are automatically covered from the moment of birth.

There is an exception to the age-26 limit listed above. This limit will not apply to any dependent child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent (in Arkansas, chiefly 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 (in Indiana, 120 days) following the dependent child's 26th birthday.

- In South Dakota, this limit will not apply to any child who is incapable of self-sustaining employment and is chiefly dependent upon the insured for support and maintenance.
- In Texas, this limit will not apply to any dependent child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support and maintenance. Dependent Children may also include grandchildren, who are unmarried, under age 26, and if they are your dependents for federal income tax purposes, or if you must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in this state.
- In New Mexico, coverage may be provided for the children of custodial and non-custodial parents.
- In Illinois, coverage of an unmarried dependent child who is under age 30 and who served in the military will not terminate if he/she is an Illinois resident, served as a member of the active or reserve components of any United States Armed Forces branch, and has received a release or discharge (other than a dishonorable discharge). To be eligible for coverage, the eligible dependent must submit to us a form approved by the Illinois Department of Veterans' Affairs stating the date on which the dependent was released from service.
- In Louisiana, dependent children must be unmarried and may also include grandchildren who are in the legal custody of and residing with a grandparent. Regarding the Age 26 limit exception - we will not require proof of incapacity and dependency more frequently than annually after the two-year period following the child's attainment of the limiting age.

Diagnosis (Diagnosed) refers to the definitive and certain identification of an illness or disease that:

- Is made by a doctor and
- Is based on clinical or laboratory investigations, as supported by your medical records.

Doctor is 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.
- In Montana, for purposes of treatment, you have full freedom of choice in the selection of any licensed physician, physician assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, licensed social worker, psychologist, licensed professional counselor, acupuncturist, naturopathic physician, physical therapist, or advanced practice registered nurse.
- In New Mexico, a doctor is also a practitioner of the healing arts.

A doctor does not include you or any of your family members.

- In South Dakota, a doctor who is your family member may treat you if that doctor is the only doctor in the area and acts within the scope of his or her practice.

For the purposes of this definition, family member includes your spouse as well as the following members of your immediate family:

- Son
- Daughter
- Mother
- Father
- Sister
- Brother

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

Domestic Partner:

- In Washington DC, Domestic Partner is an unmarried same or opposite sex adult who resides with you and has registered in a state or local domestic partner registry with you.
- In Nevada, Domestic Partner is defined as a person who is party to a valid domestic partnership, has not terminated that domestic partnership, and meets the requisites for a valid domestic partnership. In order to enter into a valid domestic partnership, it is necessary that the two persons register with the state of Nevada when it is established, by having previously furnished proof to the state of Nevada, that both persons have a common residence, neither person is married or a member of another domestic partnership, the two persons are not related by blood in a way that would prevent them from being married to each other in the state of Nevada, both persons are at least 18 years of age, and both persons are competent to consent to the domestic partnership.

Employee is a person who meets eligibility requirements and who is covered under the plan. The employee is the primary insured under the plan.

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 (Myocardial Infarction) does not include:

- Any other disease or injury involving the cardiovascular system.
- Cardiac arrest not caused by a heart attack (myocardial infarction).

Diagnosis of a Heart Attack (Myocardial Infarction) must include the following:

- New and serial electrocardiographic (ECG) findings consistent with heart attack (myocardial infarction), and
- 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.)

Confirmatory imaging studies, such as thallium scans, MUGA scans, or

stress echocardiograms may also be used.

Kidney Failure (End-Stage Renal Failure) means end-stage renal failure caused by end-stage renal disease, which results in the chronic, irreversible failure of both kidneys to function.

Kidney Failure (End-Stage Renal Failure) is covered only under the following conditions:

- A doctor advises that regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) is necessary to treat the kidney failure (end-stage renal failure); or
- The kidney failure (end-stage renal failure) results in kidney transplantation.

Maintenance Drug Therapy is a course of systemic medication given to a patient after a cancer goes into complete 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 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. A transplant must be caused by one or more of the following diseases:

- Bronchiectasis
- Cardiomyopathy
- Cirrhosis
- Chronic obstructive pulmonary disease
- Congenital Heart Disease
- Coronary Artery Disease
- Cystic fibrosis
- Hepatitis
- Interstitial lung disease
- Lymphangioleiomyomatosis.
- Polycystic liver disease
- Pulmonary fibrosis
- Pulmonary hypertension
- Sarcoidosis
- Valvular heart disease

A Major Organ Transplant benefit is not payable if the major organ transplant results from a covered critical illness for which a benefit has been paid.

