Aflac Group Critical Illness with Cancer Plan

Plan Features

- Benefits are paid directly to you, unless otherwise assigned
- Benefit amounts are available up to $50,000 for employees and up to $30,000 for spouses.
- Dependent children are covered at 50% of the primary insured's amount at no additional charge.
- Guaranteed-issue coverage is available (which means you may qualify for coverage without having to answer health questions).
- Premiums are paid through convenient payroll deduction.
- There are no pre-existing condition limitations.
- The plan doesn't have a waiting period for benefits.
- Benefits do not reduce as insureds get older.
- Coverage is portable, with certain stipulations.
- Annual health screening benefit is included.

Underwriting Guidelines – Guaranteed-Issue

Guaranteed-issue coverage is offered during the first three annual open enrollments and for new hires thereafter:

Up to **$20,000** for employees and up **to $10,000** for spouses with no participation requirement.

For employee amounts over **$20,000** and spouse amounts over **$10,000:**
All applicants are required to answer underwriting questions. Employees who would otherwise be declined will be issued the lesser of the amount applied for or the guaranteed-issue limit.

Individual Eligibility

Issue Ages:

- Employee 18+
- Spouse 18+
- Children under age 26

Benefit-eligible employees who work at least **30 hours** weekly are eligible. If an employee is eligible, his spouse is also eligible to apply for coverage. Dependent children under the age of 26 are automatically covered. Seasonal and temporary workers are not eligible to participate.

Class I
All full-time and part-time benefit-eligible employees are eligible for Class I coverage. That eligibility extends to their spouses and children under age 26.

Class II
A Class I primary insured is eligible for Class II coverage if he:

- Was previously insured under Class I; and
- Is no longer employed by the policyholder.

The employee must elect Class II coverage under the Portability Privilege within 31 days after the date for which his Class I eligibility would otherwise terminate. Only dependents covered under Class I coverage are eligible for continued coverage under Class II. Class II insureds cannot continue coverage through the employer's payroll deduction process. They must remit premiums directly to the company.

Spouse Coverage Available

Spouse coverage is available up to **100%** of the employee's face amount, subject to the minimum face amount of $5,000. To apply for spouse coverage, ***the employee must also apply***. To be eligible, the spouse must not be disabled or unable to work at the time of application.

If the employee does not meet the underwriting requirements necessary to participate in the plan, the spouse can still obtain coverage. The spouse would then become the primary insured and be limited to face amounts between $5,000 and $30,000.

Dependent Children Coverage

Dependent children under the age of 26 are automatically covered at 50% of the primary insured's face amount at no additional charge. ***Children-only coverage is not available.***

Waiver of Premium Benefit

If the employee becomes totally disabled due to a covered critical illness, after 90 days of total disability, we will waive premiums for the insured and any covered dependents. As long as the insured remains totally disabled, premium will be waived up to 24 months, subject to the terms of the policy.

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.

Portability

When coverage is effective and would otherwise terminate because the employee ends employment with the employer, coverage may be continued. He may exercise the Portability Privilege when there is a change to his coverage class. The employee — and any covered dependents — will continue the coverage that is in-force on the date employment ends. The continued coverage will be provided under Class II.

The premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least 45 days before any change is to take effect.

The employee may continue the coverage until the earlier of:

- The date he fails to pay the required premium; or
- The date the class of coverage is terminated.

Coverage may not be continued:

- If the employee fails to pay any required premium; or
- If the company receives notice of Class I plan termination.

Termination of an Employee's Insurance

An employee's insurance will terminate on the earliest of the following:

- The date the plan is terminated, for Class I insureds;
- The 31st day after the premium due date if the required premium has not been paid;
- The date he ceases to meet the definition of an employee as defined in the plan, for Class I insureds; or
- The date he is no longer a member of the Class eligible for coverage.

Insurance for dependents will terminate on the earliest of the following:

- The date the Plan is terminated, for dependents of Class I insureds;
- The 31st day after the premium due date, if the required premium has not been paid;
- The date the spouse or dependent child ceases to be a dependent; or
- The premium due date following the date we receive the employee's written request to terminate coverage for his spouse and/or all dependent children.

