Aflac

Group Critical Illness

INSURANCE – PLAN INCLUDES BENEFITS FOR CANCER AND HEALTH SCREENING

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

This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law.

THIS IS NOT A MEDICARE SUPPLEMENT PLAN. PLEASE READ CAREFULLY.

In California, coverage is underwritten by Continental American Life Insurance Company.

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AFLAC GROUP CRITICAL ILLNESS

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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 notice the difference in 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 may not be covered. And, during recovery, having to worry about out-of-pocket expenses is the last thing anyone needs.

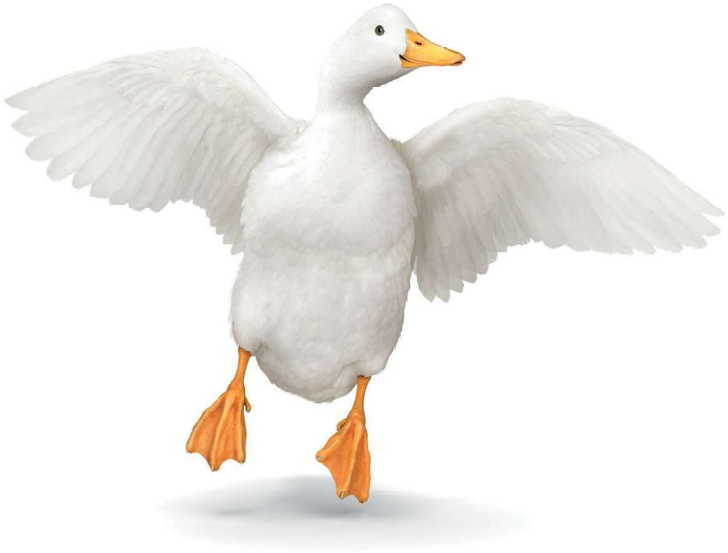
That's the benefit of an Aflac Group Critical Illness plan.

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

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

What you need, when you need it.

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



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

For more than 60 years, Aflac has been dedicated to helping provide individuals and families peace of mind and financial security when they've needed it most. The Aflac Group Critical Illness plan is just another innovative way to help make sure you're well protected.

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.

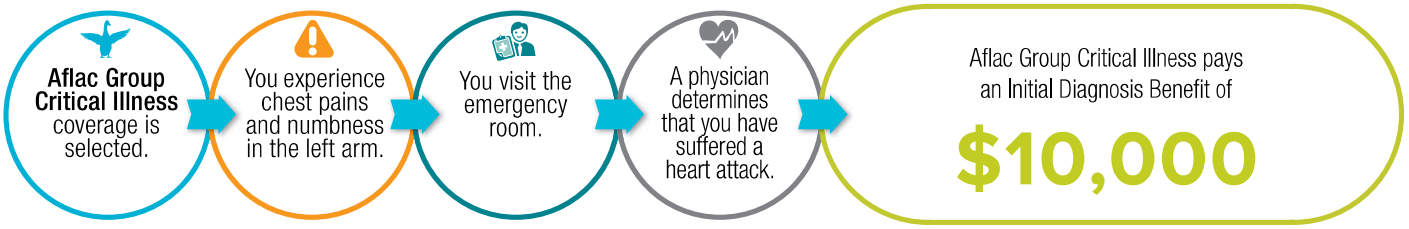
The Aflac Group Critical Illness plan benefits include:

- Critical Illness Benefit payable for:
  - Cancer
  - Heart Attack (Myocardial Infarction)
  - Stroke
  - Kidney Failure (End-Stage Renal Failure)
  - Limited Benefit Major Organ Transplant
  - Bone Marrow Transplant (Stem Cell Transplant)
  - Sudden Cardiac Arrest
  - Coronary Artery Bypass Surgery
  - Non-Invasive Cancer
  - Skin Cancer
- Health Screening Benefit
- Mammography

Features:

- Benefits are paid directly to you, unless otherwise assigned.
- Coverage is available for you, your spouse, and dependent children.
- Coverage may be continued (with certain stipulations). That means you can take it with you if you change jobs or retire.

How it works



Amount payable based on $10,000 Initial Diagnosis Benefit.

