

Aflac Group Insurance Plans

Accident

Critical Illness

Hospital Indemnity



Underwritten by:
Continental American Insurance Company (CAIC)

In California, coverage is underwritten by
Continental American Life Insurance Company.



AFLAC GROUP ACCIDENT INSURANCE

Policy Series C70000



Just because an accident can change your health, doesn't mean it should change your lifestyle too.

Accidents can happen in an instant affecting you or a loved one. Aflac is designed to help families plan for the health care bumps ahead and take some of the uncertainty and financial insecurity out of getting better.

Protection for the unexpected, that's the benefit of the Aflac Group Accident Plan.

After an accident, you may have expenses you've never thought about. Can your finances handle them? It's reassuring to know that an accident insurance plan can be there for you in your time of need to help cover expenses such as:

- Ambulance rides
- Emergency room visits
- Surgery and anesthesia
- Prescriptions
- Major Diagnostic Testing
- Burns

Plan Features

- Benefits are paid directly to you, unless otherwise assigned.
- Coverage is guaranteed-issue (which means you may qualify for coverage without having to answer health questions).
- Benefits are paid regardless of any other medical insurance.

What you need, when you need it.

Group accident insurance pays cash benefits that you can use any way you see fit.



ACCIDENT BENEFITS	HIGH	LOW
INITIAL TREATMENT (once per accident, within 7 days after the accident, not payable for telemedicine services) Payable when an insured receives initial treatment for a covered accidental injury. This benefit is payable for initial treatment received under the care of a doctor when an insured visits the following:		
Hospital emergency room with X-Ray / without X-Ray	\$200/\$150	\$125/\$100
Urgent care facility with X-Ray / without X-Ray	\$200/\$150	\$125/\$100
Doctor's office or facility (other than a hospital emergency room or urgent care) with X-Ray / without X-Ray	\$100/\$75	\$75/\$50
AMBULANCE (within 90 days after the accident) Payable when an insured receives transportation by a professional ambulance service due to a covered accidental injury.	\$300 Ground \$900 Air	\$200 Ground \$600 Air
MAJOR DIAGNOSTIC TESTING (once per accident, within 6 months after the accident) Payable when an insured requires one of the following exams: Computerized Tomography (CT/CAT scan), Magnetic Resonance Imaging (MRI), or Electroencephalography (EEG) due to a covered accidental injury. These exams must be performed in a hospital, a doctor's office, a medical diagnostic imaging center or an ambulatory surgical center.	\$150	\$100
EMERGENCY ROOM OBSERVATION (within 7 days after the accident) Payable when an insured receives treatment in a hospital emergency room, and is held in a hospital for observation without being admitted as an inpatient because of a covered accidental injury.	\$70 Each 24 hour period \$35 Less than 24 hours, but at least 4 hours	\$50 Each 24 hour period \$25 Less than 24 hours, but at least 4 hours
PRESCRIPTIONS (2 times per accident, within 6 months after the accident) Payable for a prescription filled that - due to a covered accidental injury - is ordered by a doctor, dispensed by a licensed pharmacist and medically necessary for the care and treatment of the insured (in Alaska, Massachusetts and Montana prescriptions do not have to be medically necessary). This benefit is not payable for therapeutic devices or appliances; experimental drugs; drugs, medicines or insulin used by or administered to a person while he is confined to a hospital, rest home, extended-care facility, convalescent home, nursing home or similar institution; or immunization agents, biological sera, blood or blood plasma. This benefit is not payable for pain management techniques for which a benefit is paid under the Pain Management Benefit (if available).	\$5	\$5
BLOOD/PLASMA/PLATELETS (3 times per accident, within 6 months after the accident) Payable for each day that an insured receives blood, plasma or platelets due to a covered accidental injury.	\$200	\$100
PAIN MANAGEMENT (once per accident, within 6 months after the accident) Payable when an insured, due to a covered accidental injury, is prescribed and receives a nerve ablation and/or block, or an epidural injection administered into the spine. This benefit is only payable for pain management techniques (as shown above) that are administered in a hospital or doctor's office. This benefit is not payable for an epidural administered during a surgical procedure.	\$75	\$50
CONCUSSION (once per accident, within 6 months after the accident) Payable when an insured is diagnosed by a doctor with a concussion due to a covered accident.	\$350	\$250
TRAUMATIC BRAIN INJURY (once per accident, within 6 months after the accident) Payable when an insured is diagnosed by a neurologist with Traumatic Brain Injury (TBI) due to a covered accident. To qualify as TBI, the neurological deficit must require treatment by a neurologist and a prescribed course of physical, speech and/or occupational therapy under the direction of a neurologist.	\$3,500	\$2,500