Group Critical Illness Benefits

Where applicable, covered conditions must be caused by underlying diseases as defined in the plan.

Initial Diagnosis+

An insured may receive up to 100% of his face amount upon the diagnosis of a covered critical illness.

Covered Critical Illnesses and Additional Benefits	Percentage of Face Amount/Benefit
Cancer (Internal or Invasive)	100%
Heart Attack	100%
Major Organ Transplant	100%
Kidney Failure (End-Stage Renal Failure)	100%
Stroke	100%
Bone Marrow Transplant (Stem Cell Transplant)	100%
Sudden Cardiac Arrest	100%
Non-Invasive Cancer	25%
Coronary Artery Bypass Surgery	25%
Coma**	100%
Severe Burns*	100%
Paralysis**	100%
Loss of Sight**	100%
Loss of Hearing**	100%
Loss of Speech**	100%
Skin Cancer	$250 (once per calendar year/insured)
Transient Ischemic Attack (TIA)	$250 (once per calendar year/insured)

Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

*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.

Additional Diagnosis +

Once benefits have been paid for a covered critical illness, we will pay benefits for each different critical illness when the date of diagnosis is separated by at least 6 consecutive months.

Reoccurrence +

Once benefits have been paid for a covered critical illness, benefits are payable for that same critical illness when the date of diagnosis is separated by at least 6 consecutive months.

+ If the claim is for a cancer diagnosis, the insured must be treatment-free from cancer for at least 12 months and must be in complete remission before the date of a subsequent cancer diagnosis.

Health Screening Benefit

Benefit	Benefit Amount
Health Screening Benefit	$100 per calendar year

The Health Screening Benefit is payable once per calendar year 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. The covered health screening tests include, but are not limited to, the following:

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

Heart Event Rider

Surgeries and Procedures Covered Under Plan	Percentage of Maximum Benefit
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%
Category 2 Invasive Procedures and Techniques of the Heart	
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%

**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.*

Benefits are payable for the specified surgeries and procedures listed above. Benefits from each category are payable once per calendar year, per insured.

If Category I and Category II 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.

Optional Benefits Rider

Illnesses Covered Under Plan	Percentage of Face Amount
Benign Brain Tumor	100%
Advanced Alzheimer's Disease	25%
Advanced Parkinson's Disease	25%

Benefits are payable if an insured is diagnosed with one of the conditions listed.

Limitations and Exclusions
(Applies to all riders unless otherwise noted)

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 any of the following:

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured.
- **Suicide** – committing or attempting to commit suicide, while sane or insane.
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job.
- **Participation in Aggressive Conflict** of any kind, including:
    - War (declared or undeclared) or military conflicts. This does not include errorism.
    - Insurrection or riot.
    - Civil commotion or civil state of belligerence.
- **Illegal substance abuse, which includes the following**:
    - Abuse of legally-obtained prescription medication.
    - Illegal use of non-prescription drugs.

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, may be 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.

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.
- 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 this 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.
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,
   - A doctor is treating the insured for cancer or carcinoma in situ, or

- A positive diagnosis cannot otherwise be made by a doctor without jeopardizing the life of the claimant.

If a pathological or clinical diagnosis can only be made postmortem, liability shall be assumed retroactively beginning with the date of the terminal admission to the hospital for not less than 45 days before the date of death.

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

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.

Date of Diagnosis is defined as follows:

- **Bone Marrow Transplant (Stem Cell Transplant)**: The date the surgery occurs.
- **Cancer:** The day tissue specimens, biopsy, culture, blood samples, or titer(s) are taken upon which the positive medical diagnosis is the date the diagnosis is communicated to the insured. (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, biopsy, culture, blood samples, or titer(s) are taken upon which the positive medical diagnosis is the date the diagnosis is communicated to the insured. (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).
- **Transient Ischemic Attack (TIA)**: The date the transient ischemic attack occurs (based on documented diagnostic tests, such as a CT scan or an MRI of the brain, a Doppler ultrasound, or an echocardiogram of the heart).
- **Coma:** The first day of the period for which a doctor confirms a coma that is due to one of the underlying diseases and that has lasted for at least seven consecutive days.
- **Loss of Sight, Speech, or Hearing:** The date the loss due to one of the underlying diseases is objectively determined by a doctor to be total and irreversible.
- **Paralysis:** The date a doctor diagnoses an insured with paralysis due to one of the underlying diseases as specified in this plan, where such diagnosis is based on clinical and/or laboratory findings as supported by the insured's medical records.
- **Severe Burn:** The date the burn takes place.

