Aflac
Group Insurance Plans

ACCIDENT
CANCER/Critical Illness
DISABILITY
HOSPITAL INDEMNITY
TERM LIFE
Aflac for Pennsylvania State Corrections Officers Association

Aflac is different from major medical insurance. It’s insurance for daily living. If you’re sick or injured, Aflac pays cash benefits directly to you (unless otherwise specified) to help address out-of-pocket medical costs, everyday expenses—whatever you choose. More than 50 million people worldwide have chosen Aflac voluntary insurance products for the added comfort of being better prepared for whatever life may bring.

During this enrollment the following products are available:

- Accident Insurance
- Critical Illness Insurance
- Disability Insurance
- Hospital Indemnity Insurance
- Term Life Insurance

Why Aflac?

- Most claims processed in about 4 business days
- Cash benefits paid directly to you, unless otherwise assigned
- Benefits paid regardless of any other insurance you may have
- No deductibles or co-payments
- Freedom to choose any provider
- Plan stays with you if you leave your job (with certain stipulations)

The following pages detail the benefits offered in each product.

For more information visit aflacgroupinsurance.com or call 1-888-433-3036.
Group Accident Insurance provides benefits to help cover the costs associated with unexpected bills due to a covered accident. This plan provides you with cash benefits throughout the different stages of care, such as the following:

- Emergency treatment
- Hospital admission
- Intensive care unit
- Ambulance transportation
- Travel expenses to distant treatment centers

### Benefits Overview

<table>
<thead>
<tr>
<th>HOSPITAL BENEFITS</th>
<th>EMPLOYEE</th>
<th>SPOUSE</th>
<th>CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HOSPITAL ADMISSION</strong>&lt;br&gt;We will pay this benefit when you are admitted to a hospital and confined as a resident bed patient because of injuries received in a covered accident within six months of the date of the accident. We will pay this benefit once per calendar year. We will not pay this benefit for confinement to an observation unit, or for emergency room treatment or outpatient treatment.</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>HOSPITAL CONFINEMENT</strong> (per day)&lt;br&gt;We will provide this benefit on the first day of hospital confinement for up to 365 days when you are confined to a hospital due to a covered accident. Hospital confinement must begin within 90 days from the date of the accident.</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td><strong>HOSPITAL INTENSIVE CARE</strong> (per day)&lt;br&gt;We will pay this benefit for up to 30 days if you are injured in a covered accident and the injury causes you to be confined to a hospital intensive care unit. This benefit is payable in addition to the Hospital Confinement Benefit.</td>
<td>$400</td>
<td>$400</td>
<td>$400</td>
</tr>
<tr>
<td><strong>MEDICAL FEES</strong> (for each accident)&lt;br&gt;If you are injured in a covered accident and receive treatment within one year after the accident, we will pay up to the maximum benefit amount for physician charges, emergency room services, supplies, and X-rays. Initial treatment must be received within 60 days after the accident.</td>
<td>$125</td>
<td>$125</td>
<td>$75</td>
</tr>
<tr>
<td><strong>PARALYSIS</strong> (lasting 90 days or more and diagnosed by a physician within 90 days)&lt;br&gt;Quadriplegia</td>
<td>$10,000</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>$5,000</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
</tbody>
</table>

*Para**lysis** means the permanent loss of movement of two or more limbs. If you are injured in a covered accident and the injury causes paralysis which lasts more than 90 days and is diagnosed by a physician within 90 days after the accident, we will pay the appropriate amount shown. The amount paid will be based on the number of limbs paralyzed.

If this benefit is paid and you later die as a result of the same covered accident, we will pay the appropriate Death Benefit, less any amounts paid under the Paralysis Benefit.
**Benefits Overview**

<table>
<thead>
<tr>
<th>ACCIDENTAL-DEATH AND -DISMEMBERMENT (within 90 days)*</th>
<th>EMPLOYEE</th>
<th>SPOUSE</th>
<th>CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCIDENTAL-DEATH</td>
<td>$50,000</td>
<td>$10,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>ACCIDENTAL COMMON-CARRIER DEATH</td>
<td>$100,000</td>
<td>$50,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>SINGLE DISMEMBERMENT</td>
<td>$6,250</td>
<td>$2,500</td>
<td>$1,250</td>
</tr>
<tr>
<td>DOUBLE DISMEMBERMENT</td>
<td>$25,000</td>
<td>$10,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>LOSS OF ONE OR MORE FINGERS OR TOES</td>
<td>$1,250</td>
<td>$500</td>
<td>$250</td>
</tr>
<tr>
<td>PARTIAL AMPUTATION OF FINGERS OR TOES (including at least one joint)</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
</tr>
</tbody>
</table>

**Dismemberment** - If you are injured in a covered accident and the injury causes loss of a hand, foot or sight within 90 days after the accident, we will pay the amount shown.

If a covered accident causes you to lose one hand, foot or the sight of one eye, we will pay the single loss dismemberment benefit shown. If you lose both hands, feet, the sight of both eyes, or a combination of any two, we will pay the Double Dismemberment Benefit shown.

If you lose one or more fingers or toes in a covered accident, we will pay the finger/toe benefit shown.

**Dismemberment** means loss of a hand: the hand is cut off at or above the wrist joint; or loss of a foot: the foot is cut off at or above the ankle; or loss of sight: at least 80% of the vision in one eye is lost. Such loss of sight must be permanent and irrecoverable or loss of a finger/toe: the finger or toe is cut off at or above the joint where it is attached to the hand or foot.

If you do not qualify for the Dismemberment Benefit but lose at least one joint of a finger or toe, we will pay the Partial Dismemberment Benefit.

If this benefit is paid and you later die as a result of the same covered accident, we will pay the appropriate Accidental-Death Benefit less any amounts paid under this benefit.

*If you are injured in a covered accident and the injury causes death, we will pay the Accidental-Death Benefit shown. If the Accidental-Death Benefit is paid, we will not pay the Accidental Common Carrier Death Benefit.

If you are injured in a covered accident as a result of traveling as a fare-paying passenger on a common carrier and the injury causes death days after the accident, we will pay the Accidental Common Carrier Death Benefit in the amount shown.

**Common carrier** means an airline carrier which is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports; or a railroad train which is licensed and operated for passenger service only; or a boat or ship which is licensed for passenger service and operated on a regular schedule between established ports.

If the Accidental Common Carrier Death Benefit is paid, we will **not** pay the Accidental-Death Benefit.

**Accidental injury** means bodily injury caused solely by or as the result of a covered accident.

**Covered accident** means an accident that occurs on or after the effective date, while the certificate is in force, and that is not specifically excluded.

