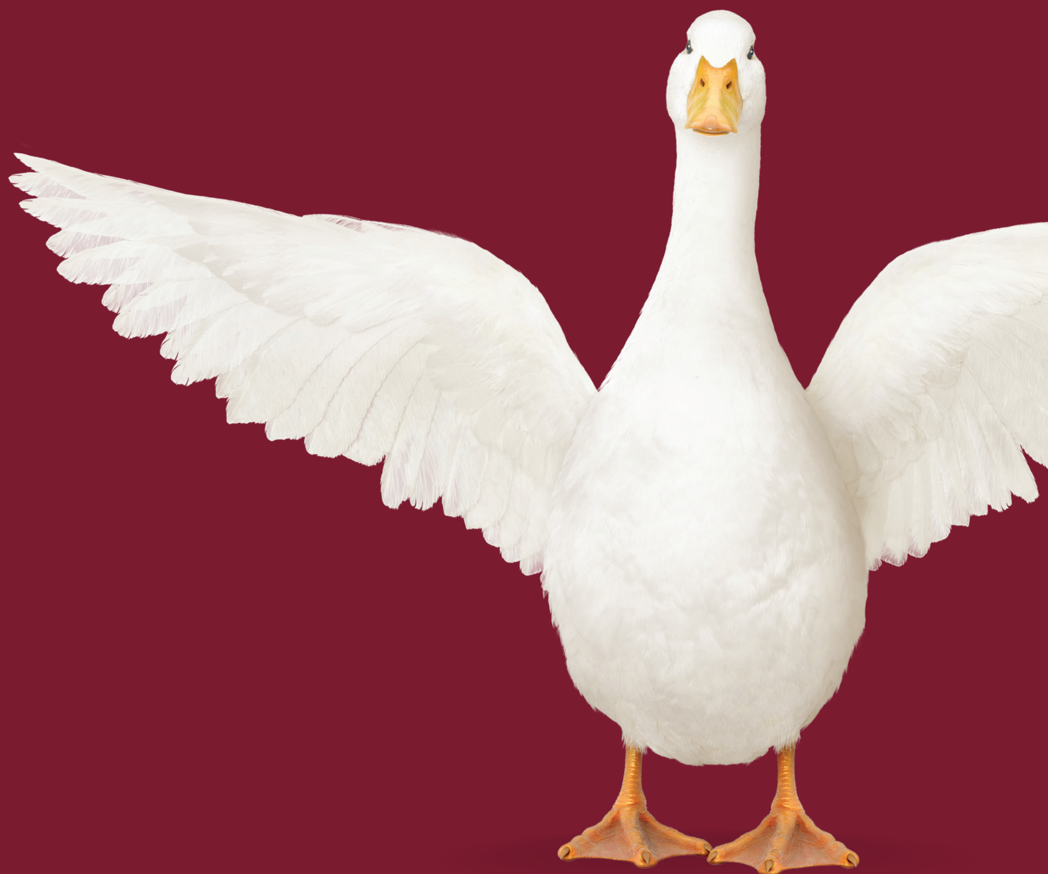
Aflac

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.



THIS IS NOT A MEDICARE SUPPLEMENT POLICY. THIS PLAN CONTAINS A PRE-EXISTING CONDITION LIMITATION.
If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the company.

We've got you under our wing.®

AFLAC GROUP CRITICAL ILLNESS INSURANCE

Policy Series C20000

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

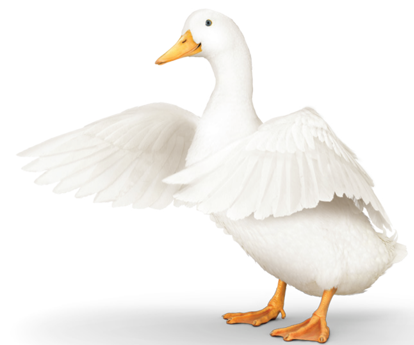
Chances are you may know someone who's been diagnosed with a critical illness. You can't help but notice the strain it's placed on the person's life—both physically and emotionally. What's not so obvious is the impact a critical illness may have on someone's personal finances.

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.

