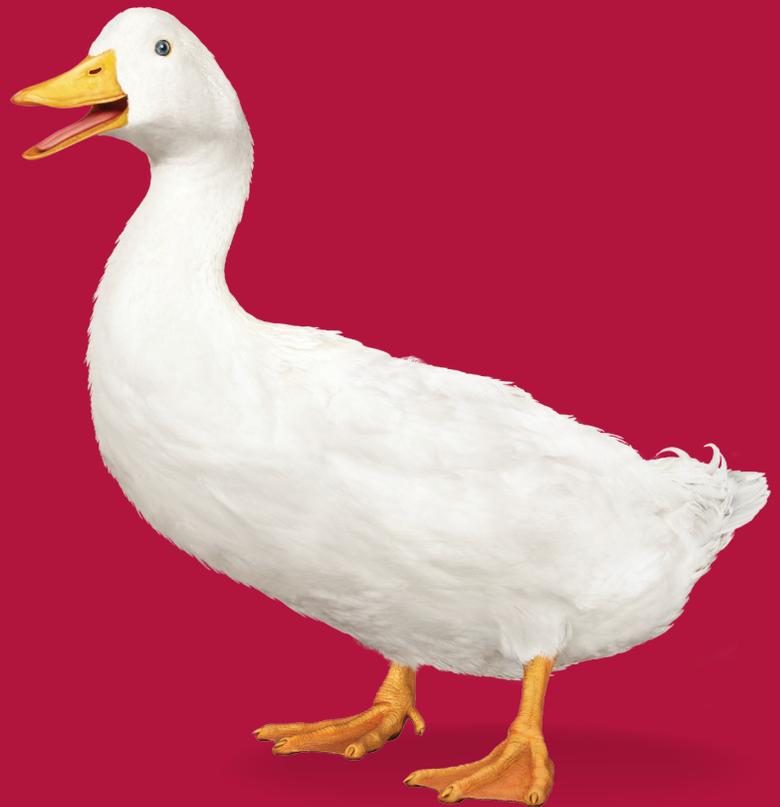


Aflac Group Critical Illness

Lump Sum Single Payment Policy / First Occurrence

INSURANCE – PLAN INCLUDES BENEFITS FOR CANCER AND HEALTH SCREENING

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



THERE MAY BE NO RECOVERY FOR PRE-EXISTING CONDITIONS FOR THE FIRST YEAR.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from Aflac.

The State Employee's Association of North Carolina, Inc. (hereinafter called SEANC) will hold the master policy which will govern the certificates issued to all members applying and approved for insurance offered by Continental American Insurance Company (hereinafter called CAIC) a proud member of the Aflac family of insurers.



AFLAC GROUP CRITICAL ILLNESS INSURANCE

LUMP SUM SINGLE PAYMENT POLICY / FIRST OCCURRENCE
Policy Series CAI2800



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

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

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

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

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

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



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

FACT NO. 1

AN ESTIMATED **82.6** MILLION

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

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>

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.

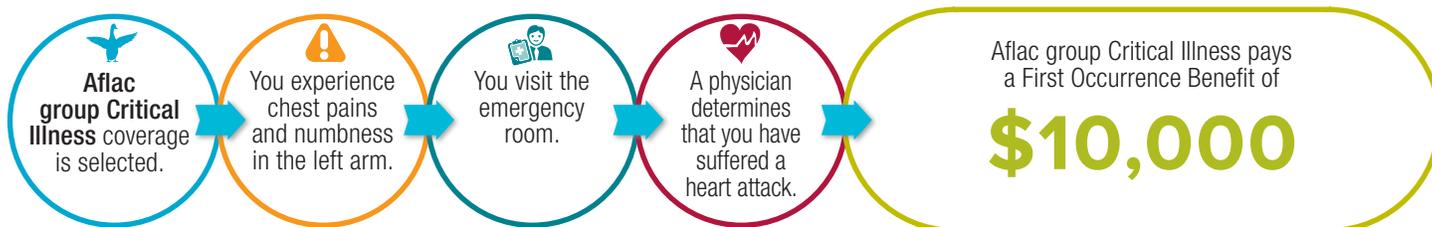
The Aflac group Critical Illness plan benefits include:

- 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 exceptions and reductions that may affect benefits payable. This brochure is for illustrative purposes only. Refer to your certificate for complete details, definitions, exceptions and reductions.

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%

FIRST OCCURRENCE BENEFIT

After the waiting period, a lump sum benefit is payable upon initial diagnosis of a covered critical illness. Member 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 member's amount. Coverage is guaranteed issue for benefit amounts up to \$20,000 for member and \$10,000 for spouse. If you are deemed ineligible due to a previous medical condition, you still retain the ability to purchase spouse coverage.