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### Fractures (closed reduction)

<table>
<thead>
<tr>
<th>Injury</th>
<th>Employee</th>
<th>Spouse/Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip/Thigh</td>
<td>$4,500</td>
<td>$4,000</td>
</tr>
<tr>
<td>Vertebrae (except processes)</td>
<td>$4,050</td>
<td>$3,600</td>
</tr>
<tr>
<td>Pelvis</td>
<td>$3,600</td>
<td>$3,200</td>
</tr>
<tr>
<td>Skull (depressed)</td>
<td>$3,375</td>
<td>$3,000</td>
</tr>
<tr>
<td>Leg</td>
<td>$2,700</td>
<td>$2,400</td>
</tr>
<tr>
<td>Forearm/Hand/Wrist</td>
<td>$2,250</td>
<td>$2,000</td>
</tr>
<tr>
<td>Foot/Ankle/Knee Cap</td>
<td>$2,250</td>
<td>$2,000</td>
</tr>
<tr>
<td>Shoulder Blade/Collar Bone</td>
<td>$1,800</td>
<td>$1,600</td>
</tr>
<tr>
<td>Lower Jaw (mandible)</td>
<td>$1,800</td>
<td>$1,600</td>
</tr>
<tr>
<td>Skull (simple)</td>
<td>$1,575</td>
<td>$1,400</td>
</tr>
<tr>
<td>Upper Arm/Upper Jaw</td>
<td>$1,575</td>
<td>$1,400</td>
</tr>
<tr>
<td>Facial Bones (except teeth)</td>
<td>$1,350</td>
<td>$1,200</td>
</tr>
<tr>
<td>Vertebral Processes</td>
<td>$900</td>
<td>$800</td>
</tr>
<tr>
<td>Coccyx/Rib/Finger/Toe</td>
<td>$360</td>
<td>$320</td>
</tr>
</tbody>
</table>

### Dislocations (closed reduction)

<table>
<thead>
<tr>
<th>Injury</th>
<th>Employee</th>
<th>Spouse/Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip</td>
<td>$3,600</td>
<td>$2,700</td>
</tr>
<tr>
<td>Knee (not knee cap)</td>
<td>$2,600</td>
<td>$1,950</td>
</tr>
<tr>
<td>Shoulder</td>
<td>$2,000</td>
<td>$1,500</td>
</tr>
<tr>
<td>Foot/Ankle</td>
<td>$1,600</td>
<td>$1,200</td>
</tr>
<tr>
<td>Hand</td>
<td>$1,400</td>
<td>$1,050</td>
</tr>
<tr>
<td>Lower Jaw</td>
<td>$1,200</td>
<td>$900</td>
</tr>
<tr>
<td>Wrist</td>
<td>$1,000</td>
<td>$750</td>
</tr>
<tr>
<td>Elbow</td>
<td>$800</td>
<td>$600</td>
</tr>
<tr>
<td>Finger/Toe</td>
<td>$320</td>
<td>$240</td>
</tr>
</tbody>
</table>

- **Fracture**: A fracture is a break in the bone which can be seen by X-ray. If you fracture a bone in a covered accident, and it is diagnosed and treated by a doctor within 90 days, we will pay the appropriate amount shown.
- **Dislocation**: Dislocation means a completely separated joint. If you dislocate a joint in a covered accident, and it is diagnosed and treated by a doctor within 90 days after the accident, we will pay the amount shown.
- **We will pay no more than 150% of the benefit amount for the bone fracture or dislocated joint which has the higher dollar value.** If you fracture a bone and dislocate a joint, we will pay for both, but no more than 150% of the benefit amount for the bone fractured or joint dislocated that has the higher dollar value.
- **Open reduction is paid at 150% of closed reduction.**
- **A chip fracture**: A chip fracture is a piece of bone which is completely broken off near a joint. Chip fractures are paid at 10% of the benefit shown.
- **Partial dislocations are paid at 25% of the dislocation benefit.**

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### SPECIFIC INJURIES

<table>
<thead>
<tr>
<th>Injury Type</th>
<th>Description</th>
<th>Benefits Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RUPTURED DISC</strong></td>
<td>(treatment within 60 days; surgical repair within one year)</td>
<td>ALL*</td>
</tr>
<tr>
<td>Injury occurring during first certificate year</td>
<td>$100</td>
<td></td>
</tr>
<tr>
<td>Injury occurring after first certificate year</td>
<td>$400</td>
<td></td>
</tr>
<tr>
<td><strong>TENDONS/LIGAMENTS</strong></td>
<td>(within 60 days; surgical repair within 90 days)</td>
<td>$600 (Multiple)</td>
</tr>
<tr>
<td>If you tear, sever, or rupture a tendon or ligament in a covered accident, receive treatment from a doctor within 60 days, and have surgical repair within 90 days after the accident, we will pay the appropriate amount shown. The amount paid will be based on the number (single or multiple) of tendons or ligaments repaired. If you fracture a bone or dislocate a joint in addition to tearing, severing, or rupturing a tendon or ligament, we will only pay one benefit. We will pay the largest of the fracture, dislocation, tendon, or ligament benefits.</td>
<td>$400 (Single)</td>
<td></td>
</tr>
<tr>
<td>Injury occurring during first certificate year</td>
<td>$100</td>
<td></td>
</tr>
<tr>
<td>Injury occurring after first certificate year</td>
<td>$400</td>
<td></td>
</tr>
<tr>
<td><strong>TORN KNEE CARTILAGE</strong></td>
<td>(treatment within 60 days; surgical repair within one year)</td>
<td></td>
</tr>
<tr>
<td>Injury occurring during first certificate year</td>
<td>$100</td>
<td></td>
</tr>
<tr>
<td>Injury occurring after first certificate year</td>
<td>$400</td>
<td></td>
</tr>
<tr>
<td><strong>EYE INJURIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment and surgical repair within 90 days</td>
<td>$250</td>
<td></td>
</tr>
<tr>
<td>Removal of foreign body, with or without anesthesia</td>
<td>$50</td>
<td></td>
</tr>
<tr>
<td><strong>CONCUSSION</strong></td>
<td>(a head injury resulting in electroencephalogram abnormality)</td>
<td>$200</td>
</tr>
<tr>
<td><strong>COMA</strong></td>
<td>(a state of profound unconsciousness lasting more than 30 days)</td>
<td>$10,000</td>
</tr>
<tr>
<td><strong>EMERGENCY DENTAL</strong></td>
<td>(injury to sound natural teeth)</td>
<td></td>
</tr>
<tr>
<td>Repaired with crown</td>
<td>$150</td>
<td></td>
</tr>
<tr>
<td>Resulting in extraction</td>
<td>$50</td>
<td></td>
</tr>
<tr>
<td><strong>BURNS</strong></td>
<td>(treatment within 72 hours and based on percent of body surface burned)</td>
<td></td>
</tr>
<tr>
<td><strong>Second-Degree Burns</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10%</td>
<td>$100</td>
<td></td>
</tr>
<tr>
<td>At least 10%, but less than 25%</td>
<td>$200</td>
<td></td>
</tr>
<tr>
<td>At least 25%, but less than 35%</td>
<td>$500</td>
<td></td>
</tr>
<tr>
<td>35% or more</td>
<td>$1,000</td>
<td></td>
</tr>
<tr>
<td><strong>Third-Degree Burns</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 10%</td>
<td>$500</td>
<td></td>
</tr>
<tr>
<td>At least 10%, but less than 25%</td>
<td>$3,000</td>
<td></td>
</tr>
<tr>
<td>At least 25%, but less than 35%</td>
<td>$7,000</td>
<td></td>
</tr>
<tr>
<td>35% or more</td>
<td>$10,000</td>
<td></td>
</tr>
<tr>
<td><strong>First-degree burns are not covered.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>LACERATIONS</strong></td>
<td>(treatment and repair within 72 hours)</td>
<td></td>
</tr>
<tr>
<td>Under 2” long</td>
<td>$50</td>
<td></td>
</tr>
<tr>
<td>2” to 6” long</td>
<td>$200</td>
<td></td>
</tr>
<tr>
<td>Over 6” long</td>
<td>$400</td>
<td></td>
</tr>
<tr>
<td>Lacerations not requiring stitches</td>
<td>$25</td>
<td></td>
</tr>
</tbody>
</table>