Dependent means the primary insured's spouse or dependent child. **Spouse** is the primary insured's legal wife or husband who is listed on his application. **Dependent Children** are the primary insured's or his spouse's natural children, foster 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 dependent 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 provide us with proof of this incapacity and dependency within 31 days following the dependent child's 26th birthday, but not more frequently than annually.

Newborn, adopted and foster children are equally considered under this plan. A newborn child will be covered from the moment of birth, if the birth occurs while the plan is in force. Foster children and adopted children will be treated the same as newborn infants and eligible for coverage on the same basis upon placement in the foster home or placement for adoption. Prior notification will not be required unless an additional premium charge to add the dependent is due. If an additional premium charge is due to cover the dependent, we will cover the newborn child, foster child or adopted child from the moment of birth or placement if the child is enrolled within 30 days after the date of birth or placement.

If a parent is required by a court or administrative order to provide insurance for a child, and the parent is eligible for family insurance coverage, we:

- Will allow the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions.
- Will enroll the child under family coverage upon application of the child's other parent or the Department of Health and Human Services in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the parent is enrolled but fails to make application to obtain coverage for the child.
- Will not dis-enroll or eliminate coverage of the child unless we are provided satisfactory written evidence that:
  a. The court or administrative order is no longer in effect; or
  b. The child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect no later than the effective date of disenrollment.

We will not decline enrollment of a child on the grounds the child was born out of wedlock, the child was not claimed as dependent on the parent's federal tax return; or the child does not reside with the parent or the insurer's service area.

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.

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 or its territories.

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.

A doctor does not include the primary insured or any of his family members. For the purposes of this definition, family member includes the primary insured's spouse as well as the following members of his immediate family:

- Son
- Daughter
- Mother
- Father
- Sister
- Brother
- Step-Family Members and Family-Members-in-law

Employee is a person who meets eligibility requirements under Section I – Eligibility, Effective Date, and Termination, and who is covered under this plan. The employee is the primary insured under this 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 the following:

- 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, which is a lung disease state defined by localized, irreversible dilation of the bronchial tree caused by destruction of the muscle and elastic tissue.
- Cardiomyopathy, which is a heart disease characterized by the measurable deterioration of the function of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid.
- Cirrhosis, which is a liver disease characterized by replacement of liver tissue by fibrosis, scar tissue, and regenerative nodules, leading to loss of liver function.

- Chronic obstructive pulmonary disease, which is a lung disease characterized by persistently poor airflow as a result of breakdown of lung tissue and dysfunction of the small airways.
- Congenital heart disease, which is heart disease characterized by abnormalities in cardiovascular structures that occur before birth.
- Coronary artery disease.
- Cystic fibrosis, which is a hereditary disease of the exocrine glands affecting the pancreas, respiratory system, and sweat glands. It is characterized by the production of abnormally viscous mucus by the affected glands.
- Hepatitis, which is a disease caused by the hepatitis A, B, or C virus and is characterized by the inflammation of the liver.
- Interstitial lung disease, which is a lung disease that affects the interstitium of the lungs.
- Lymphangioleiomyomatosis, which is a lung disease characterized by an indolent, progressive growth of smooth muscles cells throughout the lungs, pulmonary blood vessels, lymphatics, and pleurae.
- Polycystic liver disease, which is characterized by multiple variable-sized cysts lined by cuboidal epithelium.
- Pulmonary fibrosis, which is a lung disease where the lung tissue becomes thickened, stiff, and scarred due to chronic inflammation.
- Pulmonary hypertension, which is a disease characterized by increased pressure in the pulmonary artery and results in the thickening of the pulmonary arteries and the narrowing of these blood vessels, which causes the right side of the heart to become enlarged.
- Sarcoidosis, which is a disease characterized by the growth of granulomatous lesions that appear in the body.
- Valvular heart disease, which is a disease of the heart valves.