Party to a Civil Union: In Illinois, a person who has established a civil union pursuant to the Illinois Religious Freedom Protection and Civil Union Act.

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.

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 apoplexy due to rupture or acute occlusion of a cerebral artery. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. Stroke must be either:

- Ischemic: Due to advanced arteriosclerosis or arteriosclerosis of the arteries of the neck or brain, or vascular embolism, or
- Hemorrhagic: Due to uncontrolled hypertension, malignant hypertension, brain aneurysm, or arteriovenous malformation.

The stroke must be positively diagnosed by a doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

Stroke does not include:

- Transient Ischemic Attacks (TIAs)
- Head injury
- Chronic cerebrovascular insufficiency
- Reversible ischemic neurological deficits unless brain tissue damage is confirmed by neurological imaging

Stroke will be covered only if the Insured submits evidence of the neurological damage by providing:

- Computed Axial Tomography (CAT scan) images, or
- Magnetic Resonance Imaging (MRI).

Sudden Cardiac Arrest is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to coronary artery disease, cardiomyopathy, or hypertension.

Sudden Cardiac Arrest is not a heart attack (myocardial infarction). A sudden cardiac arrest benefit is not payable if the sudden cardiac arrest is caused by or contributed to by a heart attack (myocardial infarction).

Total Disability or Totally Disabled means you are:

- Not working at any job for pay or benefits,
- Under the care of a doctor for the treatment of a covered critical illness, and
- Unable to Work, which means either:
  - During the first 365 days of total disability, you are unable to work at the occupation you were performing when your total disability began; or
  - After the first 365 days of total disability, you are unable to work at any gainful occupation for which you are suited by education, training, or experience.
  - In Ohio, Unable to Work is defined as the inability to perform duties of any gainful occupation for which you are reasonably fitted by training, experience, and accomplishment.

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.

In Montana, Consultation is not considered treatment or medical treatment.

OPTIONAL BENEFITS DEFINITIONS

- 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
  - Bradykinesis (abnormal slowness of movement, sluggishness of

physical and mental responses), and

– 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. Benign Brain Tumor must be caused by Multiple Endocrine

Neoplasia, Neurofibromatosis, or Von Hippel-Lindau Syndrome.

Multiple Endocrine Neoplasia is a genetic disease in which one or more of the endocrine glands are overactive or form a tumor.

Neurofibromatosis is a genetic disease in which the nerve tissue grows tumors that may be benign and may cause serious damage by compressing nerves and other tissue.

Von Hippel-Lindau Syndrome is a genetic disease that predisposes a person to have benign or malignant tumors.

PROGRESSIVE DISEASE DEFINITIONS

Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease) means a chronic, progressive motor neuron disease occurring when nerve cells in the brain and spinal cord that control voluntary movement degenerate, causing muscle weakness and atrophy, eventually leading to paralysis.

Sustained Multiple Sclerosis means a chronic degenerative disease of the central nervous system in which gradual destruction of myelin occurs in the brain or spinal cord or both, interfering with the nerve pathways. Sustained Multiple Sclerosis results in one of the following symptoms for at least 90 consecutive days:

- Muscular weakness,
- Loss of coordination,
- Speech disturbances, or
- Visual disturbances.

YOU MAY CONTINUE YOUR COVERAGE

Your coverage may be continued with certain stipulations. See certifcate for details.

TERMINATION OF COVERAGE

Your insurance may terminate when the plan is terminated; the 31st day after the premium due date if the premium has not been paid; or the date you no longer belong to an eligible class. If your coverage terminates, we will provide benefits for valid claims that arose while your coverage was in force.

NOTICES

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

Continental American 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 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.

In Nevada: This limited plan provides supplemental benefits only. It does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

In New Mexico: This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a tax penalty. Please consult your tax advisor.

In Washington DC: NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

* Definitions, limitations and exclusions may vary by state.

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