Aflac
Group Critical Illness

INSURANCE – PLAN INCLUDES BENEFITS FOR CANCER AND HEALTH SCREENING

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

Coverage is underwritten by Continental American Life Insurance Company.

The Aflac group Critical Illness plan is a supplement to health insurance. It is not a substitute for Hospital or Medical Expense Insurance, a Health Maintenance Organization (HMO) Contract, or Major Medical Expense Insurance.
Aflac can help ease the financial stress of surviving a critical illness.

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

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

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

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

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

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

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**FACT NO. 1**

AN ESTIMATED 82.6 MILLION AMERICAN ADULTS—GREATER THAN 1 IN 3—HAVE ONE OR MORE TYPES OF CARDIOVASCULAR DISEASE (CVD).¹

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**FACT NO. 2**

MORE THAN $44 BILLION IN EXPENSES MADE CORONARY ARTERY DISEASE THE MOST EXPENSIVE CONDITION TREATED IN 2004.²

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¹ & ²http://circ.ahajournals.org/content/125/1/e2.full
For almost 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 you choose otherwise.
- Coverage is available for you, your spouse, and dependent children.
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire.
- Fast claims payment. Most claims are processed in about four days.
- If you are deemed ineligible due to a previous medical condition, you still retain the ability to purchase spouse coverage.

How it works

Aflac group Critical Illness coverage is selected.

You experience chest pains and numbness in the left arm.

You visit the emergency room.

A physician determines that you have suffered a heart attack.

Aflac group Critical Illness pays a First Occurrence Benefit of $10,000.

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

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

For more information, ask your insurance agent/producer, call 1.800.433.3036, or visit aflacgroupinsurance.com.
### Covered Critical Illnesses:

<table>
<thead>
<tr>
<th>Illness</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancer</strong> (Internal or Invasive)</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Heart Attack</strong> (Myocardial Infarction)</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Stroke</strong> (Apoplexy or Cerebral Vascular Accident)</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Major Organ Transplant</strong></td>
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</tr>
<tr>
<td><strong>End-Stage Renal Failure</strong></td>
<td>100%</td>
</tr>
<tr>
<td><strong>Carcinoma In Situ</strong> (Payment of this benefit will reduce your benefit for cancer by 25%)</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Coronary Artery Bypass Surgery</strong> (Payment of this benefit will reduce your benefit for heart attack by 25%)</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Skin Cancer</strong></td>
<td>10%</td>
</tr>
</tbody>
</table>

### First Occurrence Benefit

After the waiting period, a lump sum benefit is payable upon initial diagnosis of a covered critical illness. Employee benefit amounts are available are $10,000, $15,000 or $20,000. Spouse coverage is also available in benefit amounts of $5,000, $7,500 or $10,000, 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.

### Recurrence Benefit

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

### Child Coverage at No Additional Cost

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

### Mammography Benefit

After the waiting period, we will pay a $200 mammography benefit once per calendar year for mammography tests. This benefit is payable for a baseline mammogram for women age 35 to 39, inclusive; a mammogram for women age 40 to 49, inclusive, every two years or more frequently based on the women’s physician’s recommendations; or mammogram every year for women age 50 and over. Payment of this benefit will not reduce the face amount of the certificate.
HEALTH SCREENING BENEFIT
(Employee and Spouse only)
After the waiting period, you may receive a maximum of $50 for any one covered health screening test per calendar year. We will pay this benefit regardless of the results of the test. Payment of this benefit will not reduce the critical illness benefit payable under the plan. There is no limit to the number of years you can receive the Health Screening Benefit; it will be payable as long as coverage remains in force. This benefit is payable for the covered employee and spouse. **This benefit is not paid for dependent children.**

COVERED HEALTH SCREENING TESTS INCLUDE:

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

**What you need, when you need it.**

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

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;
- Participation in a felony;
- War, whether declared or undeclared or military conflicts, participation in an insurrection or riot; 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.

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.

Class I

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

Class II

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

- was previously insured under Class I; and
- is no longer employed by the Policyholder.

The employee must elect Class II coverage under the Portability Privilege within 31 days after the date for which his Class I eligibility would otherwise terminate.

Only Dependents covered under Class I coverage are eligible for continued coverage under Class II.

Class II insureds cannot continue coverage through the employer’s payroll deduction process. They must remit premiums directly to the Company.

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

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

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

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

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

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

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

1. New and serial electrocardiographic (EKG) findings consistent with myocardial infarction; 2. Elevation of cardiac enzymes above generally accepted medical standards, and provided medical evidence substantially documents the diagnosis of cancer or the insured person receives care for cancer from a doctor.

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

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

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

Skin Cancer is cancer on the surface of the body (skin) that may be a malignant tumor, ulcer, pimple or mole. Malignant melanomas classified as Clark’s Level I and II are included in the definition of skin cancer. The diagnosis of skin cancer must be consistent with professional medical standards after a study of the histologic architecture or pattern of the skin cancer. Pre-malignant conditions or conditions with malignant potential are not to be construed as cancer for the purposes of the plan. In the plan, we pay benefits according to the type of cancer as defined below:

Internal Cancer is cancer which is not skin cancer or carcinoma in situ, but includes malignant melanomas of Clark’s Level III and higher. Carcinoma in situ is cancer whose cells are localized or confined to the site of origin and show no tendency to invade or metastasize to other tissues. Example- should an insured person have a tumor removed from an organ (such as a breast or prostate) and that tumor has not spread, the insured person is eligible for only the limited benefit shown on the benefits schedule. However, if that tumor has metastasized to other tissue (such as lymph nodes), benefits may be payable for internal cancer.

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

Cervical Cancer Screening means conventional Pap test, a human papillomavirus screening test that is approved by the federal Food and Drug Administration, and any cervical cancer screening test approved by the federal Food and Drug Administration.
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 is effective and would otherwise terminate because the employee ends employment with the employer, coverage may be continued. He may exercise the Portability Privilege when there is a change to his coverage class. The employee — and any covered dependents — will continue the coverage that is in-force on the date employment ends. The continued coverage will be provided under Class II.

The premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least 31 days before any change is to take effect.

The employee may continue the coverage until the earlier of:
• the date he fails to pay the required premium; or
• the date the class of coverage is terminated.

Coverage may not be continued:
• if the employee fails to pay any required premium; or
• if the Company receives notice of Class I plan termination.

TERMINATION
An Employee’s insurance will terminate on the earliest of the following: the date the Plan is terminated, for Class I insureds; the 31st day after the premium due date if the required premium has not been paid; the date he ceases to meet the definition of an Employee as defined in the Plan, for Class I insureds; or the date he is no longer a member of the Class eligible for coverage.

Insurance for Dependents will terminate on the earliest of the following: the date the Plan is terminated, for Dependents of Class I insureds; the 31st day after the premium due date, if the required premium has not been paid; the date the Spouse or Dependent Child ceases to be a dependent; or the premium due date following the date we receive the Employee’s written request to terminate coverage for his Spouse and/or all Dependent Children.

Termination of the insurance on any Insured will not prejudice his rights regarding any claim arising prior to termination.
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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.