COMA (once per accident) Payable when an insured is in a coma lasting 30 days or more as the result of a covered accident. For the purposes of this benefit, Coma means a profound state of unconsciousness caused by a covered accident.	\$7,500	\$5,000
EMERGENCY DENTAL WORK (once per accident, within 6 months after the accident) Payable when an insured's natural teeth are injured as a result of a covered accident.	\$30 Extraction \$120 Repair with a crown	\$25 Extraction \$100 Repair with a crown
BURNS (once per accident, within 6 months after the accident) Payable when an insured is burned in a covered accident and is treated by a doctor. We will pay according to the percentage of body surface burned. First degree burns are not covered.		
Second Degree		
Less than 10%	\$75	\$50
At least 10% but less than 25%	\$150	\$100
At least 25% but less than 35%	\$375	\$250
35% or more	\$750	\$500
Third Degree		
Less than 10%	\$750	\$500
At least 10% but less than 25%	\$3,750	\$2,500
At least 25% but less than 35%	\$7,500	\$5,000
35% or more	\$15,000	\$10,000
EYE INJURIES Payable for eye injuries if, because of a covered accident, a doctor removes a foreign body from the eye, with or without anesthesia.	\$175	\$125
FRACTURES (once per accident, within 90 days after the accident) Payable when an insured fractures a bone because of a covered accident and is treated by a doctor. If the fracture requires open reduction, 200% of the benefit is payable for that bone. For multiple fractures (more than one bone fractured in one accident), we will pay a maximum of 200% of the benefit amount for the bone fractured that has the highest dollar amount. For a chip fracture (a piece of bone that is completely broken off near a joint), we will pay 25% of the amount for the affected bone. This benefit is not payable for stress fractures.		
Hip/Thigh	\$3,000	\$2,000
Vertebrae (except processes)	\$2,700	\$1,800
Pelvis	\$2,400	\$1,600
Skull (depressed)	\$2,250	\$1,500
Leg	\$1,800	\$1,200
Forearm/Hand/Wrist	\$1,500	\$1,000
Foot/Ankle/Kneecap	\$1,500	\$1,000
Shoulder Blade/Collar Bone	\$1,200	\$800
Lower Jaw (mandible)	\$1,200	\$800
Skull (simple)	\$1,050	\$700
Upper Arm/Upper Jaw	\$1,050	\$700
Facial Bones (except teeth)	\$900	\$600
Vertebral Processes	\$600	\$400
Coccyx/Rib/Finger/Toe	\$240	\$160
Sternum	\$2,700	\$1,800
Sacral/Sacrum	\$600	\$400

DISLOCATIONS (once per accident, within 90 days after the accident) Payable when an insured dislocates a joint because of a covered accident and is treated by a doctor. If the dislocation requires open reduction, 200% of the benefit for that joint is payable. We will pay benefits only for the first dislocation of a joint. We will not pay for recurring dislocations of the same joint. If the insured dislocated a joint before the effective date of his certificate and then dislocates the same joint again, it will not be covered by the plan. For multiple dislocations (more than one dislocated joint in one accident), we will pay a maximum of 200% of the benefit amount for the joint dislocated that has the highest dollar amount. For a partial dislocation (joint is not completely separated, including subluxation), we will pay 25% of the amount for the affected joint.

Hip	\$2,250	\$1,500
Knee	\$1,462.50	\$975
Shoulder	\$1,125	\$750
Foot/Ankle	\$900	\$600
Hand	\$787.50	\$525
Lower Jaw	\$675	\$450
Wrist	\$562.50	\$375
Elbow	\$450	\$300
Finger/Toe	\$180	\$120

LACERATIONS (once per accident, within 7 days after the accident) Payable when an insured receives a laceration in a covered accident and the laceration is repaired by a doctor. For multiple lacerations, we will pay a maximum of 200% of the benefit for the largest single laceration requiring stitches. Lacerations requiring stitches (including liquid skin adhesive):

Over 15 centimeters	\$600	\$400
5-15 centimeters	\$300	\$200
Under 5 centimeters	\$75	\$50
Lacerations not requiring stitches	\$37.50	\$25

OUTPATIENT SURGERY AND ANESTHESIA (per day / performed in hospital or ambulatory surgical center, within one year after the accident) Payable for each day that, due to a covered accidental injury, an insured has an outpatient surgical procedure performed by a doctor in a hospital or ambulatory surgical center. Surgical procedure does not include laceration repair. If an outpatient surgical procedure is covered under another benefit in the plan, we will pay the higher benefit amount.

FACILITIES FEE FOR OUTPATIENT SURGERY (surgery performed in hospital or ambulatory surgical center, within one year after the accident) Payable once per each eligible Outpatient Surgery and Anesthesia Benefit (in a hospital or ambulatory surgical center).	\$75	\$50
--	------	------

OUTPATIENT SURGERY AND ANESTHESIA (per day / performed in a doctor's office, urgent care facility, or emergency room; maximum of two procedures per accident, within one year of the accident)
Payable for each day that, due to a covered accidental injury, an insured has an outpatient surgical procedure performed by a doctor in a doctor's office, urgent care facility or emergency room. Surgical procedure does not include laceration repair. If an outpatient surgical procedure is covered under another benefit in this plan, we will pay the higher benefit amount.