**Multiple Lacerations:** We will pay for the largest single laceration requiring stitches.

*EMPLOYEE/ SPOUSE/ CHILD

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## Benefits Overview

### ADDITIONAL BENEFITS

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>ALL*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WELLNESS BENEFIT</strong> (per 12-month period)</td>
<td>$60</td>
</tr>
<tr>
<td>After 12 months of paid premium and while coverage is in force, we will pay this benefit for preventive testing once each 12-month period. Benefits include and are payable for annual physical exams, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, PSA tests, ultrasounds, and blood screenings.</td>
<td></td>
</tr>
<tr>
<td><strong>AMBULANCE</strong></td>
<td>$100</td>
</tr>
<tr>
<td><strong>AIR AMBULANCE</strong></td>
<td>$500</td>
</tr>
<tr>
<td>If you require transportation to a hospital by a professional ambulance or air ambulance service within 90 days after a covered accident, we will pay the amount shown.</td>
<td></td>
</tr>
<tr>
<td><strong>BLOOD/PLASMA</strong></td>
<td>$100</td>
</tr>
<tr>
<td>If you receive blood or plasma within 90 days following a covered accident, we will pay the amount shown.</td>
<td></td>
</tr>
<tr>
<td><strong>APPLIANCES</strong></td>
<td>$100</td>
</tr>
<tr>
<td>We will pay this benefit when you are advised by a physician to use a medical appliance due to injuries received in a covered accident. Benefits are payable for crutches, wheelchairs, leg braces, back braces, and walkers.</td>
<td></td>
</tr>
<tr>
<td><strong>INTERNAL INJURIES</strong></td>
<td>$1,000</td>
</tr>
<tr>
<td>We will pay this benefit if you have internal injuries as the result of a covered accident which results in open abdominal or thoracic surgery.</td>
<td></td>
</tr>
<tr>
<td><strong>ACCIDENT FOLLOW-UP TREATMENT</strong></td>
<td>$25</td>
</tr>
<tr>
<td>We will pay this benefit for up to six treatments per covered accident, per insured for follow-up treatment. The insured must have received initial treatment within 72 hours of the accident, and the follow-up treatment must begin within 30 days of the covered accident or discharge from the hospital. This benefit is not payable for the same visit that the Physical Therapy Benefit is paid.</td>
<td></td>
</tr>
<tr>
<td><strong>EXPLORATORY SURGERY</strong> without repair (e.g., arthroscopy)</td>
<td>$250</td>
</tr>
<tr>
<td><strong>PROSTHESIS</strong></td>
<td>$500</td>
</tr>
<tr>
<td>If you require the use of a prosthetic device due to injuries received in a covered accident, we will pay this benefit. Hearing aids, wigs, or dental aids, including but not limited to false teeth, are not covered.</td>
<td></td>
</tr>
<tr>
<td><strong>PHYSICAL THERAPY</strong></td>
<td>$25</td>
</tr>
<tr>
<td>We will pay this benefit for up to six treatments per covered accident, per insured for treatment from a physical therapist. The insured must have received initial treatment within 72 hours of the accident, and physical therapy must begin within 30 days of the covered accident or discharge from the hospital. Treatment must take place within six months after the accident. This benefit is not payable for the same visit that the Accident Follow-Up Treatment Benefit is paid.</td>
<td></td>
</tr>
<tr>
<td><strong>TRANSPORTATION</strong></td>
<td>$300 (train/ plane)</td>
</tr>
<tr>
<td>If hospital treatment or diagnostic study is recommended by your physician and is not available in your city of residence, we will pay the amount shown. Transportation must begin within 90 days from the date of the covered accident. The distance to the hospital must be greater than 50 miles from your residence.</td>
<td></td>
</tr>
<tr>
<td><strong>FAMILY LODGING BENEFIT</strong> (per night)</td>
<td>$150 (bus)</td>
</tr>
<tr>
<td>If you are required to travel more than 100 miles from your home for inpatient treatment of injuries received in a covered accident, we will pay this benefit for an immediate adult family member’s lodging. Benefits are payable up to 30 days per accident and only while you are confined to the hospital. The treatment must be prescribed by your local physician.</td>
<td></td>
</tr>
</tbody>
</table>

*EMPLOYEE/ SPOUSE/ CHILD

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The Aflac group Critical Illness insurance plan 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 the costs of medical and personal bills. With group Critical Illness insurance from Aflac, 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.

### Benefits Overview

**Covered Critical Illnesses:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer (Internal or Invasive)</td>
<td>100%</td>
</tr>
<tr>
<td>Heart Attack (Myocardial Infarction)</td>
<td>100%</td>
</tr>
<tr>
<td>Stroke (Apoplexy or Cerebral Vascular Accident)</td>
<td>100%</td>
</tr>
<tr>
<td>Major Organ Transplant</td>
<td>100%</td>
</tr>
<tr>
<td>End-Stage Renal Failure</td>
<td>100%</td>
</tr>
<tr>
<td>Carcinoma In Situ (Payment of this benefit will reduce your benefit for cancer by 25%)</td>
<td>25%</td>
</tr>
<tr>
<td>Coronary Artery Bypass Surgery (Payment of this benefit will reduce your benefit for heart attack by 25%)</td>
<td>25%</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 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. 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 6 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.

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

**EXPENSE BENEFITS UP TO $5,000**

Subject to the provisions of the plan, if you incur eligible medical expenses for cancer (internal or invasive) and/or skin cancer that is initially diagnosed while the plan is in force, the following benefits are available:

1. Cancer (internal or invasive): For the treatment of cancer, we will pay the actual expenses incurred in any calendar year, not to exceed the calendar year maximum as shown in the certificate schedule, provided the cancer is initially diagnosed while your coverage is in force.

2. Skin Cancer: For the treatment of skin cancer, we will pay 10% of the actual expenses incurred for eligible medical expenses in any calendar year, not to exceed the calendar year maximum shown in the certificate schedule, provided the skin cancer is initially diagnosed while your coverage is in force.

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

Group cancer/critical illness insurance pays cash benefits that you can use any way you see fit.
If you became disabled and couldn’t work, how would you pay the mortgage? Buy groceries? Address all the other bills that won’t go away, just because your paycheck is gone? That’s where the Aflac Short-Term Disability insurance plan can help make the difference, providing a source of income while you’re taking care of yourself.

This Disability plan includes 24-hour coverage. This means it covers disability due to on- and off-the-job injuries and sicknesses. Benefits for on-the-job injuries and sicknesses are paid at 40% of the monthly benefit amount you choose.

The Aflac group disability plan benefits:

- Benefits are paid when you are sick or hurt and unable to work, up to 60 percent of your salary (up to 40% in states with state disability).
- Minimum and Maximum Total Monthly Benefit – $300 to $6,000.
- Partial Disability Benefit.

Features:

- Benefits are paid directly to you unless you choose otherwise.
- Coverage is portable. That means you can take it with you if you change jobs (with certain stipulations).
- Payroll Deduction – Premiums are paid through convenient payroll deduction.
- Fast claims payment. Most claims are processed in about four days.

Benefits Overview

| TOTAL DISABILITY | This convenient, affordable disability income plan will help provide needed income if you become Totally Disabled and are unable to work due to a covered injury or illness. |
| PARTIAL DISABILITY | This benefit pays 50% of the monthly benefit when you are partially disabled and return to work earning less than 80% of base income due to sickness or injury. Benefits begin following the expiration of an applicable elimination period. Partial Disability Benefits will end when:
  - You are cleared by the doctor and return to your full-time job, or
  - You earn 80% or more of pre-disability income working at any job, or
  - You reach the end of the partial disability benefit period, a maximum of 3 months.