FACT NO. 1

ESTIMATED **82.6** MILLION

AMERICAN ADULTS–GREATER THAN 1 IN 3–HAVE ONE OR MORE TYPES OF CARDIOVASCULAR DISEASE (CVD).[1]

FACT NO. 2

MORE THAN **$44** BILLION

IN EXPENSES MADE CORONARY ARTERY DISEASE THE MOST EXPENSIVE CONDITION TREATED IN 2004.[2]

[1 & 2] http://circ.ahajournals.org/content/125/1/e2.full

Coverage underwritten by Continental American Insurance Company (CAIC)
A proud member of the Aflac family of insurers

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

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.

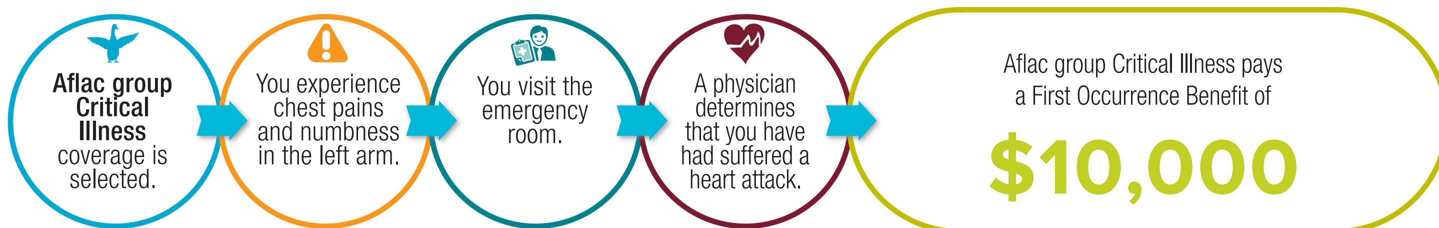
The Aflac group Critical Illness plan benefits include:

- 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.

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 are available from $5,000 to $50,000. Spouse coverage is also available in benefit amounts up to $25,000, not to exceed one half of the employee's amount. If you are deemed ineligible due to a previous medical condition, you still retain the ability to purchase spouse coverage. We will pay benefits for a critical illness in the order the events occur. We will deduct any previously-paid partial benefits from the appropriate critical illness benefit.

SEPARATE DIAGNOSIS BENEFIT

We will pay benefits for each **different** critical illness after the first when the following conditions are met: the two dates of diagnosis must be separated by at least 6 months, or if the insured is treatment-free from cancer for at least 6 months, and the new critical illness is not caused by or contributed to by a critical illness for which benefits have been paid.

REOCCURRENCE BENEFIT

Once benefits have been paid for a critical illness, we will pay additional benefits for that **same** critical illness when the dates of diagnosis are separated by at least 12 months, or the insured has been treatment-free from cancer for at least 12 months and is currently treatment-free.

Cancer that has metastasized (spread), even though there is a new tumor, is not considered an additional occurrence unless the insured has been treatment-tree for 12 months and is currently treatment-free.

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.

WAIVER OF PREMIUM BENEFIT

A critical illness may result in more than 90 days of total disability for you. If a covered critical illness causes you to be totally disabled for 90 days, we will waive the premium payments for this coverage for the first 90 days of total disability and for each following day until the earliest of the following: · You are no longer totally disabled, · We has waived premiums for a total of 24 months of total disability, · You reach age 65 or are 2 years from the date of total disability, whichever occurs last, or · Coverage ends according to the termination of coverage provision.

At the end of the waiver period, you must resume paying premiums to keep this coverage in force. Premiums waived include those for the employee and those for currently covered dependents or riders that are in force.

For premiums to be waived, you must provide satisfactory proof of total disability at least once every 12 months.

HEALTH SCREENING BENEFIT

(Employee and Spouse only)

After the Waiting Period, 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.**

COVERED HEALTH SCREENING TESTS INCLUDE:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test, blood test for triglycerides or serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast Cancer)
- CA 125 (blood test for ovarian Cancer)
- CEA (blood test for colon Cancer)
- Chest x-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate Cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Thermograph

SPECIFIED CRITICAL ILLNESS RIDER

After the waiting period, we will pay this benefit if you are diagnosed with one of the specified critical illnesses shown below. For benefits to be payable on multiple specified critical illnesses, the date of diagnosis for each illness must be separated by at least 12 months.