ADDITIONAL OCCURRENCE BENEFIT

We will pay benefits for each different critical illness in the order the events occur. We will pay benefits for any one critical illness once every six months. Therefore, no benefits are payable for each different critical illness after the first unless its date of diagnosis is separated from the prior critical illness by at least 6 months.

REOCCURRENCE BENEFIT

We will pay benefits for the re-occurrence any critical illness once every twelve months. Therefore, once benefits have been paid for critical illness, no additional benefits are payable for that same critical illness unless the dates of diagnosis are separated by at least 12 months (Cancer benefits must be medically unrelated to any cancer for which benefits have already been paid).

CHILD COVERAGE AT NO ADDITIONAL COST

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

HEALTH SCREENING BENEFIT (Member and Spouse only)

After the waiting period, you may receive a maximum of \$100 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 member and spouse. **This benefit is not paid for dependent children.**

COVERED HEALTH SCREENING TESTS INCLUDE:

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

ADDITIONAL BENEFITS RIDER

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

HEART EVENT RIDER

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

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

***NO RECOVERY FOR PRE-EXISTING CONDITIONS--READ CAREFULLY.** No benefits will be provided during the first twelve months of the rider for conditions diagnosed within the 12-month period prior to the effective date shown in the rider schedule.

CRITICAL ILLNESS EXCEPTIONS AND REDUCTIONS

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

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

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

REDUCTIONS

Benefits will not be paid for loss due to:

- Intentionally self-inflicted injury or action;
- Suicide or attempted suicide while sane or insane;
- Illegal activities or participation in an illegal occupation;

- War, whether declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence;
- Substance abuse; or
- Pre-Existing Conditions (except as stated below).

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

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

PRE-EXISTING CONDITION LIMITATION AND EXCEPTIONS - NOT APPLICABLE TO CANCER AND/OR CARCINOMA IN SITU

Pre-Existing Condition means a sickness or physical condition which, within the 12-month period prior to the effective date, resulted in you receiving medical advice or treatment.

We will not pay benefits for any critical illness starting within 12 months of the 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 the 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 the effective date.

TERMS YOU NEED TO KNOW

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

Member means the insured as shown on the certificate schedule.

Spouse means your legal wife or husband.

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

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

Your newborn children and newborn adopted children are automatically covered from the moment of birth, under the same terms and conditions that apply to the natural, dependent children of covered persons.

Other foster children and adopted children shall be treated the same as newborn infants and are eligible for coverage on the same basis upon placement in your home, under the same terms and conditions that apply to the natural, dependent children of covered persons.

If a parent is required by a court or administrative order to provide health benefit plan coverage for a child, and the parent is eligible for family health benefit plan coverage through a health insurer, the health insurer:

- a. Must 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.

b. Must 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.

c. May not disenroll or eliminate coverage of the child unless the health insurer is provided satisfactory written evidence that the court or administrative order is no longer in effect or the child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect not later than the effective date of disenrollment.

d. Will not impose pre-ex limitations or waiting periods.

If your children are covered under the plan, children born or placed in your home after the effective date of this rider will also be covered from the moment of birth. No notice or additional premium is required and the enrollment period will be waived. The company will not impose pre-ex limitations or waiting periods for newborn children, foster and adopted children if they are enrolled upon placement or children covered by the court or administrative order.

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

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

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

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

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

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

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

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

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

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

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

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

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

Licensed Health Care Practitioner means an individual who has successfully completed a prescribed program of study in a variety of health fields and who has obtained a license or certificate indicating his or her competence to practice in that field.

PORTABLE COVERAGE

When coverage would otherwise terminate because you end membership with the policyholder, coverage may be continued. You may continue the coverage that is in force on the date membership 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 a member as defined in the master policy; or (4) The date the member 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 your spouse and/or all dependent children.

HEART RIDER

The rider contains a 30-day Waiting Period. This means no benefits are payable for any insured who has been diagnosed before the coverage has been in force 30 days from the Effective Date. If an insured is first diagnosed during the Waiting Period, benefits for Treatment of that Critical Illness will apply only to loss commencing after 12 months from the Effective Date; or, at the Member's option, the Member may elect to void the certificate from the beginning and receive a full refund of premium. We will pay the indicated percentages of your maximum benefit if you are treated with one of the specified surgical procedures (Category I) or interventional procedures (Category II) shown if the date of treatment is after the waiting period; treatment is incurred while coverage is in force; treatment is recommended by a physician; and is not excluded by name or specific description. This benefit is paid based on your selected benefit amount.