The Partial Disability Benefit has its own benefit period; it is not subject to the Total Disability Benefit Period. You may be eligible for the Partial Disability Benefit even if you have not received the Total Disability Benefit.

| PRE-EXISTING CONDITION BENEFIT | This benefit pays 50% of your applicable monthly disability benefit for a disability occurring after the effective date of coverage resulting from or affected by a pre-existing condition, if the disability occurs within the 90-day period prior to the effective date of coverage. Benefits begin following the expiration of an applicable elimination period. |
| PORTABILITY | This valuable coverage may be continued, even if you change employers. You must apply to continue coverage within 31 days of ending employment with your current employer. You must be working as a full-time employee with a new employer and pay the required premiums. The coverage continued will include the same benefits, same plan provisions, and same premium rates as previously issued. The coverage may be continued as long as the required premiums are paid and the group master policy issued to the employer remains in force. |
AFLAC GROUP HOSPITAL INDEMNITY PLAN 2
Policy Form Series CA8500-MP-PA, CA8500-CI-PA, CA8521PA, CA8500-DSR 1-PA

You might think of the hospital as a place to go if you have an accident, but the truth is the majority of hospital stays are due to sickness (Injury Facts, 2011 Edition, National Safety Council). Just a few days in the hospital for illness can be costly. Cash benefits from the Aflac Hospital Indemnity insurance plan may offer a measure of financial protection when you’re hospitalized due to a covered accident or covered sickness.

Benefits Overview

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Benefit Details</th>
<th>Plan 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HOSPITAL ADMISSION</strong></td>
<td>The benefit is paid when a Covered Person is admitted to a hospital and confined as a resident bed patient because of Injuries received in a Covered Accident or because of a Covered Sickness. In order to receive this benefit for Injuries received in a Covered Accident, the Covered Person must be admitted to a hospital within six months of the date of the Covered Accident. We will not pay benefits for confinement to an observation unit, or for emergency treatment or outpatient treatment. We will pay this benefit once for a period of confinement. We will only pay this benefit once for each Covered Accident or Covered Sickness. If a Covered Person is confined to the hospital because of the same or related Injury or Sickness, we will not pay this benefit again.</td>
<td>$300 per admission</td>
</tr>
<tr>
<td><strong>HOSPITAL CONFINEMENT</strong></td>
<td>This benefit is paid when a Covered Person is confined to a hospital as a resident bed patient because of a Covered Sickness or as the result of injuries received in a Covered Accident. To receive this benefit for Injuries received in a Covered Accident, the Covered Person must be confined to a hospital within six months of the date of the Covered Accident. This benefit is payable for only one hospital confinement at a time even if caused by more than one Covered Accident, more than one Covered Sickness, or a Covered Accident and a Covered Sickness.</td>
<td>$200 per day</td>
</tr>
<tr>
<td><strong>HOSPITAL INTENSIVE CARE</strong></td>
<td>This benefit is paid when a Covered Person is confined in a hospital intensive care unit because of a Covered Sickness or due to an Injury received from a Covered Accident. To receive this benefit for injuries received in a Covered Accident, the Covered Person must be admitted to a hospital intensive care unit within six months of the date of the Covered Accident. We will pay benefits for only one confinement in a hospital intensive care unit at a time, even if it is caused by more than one Covered Accident, more than one Covered Sickness, or a Covered Accident and a Covered Sickness. If we pay benefits for confinement in a hospital intensive care unit and a Covered Person becomes confined to a hospital intensive care unit again within six months because of the same or related condition, we will treat this confinement as the same period of confinement.</td>
<td>$200 per day</td>
</tr>
<tr>
<td><strong>SURGICAL AND ANESTHESIA BENEFIT</strong></td>
<td>This benefit is paid when a Covered Person has surgery performed by a physician due to an Injury received in a Covered Accident or because of a Covered Sickness. If two or more surgical procedures are performed at the same time through the same or different incisions, only one benefit, the largest, will be provided. Surgical and anesthesia benefits are available subject to plan definitions and the surgical schedule. (The anesthesia benefit will be 25 percent of the surgical benefit performed.)</td>
<td>Surgery up to $2,000; Anesthesia up to $500</td>
</tr>
</tbody>
</table>

The plan has limitations and exclusions that may affect benefits payable. This brochure is for illustrative purposes only. Refer to the plan for complete details, definitions, limitations, and exclusions.
### OUT-OF-HOSPITAL PRESCRIPTION DRUG BENEFIT

We will pay an indemnity benefit, based on the plan definitions, for each prescription filled for a Covered Person. Prescription drugs must meet three criteria: (1) be ordered by a doctor; (2) be dispensed by a licensed pharmacist; and (3) be medically necessary for the care and treatment of the patient. This benefit is subject to the Out-of-Hospital Prescription Drug Benefit Maximum.

This benefit does not include benefits for: (a) therapeutic devices or appliances; (b) experimental drugs; (c) drugs, medicines or insulin used by or administered to a person while they are confined to a hospital, rest home, extended care facility, convalescent home, nursing home or similar institution; (d) immunization agents, biological sera, blood, or blood plasma; or (e) contraceptive materials, devices, or medications or infertility medication, except where required by law.

| $10 with a 5-prescription maximum per year per covered person |

### HOSPITAL EMERGENCY ROOM/PHYSICIAN BENEFIT (MEDICAL FEES)

If an insured is injured in a Covered Accident or has treatment as the result of a Covered Sickness, he will receive the following:

- $50 - Physician (per visit)
- $50 - X-ray (per visit)
- $25 - Laboratory fees (per visit)
- $25 - Injections/medications (per visit)

Not to exceed a maximum of $50 per visit.

| Up to a maximum of $50 per visit |
| Maximum $250 per Insured per calendar year |
| Maximum $1,000 per Family per calendar year |

### WELL BABY CARE

We will pay the Well Baby Care Benefit amount associated with each benefit plan option when an insured baby receives well baby care (four visits per calendar year per insured baby). For this plan, a baby is a Dependent Child 12 months of age or younger. This benefit is payable only if coverage is issued with the Dependent Children Rider.

| $25 per visit |

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You deserve it. We’ll help provide it with a financial cushion.
Aflac group term life insurance helps take care of your loved ones’ immediate and future needs if you should pass away. Immediate needs can include burial/funeral expenses, uninsured medical costs and current bills and debts. Future needs could include income replacement, education plans, ongoing family obligations, emergency funds, and retirement expenses.

It’s insurance for daily living:
Aflac pays cash benefits directly to you, unless you choose otherwise. This means that your family will have added financial resources to help with ongoing living expenses. Aflac group term life insurance plans** are designed to provide you with cash benefits such as the following:

- Up to $100,000 of Term Life coverage
- Employee–Coverage amount: up to $100,000. Employees do not have to take a physical to be eligible for coverage; however, if the coverage elected is above the guaranteed-issue amount, evidence of insurability will be required. Spouse–Coverage amount: up to $50,000 (not to exceed 50% of employee’s coverage). Children–Coverage amount: up to $25,000.
- Waiver of premium

** Benefits Overview **

DEATH BENEFIT
We will pay the Death Benefit upon receipt of proof of loss showing that the insured has died. The amount of the Death Benefit will be equal to the face amount, plus any life insurance provided by an optional benefit rider, plus any portion of premium paid beyond the person’s month of death, plus any interest, minus any unpaid premium due or any accelerated benefit paid to the insured previously.