We will not pay benefits under the rider if these conditions result from another Specified Critical Illness.

PARALYSIS	100%
SEVERE BURNS	100%
COMA	100%
LOSS OF SPEECH / SIGHT / HEARING	100%
BENIGN BRAIN TUMOR	100%
ADVANCED ALZHEIMER'S DISEASE	25%
ADVANCED PARKINSON'S DISEASE	25%

LIMITATIONS AND EXCLUSIONS

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 we will not pay benefits to you if you were diagnosed or had a health screening test performed before your coverage was in force 30 days from the effective date. If a critical illness is first diagnosed during the waiting period, we will only pay benefits for loss beginning after coverage has been in force for 12 months. Or, you may elect to void the certificate from the beginning and receive a full premium refund.

The applicable benefit amount will be paid if the date of diagnosis occurs after the Waiting Period, the date of diagnosis occurs while the Insured's coverage is in force; and the cause of the illness is not excluded by name or specific description.

Exclusions

We will not pay for loss due to any of the following:

1. Self-Inflicted Injuries – injuring or attempting to injure yourself intentionally or taking action that causes you to become injured
2. Suicide – committing or attempting to commit suicide, while sane or insane
3. Illegal Acts – participating or attempting to participate in an illegal activity, or working at an illegal job
4. Participation in Aggressive Conflict of any kind, including:
    a. War (declared or undeclared) or military conflicts (this does not include terrorism)
    b. Insurrection or riot
    c. Civil commotion or civil state of belligerence
5. Illegal substance abuse, which includes:
    a. Abuse of legally-obtained prescription medication
    b. Illegal use of non-prescription drugs
6. Pre-Existing Conditions
7. No benefits will be paid for diagnosis made or Treatment received outside the United States

PRE-EXISTING CONDITION LIMITATION*

"Pre-existing Condition" is a sickness or physical condition that existed within the 12-month period before your effective date. For this pre-existing condition, a medical professional must have advised, diagnosed, or treated you. We will not pay benefits for any critical illness resulting from or affected by a pre-existing condition if the critical illness was diagnosed within the 12-month period after your effective date. We will not reduce or deny a claim for benefits for any critical illness that was diagnosed more than 12 months after your effective date. We will not reduce or deny a claim for benefits for any pre-existing condition after the plan has been in effect for 12 months.

*Benefits are payable for the reoccurrence of a previously Diagnosed Cancer and/or Carcinoma in Situ as long as you:

· Have been free from Signs or Symptoms of that Cancer for a consecutive 12-month period before the Date of Diagnosis (for the reoccurrence) and

· Have been Treatment-Free from that Cancer for the 12 consecutive months before the Date of Diagnosis (for the reoccurrence).

SPECIFIED CRITICAL ILLNESS RIDER LIMITATIONS AND EXCLUSIONS

All limitations and exceptions that apply to the Critical Illness plan also apply to this rider. The Waiting Period and Pre-existing condition limitation apply from the date of this rider is effective.

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

Benefits are not payable under for Loss if these conditions result from another Specified Critical Illness.

SPECIFIED CRITICAL ILLNESS BENEFIT EXCEPTIONS

The plan contains a 30-day Waiting Period. This means that we will not pay benefits to an insured who has been diagnosed before his coverage has been in force 30 days from the effective date. If a critical illness is first diagnosed during the waiting period, we will only pay benefits for loss beginning after coverage has been in force for 12 months. Or, the insured may elect to void the certificate from the beginning and receive a full premium refund.

PRE-EXISTING CONDITION LIMITATION

Pre-existing Condition is a sickness or physical condition that existed within the 12-month period before the insured's effective date. For this pre-existing condition, a medical professional must have advised, diagnosed, or treated the insured. We will not pay benefits for any critical illness resulting from or affected by a pre-existing condition if the critical illness was diagnosed within the 12-month period after the insured's effective date.

We will not reduce or deny a claim for benefits for any critical illness that was diagnosed more than 12 months after the effective date of the rider. We will not reduce or deny a claim for benefits for any pre-existing condition after the plan has been in effect for 12 months.