INPATIENT SURGERY AND ANESTHESIA (per day / within one year after the accident) Payable for each day that, due to a covered accidental injury, an insured has an inpatient surgical procedure performed by a doctor. The surgery must be performed while the insured is confined to a hospital as an inpatient. If an inpatient surgical procedure is covered under another benefit in the plan, we will pay the higher benefit amount.	\$750	\$500
--	-------	-------

<p>TRANSPORTATION (greater than 100 miles from the insured's residence, 3 times per accident, within 6 months after the accident) Payable for transportation if, because of a covered accident, an insured is injured and requires doctor-recommended hospital treatment or diagnostic study that is not available in the insured's resident city.</p>	<p>\$350 Plane \$150 Any ground transportation</p>	<p>\$250 Plane \$100 Any ground transportation</p>
<p>SUCCESSOR INSURED BENEFIT If spouse coverage is in force at the time of the employee's death, the surviving spouse may elect to continue coverage. Coverage would continue according to the existing plan and would also include any dependent child coverage in force at the time.</p>		
<p>Surgical Procedures may include, but are not limited to, surgical repair of: ruptured disc, tendons/ligaments, hernia, rotator cuff, torn knee cartilage, skin grafts, joint replacement, internal injuries requiring open abdominal or thoracic surgery, exploratory surgery (with or without repair), etc., unless otherwise noted due to an accidental injury.</p>		
<p>AFTER CARE BENEFITS</p>	<p>HIGH</p>	<p>LOW</p>
<p>APPLIANCES (within 6 months after the accident) Payable if, as a result of an injury received in a covered accident, a doctor advises the insured to use a listed medical appliance as an aid in personal locomotion. Cane, Ankle Brace Walking Boot, Walker, Crutches, Leg Brace, Cervical Collar Wheelchair, Knee Scooter, Body Jacket, Back Brace</p>	<p>\$30 \$75 \$300</p>	<p>\$20 \$50 \$200</p>
<p>ACCIDENT FOLLOW-UP TREATMENT (maximum of 6 per accident, within 6 months after the accident provided initial treatment is within 7 days of the accident) Payable for doctor-prescribed follow-up treatment for injuries received in a covered accident. Follow-up treatments do not include physical, occupational or speech therapy. Chiropractic or acupuncture procedures are also not considered follow-up treatment.</p>	<p>\$35</p>	<p>\$25</p>
<p>POST-TRAUMATIC STRESS DISORDER (PTSD) (once per accident, within 6 months after the accident) Payable if the insured is diagnosed with PTSD, a mental health condition triggered by a covered accident. An insured must meet the diagnostic criteria for PTSD, stipulated in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV-TR), and be under the active care of either a psychiatrist or Ph.D.-level psychologist.</p>	<p>\$150</p>	<p>\$100</p>
<p>REHABILITATION UNIT (maximum of 31 days per confinement, no more than 62 days total per calendar year for each insured) Payable for each day that, due to a covered accidental injury, an insured receives treatment as an inpatient at a rehabilitation facility. For this benefit to be payable, the insured must be transferred to the rehabilitation facility for treatment following an inpatient hospital confinement. We will not pay the rehabilitation facility benefit for the same days that the hospital confinement benefit is paid. We will pay the highest eligible benefit.</p>	<p>\$75 per day</p>	<p>\$50 per day</p>
<p>THERAPY (maximum of 10 per accident, beginning within 90 days after the accident provided initial treatment is within 7 days after the accident) Payable if because of injuries received in a covered accident, an insured has doctor-prescribed therapy treatment in one of the following categories: physical therapy provided by a licensed physical therapist, occupational therapy provided by a licensed occupational therapist, or speech therapy provided by a licensed speech therapist.</p>	<p>\$35</p>	<p>\$25</p>
<p>CHIROPRACTIC OR ALTERNATIVE THERAPY (maximum of 6 per accident, beginning within 90 days after the accident provided initial treatment is within 7 days after the accident) Payable if because of injuries received in a covered accident, an insured receives acupuncture or chiropractic treatment.</p>	<p>\$25</p>	<p>\$15</p>

HOSPITALIZATION BENEFITS**HIGH****LOW****HOSPITAL ADMISSION** (once per accident, within 6 months after the accident)

Payable when an insured is admitted to a hospital and confined as an inpatient because of a covered accidental injury.

This benefit is not payable for confinement to an observation unit, for emergency room treatment or for outpatient treatment.

\$1,000
per
confinement

\$625
per
confinement

HOSPITAL CONFINEMENT (maximum of 365 days per accident, within 6 months after the accident)

Payable for each day that an insured is confined to a hospital as an inpatient because of a covered accidental injury.

If we pay benefits for confinement and the insured is confined again within 6 months because of the same accidental injury, we will treat this confinement as the same period of confinement.

This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accidental injury. This benefit is not payable for confinement to an observation unit or a rehabilitation facility.

\$300
per day

\$150
per day

HOSPITAL INTENSIVE CARE (maximum of 30 days per accident, within 6 months after the accident)

Payable for each day an insured is confined in a hospital intensive care unit because of a covered accidental injury.

We will pay benefits for only one confinement in a hospital intensive care unit at a time, even if it is caused by more than one covered accidental injury.

If we pay benefits for confinement in a hospital intensive care unit and an insured becomes confined to a hospital intensive care unit again within 6 months because of the same accidental injury, we will treat this confinement as the same period of confinement.

This benefit is payable in addition to the Hospital Confinement Benefit.

\$400
per day

\$200
per day

INTERMEDIATE INTENSIVE CARE STEP-DOWN UNIT (maximum of 30 days per accident, within 6 months after the accident)

Payable for each day an insured is confined in an intermediate intensive care step-down unit because of a covered accidental injury.