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.

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 the following:

- 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.

Transient Ischemic Attack (TIA) occurs when blood flow to part of the brain is temporarily blocked or reduced. For a benefit to be payable, the TIA must be caused by one or more of the following diseases:

- Advanced arteriosclerosis
- Arteriosclerosis of the arteries of the neck or brain
- Vascular embolism
- Hypertension
- Malignant hypertension
- Brain aneurysm
- Arteriovenous malformation

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

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.

Coma means a state of continuous, profound unconsciousness, lasting at least seven consecutive days, and characterized by the absence of:

- Spontaneous eye movements,
- Response to painful stimuli, and
- Vocalization.

Coma does not include a medically-induced coma.

To be payable as an Accident benefit, the coma must be caused solely by or be solely attributed to a covered accident.

To be considered a critical illness, the coma must be caused solely by or be solely attributed to one of the following diseases:

- Brain Aneurysm, which is an excessive, localized enlargement of an artery in the brain caused by a weakening of the artery wall, usually due to a defect in the vessel at birth or resulting from high blood pressure.
- Diabetes, which is a metabolic disease characterized by the inadequate secretion or utilization of insulin, by excessive urine production, by excessive amounts of sugar in the blood and urine, and by thirst, hunger, and loss of weight.
- Encephalitis, which is a disease characterized by inflammation of the brain, usually caused by a direct viral infection or a hypersensitive reaction to a virus or foreign protein.
- Epilepsy, which is a neurological disease characterized by sudden, recurring attacks of motor, sensory, or psychic malfunction with or without loss of consciousness or convulsive seizures.
- Hyperglycemia, which is a disease where an excessive amount of glucose circulates in the blood plasma.
- Hypoglycemia, which is a disease where blood glucose concentrations fall below the necessary level to support the body's need for energy and stability throughout its cells.
- Meningitis, which is a disease caused by viral or bacterial infection and characterized by inflammation of the meninges.

Loss of Sight means the total and irreversible loss of all sight in both eyes. To be payable as an Accident benefit, loss of sight must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of sight must be caused solely by or be solely attributed to one of the following diseases:

- Retinal disease, which is a disease that affects the retina of the eye;
- Optic nerve disease, which is a disease that affects the optic nerve of the eye; or
- Hypoxia, which is a disease characterized by a deficiency in the amount of oxygen reaching the tissues of the eyes

Loss of Speech means the total and permanent loss of the ability to speak. To be payable as an Accident benefit, loss of speech must be caused solely by or be solely attributed to a covered

accident. To be considered a critical illness, loss of speech must be caused solely by or be solely attributable to one of the following diseases:

- Alzheimer's disease, which is a progressive mental deterioration due to generalized degeneration of the brain; or
- Arteriovenous malformation, which is a congenital disease of blood vessels in the brain, brain stem, or spinal cord that is characterized by a complex, tangled web of abnormal arteries and veins connected by one or more fistulas

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. To be payable as an Accident benefit, loss of hearing must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of hearing must be caused solely by or be solely attributed to one of the following diseases:

- Alport syndrome, which is an inherited disease of the kidney caused by a genetic mutation and can be characterized by hearing loss;
- Autoimmune inner ear disease, which is an inflammatory condition of the inner ear occurring when the body's immune system attacks cells in the inner ear that are mistaken for bacteria or a virus;
- Chicken pox, which is an acute contagious disease that is caused by the varicella-zoster virus and is characterized by skin eruptions, slight fever, and malaise;
- Diabetes, which is a metabolic disease characterized by the inadequate secretion or utilization of insulin, by excessive urine production, by excessive amounts of sugar in the blood and urine, and by thirst, hunger, and loss of weight;
- Goldenhar syndrome, which is rare congenital disease that causes abnormalities in the face and head and can cause hearing loss;
- Meniere's disease, which is a disorder of the inner ear that causes spontaneous episodes of vertigo, hearing loss, ear ringing, and a feeling of fullness or pressure in the ear;
- Meningitis, which is a disease characterized by inflammation of the meninges caused by viral or bacterial infection; or
- Mumps, which is an infectious disease caused by paramyxovirus, and characterized by inflammatory swelling of the parotid and/or other salivary glands

