

Aflac Group Critical Illness

**INSURANCE – PLAN INCLUDES BENEFITS
FOR CANCER AND HEALTH SCREENING**

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



Aflac®

We've got you under our wing.®

AFLAC GROUP CRITICAL ILLNESS INSURANCE

Policy Series CAI2800



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

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

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

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

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

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

What you need, when you need it.

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



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 under our wing.

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

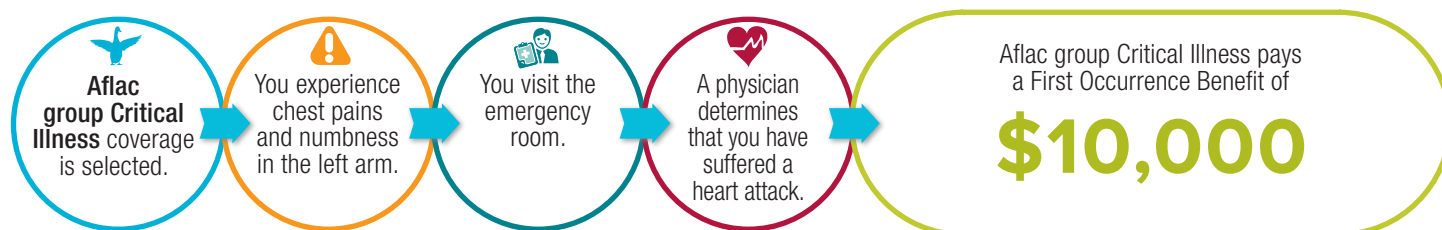
The Aflac group Critical Illness plan benefits include:

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

Features:

- Benefits are paid directly to you unless otherwise assigned.
- Coverage is available for you, your spouse, and dependent children.
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire.
- Fast claims payment. Most claims are processed in about four days.
- If you are deemed ineligible due to a previous medical condition, you still retain the ability to purchase spouse coverage.

How it works



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

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

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

Benefits Overview

COVERED CRITICAL ILLNESSES:

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

FIRST OCCURRENCE BENEFIT

After the waiting period, a lump sum benefit is payable upon initial diagnosis of a covered critical illness. Employee benefit amounts available are \$10,000, \$20,000 or \$30,000. Spouse coverage is also available in benefit amounts of \$5,000, \$10,000 or \$15,000, not to exceed one half of the employee's amount. Recurrence of a previously diagnosed cancer is payable provided the diagnosis is made when the certificate is in-force, and provided the insured is free of any signs or symptoms of that cancer for 12 consecutive months, and has been treatment-free for that cancer for 12 consecutive months.

ADDITIONAL OCCURRENCE BENEFIT

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

REOCCURRENCE BENEFIT

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

CHILD COVERAGE AT NO ADDITIONAL COST

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

HEALTH SCREENING BENEFIT (Employee and Spouse only)

After the waiting period, you may receive a maximum of \$50 for any one covered health screening test per calendar year. We will pay this benefit regardless of the results of the test. Payment of this benefit will not reduce the critical illness benefit payable under the plan. There is no limit to the number of years you can receive the Health Screening Benefit; it will be payable as long as coverage remains in force. This benefit is only payable for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for the covered employee and spouse. **This benefit is not paid for dependent children.**

COVERED HEALTH SCREENING TESTS INCLUDE:

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

ADDITIONAL BENEFITS RIDER (This benefit is paid based on your selected benefit amount.)

PARALYSIS	100%
SEVERE BURNS	100%
COMA	100%
LOSS OF SPEECH / SIGHT / HEARING	100%

HEART EVENT RIDER (This benefit is paid based on your selected benefit amount.)

OPEN HEART SURGERIES (Category I: Coronary Artery Bypass Surgery (CABS)*, Mitral Valve Replacement or Repair, Aortic Valve Replacement or Repair, Surgical Treatment of Abdominal Aortic Aneurysm). *Payment of this benefit will still reduce the benefit payable for Heart Attack by 25%.	100%
INVASIVE HEART PROCEDURE (Category II: AngioJet Clot Busting, Balloon Angioplasty, Laser Angioplasty, Atherectomy, Stent Implantation, Cardiac Catheterization, Automatic Implantable (or Internal) Cardioverter Defibrillator, Pacemakers)	10%

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

OCCUPATIONAL HIV RIDER

100%

This benefit pays the applicable maximum benefit amount for the initial positive diagnosis of occupational human immunodeficiency virus (HIV), as a result of a covered injury. This benefit is payable once, and once the benefit is paid, coverage for that individual will terminate.

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

CRITICAL ILLNESS LIMITATIONS AND EXCLUSIONS

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

IF DIAGNOSIS OCCURS AFTER THE AGE OF 70, HALF OF THE BENEFIT IS PAYABLE.