We will pay benefits for only one confinement in an intermediate intensive care step-down unit at a time, even if it is caused by more than one covered accidental injury.

If we pay benefits for confinement in an intermediate intensive care step-down unit and an insured becomes confined to an intermediate intensive care step-down unit again within 6 months because of the same condition, we will treat this confinement as the same period of confinement.

This benefit is payable in addition to the Hospital Confinement Benefit.

\$200
per day

\$100
per day

FAMILY MEMBER LODGING (greater than 100 miles from the insured's residence, maximum of 30 days per accident, within 6 months after the accident)

Payable for each night's lodging in a motel/hotel/rental property for an adult member of the insured's immediate family. For this benefit to be payable:

- The insured must be confined to a hospital for treatment of a covered accidental injury;
- The hospital and motel/hotel must be more than 100 miles from the insured's residence; and
- The treatment must be prescribed by the insured's treating doctor.

\$200
per day

\$100
per day

WAIVER OF PREMIUM RIDER

If the employee becomes totally disabled due to a covered sickness* or accidental injury, after 90 days of total disability, we will waive premiums for the employee and any covered dependents. As long as the employee remains totally disabled, premium will be waived up to 24 months, subject to the terms of the plan.

*In New Hampshire, Tennessee, and Texas, not applicable.

LIFE CHANGING EVENTS BENEFITS

DISMEMBERMENT (once per accident, within 6 months after the accident)

Payable if an insured loses a hand or foot or experiences loss of sight as the result of a covered accident.

Dismemberment means:

- Loss of a hand -The hand is removed at or above the wrist joint;
- Loss of a foot -The foot is removed at or above the ankle;
- Loss of a finger/toe - The finger or toe is removed at or above the joint where it is attached to the hand or foot; or
- Loss of sight - At least 80% of the vision in one eye is lost (such loss of sight must be permanent and irrecoverable).

If the Dismemberment Benefit is paid and the insured later dies as a result of the same covered accident, we will pay the appropriate death benefit (if available), less any amounts paid under this benefit.

SINGLE LOSS (the loss of one hand, one foot, or the sight of one eye)

HIGH

LOW

Employee	\$8,750	\$6,250
Spouse	\$3,750	\$2,500
Child(ren)	\$1,750	\$1,250

DOUBLE LOSS (the loss of both hands, both feet, the sight of both eyes, or a combination of any two)

Employee	\$17,500	\$12,500
Spouse	\$7,500	\$5,000
Child(ren)	\$3,500	\$2,500

LOSS OF ONE OR MORE FINGERS OR TOES

Employee	\$875	\$625
Spouse	\$375	\$250
Child(ren)	\$175	\$125

PARTIAL DISMEMBERMENT (INCLUDES AT LEAST ONE JOINT OF A FINGER OR A TOE)

Employee / Spouse / Children	\$87.50	\$62.50
------------------------------	---------	---------

PARALYSIS (once per accident, diagnosed by a doctor within six months after the accident)

Payable if an insured has permanent loss of movement of two or more limbs for more than 90 days (in Utah, 30 days) as the result of a covered accidental injury.

Paraplegia

\$3,500 \$2,500

Quadriplegia

\$7,500 \$5,000

RESIDENCE/VEHICLE MODIFICATION (once per accident, within one year after the accident)

Payable for a permanent structural modification to an insured's primary residence or vehicle when the insured suffers total and permanent or irrevocable loss of one of the following, due to a covered accidental injury:

- The sight of one eye;
- The use of one hand/arm; or
- The use of one foot/leg.

\$1,500 \$1,000

PROSTHESIS (once per accident, one replacement per device per insured)*

Payable when an insured receives a prosthetic device, prescribed by a doctor, as a result of a covered accidental injury.

Prosthetic Device/Prosthesis means an artificial device designed to replace a missing part of the body. This benefit is not payable for hearing aids, wigs, or dental aids (to include false teeth), repair or replacement of prosthetic devices* and /or joint replacements.

\$2,000 \$1,500

* We will pay this benefit again once to cover the replacement of a prosthesis for which a benefit has been paid, provided the replacement takes place within three years of the initial benefit payment.

Aflac can help ease the financial stress of surviving a critical illness.

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

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

That's the benefit of an Aflac Group Critical Illness plan.

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

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

What you need, when you need it.

Group critical illness insurance pays cash benefits that you can use any way you see fit.



Here's why the Aflac Group Critical Illness plan may be right for you.