Paralysis or Paralyzed means the permanent, total, and irreversible loss of muscle function to the whole of at least two limbs. To be payable as an Accident benefit, the paralysis must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, paralysis must be caused solely by or be solely attributed to one or more of the following diseases:

- Amyotrophic lateral sclerosis, which is a progressive degeneration of the motor neurons of the central nervous system, leading to wasting of the muscles and paralysis;
- Cerebral palsy, which is a disorder of movement, muscle tone, or posture that is caused by injury or abnormal development in the immature brain. Cerebral palsy can be characterized by stiffness and movement difficulties, or by involuntary and uncontrolled movements;
- Parkinson's disease, which is a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement; or
- Poliomyelitis, which is an acute infectious disease caused by the poliovirus and characterized by fever, motor paralysis, and atrophy of skeletal muscles. This often results in permanent disability and deformity, and is marked by inflammation of nerve cells in the anterior gray matter in each lateral half of the spinal cord.

The diagnosis of paralysis 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 meet all of the following criteria:

- 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.
- Be caused solely by or be solely attributed to a covered accident.

Heart Event Rider

Covered Heart Procedure is one of the Category I or Category II procedures defined below:

Category I – Specified Surgeries of the Heart

Specified surgeries of the heart (open heart surgery) refers to open chest surgery, where the heart is exposed and/or manipulated for open cardiothoracic situations. We will pay benefits for the following open heart surgery procedures when they are performed as a direct result of one of the following: acute coronary syndrome, atherosclerosis, coronary artery disease, cardiomyopathy, or valvular heart disease.

- **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. A blood vessel 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.
- **Mitral Valve Replacement or Repair** is a surgical procedure in which a patient's mitral valve is repaired or replaced by a different valve.
- **Aortic Valve Replacement or Repair** is a surgical procedure in which a patient's aortic valve is repaired or replaced by a different valve.
- **Surgical Treatment of Abdominal Aortic Aneurysm** involves opening the abdomen and repairing or removing an abdominal aortic aneurysm.

Category II – Invasive Procedures and Techniques of the Heart

We will pay Category II benefits for the following invasive procedures and techniques of the heart when they are performed as a result of one of the following: acute coronary syndrome, atherosclerosis, coronary artery disease, cardiomyopathy, or valvular heart disease.

- **AngioJet Clot Busting** clears 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)** opens 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** uses a laser tip to burn/break down plaque in the clogged blood vessel.
- **Atherectomy** opens blocked coronary arteries or clears bypass grafts by using a device on the end of a catheter to cut or shave away atherosclerotic plaque.
- **Stent Implantation** is the implantation of a stainless steel mesh coil in a narrowed part of an artery to keep it propped open.
- **Cardiac Catheterization (also 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)** refers to 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.
- **Pacemaker Placement** refers to the initial placement/implantation of a pacemaker, which sends electrical signals to make the heart beat when a person'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.
- **Valvular Heart Disease** is a disease characterized by damage to or a defect in one of the four heart valves.

Optional Benefits Rider

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 plan, ADLs include the following:

- Bathing – the ability to wash oneself in a tub, shower, or by sponge bath. This includes the ability to get into and out of the tub or shower with or without the assistance of equipment;
- Dressing – the ability to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;
- Toileting – the ability to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene with or without the assistance of equipment;
- Transferring – the ability to move in and out of a bed, chair, or wheelchair with or without the assistance of equipment;
- Mobility – the ability to walk or wheel on a level surface from one room to another with or without the assistance of equipment;
- Eating – the ability to get nourishment into the body by any means once it has been prepared and made available with or without the assistance of equipment; and
- Continence – the ability to voluntarily maintain control of bowel and/or bladder function. In the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

Date of Diagnosis is defined as follows:

- **Advanced Alzheimer's Disease**: The date a doctor diagnoses the insured as incapacitated due to Alzheimer's disease.
- **Advanced Parkinson's Disease**: The date a doctor diagnoses the insured as incapacitated due to Parkinson's disease.
- **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.

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.