The plan contains a 30-day waiting period. This means that no benefits are payable for anyone who has been diagnosed before your coverage has been in force 30 days from the effective date. If you are first diagnosed during the waiting period, benefits for treatment of that critical illness will apply only to loss starting after 12 months from the effective date or the employee can elect to void the coverage and receive a full refund of premium.

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

EXCLUSIONS

Benefits will not be paid for loss due to:

- Intentionally self-inflicted injury or action;
- Suicide or attempted suicide while sane or insane;
- Illegal activities or participation in an illegal occupation;
- War, whether declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence; or
- Substance abuse.

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

No benefits will be paid for diagnosis made or treatment received outside of the United States.

Applicable to Cancer and/or Carcinoma in Situ: If all other plan provisions are met, recurrence of a previously diagnosed cancer will not be reduced or denied provided the diagnosis is made when the certificate is in-force, and provided the insured is free of any signs or symptoms of that cancer for 12 consecutive months, and has been treatment-free for that cancer for 12 consecutive months.

TERMS YOU NEED TO KNOW

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

Employee means the insured as shown on the certificate schedule.

Spouse means your legal wife or husband.

Dependent Children means your natural children, step-children, foster children, legally adopted children or children placed for adoption, who are under age 26.

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

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

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

Treatment Free means a period of time without the consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines. For the purpose of this definition treatment does not include maintenance drug therapy or routine follow-up visits to verify if cancer or carcinoma in situ has returned.

Maintenance Drug Therapy means ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer due to primary treatment. It is meant to decrease the risk of cancer recurrence rather than the palliative or suppression of a cancer that is still present.

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

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

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

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

Cancer (Internal or Invasive) means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes leukemia. Excluded are cancers that are noninvasive, such as (1) Premalignant tumors or polyps; (2) Carcinoma in Situ; (3) Any skin cancers except melanomas; (4) Basal cell carcinoma and squamous cell carcinoma of the skin; and (5) Melanoma that is diagnosed as Clark's Level I or II or Breslow thickness less than .77 mm.

Cancer is also defined as a disease which meets the diagnosis criteria of malignancy established by The American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen.

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

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

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

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

PORTABLE COVERAGE

When coverage would otherwise terminate because you end employment with the employer, coverage may be continued. You may continue the coverage that is in force on the date employment ends, including dependent coverage then in effect. You must apply to us in writing within 31 days after the date that the insurance would terminate.

You may be allowed to continue the coverage until the earlier of the date you fail to pay the required premium or the date the group master policy is terminated. Coverage may not be continued if you fail to pay any required premium or the group master policy terminates.

TERMINATION

Coverage will terminate on the earliest of: (1) The date the master policy is terminated; (2) The 31st day after the premium due date if the required premium has not been paid; (3) The date the insured ceases to meet the definition of an employee as defined in the master policy; or (4) The date the employee is no longer a member of the class eligible.

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

ADDITIONAL BENEFITS RIDER

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

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

The coverage in this plan summary contains a 30-day waiting period. This means no benefits are payable for any insured who has been diagnosed before his or her coverage has been in force 30 days from the effective date. If an insured is first diagnosed during the waiting period, benefits for treatment of that specified critical illness will apply only to loss commencing after 12 months from the effective date; or, you may elect to void the certificate from the beginning and receive a full refund of premium. The date of diagnosis of a specified critical illness must be separated from the date of diagnosis of a subsequent different critical illness by at least 6

months.

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

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

Unless amended the by Additional Benefits Rider, certificate definitions and terms and other provisions apply.

ADDITIONAL BENEFITS DEFINITIONS

Coma means a state of unconsciousness for 30 consecutive days with:

- No reaction to external stimuli;
- No reaction to internal needs; and
- The use of life support systems.

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

Severe Burn/Severely Burned means cosmetic disfigurement of the surface of a body area not less than 35 square inches due to fire, heat, caustics, electricity, or radiation that is a full-thickness or third-degree burn, as determined by a physician.

A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the

dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity, or radiation.

Loss of Speech means the total and permanent loss of the ability to speak as the result of physical injury.

Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of hearing that can be corrected by the use of any hearing aid or device shall not be considered an irrevocable loss.

Loss of Sight means the total and irreversible loss of all sight in both eyes.

HEART EVENT RIDER

We will pay the indicated percentages of your maximum benefit if you are treated with one of the specified surgical procedures (Category I) or interventional procedures (Category II) shown if the date of treatment is after the waiting period; treatment is incurred while coverage is in force; treatment is recommended by a physician; and is not excluded by name or specific description. This benefit is paid based on your selected benefit amount.

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

The rider contains a 30-day waiting period. This means no benefits are payable for any insured who has been diagnosed before the coverage has been in force 30 days from the effective date. If an insured is first diagnosed during the waiting period, benefits for treatment of that critical illness will apply only to loss commencing after 12 months from the effective date; or, at your option, you may elect to void the coverage from the beginning and receive a full refund of premium.