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

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

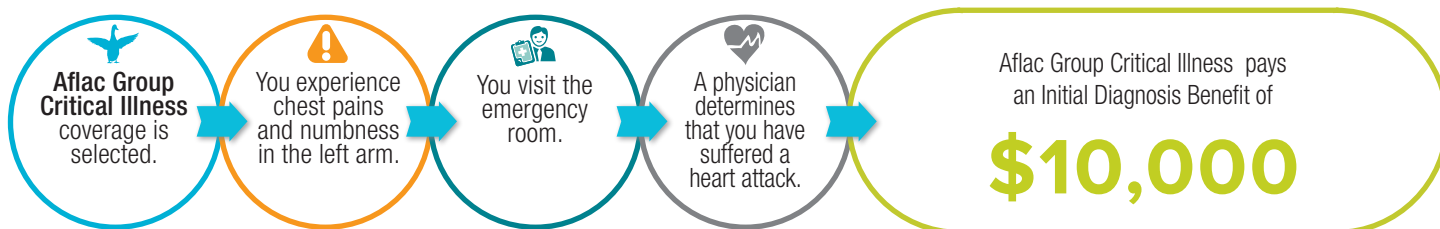
The Aflac Group Critical Illness plan benefits include:

- Critical Illness Benefit payable for:
 - Cancer
 - Heart Attack (Myocardial Infarction)
 - Stroke
 - Kidney Failure (End-Stage Renal Failure)
 - Major Organ Transplant
 - Bone Marrow Transplant (Stem Cell Transplant)
 - Sudden Cardiac Arrest
 - Coronary Artery Bypass Surgery
 - Non-Invasive Cancer
 - Skin Cancer
 - Severe Burn
 - Paralysis
 - Coma
 - Loss of Speech/Sight/Hearing
- Health Screening Benefit

Features:

- Benefits are paid directly to you, unless otherwise assigned.
- Coverage is available for you, your spouse, and dependent children.
- Coverage may be continued (with certain stipulations). That means you can take it with you if you change jobs or retire.

How it works



Amount payable based on \$10,000 Initial Diagnosis Benefit.

Benefits Overview

COVERED CRITICAL ILLNESSES:

CANCER (Internal or Invasive)	100%
HEART ATTACK (Myocardial Infarction)	100%
STROKE (Ischemic or Hemorrhagic)	100%
MAJOR ORGAN TRANSPLANT (25% of this benefit is payable for insureds placed on a transplant list for a major organ transplant)	100%
KIDNEY FAILURE (End-Stage Renal Failure)	100%
BONE MARROW TRANSPLANT (Stem Cell Transplant)	100%
SUDDEN CARDIAC ARREST	100%
SEVERE BURN*	100%
COMA**	100%
PARALYSIS**	100%
LOSS OF SIGHT / HEARING / SPEECH**	100%
NON-INVASIVE CANCER	25%
CORONARY ARTERY BYPASS SURGERY	25%

INITIAL DIAGNOSIS

We will pay a lump sum benefit upon initial diagnosis of a covered critical illness when such diagnoses 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

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. Cancer diagnoses are subject to the cancer diagnosis limitation.

REOCCURRENCE

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. 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’s benefit amount at no additional charge. Children-only coverage is not available.

SKIN CANCER BENEFIT

We will pay \$250 for the diagnosis of skin cancer. We will pay this benefit once per calendar year.

TIA BENEFIT

Transient Ischemic Attack \$250 per calendar year

*This benefit is only payable for a burn 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.

WAIVER OF PREMIUM

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, premiums 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.

HEALTH SCREENING BENEFIT (Employee and Spouse only)

We will pay \$100 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.

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

This brochure is for illustrative purposes only. Refer to your certificate for complete details, definitions, limitations, and exclusions.

AFLAC GROUP HOSPITAL INDEMNITY

Policy Series C80000



The plan that can help with expenses and protect your savings.

Does your major medical insurance cover all of your bills?

Even a minor trip to the hospital can present you with unexpected expenses and medical bills. And even with major medical insurance, your plan may only pay a portion of your entire stay.

That's how the Aflac Group Hospital Indemnity plan can help.

It provides financial assistance to enhance your current coverage. So you may be able to avoid dipping into savings or having to borrow to address out-of-pocket-expenses major medical insurance was never intended to cover. Like transportation and meals for family members, help with child care, or time away from work, for instance.

The Aflac Group Hospital Indemnity plan benefits include the following:

- Hospital Confinement Benefit
- Hospital Admission Benefit
- Hospital Intensive Care Benefit
- Intermediate Intensive Care Step-Down Unit
- Successor Insured Benefit



How it works



Amount payable was generated based on benefit amounts for: Hospital Admission (\$2,000), and Hospital Confinement (\$200 per day).