TERMS YOU NEED TO KNOW

Actively at Work refers to your ability to perform your regular employment duties for a full normal workday. You may perform these activities either at your employer's regular place of business or at a location where you may be required to travel to perform the regular duties of your employment.

Cancer (internal or invasive) is defined as an Illness meeting 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 Diagnosis criteria of malignancy, as established by the American Board of Pathology. The Doctor must have studied the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen.

Cancer includes leukemia and melanoma.

The following are not internal or invasive Cancers:

- Pre-malignant tumors or polyps
- Carcinoma in Situ
- Any skin cancers (except melanomas)

- Basal cell carcinoma and squamous cell carcinoma of the skin
- Melanoma that is Diagnosed as
  - Clark's Level I or II or
  - Breslow less than .77mm

Carcinoma in Situ is non-invasive Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

Cancer or Carcinoma in Situ 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 whose malignancy Diagnosis conforms to the American Board of Pathology standards.
2. Clinical Diagnosis is based only on the study of symptoms. The Company will accept a Clinical Diagnosis only if:

- A Doctor cannot make a Pathological Diagnosis because it is medically inappropriate or life-threatening,
- Medical evidence exists to support the Diagnosis, and
- Doctor is treating you for Cancer or Carcinoma in Situ.

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

Critical Illness is a sickness or disease that first manifests while the Insured's coverage is in force and after any applicable Waiting Period. Any loss due to Critical Illness must begin while the Insured's coverage is in force. Critical Illness includes only the following:

- Cancer
- Heart Attack due to coronary artery disease or acute coronary syndrome
- Stroke
  - Ischemic Stroke due to advanced arteriosclerosis of the arteries of the neck or brain
  - Hemorrhagic Stroke due to uncontrolled high blood pressure, malignant hypertension, brain aneurysm, or arteriovenous malformation
- Sudden Cardiac Arrestdue to cardiac rhythm abnormalities or acute coronary syndrome
- Kidney Failure
- Major Organ Transplant

Date of Diagnosis is defined for each Critical Illness as follows:

- Cancer and/or Carcinoma in Situ: The day tissue specimens, blood samples, or titer(s) are taken (Diagnosis of Cancer and/or Carcinoma in Situ is based on such specimens). This includes the recurrence of a previously Diagnosed Cancer as long as you:
  - Are free from any Signs or Symptoms for a consecutive 12-month period before the Date of Diagnosis (for the reoccurrence),
  - Are currently Treatment-Free from that Cancer, and
  - Have been Treatment-Free from that Cancer for 12 consecutive months.
- Heart Attack: The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the Heart Attack definition.
- Ischemic or Hemorrhagic 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).
- Kidney Failure: The date a Doctor recommends that an Insured begin renal dialysis.
- Major Organ Transplant or Coronary Artery Bypass: The date the surgery occurs.

Dependent means your Spouse or your Dependent Child. Dependent Children are your or your Spouse's natural children, step-children, foster children, legally adopted children, or children placed for adoption who are younger than age 26.

However, there is an exception to the age-26 limit listed above. This limit will not apply to any child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. You or your Spouse must furnish us with proof of this incapacity and dependency within 31 days following the child's 26th birthday, but not more frequently than annually.

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

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

- will allow the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions.
- will enroll the child under family coverage upon application of the child's other parent or the Department of Health and Human Services in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the parent is enrolled but fails to make application to obtain coverage for the child.
- will not disenroll or eliminate coverage of the child unless we are provided satisfactory written evidence that:

  a. The court or administrative order is no longer in effect; or

  b. The child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect no later than the effective date of disenrollment.

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

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

- Is made by a Doctor and
- Is based on clinical or laboratory investigations, as supported by the Insured's medical records.

The illness must meet the requirements outlined in this Certificate for the particular Critical Illness being Diagnosed.

Diagnosis must be made and treatment must be received in the United States.

Doctor is defined as a person who is:

- Legally qualified to practice medicine,
- Licensed as a Doctor by the state where Treatment is received, and
- Licensed to treat the type of condition for which a claim is made.

A Doctor does not include you or your Family Member.

Employee is is the primary Insured under this Plan.