ACCIDENTAL DEATH, DISMEMBERMENT, LOSS OF SIGHT AND SEATBELT BENEFIT
A Basic Accidental Death, Loss of Sight, and Dismemberment Benefit is built into the term life plan and pays an additional 10% of the Death Benefit for covered losses.

The Accidental Death, Loss of Sight and Dismemberment Benefit Rider is included with the plan, and pays an additional benefit for covered losses. An additional 100% of the Accidental Death Benefit is payable if the insured or spouse suffers accidental loss of life. We will pay 50% of the Accidental Death Benefit accidental loss of A) both hands, B) both feet, C) sight of both eyes, D) one hand and one foot, E) one hand and sight of one eye, or F) one foot and sight of one eye. A benefit of 125% of the Accidental Death Benefit is payable for death resulting from a motor vehicle or common carrier while the insured is wearing a seat belt, and driving or riding in a motor vehicle or is a passenger on a common carrier. The amount of life insurance as shown on the certificate schedule. The loss must occur within 180 days after the accidental injury.

WAIVER OF PREMIUM (EMPLOYEE ONLY)
Prior to attained age 60, this benefit waives all plan premium, including riders, after the insured is totally disabled for more than six (6) consecutive months.

ACCELERATED BENEFIT FOR TERMINAL ILLNESS
This benefit pays 50% of the Death Benefit when an insured is suffering from a terminal illness that will result in death within six months.

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

WE WILL NOT PAY BENEFITS FOR LOSS, INJURY, OR DEATH CONTRIBUTED TO, CAUSED BY, OR RESULTING FROM:

- Participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. We will return the prorated premium for any period not covered when you are in such service.
- Operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those that are not motor-driven.
- Participating or attempting to participate in an illegal activity or working at an illegal job.
- Committing or attempting to commit suicide, while sane or insane.
- Injuring or attempting to injure yourself intentionally.
- Having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness.
- Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, the Virgin Islands, Bermuda, and Jamaica, except under the Accidental Common-Carrier Death Benefit.
- Riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.
- Participating in any professional or semiprofessional organized sport.
- Being legally intoxicated or under the influence of any narcotic, unless taken under the direction of a physician.
- Driving any taxi, or intrastate or interstate long-distance vehicle for wage, compensation, or profit.
- Mountaineering using ropes and/or other equipment, parachuting, or hang gliding.
- Having cosmetic surgery or other elective procedures that are not medically necessary, or having dental treatment, except as a result of a covered accident. A doctor or physician does not include you or a member of your immediate family. A hospital is not a nursing home, an extended-care facility, a convalescent home, a rest home or a home for the aged, a place for alcoholics or drug addicts, or a mental institution.

PRE-EXISTING CONDITION LIMITATION

We will not pay benefits for a loss that is caused by, that is contributed to, or that results from a pre-existing condition for 12 months after the effective date of coverage.

Pre-Existing Condition means a disease or physical condition caused by sickness or injury for which you received medical advice or treatment within 90 days immediately prior to becoming covered under this plan. Such condition will be covered after you have been covered for more than 12 months under this plan.

A claim for benefits for loss starting after 12-months from the effective date of a certificate and attached riders will not be reduced or denied on the grounds that it is caused by a pre-existing condition.

A certificate may have been issued as a replacement for a certificate previously issued under the plan. If so, then the pre-existing condition limitation provision of the certificate applies only to any increase in benefits over the prior certificate. Any remaining period of the pre-existing condition limitation of the prior certificate will continue to apply to the prior level of benefits.

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

You and Your refer to an employee as defined in the plan.

Spouse means the person married to you on the effective date of coverage. Spouse coverage may only be issued to your spouse if your spouse is between ages 18 and 64, inclusive. Coverage on your spouse terminates when your spouse attains age 70.

Dependent Children means your natural children, stepchildren, foster children, legally adopted children, or children placed for adoption, who are under age 26. Your natural children born after the effective date of coverage 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 retardation or physical handicap and is dependent on his or her parent(s) for support, the above age 26 limitation shall not apply. Proof of such incapacity and dependency must be furnished to the company within 31 days following such child’s 26th birthday.

PORTABLE COVERAGE

When coverage would otherwise terminate because you end employment with your 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. Coverage may not be continued if you fail to pay any required premium, you attain age 70, or the group master policy terminates.

TERMINATION

Your insurance 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 you cease to meet the definition of an employee as defined in the master policy, (4) the premium due date which falls on or first follows the employee’s 70th birthday, or (5) the date you are no longer a member of the class eligible. Insurance 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 your spouse and/or all dependent children.

EFFECTIVE DATE

The Effective Date for coverage is as follows: (1) Your insurance will be effective on the date shown on the certificate schedule, provided you are then actively at work. (2) If you are not actively at work on the date coverage would otherwise become effective, the effective date your coverage will be the date on which you are first thereafter actively at work.

CANCER

No benefits will be paid for any cancer treatments that have not been approved by a physician as being medically necessary.

CRITICAL ILLNESS - PRE-EXISTING CONDITIONS LIMITATION

Pre-existing condition means a sickness or physical condition which, within the 90-day period prior to your effective date, resulted in medical advice or treatment. We will not pay benefits for any critical illness starting within 12 months of your effective date which is caused by, contributed to, or resulting from a pre-existing condition. A claim for benefits for loss starting after 12 months from your effective date will not be reduced or denied on the grounds that it is caused by a pre-existing condition. A critical illness will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after your effective date of coverage. 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.

EXCLUSIONS
Pre-Existing Conditions (except as stated above).

- Substance abuse; or

Skin Cancer

Definition:

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

Skin Cancer

Definition:

Basal cell carcinoma, basal cell epithelioma, or squamous cell carcinoma of the skin.

The diagnosis of skin cancer must be established according to the 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.

Clinical diagnosis of skin cancer will be accepted as evidence that skin cancer exists in an insured when a pathological diagnosis cannot be made, provided such medical evidence substantially documents the diagnosis of skin cancer.

End-Stage Renal Failure

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.

Written Request

Means a written request in a form satisfactory to us signed by you and received at our home office in Columbia, South Carolina.

Eligible Medical Expenses:

- Eligible Medical Expenses means medically necessary expenses for services and supplies required by a physician and incurred by an insured as a result of treatment of cancer or skin cancer. An expense is incurred on the date the service is performed or supplies are furnished.

For Hospital and Medical Services

- Hospital room and board
- Hospital Miscellaneous Services and Supplies
- Intensive Care room and board
- Medical & surgical services of a Physician
- Biopsies
- Physicians visits in the hospital
- Nursing care by other than an immediate family member
- Anesthesia
- Physical exams
- Laboratory tests
- Diagnostic X-rays
- Blood and blood transfusions
- Second and third surgical opinions
- Breast or artificial limb and prosthesis
- Specialized Cancer Treatment
- Chemotherapy
- Immunotherapy
- Gene therapy
- Cobalt and radiation treatment
- Transplant of tissue, body organs, and bone marrow

For Drugs and Medicines

- Prescription Drugs and Medicines
- Medication for side effects related to Cancer treatment
- For Transportation and Lodging
- Ambulance - ground or air
- Commercial transportation to a specialized treatment center when recommended by your Physician
- Lodging for Cancer patient when receiving treatment on an outpatient basis

For Out of Hospital Treatment

- Home health care services and supplies treatment on an outpatient basis
- Hospice Care
- Rental or purchase of durable medical equipment
- Nursing care facility
- Extra Benefits
- Physical or speech therapy treatment
- Hairpiece- wigs
- Tutorial services for any dependent child who is undergoing Cancer

Professional mental health consultation

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.