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

Benefits Overview

	HIGH	LOW
<p>HOSPITAL ADMISSION BENEFIT per first day of confinement (once per covered sickness or accident per calendar year for each covered person)</p> <p>Payable when a covered person is admitted to a hospital and confined as an in-patient because of a covered accidental injury or covered sickness. We will not pay benefits for confinement to an observation unit, or for emergency room treatment or outpatient treatment.</p> <p>We will not pay benefits for admission of a newborn child following his birth; however, we will pay for a newborn's admission to a Hospital Intensive Care Unit if, following birth, he is confined as an inpatient as a result of a covered accidental injury or covered sickness (including congenital defects, birth abnormalities, and/or premature birth).</p>	\$2,000	\$500
<p>HOSPITAL CONFINEMENT per day (maximum of 31 days per confinement for each covered sickness or accident for each covered person)</p> <p>Payable for each day that a covered person is confined to a hospital as an in-patient as the result of a covered accidental injury or covered sickness. If we pay benefits for confinement and the covered person becomes confined again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accidental injury, more than one covered sickness, or a covered accidental injury and a covered sickness.</p>	\$200	\$100
<p>HOSPITAL INTENSIVE CARE BENEFIT per day (maximum of 10 days per confinement for each covered sickness or accident for each covered person)</p> <p>Payable for each day when a covered person is confined in a Hospital Intensive Care Unit because of a covered accidental injury or covered sickness. We will pay benefits for only one confinement in a Hospital's Intensive Care Unit at a time. Once benefits are paid, if a covered person becomes confined to a Hospital's Intensive Care Unit again within six months because of the same or related condition, we will treat this confinement as the same period of confinement.</p> <p>This benefit is payable in addition to the Hospital Confinement Benefit.</p>	\$200	\$100
<p>INTERMEDIATE INTENSIVE CARE STEP-DOWN UNIT per day (maximum of 10 days per confinement for each covered sickness or accident for each covered person)</p> <p>Payable for each day when a covered person is confined in an Intermediate Intensive Care Step-Down Unit because of a covered accidental injury or covered sickness. We will pay benefits for only one confinement in an Intermediate Intensive Care Step-Down Unit at a time.</p> <p>Once benefits are paid, if a covered person becomes confined to a Hospital's Intermediate Intensive Care Step-Down Unit again within six months because of the same or related condition, we will treat this confinement as the same period of confinement.</p> <p>This benefit is payable in addition to the Hospital Confinement Benefit.</p>	\$100	\$50
<p>WAIVER OF PREMIUM RIDER</p> <p>If the employee becomes totally disabled due to a covered sickness or accidental injury, 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 plan.</p>		
<p>SUCCESSOR INSURED BENEFIT</p> <p>If spouse coverage is in force at the time of the employee's death, the surviving spouse may elect to continue coverage. Coverage would continue according to the existing plan and would also include any dependent child coverage in force at the time.</p>		

In order to receive benefits for accidental injuries due to a covered accident, a covered person must be admitted within six months of the date of the covered accident.

INITIAL ACCIDENT EXCLUSIONS

This brochure is subject to the terms, conditions, and limitations of Policy Series C70000.

Plan exclusions apply to all riders unless otherwise noted.

We will not pay benefits for accidental injury, disability or death contributed to, caused by, or resulting from*:

- War – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.
 - In California: voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the insured is in such service.) War also includes voluntary participation in an insurrection or riot.
 - In Idaho: participating in any war or act of war, declared or undeclared, or participating or serving in the armed forces or units auxiliary thereto. War also includes participation in a riot or an insurrection.
 - In Illinois: the statement “war does not include acts of terrorism” is deleted.
 - In Michigan: voluntarily participating in war or any act of war. War also includes voluntary felonious participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.
 - In North Carolina: War – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the insured is in such service.) War also includes civil participation in an active riot. War does not include acts of terrorism.
- Suicide – committing or attempting to commit suicide, while sane or insane.
 - In Montana: committing or attempting to commit suicide, while sane
 - In Illinois, Michigan and Minnesota: this exclusion does not apply
- Sickness – having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for:
 - Allergic reactions
 - Any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid or other arthropod bites or stings. In Illinois: any bacterial infection, except an infection which results from an accidental injury or an infection which results from accidental, involuntary or unintentional ingestion of a contaminated substance; any viral or microorganism infection or infestation; or any condition resulting from insect, arachnid or other arthropod bites or stings. In North Carolina: any viral or microorganism infestation or any condition resulting from insect, arachnid or other arthropod bites or stings
 - An error, mishap or malpractice during medical, diagnostic, or surgical treatment or procedure for any sickness
 - Any related medical/surgical treatment or diagnostic procedures for such illness
- Self-Inflicted Injuries – injuring or attempting to injure oneself intentionally.
 - In Idaho: intentionally self-inflicting injury.
 - In Montana: injuring or attempting to injure oneself intentionally, while sane
 - In Michigan: this exclusion does not apply
- Racing – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semi-professional capacity.
 - In Idaho: this exclusion does not apply
- Illegal Occupation – voluntarily participating in, committing or attempting to commit a felony or illegal act or activity, or voluntarily working at or being engaged in, an illegal occupation or job.
 - In California, Nebraska and Tennessee: voluntarily participating in, committing, or attempting to commit a felony; or voluntarily working at, or being engaged in, an illegal occupation or job.
 - In Illinois and Pennsylvania: committing or attempting to commit a felony or being engaged in an illegal occupation
 - In Michigan: voluntarily participating in, committing or attempting to commit a felony, or being engaged in an illegal occupation
 - In Idaho and South Dakota: this exclusion does not apply
- Sports – participating in any organized sport in a professional or semi-professional capacity for pay

or profit.

- In California and Idaho: participating in any organized sport in a professional capacity for pay or profit
- Cosmetic Surgery – having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of a covered accident.
 - In Alaska, Massachusetts and Montana: having cosmetic surgery, other elective procedures or dental treatment except as a result of a covered accident.
 - In California: having cosmetic surgery or other elective procedures that are not medically necessary (“cosmetic surgery” does not include reconstructive surgery when the service is related to or follows surgery resulting from a covered accident); or having dental treatment except as a result of a covered accident.
 - In Idaho: having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of a covered accident. Cosmetic surgery shall not include reconstructive surgery because of a Congenital Anomaly of a covered dependent child.
- Felony (In Idaho only) – participation in a felony

For 24-Hour Coverage, the following exclusions will not apply:

An injury arising from any employment.