Family Member includes your Spouse (who is defined as your legal wife or husband) as well as the following members of your immediate family:

- son
- daughter
- mother
- father
- sister
- brother

Activities of Daily Living (ADLs) are activities used in measuring levels of personal functioning capacity. These activities are normally performed without assistance, allowing personal independence in everyday living. For the purposes of this policy, ADLs include the following:

- Maintaining continence – controlling urination and bowel movements, including the ability to use ostomy supplies or other devices (such as catheters).
- Transferring – moving between a bed and a chair or a bed and a wheelchair.
- Dressing – putting on and taking off all necessary items of clothing.
- Toileting – getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene.
- Eating – performing all major tasks of getting food into the body.
- Bathing – washing oneself by sponge bath or in either a tub or shower, including getting into or out of the tub or shower.

Covered Accident means an unforeseen and unexpected traumatic event resulting in bodily injury. An event meets the qualifications of Covered Accident if it:

- Occurs on or after the Plan's Effective Date,
- Occurs while coverage is in force, and
- Is not specifically excluded.

A Covered Accident must occur while you are covered by this Rider.

Date of Diagnosis is defined for each Specified Critical Illness as follows:

- Advanced Alzheimer's Disease – The date a Doctor Diagnoses you as incapacitated due to Alzheimer's disease.
- Advanced Parkinson's Disease: The date a Doctor Diagnoses you as incapacitated due to Parkinson's disease.
- Benign Brain Tumor: The date a Doctor determines a Benign Brain Tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.
- Coma: The first day of the period for which a Doctor confirms a Coma has lasted for 7 consecutive days.
- Loss of Sight, Speech, or Hearing: The date the loss is objectively determined by a Doctor to be total and irreversible.
- Paralysis: The date a Doctor establishes the Diagnosis of Paralysis on clinical and/or laboratory findings as supported by medical records (based on the Paralysis definition).
- Severe Burn: The date the burn takes place.

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

- Is made by a Doctor and
- Is based on clinical or laboratory investigations, as supported by the Insured's medical records.

The illness must meet the requirements outlined in this Rider for the particular Specified Critical Illness being Diagnosed.

Diagnosis must be made and treatment must be received in the United States.

Specified Critical Illness is one of the illnesses defined below and shown in the Rider Schedule:

Advanced Alzheimer's Disease means Alzheimer's Disease that causes the Insured to be incapacitated. Alzheimer's Disease is a progressive degenerative disease of the brain that is Diagnosed by a psychiatrist or neurologist as Alzheimer's Disease. To be incapacitated due to Alzheimer's Disease, the Insured must:

- Exhibit the loss of intellectual capacity involving impairment of memory and judgment, resulting in a significant reduction in mental and social functioning, and
- Require substantial physical assistance from another adult to perform at least three ADLs.

Advanced Parkinson's Disease means Parkinson's Disease that causes the Insured to be incapacitated. Parkinson's Disease is a brain disorder that is Diagnosed by a psychiatrist or neurologist as Parkinson's Disease. To be incapacitated due to Parkinson's Disease, the Insured must:

- Exhibit at least two of the following clinical manifestations:
    i. Muscle rigidity
    ii. Tremor
    iii. Bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses), and
- Require substantial physical assistance from another adult to perform at least three ADLs.

Benign Brain Tumor is a mass or growth of abnormal, noncancerous cells in the brain. The tumor is composed of similar cells that do not follow normal cell division and growth patterns and develop into a mass of cells that microscopically do not have the characteristic appearance of a Cancer.

Coma means a state of unconsciousness for 7 consecutive days with:

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

Loss of Sight, Speech, or Hearing

- Loss of Sight means the total and irreversible loss of all sight in both eyes.
- Loss of Speech means the total and permanent loss of the ability to speak.
- 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.

Paralysis or Paralyzed means the permanent, total, and irreversible loss of muscle function to the whole of at least two limbs as a result of a Covered Accident or disease. This must be supported by neurological evidence.

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

- 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.

This includes Step-Family Members and Family-Members-in-law.

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 does not include:

- Any other disease or injury involving the cardiovascular system.
- Cardiac Arrest not caused by a Myocardial Infarction.

Diagnosis of a Heart Attack must include all of the following:

- New and serial electrocardiographic (EKG) findings consistent with Myocardial Infarction;
- Elevation of cardiac enzymes above generally accepted laboratory levels of normal (in the case of creatine physphokinase {CPK}, a CPK-MB measurement must be used); and
- Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms.