**EXCLUSIONS AND LIMITATIONS**
We will pay all applicable benefits if the covered employee’s disability is caused by a covered sickness or covered injury and if it occurs while this coverage is in force. All benefits are subject to the limitations and exclusions, pre-existing condition limitations, and other plan terms.

Benefits will be paid for only one disability at a time, even if the disability is caused by more than one sickness, more than one injury, or a sickness and an injury. We reserve the right to meet with the covered employee while a claim is pending, or to use an independent consultant and doctor’s statement to determine whether the covered employee is qualified to receive disability benefits.

The covered employee must be under the care and attendance of a doctor for these benefits to be payable. Benefits will cease on the date of the covered employee’s death.

Limitations and Exclusions
A. We will not pay benefits whenever coverage provided by this plan is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.
B. We will not pay benefits whenever fraud is committed in making a claim under this coverage or any prior claim under any other Aflac coverage for which you received benefits that were not lawfully due and that fraudulently induced payment.
C. We will not pay benefits for disability that is caused by or occurs as a result of:
   1. Any act of war, declared or undeclared; insurrection; rebellion; or act of participation in a riot.
   2. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve.
   3. An intentionally self-inflicted injury.
   4. A commission of a crime for which the Employee has been convicted; we will not pay a benefit for any period of disability during which the Employee is incarcerated.
   5. Travel in, or jumping or descent from any aircraft, except when a fare-paying passenger in a
   6. Mental illness as defined
   7. Alcoholism or drug addiction.

**PRE-EXISTING CONDITIONS LIMITATION**
Pre-existing Condition is an illness, disease, infection, disorder, pregnancy, or injury that existed within the 90-day period before the effective date of coverage. For a condition to have been pre-existing:
- A doctor must have advised, diagnosed, or treated the covered employee, or
- Symptoms existed that would ordinarily cause a prudent person to seek medical advice or treatment.
We will not reduce or deny a claim for benefits for any disability due to a pre-existing condition that was diagnosed more than 12 months after the effective date of coverage.

Pregnancy Limitation
Within the first nine months of the effective date of coverage, we will pay benefits for a disability that is caused by, or occurs as a result of, pregnancy or childbirth. Disability due to complications of pregnancy will be covered to the same extent as a covered sickness.

After this coverage has been in force for nine months from the effective date of coverage, disability benefits for childbirth will be payable. The maximum period of disability allowed for disability due to childbirth is six weeks for non-cesarean delivery and eight weeks for cesarean delivery, less the elimination period, unless proof is furnished that disability continues beyond these time frames due to complications of pregnancy.

Separate Periods of Disability
Same or Related Conditions
Separate periods of disability resulting from the same condition or a related condition are considered a continuation of the prior disability if they are not separated by 180 days or more.

Once the maximum Disability Benefit has been paid, the covered employee will not be eligible for a new Disability Benefit due to the same or a related condition for 180 days after all the following conditions are met:
- The employee has been released by a doctor from the prior disability.
- The employee is no longer disabled.
- The employee is no longer qualified to receive any disability benefits under the certificate.

After the disability benefit period, the employee may continue coverage if all of the following conditions are met:
- The employee returns to work within 90 days after the benefit period ends.
- Premium payments for the coverage resume upon return to work.
- The group master policy is still in force upon return to work.

**UNRELATED CAUSES**
Separate periods of disability resulting from unrelated causes are considered a continuation of the prior disability if they are not separated by the covered employee returning to work at a full-time job for 30 consecutive days, during which the employee is performing the material and substantial duties of that job. Once the maximum Disability Benefit has been paid, the employee will not be eligible for a new Benefit for disability due to an unrelated cause, until 30 consecutive days after all the following conditions are met:
- The employee has been released by a doctor from a prior disability.
- The employee is no longer qualified to receive any disability benefits under this certificate.

After the disability benefit period, the employee may continue coverage if all of the following conditions are met:
- The employee returns to work within 90 days after the benefit period ends.
- Premium payments for the coverage resume upon return to work.
- The group Policy is still in force upon return to work.

**PERIODS OF DISABILITY**
Periods of disability meeting either of these separation requirements will begin a new Disability Benefit Period, subject to a new elimination period.

**TERMS YOU NEED TO KNOW**
Actively at Work refers to a covered employee’s ability to perform his regular employment duties for a full normal workday. The covered employee may perform these activities either at his employer’s regular place of business or at a location where the covered employee may be required to travel to perform the regular duties of his employment.

Base Annual Pay is the covered employee’s annual income from his full-time job with the policyholder. This pay excludes overtime pay, bonuses, or any other special pay.

Benefit Period is the maximum number of days after the elimination period, if any, for which the covered employee can be paid benefits for any period of disability. Each new benefit period is subject to a new elimination period.

For the purpose of this calculation, a “month” is defined as 30 days for which benefits are paid.

Complications of Pregnancy refers to:
- Conditions requiring medical treatment that comes before or comes after the termination of a pregnancy. The diagnoses for this medical treatment must be distinct from pregnancy but either adversely affected by pregnancy or caused by pregnancy.
- For a condition to be a complication of pregnancy, it must constitute a classifiably distinct pregnancy complication. Examples of such complications of pregnancy are:
  - Acute nephritis,
  - Nephrosis,
  - Cardiac decompensation,
  - Missed abortion,
  - Disease of the vascular, hemopoietic, nervous, or endocrine systems, and
  - Similar medical and surgical conditions of comparable severity.
- Further complications of pregnancy include:
  - Hyperemesis gravidarum and pre-eclampsia requiring hospital confinement,
  - Ectopic pregnancy that is terminated, and
  - Spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.
- Complications of pregnancy do not include:
- Multiple gestation pregnancy.
- False labor.
- Occasional spotting.
- Morning sickness.

Other similar conditions associated with a difficult pregnancy are not considered complications of pregnancy.

Cesarean deliveries are not considered complications of pregnancy.

Disability
Total Disability refers to the employee being under the care and attendance of a doctor due to a condition that causes his inability to perform the material and substantial duties of his full-time job with the employer. To qualify as total disability, the employee may not be working at any job.

Partial Disability refers to the Employee’s being under the care and attendance of a doctor due to a condition that causes his inability to perform the material and substantial duties of his full-time job. To qualify as partial disability, the employee is able to work at any job earning less than 80 percent of the base annual pay of his full-time job at the time he became disabled.

Doctor is defined as a person who meets all the following criteria: A person who is legally qualified to practice medicine; A person who is licensed as a physician by the state where treatment is received; and A person who is licensed to treat the type of condition for which a claim is made.

A doctor does not include the employee or the employee’s family member.

Elimination Period is the number of continuous days at the beginning of the employee’s period of disability for which no benefits are payable. Each new benefit period is subject to a new elimination period.

Employee is a person who meets eligibility requirements set by the policyholder and who is covered under this plan. The employee is the employee under this plan.

Family Member includes anyone related to the Employee in the following manner: spouse, brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren, father- or mother-in-law; and spouses, as applicable.