An injury or sickness covered by worker’s compensation.

In North Carolina: services or supplies for the treatment of an occupational injury or sickness which are paid under the North Carolina workers’ compensation act only to the extent such services or supplies are the liability of the employee, employer, or workers’ compensation insurance carrier according to a final adjudication under the North Carolina Workers’ Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers’ Compensation Act.

*“Contributed to” language doesn’t apply in Illinois

DEFINITIONS

Accidental Injury means accidental bodily damage to an insured resulting from an unforeseen and unexpected traumatic event. This must be the direct result of an accident and not the result of disease or bodily infirmity. A Covered Accidental Injury is an accidental injury that occurs while coverage is in force. A Covered Accident is an accident that occurs on or after an insured’s effective date while coverage is in force, and that is not specifically excluded by the plan.

Ambulatory Surgical Center is defined as a licensed surgical center consisting of an operating room; facilities for the administration of general anesthesia; and a post-surgery recovery room in which the patient is admitted and discharged within a period of less than 24 hours.

Dependent Child or Dependent Children means your or your spouse’s natural children, step-children, grandchildren who are in your legal custody and residing with you, foster children, children subject to legal guardianship, legally adopted children, or children placed for adoption, who are younger than age 26 (and in Louisiana, unmarried). Newborn children may be automatically covered from the moment of birth for 60 days. Newly adopted children (and foster children in North Carolina and Florida) may also be automatically covered for 60 days. See certificate for details.

Doctor is a person who is duly qualified as a practitioner of the healing arts acting within the scope of his license, and is licensed to practice medicine; prescribe and administer drugs; or to perform surgery, or is a duly qualified medical practitioner according to the laws and regulations in the state in which treatment is made.

In Montana, for purposes of treatment, the insured has full freedom of choice in the selection of any licensed physician, physician assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, acupuncturist, naturopathic physician, physical therapist, speech-language pathologist, audiologist, licensed addiction counselor, or advanced practice registered nurse.

A Doctor does not include the insured or an insured’s family member. In South Dakota however, a doctor who is an employee’s family member may treat the insured if that doctor is the only doctor in the area and acts within the scope of his practice. For the purposes of this definition, family member includes the employee’s spouse as well as the following members of the employee’s immediate family son, daughter, mother, father, sister, and brother. This includes step-family members and family-members-in-law.

The term Hospital specifically excludes any facility not meeting the definition of hospital as defined in this plan, including but not limited to:

- A nursing home,
- An extended-care facility,
- A skilled nursing facility,
- A rest home or home for the aged,
- A rehabilitation facility,

- A facility for the treatment of alcoholism or drug addiction, or
- An assisted living facility.

Spouse is your legal wife, husband, or partner in a legally recognized union. Refer to your certificate for details.

Telemedicine Service means a medical inquiry with a doctor via audio or video communication that assists with a patient's assessment, diagnosis, and consultation.

Treatment is the consultation, care, or services provided by a doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines. Treatment does not include telemedicine services.

Urgent Care is a walk-in clinic that delivers ambulatory, outpatient care in a dedicated medical facility for illnesses or injuries that require immediate care but that are not serious enough to require a visit to an emergency room.

HOSPITALIZATION BENEFITS

Hospital Intensive Care Unit means a place that meets all of the following criteria:

- Is a specifically designated area of the hospital called a hospital intensive care unit;
- Provides the highest level of medical care;
- Is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- Is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement;
- Is permanently equipped with special life-saving equipment for the care of the critically ill or injured;
- Is under close observation by a specially trained nursing staff assigned exclusively to the hospital intensive care unit 24 hours a day; and
- Has a doctor assigned to the hospital intensive care unit on a full-time basis.

The term Hospital Intensive Care Unit specifically excludes any type of facility not meeting the definition of hospital intensive care unit as defined in this plan, including but not limited to private monitored rooms, surgical recovery rooms, observation units and the following step-down units:

- A progressive care unit;
- A sub-acute intensive care unit; or
- An intermediate care unit.

Intermediate Intensive Care Step-Down Unit means any of the following:

- A progressive care unit;
- A sub-acute intensive care unit;
- An intermediate care unit; or
- A pre- or post-intensive care unit.

An intermediate intensive care step-down unit is not a hospital intensive care unit as defined in this plan.

AFTER CARE BENEFITS

Psychiatrist is a doctor of medicine who specializes in the diagnosis and treatment of mental disorders.

Psychologist is a clinical, mental health professional who works with patients. A psychologist is not a doctor of medicine who typically provides medical interventions and drug therapies, but provides analysis and counseling.

Rehabilitation Facility is a unit or facility providing coordinated multidisciplinary physical restorative services. These services must be provided to inpatients under a doctor's direction. The doctor must be knowledgeable and experienced in rehabilitative medicine. Beds must be set up in a unit or facility specifically designated and staffed for this service. This is not a facility for the treatment of alcoholism or drug addiction.

WAIVER OF PREMIUM RIDER

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 accidental injury (or a covered sickness if applicable), and
- Unable to work.