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

Unless amended by the Heart Event Rider, certificate definitions, other provisions and terms apply. Benefits provided by the Heart Event Rider amend any benefits shown in the base plan for the same conditions. Benefits for Category II will reduce the benefit amounts payable for Category I benefits. Benefits will be paid only at the highest benefit level. If Category I and Category II procedures are performed at the same time, benefits are only eligible at the 100% (higher) event and will not exceed the initial face amount shown. The insured is only eligible to receive one payment for each benefit category listed. The dates of loss for covered procedures must be separated by at least 12 months for benefits to be payable for multiple covered procedures. Payment of initial, reoccurrence, or additional occurrence benefits are subject to the benefits section of the base certificate.

EXCLUSIONS

No benefits will be paid if the specified critical illness is a result of: (a) Intentionally self-inflicted injury or action; (b) Suicide or attempted suicide while sane or insane; (c) Illegal activities or participation in an illegal occupation; (d) War, declared or undeclared, or military conflicts, participation in an insurrection or riot, civil commotion, or state of belligerence; or (e) An injury sustained while under the influence of alcohol, narcotics, or any other controlled substance or drug, unless properly administered upon the advice of a physician. No benefits will be paid for

loss which occurred prior to the effective date of coverage. Diagnosis must be made and treatment received in the United States.

HEART RIDER DEFINITIONS

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

*Category I – Specified Surgeries of the Heart

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

Benefits are paid for the following open heart surgery procedures only:

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

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

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

Mitral Valve Replacement or Repair is a cardiac surgery procedure in which a patient's mitral valve is repaired or replaced by a different valve.

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

Surgical Treatment of Abdominal Aortic Aneurysm is a procedure performed to prevent aneurysm rupture. The operation consists of opening the abdomen, finding the aorta, and removing (excising) the aneurysm.

Abdominal aortic aneurysm is a ballooning or widening of the main artery (the aorta) as it courses down through the abdomen. At the point of the aneurysm, the aneurysm generally measures 3 cm or more in diameter.

Category I Benefits exclude all procedures not specifically listed above, including procedures such as, but not limited to, angioplasty, laser relief, stent implantation, or other surgical and nonsurgical procedures.

****Category II Benefits (Invasive, Procedures and Techniques of the Heart)** are paid for the following procedures only:

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

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

Laser Angioplasty is similar to Balloon Angioplasty. A laser tip is used to burn/break down plaque in the clogged blood vessel.

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

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

Cardiac Catheterization (also **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.

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

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

Category II benefits exclude all procedures not specifically listed above.

OCCUPATIONAL HIV RIDER

This benefit pays the applicable maximum benefit amount for the initial positive diagnosis of occupational human immunodeficiency virus (HIV), as a result of a covered injury.

This benefit is payable once, and once the benefit is paid, coverage for that individual will terminate.

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

EXCLUSIONS

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

No benefits will be paid for occupational HIV resulting from a needle stick or sharp injury or a mucous membrane exposure to blood or bloodstained bodily fluid, which occurred prior to the effective date of the rider. We will not pay for any cost incurred for HIV tests or any related testing. No benefits will be paid for HIV contracted outside the United States. Unless amended by the Occupational HIV Rider, certificate definitions and terms and other provisions apply.

OCCUPATIONAL HIV RIDER DEFINITIONS

HIV means human immunodeficiency virus.

HIV Positive means the presence of HIV antibodies in the blood of an insured as substantiated through both a positive screening test enzyme-linked immunosorbent assay (ELISA) and a positive supplement test, such as the western blot. All such tests must be approved by the Food and Drug Administration (FDA) with the interpretation of positive results as specified by the manufacturer(s).

Occupational HIV means an insured, as a direct result of a covered injury, tests HIV-positive, subject to the following: (1) an incident report (notice of exposure) on a form acceptable to the company, which describes the nature of the exposure to HIV, must be filed with the insured's employer within 48 hours and be sent to the company, as soon as reasonably possible, after the covered injury; (2) the insured must not have previously tested positive for HIV, or if he had previously tested positive for HIV, the insured subsequently tested negative for HIV prior to the date of the covered injury; (3) the insured must have a preliminary screening test, such as an ELISA or other appropriate Food and Drug Administration (FDA) approved test (other than saliva or urine testing), for HIV within 14 days of the covered injury at an authorized laboratory other than the laboratory of his employer. We must receive notification: (a) of the results of that test as soon as reasonably possible; and (b) that the results are negative; and (c) thereafter, the insured must test HIV-positive within 26 weeks of the date of the covered injury reported in item (1) above. We must receive notification of HIV-positive test results as soon as reasonably possible.

Covered Injury means an accidental: (1) cutaneous exposure through abraded skin; (2) percutaneous exposure; or (3) mucocutaneous exposure that occurs while the insured is covered by the rider, actively at work, and performing all the regular duties of his occupation on a full-time basis.

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.

**We've got you
under our wing.®**

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

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.

This brochure is subject to the terms, conditions, and limitations of Policy Series CAI2800.