Full-Time Job refers to a job at which the employee works, performing his occupational duties for pay or benefits, for the required number of hours per week.

Injury refers to an off-the-job or on-the-job bodily injury not otherwise excluded. An injury meets all the following criteria: It is directly caused by a covered accident; It is not caused by sickness, disease, bodily infirmity, or any other cause; It occurs on or after the effective date of coverage and while coverage is in force.

Employee means the eligible person whose coverage under the certificate becomes effective. The Employee is named on his certificate schedule. The Employee is always the covered eligible employee under an employer group master policy.

Medically Necessary refers to treatment, services, or supplies that are necessary and appropriate for the diagnosis or treatment of a sickness or an injury based upon generally accepted medical practice.

Mental Illness is defined as a total disability resulting from psychiatric or psychological conditions, regardless of cause. Mental Illness includes but is not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, post-partum depression, personality disorders and adjustment disorders. It also includes any other condition usually treated by a doctor, mental health provider, or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the above conditions.

Off-the-Job Injury means an Injury that occurs while the Employee is not working at any job for pay or benefits.

On-the-Job Injury means an Injury that occurs while the Employee is working at any job for pay or benefits.

Period of Disability means the length of time the employee is either totally disabled or partially disabled from one or more causes. It starts the first full day of total disability or partial disability after the employee ceases to be actively at work for the policyholder. It ends on the earlier of the following two dates: the date the employee ceases to be totally disabled or partially disabled; or the date the employee returns to an actively at work status for any employer.

Sickness refers to a covered illness, disease, infection, or any other abnormal physical condition. Sickness must meet all the following criteria: It must not be caused by an injury; It first manifested and was first treated after the effective date of coverage; It occurs while coverage is in force. 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.

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.

TERMINATION OF YOUR INSURANCE
A covered employee’s insurance will terminate on whichever occurs first:
- The date the plan is terminated.
- The 31st day after the premium due date, if the premium has not been paid.
- The date the employee no longer meets the plan’s definition of an employee.
- The date the employee no longer belongs to an eligible class.
- The employee attaining age 75.

If the covered employee’s coverage ends, we will provide coverage for claims that arise from short-term disability that was first diagnosed while your coverage was in force.

HOSPITAL INDEMNITY LIMITATIONS AND EXCLUSIONS

EXCLUSIONS
We will not pay benefits for loss caused by Pre-Existing Conditions.

We will not pay benefits for loss contributed to, caused by, or resulting from:
- War – participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. We will return the prorated premium for any period not covered by this certificate when you are in such service.
- Suicide – committing or attempting to commit suicide, while sane or insane.
- Self-Inflicted Injuries – injuring or attempting to injure yourself intentionally.
- Traveling – traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, Bermuda, and Jamaica.
- Racing – Riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.
- Aviation – operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those which are not motor-driven.
- Intoxication – being legally intoxicated, or being under the influence of any narcotic, unless such is taken under the direction of a physician.
- Illegal Acts – participating or attempting to participate in an illegal activity, or working at an illegal job.
- Sports – participating in any organized sport; professional or semiprofessional.
- Custodial Care. This is care meant simply to help people who cannot take care of themselves.
- Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and

any related procedures, including complications.
- Services performed by a relative.
- Services related to sex change, sterilization, in vitro fertilization, or reversal of a vasectomy or tubal ligation.
- A service or a supply furnished by or on behalf of any government agency unless payment of the charge is required in the absence of insurance.
- Elective abortion.
- Treatment, services, or supplies received outside the United States and its possessions or Canada.
- Dental services or treatment.
- Cosmetic surgery, except when due to medically necessary reconstructive plastic surgery.
- Mental or emotional disorders without demonstrable organic disease.
- Alcoholism, drug addiction, or chemical dependency.
- Injury or sickness covered by Worker’s Compensation or Occupational Disease Law or by United States’ Longshoreman’s and Harbor Worker’s Compensation Act.
- Routine physical exams and rest cures.

PRE-EXISTING CONDITION LIMITATION
Pre-Existing Condition means a disease or physicalconditional caused by sickness or injury for which you received medical advice or treatment within 90 days immediately prior to becoming covered under this Plan. Such condition will be covered after you have been covered for more than 12 months under this plan. We will not pay benefits for any loss or injury that is caused by, contributed to by, or resulting from a pre-existing condition for 12 months after the insured’s effective date or for 12 months from the date medical care, treatment, or supplies were received for the pre-existing condition—whichever is less.
A claim for benefits for loss starting after 12 months from the effective date of the insured’s certificate will not be reduced or denied on the grounds that it is caused by a pre-existing condition. Pregnancy is considered a pre-existing condition if conception was before the coverage effective date. Pregnancy will be covered as any other sickness when date of conception is after the insured’s effective date of coverage.

**TERMS YOU NEED TO KNOW**

**You and Your** – Refer to an employee as defined in the Plan.  
**Spouse** – means your legal spouse who is between that ages of 18 and 64.  
**Dependent Children** – Means your natural children, stepchildren, foster children, legally adopted children, or children placed for adoption, who are under age 26. Your natural children born after the Effective Date 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 retardation or physical handicap and is dependent on his parent(s) for support, the above age of 26 shall not apply. Proof of such incapacity and dependency must be furnished to the company within 31 days following such 26th birthday.  
**Covered Person** – If the certificate is issued as: Individual coverage, the Covered Person means you; Employee/Spouse coverage, Covered Person means you and your legal spouse; Single Parent Family coverage, Covered Person means you and your covered dependent children as defined in the applicable rider; that have been accepted for coverage; Family coverage, Covered Person means you and your spouse and covered dependent children, as defined in the applicable rider, that have been accepted for coverage.  
**Injury or Injuries** – An accidental bodily injury or injuries caused solely by or as the result of a Covered Accident.  
**Covered Accident** – An accident, which occurs on or after a Covered Person’s Effective Date, while the certificate is in force, and which is not specifically excluded.  
**Sickness** – An illness, infection, disease or any other abnormal condition, which is not caused solely by or the result of an Injury.  
**Covered Sickness** – An illness, infection, disease, or any other abnormal physical condition which is not caused solely by or the result of any Injury which occurs while the certificate is in force; and was not treated for or for which a Covered Person did not receive advice within 12 months before the Effective Date of his/her coverage; and is not excluded by name or specific description in the certificate.  
**Doctor or Physician** – A person, other than yourself, or a member of your immediate family, who is licensed by the state to practice a healing art; performs services which are allowed by his or her license; and performs services for which benefits are provided by the certificate.

**TERM LIFE 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 a covered person, whether sane or insane, dies by suicide within two years of the date of certificate, our liability for death proceeds is limited to the premiums paid.
- If the age of a covered person has been misstated, and if the amount of premium is based on age, an adjustment of premiums will be made based on the covered person’s true age.
- If age is a factor in determining eligibility or amount of insurance and there has been a misstatement of age, the insurance coverages, benefit amounts (or both) for which the covered person is insured will be adjusted in accordance with the covered person’s true age. Any such misstatement of age shall neither continue insurance otherwise validly terminated nor terminate insurance otherwise validly in force.
- If it is determined after the death of a covered person that the covered person’s age was misstated, the amount of insurance will be that which the premiums would have purchased at the correct age.
- If the policyholder fails to report any employee’s termination of coverage while the group’s master policy remains in effect, our liability will be limited to a return of premium retroactive to the date on which insurance should have been terminated, less any claims paid during this period. In no event will we refund more than two months’ premium.
- We must receive proof of loss within 90 days after a loss occurs or starts.
- Any change in beneficiary must be made to us in writing. The change will be effective as of the date signed.