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 (Ischemic or Hemorrhagic)	100%
KIDNEY FAILURE (End-Stage Renal Failure)	100%
BONE MARROW TRANSPLANT (Stem Cell Transplant)	100%
SUDDEN CARDIAC ARREST	100%
LIMITED BENEFIT MAJOR ORGAN TRANSPLANT (25% of this benefit is payable for insureds placed on a transplant list for a limited benefit major organ transplant)	100%
NON-INVASIVE CANCER	25%
CORONARY ARTERY BYPASS SURGERY	25%

INITIAL DIAGNOSIS
We will pay a lump sum benefit upon initial diagnosis of a covered critical illness when such diagnoses is caused by or solely attributed to an underlying disease. Cancer diagnoses are subject to the cancer diagnosis limitation. Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

ADDITIONAL DIAGNOSIS
We will pay benefits for each different critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months. Cancer diagnoses are subject to the cancer diagnosis limitation.

REOCCURRENCE
We will pay benefits for the same critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months. Cancer diagnoses are subject to the cancer diagnosis limitation.

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. Children-only coverage is not available.

SKIN CANCER BENEFIT
We will pay $250 for the diagnosis of skin cancer. We will pay this benefit once per calendar year.

MAMMOGRAPHY BENEFIT
We will pay $200 for mammography tests performed while an insured's coverage is in force. This benefit is payable as follows:

a) A baseline mammogram for women age 35 to 39, inclusive.

b) A mammogram for women age 40 to 49, inclusive, every two years or more frequently based on the women's physicians' recommendations.

c) A mammogram every year for women age 50 and over.

Payment of this benefit will not reduce the face amount of the certificate. This benefit is payable once per calendar year.

WAIVER OF PREMIUM

If you become totally disabled due to a covered critical illness prior to age 65, after 90 continuous days of total disability, we will waive premiums for you and any of your covered dependents. As long as you remain totally disabled, premiums will be waived up to 24 months, subject to the terms of the plan.

SUCCESSOR INSURED BENEFIT

If spouse coverage is in force at the time of the primary insured's death, the surviving spouse may elect to continue coverage. Coverage would continue at the existing spouse face amount and would also include any dependent child coverage in force at the time.

HEALTH SCREENING BENEFIT (Employee and Spouse only)

We will pay $50 for health screening tests performed while an insured's coverage is in force. We will pay this benefit once per calendar year.

This benefit is only payable for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for the covered employee and spouse. **This benefit is not paid for dependent children.**

LIMITATIONS AND EXCLUSIONS

All limitations and exclusions that apply to the critical illness plan also apply to all riders, if applicable, unless amended by the riders.

Cancer Diagnosis Limitation Benefits are payable for cancer and/or non-invasive cancer as long as the insured:

- Is treatment-free from cancer for at least 12 months before the diagnosis date; and
- Is in complete remission prior to the date of a subsequent diagnosis, as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the cancer.

EXCLUSIONS

We will not pay for loss due to:

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured;
- **Suicide** – committing or attempting to commit suicide, while sane or insane;
- **Illegal Occupation** – committing or attempting to commit a felony, or being engaged in an illegal occupation;
- **Participation in Aggressive Conflict of any kind, including:**
  - War (declared or undeclared) or military conflicts;
  - Insurrection or riot
- **Intoxicants and controlled substances:** loss sustained or contracted in consequence of the Insured's being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician

Diagnosis, treatment, testing, and confinement must be in the United States or its territories.

All benefits under the plan, including benefits for diagnoses, treatment, confinement and covered tests, are payable only while coverage is in force.

TERMS YOU NEED TO KNOW

The Bone Marrow Transplant (Stem Cell Transplant) benefit is not payable if the transplant results from a covered critical illness for which a benefit has been paid under this plan.

The following are not considered internal or invasive Cancers:

- Superficial cervical cancer, superficial bladder tumors, or pre-malignant tumors or polyps
- Early breast cancer requiring lumpectomy without radiation or chemotherapy
- Early prostate (Stage A) cancer
- Non-Invasive Cancer
- Skin Cancer Melanoma that is diagnosed as: Clark's Level I or II, Breslow depth less than 0.77mm, or Stage 1A melanomas under TNM Staging

Skin cancers are are not payable under the Cancer (internal or invasive) Benefit or the Non-Invasive Cancer Benefit. The following are considered skin cancers:

- Basal cell carcinoma
- Squamous cell carcinoma of the skin
- Melanoma in Situ – that is, melanoma cells that occur only on the outer layer of the skin (the epidermis), where there is no invasion of the deeper layer (the dermis)
- Melanoma that is diagnosed as
  - Clark's Level I or II,
  - Breslow depth less than 0.77mm, or
  - Stage 1A melanomas under TNM Staging

Critical Illness is a disease or a sickness as defined in the plan that first manifests while your coverage is in force.