Kidney Failure (Renal Failure) refers to end-stage renal failure, which is the chronic, irreversible failure of both kidneys to function.

Kidney Failure is covered only if one of the following occurs:

- Regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) are necessary to treat the Kidney Failure; or
- The Kidney Failure results in kidney transplantation.

The Company will not cover Kidney Failure caused by a traumatic event, including surgical trauma

Maintenance Drug Therapy is a course of systemic medication given to a patient after a Cancer goes into full 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 or suppress 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.

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. Pathologist does not include you or a Family Member.

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 the death of a portion of the brain producing neurological sequelae, including infarction of brain tissue, hemorrhage, and embolization from an extra-cranial source. There must be evidence of permanent neurological deficit.

Stroke must be either:

- Ischemic Stroke due to advanced arteriosclerosis of the arteries of the neck or brain
- Hemorrhagic Stroke due to uncontrolled high blood pressure, malignant hypertension, brain aneurysm, or arteriovenous malformation.

Stroke does not include:

- Transient ischemic attacks (TIAs).
- Head injury.
- Chronic cerebrovascular insufficiency.
- Reversible ischemic neurological deficits.

Stroke will be covered only if you submit evidence of the permanent neurological damage by providing:

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

Successor Insured means that if you die while covered under a Certificate, then your surviving Spouse becomes the primary Insured if that Spouse is also insured under this Plan. If the Certificate does not cover a surviving Spouse, the Certificate will terminate on the next premium due date.

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 cardiac rhythm abnormalities or acute coronary syndrome. For the purposes of this Plan, a death is a Sudden Cardiac Arrest when the sole cause of death (as shown on the death certificate) is one of the following, that is the result of cardiac rhythm abnormalities or acute coronary syndrome:

- Cardiovascular collapse
- Sudden Cardiac Arrest
- Cardiac arrest
- Sudden cardiac death

Sudden Cardiac Arrest is not a Heart Attack.

Total Disability or Totally Disabled means you are:

- Unable to Work (defined later in this section),
- Not working at any job for pay or benefits, and
- Under the care of a Doctor for the treatment of a covered Critical Illness if you cannot show that you have reached your maximum point of recovery, yet are still disabled under the terms of this plan.

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.

Unable to Work 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.

Waiting Period is the number of days after the Effective Date before we will pay benefits for a Critical Illness. We will not pay benefits for a Critical Illness whose Date of Diagnosis begins during the Waiting Period.

Activities of Daily Living (ADLs) are activities used in measuring levels of personal functioning capacity. These activities are normally performed without assistance, allowing personal independence in everyday living. For the purposes of this policy, ADLs include the following:

- Maintaining continence – controlling urination and bowel movements, including the ability to use ostomy supplies or other devices (such as catheters).
- Transferring – moving between a bed and a chair or a bed and a wheelchair.
- Dressing – putting on and taking off all necessary items of clothing.
- Toileting – getting to and from a toilet, getting on and off a toilet, and

performing associated personal hygiene.
- Eating – performing all major tasks of getting food into the body.
- Bathing – washing oneself by sponge bath or in either a tub or shower, including getting into or out of the tub or shower.

Covered Accident means an unforeseen and unexpected traumatic event resulting in bodily injury. An event meets the qualifications of Covered Accident if it:

- Occurs on or after the Plan's Effective Date,
- Occurs while coverage is in force, and
- Is not specifically excluded.

A Covered Accident must occur while you are covered by this Rider.

Date of Diagnosis is defined for each Specified Critical Illness as follows:

- Advanced Alzheimer's Disease – The date a Doctor Diagnoses you as incapacitated due to Alzheimer's disease.
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Diagnosis (also Diagnosed) refers to the definitive and certain identification of an illness that:

- Is made by a Doctor and
- Is based on clinical or laboratory investigations, as supported by the Insured's medical records.

The illness must meet the requirements outlined in this Rider for the particular Specified Critical Illness being Diagnosed.

Diagnosis must be made and treatment must be received in the United States.