**THE LIMITATIONS AND EXCLUSIONS BELOW APPLY TO THE FOLLOWING THREE BENEFITS:**

- the Basic Accidental Death, Loss of Sight, and Dismemberment Benefit; the Accidental Death, Loss of Sight, and Dismemberment Benefit Rider; and the Total Disability Waiver of Premium Benefit.

**LIMITATIONS AND EXCLUSIONS**

No Accidental Death, Loss of Sight, and Dismemberment Benefits or Total Disability Waiver of Premium Benefits are payable or available when the death or loss:

- Was caused directly or indirectly, wholly or partly, from suicide or attempted suicide, whether sane or insane, or any intentionally self-inflicted injury; or
- Resulted from or occurred during travel, flight, or descent from any kind of aircraft, unless the covered person was being transported as a fare-paying passenger on a regularly scheduled flight (this exclusion does not apply to airline employees flying while working, traveling for pleasure, or traveling to and from a job assignment); or
- Was caused by voluntary taking, absorbing, or inhaling poison, poison gas, or fumes; or
- Was intentionally inflicted by any person (if the covered person is an innocent bystander having no relationship to an altercation, it is covered); or
- Was incurred during travel, flight, or descent from any kind of aircraft, unless the covered person was being transported as a fare-paying passenger on a regularly scheduled flight (this exclusion does not apply to airline employees flying while working, traveling for pleasure, or traveling to and from a job assignment); or
- Was caused by disease, illness, or bacterial infection (if the infection occurs because of an injury, it is covered).

In addition to the exclusions listed above, the following limitations also apply to the Accidental Death, Loss of Sight, and Dismemberment Basic Benefit and Rider:

- The Loss of Sight or Dismemberment must occur within 180 days after the accidental injury.
- This benefit terminates for the covered person when this benefit is paid.
If employment is terminated, you may continue coverage by paying premiums on the covered person's certificate schedule. If two or more accidents cause losses covered by this benefit, we will not pay more than 100% of the Accidental Death Benefit shown on the certificate schedule for all such losses combined. This does not apply to the Seat Belt Benefit. 

*These exclusions apply to the Accidental Death, Loss of Sight, and Dismemberment Benefit Rider only.

In addition to the exclusions listed above, the following limitations and exclusions will also apply to the Total Disability Waiver of Premium:

Premiums will not be waived if total disability:

• Results from neurosis, psychoneurosis, psychopathy, psychosis, or mental and emotional disease or disorder without demonstrable organic cause (This exclusion will not apply to Alzheimer's disease, Parkinson's disease, or senile dementia).

• Results from substance abuse (This exclusion will not apply to a condition brought about by the employee's use of drugs prescribed by and taken in accordance with the directions of a physician).

Premiums are only waived in the event of a total disability suffered by the named employee shown on the certificate schedule. The employee's coverage will not continue beyond the employee's attained age of 65. Any loss due to a pre-existing condition will not be covered if the loss begins with 12 months after the covered person's effective date of insurance. However, premiums may be waived for a loss due to a pre-existing condition of a covered person who was covered by a replaced plan and by this plan on its original effective date. If this plan's pre-existing condition exclusion has been satisfied, we will waive premiums. If the employee does not satisfy the plan's pre-existing condition exclusion, but can satisfy the replaced plan's pre-existing condition exclusion, then we will waive premiums. If the employee does not satisfy the pre-existing condition exclusion of the plan or that of the replaced plan, premiums will not be waived.

This benefit shall not cause an insured's coverage or that of covered eligible dependents to continue beyond the earliest of any of the following dates:

• The date on which the insured requests termination, if the policy provides contributory insurance;
• The date on which the policy is terminated;
• The date on which the employee's class is no longer included for insurance;
• The end of the planned level premium period or renewal(s) of the planned level premium period allowed by the policy; or
• The insured's attained age 65.

Limitations and Exclusions – Accelerated Benefit for Terminal Illness

• We must receive consent of all irrevocable beneficiaries.
• We must receive a claim form for this benefit during the lifetime of the terminally ill covered person.
• Only one Accelerated Benefit for Terminal Illness for each terminal illness shall be paid on behalf of the covered person per lifetime.
• A physician must diagnose a covered terminal illness.
• We will not be liable for any payment made or action taken before we receive and acknowledge notice of the death of the terminally ill covered person.
• The employee should seek assistance from a personal tax advisor before making a claim for the Accelerated Benefit for Terminal Illness to determine any tax impact.

The Accidental Death, Loss of Sight, and Dismemberment Benefit provided by the plan will not increase or decrease the Accelerated Benefit for Terminal Illness. If two or more Accelerated Benefits for Terminal Illness are payable on behalf of the same covered person under the plan for the same or related sickness, injury, or other loss, we will pay only one Accelerated Benefit for Terminal Illness. The covered person is entitled to choose the Accelerated Benefit for Terminal Illness. The sum of all Accelerated Benefits for Terminal Illness payable under the plan—and its optional benefits and riders—will not exceed the amount of life insurance shown on the covered person's certificate schedule.

**PORTABILITY**

If employment is terminated, you may continue coverage by paying premiums directly to Aflac when due (subject to benefit conditions, limitations, and exclusions). You must contact us directly within 31 days. We must receive the first premium within 31 days after coverage is terminated. The group’s master policy must be in force on the date you port coverage. You may port benefits if you:

• Have been continuously covered by the plan for at least six months;
• Are less than age 70;
• Are not totally disabled; and
• Are no longer actively at work as an employee of his company.

If you are no longer eligible for coverage for any other reason stated in the termination of eligibility provision (except death), you may continue coverage by paying premiums when due. We must receive the first premium within 31 days after eligibility terminates.

If coverage is terminated for any reason other than death, a covered employee may continue coverage under the policy subject to the benefit conditions, limitations and exclusions and by paying premiums when due for as long as the group policy remains in force. We must receive the first premium within 31 days after coverage is terminated. The group policy must be in force on the date that the employee ports coverage. Subject to the benefit conditions, limitations and exclusions provision, a covered employee may port benefits when he is less than age 70, not totally disabled, and no longer a member of the eligible class.

**TERMINATION OF YOUR INSURANCE**

You and any covered dependents will cease to be insured under the policy and the certificate on the earliest of the following dates:

• The date on which you request termination, if the policy provides contributory insurance;
• The date on which the policy is terminated;
• The date on which You are no longer in an eligible class;
• The date on which Your class is no longer included for insurance;
• The end of the period for which the last required contribution for Your insurance has been paid;
• The date on which active employment ends or your retirement date, subject to the Continuation of Insurance Provision; or
• Your death.

Termination of your insurance is without prejudice to any claim that occurred or commenced prior to the date of such termination. The continuation of insurance provision, the conversion provision, and the portability provision, if available, provide certain rights at times when Your coverage would otherwise end as required by the termination of insurance provision. The certificate to which this sales material pertains is written only in English; the certificate prevails if interpretation of this material varies.

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.

**THIS IS NOT A MEDICARE SUPPLEMENT PLAN.**

This 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. If you are eligible for Medicare, review the Medicare Supplement Buyer’s Guide available from Aflac.
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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 booklet is subject to the terms, conditions, and limitations of Policy Forms CA7700-MP(PA) 07, CAI2800PA, C50100PA, CAI9100PA and CA8500-MP-PA.