Notices
This booklet is a brief description of coverage, not a contract. Read your certificate carefully for exact plan language, terms, and conditions.

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.

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.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. Continental American Insurance Company, Columbia, South Carolina.

AGCM321C-NC-BK IV (1/17)

Group Critical Illness With Cancer Rates

Person County Government - Semimonthly (24pp/yr) Rates

NONTOBACCO - Employee

Issue Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$ 3.20	$ 4.87	$ 6.53	$ 8.20	$ 9.86	$ 11.52	$ 13.19	$ 14.85	$ 16.52	$ 18.18
30-39	$ 4.13	$ 6.72	$ 9.32	$ 11.91	$ 14.50	$ 17.09	$ 19.68	$ 22.28	$ 24.87	$ 27.46
40-49	$ 7.03	$ 12.53	$ 18.02	$ 23.52	$ 29.01	$ 34.51	$ 40.00	$ 45.49	$ 50.99	$ 56.48
50-59	$ 11.64	$ 21.75	$ 31.85	$ 41.95	$ 52.06	$ 62.16	$ 72.26	$ 82.37	$ 92.47	$ 102.57
60+	$ 20.17	$ 38.81	$ 57.44	$ 76.07	$ 94.70	$ 113.34	$ 131.97	$ 150.60	$ 169.23	$ 187.87

NONTOBACCO - Spouse

Issue Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
18-29	$ 3.20	$ 4.87	$ 6.53	$ 8.20	$ 9.86	$ 11.52
30-39	$ 4.13	$ 6.72	$ 9.32	$ 11.91	$ 14.50	$ 17.09
40-49	$ 7.03	$ 12.53	$ 18.02	$ 23.52	$ 29.01	$ 34.51
50-59	$ 11.64	$ 21.75	$ 31.85	$ 41.95	$ 52.06	$ 62.16
60+	$ 20.17	$ 38.81	$ 57.44	$ 76.07	$ 94.70	$ 113.34

TOBACCO - Employee

Issue Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$ 3.99	$ 6.44	$ 8.88	$ 11.33	$ 13.78	$ 16.23	$ 18.67	$ 21.12	$ 23.57	$ 26.02
30-39	$ 5.92	$ 10.29	$ 14.67	$ 19.05	$ 23.42	$ 27.80	$ 32.17	$ 36.55	$ 40.93	$ 45.30
40-49	$ 10.88	$ 20.21	$ 29.55	$ 38.89	$ 48.22	$ 57.56	$ 66.90	$ 76.24	$ 85.57	$ 94.91
50-59	$ 18.94	$ 36.34	$ 53.73	$ 71.13	$ 88.53	$ 105.93	$ 123.32	$ 140.72	$ 158.12	$ 175.52
60+	$ 33.41	$ 65.29	$ 97.16	$ 129.03	$ 160.90	$ 192.78	$ 224.65	$ 256.52	$ 288.39	$ 320.27

TOBACCO - Spouse

Issue Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
18-29	$ 3.99	$ 6.44	$ 8.88	$ 11.33	$ 13.78	$ 16.23
30-39	$ 5.92	$ 10.29	$ 14.67	$ 19.05	$ 23.42	$ 27.80
40-49	$ 10.88	$ 20.21	$ 29.55	$ 38.89	$ 48.22	$ 57.56
50-59	$ 18.94	$ 36.34	$ 53.73	$ 71.13	$ 88.53	$ 105.93
60+	$ 33.41	$ 65.29	$ 97.16	$ 129.03	$ 160.90	$ 192.78

Base Plan:
-With Cancer Benefit
-$100 Health Screening Benefit
-$250 Skin Cancer Benefit
-With Additional Benefits
(Loss of Sight, Speech, Hearing)
(Coma, Burns, Paralysis)

Riders:
-Optional Benefits Rider (BTAP)
-Heart Rider
-$250 TIA (mini-stroke) Rider

Provisions:
-No Pre-Existing Condition Limitation
-Add'l Separation Waiting Period: 6 Months
-Re-Separation Waiting Period: 6 Months
-Class I/II Portability
-Rate Guarantee: 3 Years

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

Published: Feb-16 Series C21000 CI21000-160216-165738-FyjmTVjg-037ZE8B-20269