Unable to Work means either:

- You are unable to work at the occupation you were performing when your total disability began, which was during the first 365 days of total disability; or
- You are unable to work at any gainful occupation for which you are suited by education, training, or experience after the first 365 days of total disability.

Definitions in Maine:

Total Disability or Totally Disabled means you are:

- Unable to engage in any employment or occupation for which you are or become qualified by reason of education, training, or experience, and are not, in fact, engaged in any employment or occupation for wage or profit.

- Under the care of a doctor for the treatment of a covered accidental injury (or a covered sickness if applicable).

CRITICAL ILLNESS LIMITATIONS AND EXCLUSIONS

This coverage is subject to the terms, conditions, and limitations of Policy Series C21000.

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 and Minnesota: 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.

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

The burn must:

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

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

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
- Diabetes
- Encephalitis
- Epilepsy
- Hyperglycemia
- Hypoglycemia
- Meningitis

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
- Cerebral palsy
- Parkinson's disease,
- Poliomyelitis

The diagnosis of paralysis must be supported by neurological evidence.

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
- Optic nerve disease
- Hypoxia

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
- Arteriovenous malformation

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
- Autoimmune inner ear disease
- Chicken pox
- Diabetes
- Goldenhar syndrome
- Meniere's disease
- Meningitis
- Mumps

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.

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.
- 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.
- 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.
- 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.
- 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).
- 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.
- 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).

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 phosphokinase (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.

HOSPITAL INDEMNITY LIMITATIONS AND EXCLUSIONS

This coverage is subject to the terms, conditions, and limitations of Policy Series C80000.

EXCLUSIONS

We will not pay for loss due to:

- War – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the covered person is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.
- Racing – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semi-professional capacity.
- Illegal Occupation – voluntarily participating in, committing, or attempting to commit a felony, or voluntarily working at, or being engaged in, an illegal occupation or job.
- Sports – participating in any organized sport in a professional or semi-professional capacity.
- Custodial Care – this is non-medical care that helps individuals with the basic tasks of everyday life, the preparation of special diets, and the self-administration of medication which does not require the constant attention of medical personnel.
- Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including any resulting complications.
- Services performed by a family member.
- Services related to sex or gender change, sterilization, in vitro fertilization, vasectomy or reversal of a vasectomy, or tubal ligation.
- Elective Abortion – an abortion for any reason other than to preserve the life of the person upon whom the abortion is performed.
- Dental Services or Treatment.
- Cosmetic Surgery, except when due to:
 - Reconstructive surgery, when the service is related to or follows surgery resulting from a Covered Accidental Injury or a Covered Sickness, or is related to or results from a congenital disease or anomaly of a covered dependent child.
 - Congenital defects in newborns.

TERMS YOU NEED TO KNOW

A Covered Accident is an accident that occurs on or after a covered person's effective date while coverage is in force, and that is not specifically excluded by the plan.

Dependent means your spouse or dependent children, as defined in the applicable rider, who have been accepted for coverage. Spouse is your legal wife, husband, or partner in a legally recognized union. Refer to your certificate for details.

Dependent Children are your or your spouse's natural children, step-children, grandchildren who are in your legal custody and residing with you, foster children, children subject to legal guardianship, legally adopted children, or children placed for adoption. Newborn children are automatically covered from the moment of birth for 60 days. Newly adopted children are automatically covered for 60 days also. See certificate for details.

Dependent children must be younger than age 26, however this limit will not apply to any covered person dependent child who is incapable of self-sustaining employment due to mental or physical handicap and is chiefly dependent on a parent for support and maintenance.

Doctor is a person who is duly qualified as a practitioner of the healing arts acting within the scope of his license, and: is licensed to practice medicine; prescribe and administer drugs; or to perform surgery, or is a duly qualified medical practitioner according to the laws and regulations in the state in which treatment is made.

A Doctor does not include you or any of your Family Members. 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, or brother.

A Hospital is not a nursing home; an extended care facility; a skilled nursing facility; a rest home or home for the aged; a rehabilitation facility; a facility for the treatment of alcoholism or drug addiction; an assisted living facility; or any facility not meeting the definition of a Hospital as defined in the certificate.

A Hospital Intensive Care Unit is not any of the following step-down units: a progressive care unit; a sub-acute intensive care unit; an intermediate care unit; a private monitored room; a surgical recovery room; an observation unit; or any facility not meeting the definition of a Hospital Intensive Care Unit as defined in the certificate

Sickness means an illness, infection, disease, or any other abnormal physical condition or pregnancy that is not caused solely by, or the result of, any injury. A Covered Sickness is one that is not excluded by name, specific description, or any other provision in this plan. For a benefit to be payable, loss arising from the covered sickness must occur while the applicable covered person's coverage is in force.

Treatment is the consultation, care, or services provided by a doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines. Treatment does not include telemedicine services.

You May Continue Your Coverage

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

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.

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 • Columbia, South Carolina

The certificate to which this sales material pertains may be written only in English; the certificate prevails if interpretation of this material varies. This brochure is a brief description of coverage and is not a contract.

Read your certificate carefully for exact terms and conditions. You're welcome to request a full copy of the plan certificate through your employer or by reaching out to our Customer Service Center.

aflacgroupinsurance.com | 1.800.433.3036

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