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

PRE-EXISTING CONDITIONS LIMITATION

Pre-Existing Condition means a sickness or physical condition which, within the 12-month period prior to an insured's Effective Date, resulted in the insured receiving medical advice or Treatment.

We will not pay benefits for any surgical procedure occurring within 12 months of an insured's 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 an insured's 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 an insured's Effective Date.

Any benefits for Coronary Artery Bypass Surgery denied under this rider due to Pre-Existing Conditions may be paid at the reduced benefit amount under the certificate, subject to the terms of the certificate.

EXCEPTIONS

(1) No benefits will be paid if the Specified Critical Illness is a result of: (a) Intentionally self-inflicted injury or action; (b) Suicide or attempted suicide while

sane or insane; (c) Illegal activities or participation in an illegal occupation; (d) War, declared or undeclared, or military conflicts, participation in an insurrection or riot, civil commotion, or state of belligerence; or (e) an injury sustained while under the influence of alcohol, narcotics, or any other controlled substance or drug, unless properly administered upon the advice of a physician. (2) No benefits will be paid for loss which occurred prior to the effective date of this rider.

Treatment means consultation, care, or services provided by a physician, including diagnostic measures and surgical procedures.

HEART RIDER DEFINITIONS

Category I – Specified Surgeries of the Heart

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

Benefits are paid for the following Open Heart Surgery procedures only:

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

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

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

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

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

Surgical Treatment of Abdominal Aortic Aneurysm: To prevent aneurysm rupture. The operation consists of opening the abdomen, finding the aorta, and removing (excising) the aneurysm. Abdominal Aortic Aneurysm is a ballooning or widening of the main artery (the aorta) as it courses down through the abdomen. At the point of the aneurysm, the aneurysm generally measures 3 cm or more in diameter.

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

Category II – Invasive, Procedures and Techniques of the Heart

A Category II Benefit is paid for the following procedures only:

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

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

Laser Angioplasty. Similar to Balloon Angioplasty, a laser tip is used to burn/break down plaque in the clogged blood vessel.

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

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

Cardiac Catheterization (also called heart catheterization) is a diagnostic and occasionally therapeutic procedure that allows a comprehensive examination of the heart and surrounding blood vessels.

Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD). Means the initial placement of the AICD. AICDs are used for treating irregular heartbeats. The defibrillator is surgically placed inside the patient's chest, where it monitors the heart's rhythm. When it identifies a serious arrhythmia, it produces an electrical shock to disrupt the arrhythmia.

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

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

Category II Benefits exclude all procedures not specifically listed above.

ADDITIONAL BENEFITS RIDER

This plan contains a 30-day Waiting Period. This means no benefits are payable for any insured who has been diagnosed before their coverage has been in force 30 days from their Effective Date. If an insured is first diagnosed during the Waiting Period, benefits for treatment of that Specified Critical Illness will apply only to loss commencing after 12 months from their Effective Date; or, at the Member's option, they may elect to void the certificate from the beginning and receive a full refund of premium.

The date of diagnosis of a Specified Critical Illness must be separated from the date of diagnosis of a subsequent different Critical Illness by at least 6 months.

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

Benefits will not be paid for loss due to: (1) Intentionally self-inflicted injury or action; (2) Suicide or attempted suicide while sane or insane; (3) Illegal activities or participation in an illegal occupation; (4) War, whether declared or undeclared, or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence; (5) Substance abuse; or (6) No benefits will be paid for diagnosis made outside the United States; (7) No benefits will be paid for loss which occurred prior to the Effective Date of this rider.

DEFINITIONS

Coma means a state of unconsciousness for 30 consecutive days with: (1) no reaction to external stimuli; (2) no reaction to internal needs; and (3) the use of life support systems.

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

Severe Burn/Severely Burned means cosmetic disfigurement of the surface of a body area not less than 35 square inches due to fire, heat, caustics, electricity, or radiation that is a full-thickness or third-degree burn, as determined by a physician. (A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity, or radiation.)

Loss of Sight, Speech, or Hearing means: (1) Loss of Speech means the total and permanent loss of the ability to speak as the result of physical injury. (2) Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of Hearing that can be corrected by the use of any hearing aid or device shall not be considered an irrevocable loss. (3) Loss of Sight means the total and irreversible loss of all sight in both eyes.

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

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.

**We've got you
under our wing.®**

aflacgroupinsurance.com || 1.800.433.3036

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands.

Continental American Insurance Company • 2801 Devine Street • Columbia, South Carolina 29205

The certificate to which this sales material pertains is written only in English; the certificate prevails if interpretation of this material varies.

This brochure is a brief description of coverage and is not a contract. Read your certificate carefully for exact terms and conditions.

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