Specified Critical Illness is one of the illnesses defined below and shown in the Rider Schedule:

Advanced Alzheimer's Disease means Alzheimer's Disease that causes the Insured to be incapacitated. Alzheimer's Disease is a progressive degenerative disease of the brain that is Diagnosed by a psychiatrist or neurologist as Alzheimer's Disease. To be incapacitated due to Alzheimer's Disease, the Insured must:

- Exhibit the loss of intellectual capacity involving impairment of memory and judgment, resulting in a significant reduction in mental and social functioning, and
- Require substantial physical assistance from another adult to perform at least three ADLs.

Advanced Parkinson's Disease means Parkinson's Disease that causes the Insured to be incapacitated. Parkinson's Disease is a brain disorder that is Diagnosed by a psychiatrist or neurologist as Parkinson's Disease. To be incapacitated due to Parkinson's Disease, the Insured must:

- Exhibit at least two of the following clinical manifestations:
    i. Muscle rigidity
    ii. Tremor
    iii. Bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses), and
- Require substantial physical assistance from another adult to perform at least three ADLs.

Benign Brain Tumor is a mass or growth of abnormal, noncancerous cells in the brain. The tumor is composed of similar cells that do not follow normal cell division and growth patterns and develop into a mass of cells that microscopically do not have the characteristic appearance of a Cancer.

Coma means a state of unconsciousness for 7 consecutive days with:

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

Loss of Sight, Speech, or Hearing

- Loss of Sight means the total and irreversible loss of all sight in both eyes.
- Loss of Speech means the total and permanent loss of the ability to speak.
- 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.

Paralysis or Paralyzed means the permanent, total, and irreversible loss of muscle function to the whole of at least two limbs as a result of a Covered Accident or disease. This must be supported by neurological evidence.

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

- 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.

TERMINATION

The Plan will cease if the premium is not paid before the end of the Grace Period.

After the end of the first plan year, we have the right to cancel the plan. To do so, we must give 31 days' written notice that the plan will end on the date before the next premium due date.

The policyholder has the right to cancel the plan on the date before any premium due date by giving 31 days written notice.

Upon such termination, Class I and Class II coverage will be affected as follows:

Class I

If terminated, this plan and all certificates issued under this class will terminate on such date at 12:01 a.m. Standard Time at the policyholder's address. This will be without prejudice to the rights of any Insured regarding any claim arising while the plan is in force.

The policyholder has the sole responsibility to notify Class I employees of such termination. When we receive the notice of termination, the Portability Privilege under Class I coverage is no longer available.

Class II

The group policy will remain active, and coverage under Class II will continue as long as premiums are paid, subject to the premium grace period. We will

provide notification of any changes in the plan will be provided directly to each insured by the Company. The Policyholder will lose any rights and obligations under the Plan.

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.

PORTABILITY

Under the Portability Privilege provision, when coverage would otherwise terminate because an Employee ends his employment, 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.

REINSTATEMENT

If any renewal premium is not paid on time (as outlined in the initial payment agreement) for the Plan, We (or an agent who is authorized by the Company) may accept the late premium and reinstate the plan without requiring a new application.

However, if We (or authorized agent) do require an application for reinstatement and issues a conditional receipt for the premium tendered, the plan will be reinstated:
· Upon our approval, or
· Lacking such approval, upon the 45th day following the date of the conditional receipt (unless We have previously notified the policyholder in writing of its disapproval of such application).

The reinstated plan covers only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects, the Policyholder and Us will have the same rights they had under the plan immediately before the due date of the defaulted premium (subject to any provisions endorsed with or attached to the reinstatement).

Any premium accepted with a reinstatement will:
- Be applied to a period for which premium has not been previously paid, but
- Not to any period more than 60 days prior to the date of reinstatement.

Continental American Insurance Company is not aware of whether you receive benefits from Medicare, Medicaid, or a state variation. If you or a dependent are subject to Medicare, Medicaid, or a state variation, any and all benefits under the plan could be assigned. This means that you may not receive any of the benefits outlined in the plan. Please check the coverage in all health insurance plans you already have or may have before you purchase the insurance outlined in this summary to verify the absence of any assignments or liens.

Notice to Consumer: The coverages provided by Continental American Insurance Company (CAIC) represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. CAIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.

NOTICES

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

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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.

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