Date of Diagnosis is defined as follows:

- Bone Marrow Transplant (Stem Cell Transplant): The date the surgery occurs.
- Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or non-invasive cancer is based on such specimens).
- Coronary Artery Bypass Surgery: The date the surgery occurs.
- Heart Attack (Myocardial Infarction): The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the heart attack (myocardial Infarction) definition.
- Kidney Failure (End-Stage Renal Failure): The date a doctor/qualified medical professional recommends that an insured begin renal dialysis.
- Limited Benefit Major Organ Transplant: The date the surgery occurs.
- Non-Invasive Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or non-invasive cancer is based on such specimens).
- Skin Cancer: The date the skin biopsy samples are taken for microscopic examination.
- Stroke: The date the stroke occurs (based on documented neurological deficits and neuroimaging studies).
- Sudden Cardiac Arrest: The date the pumping action of the heart fails (based on the sudden cardiac arrest definition).

Dependent means your spouse or your dependent child. Spouse is your legal wife, husband, or partner in a legally recognized union. Dependent children are your or your spouse's natural children, step-children, foster children, children subject to legal guardianship, legally adopted children, or children placed for adoption, who are younger than age 26. Newborn children are automatically covered from the moment of birth. Refer to your certificate for details.

A doctor/qualified medical professional does not include you or any of your family members.

For the purposes of this definition, family member includes your spouse as well as the following members of your immediate family:

- Son
- Daughter
- Mother
- Father
- Sister
- Brother

This includes step-family members and family-members-in-law.

Employee is a person who meets eligibility requirements and who is covered under the plan. The employee is the primary insured under the plan.

Diagnosis of a Heart Attack (Myocardial Infarction) must include the following:

- New and serial electrocardiographic (ECG) findings consistent with heart attack (myocardial infarction), and
- Elevation of cardiac enzymes above generally accepted laboratory levels of normal. (In the case of creatine physphokinase (CPK) a CPK-MB measurement must be used.)

Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms may also be used.

Kidney Failure (End-Stage Renal Failure) is covered only under the following conditions:

- A doctor/qualified medical professional advises that regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) is necessary to treat the kidney failure (end-stage renal failure); or
- The kidney failure (end-stage renal failure) results in kidney transplantation.

Maintenance Drug Therapy is meant to decrease the risk of cancer recurrence; it is not meant to treat a cancer that is still present.

A Limited Benefit Major Organ Transplant benefit is not payable if the major organ transplant results from a covered critical illness for which a benefit has been paid.

Stroke does not include:

- Non-permanent, brief episodes of neurological dysfunction – such as transient ischemic attack (TIA) – caused by focal brain or retinal ischemia and including symptoms typically lasting less than one hour, and without evidence of acute infarction
- Head injury
- Chronic cerebrovascular insufficiency
- Reversible ischemic neurological deficits unless brain tissue damage is confirmed by neurological imaging

Sudden Cardiac Arrest is not a heart attack (myocardial infarction). A sudden cardiac arrest benefit is not payable if the sudden cardiac arrest is caused by or contributed to by a heart attack (myocardial infarction).

Treatment does not include maintenance drug therapy or routine follow-up visits to verify whether cancer or carcinoma in situ has returned.

YOU MAY CONTINUE YOUR COVERAGE

Your coverage may be continued with certain stipulations. See certificate for details.

TERMINATION OF COVERAGE

Your insurance may terminate when the plan is terminated; the 31st day after the premium due date if the premium has not been paid; or the date you no longer belong to an eligible class. If your coverage terminates, we will provide benefits for valid claims that arose while your coverage was in force.

NOTICES

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

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.

GROUP CRITICAL ILLNESS ADVANTAGE INSURANCE

ADDITIONAL CRITICAL ILLNESSES SUMMARY PAGE

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WHAT WE WILL PAY

COVERED CRITICAL ILLNESSES

Illnesses Covered Under Plan	Percentage of Maximum Benefit
Severe Burn*	100%
Limited Benefit Coma**	100%
Limited Benefit Paralysis**	100%
Limited Benefit Loss of Sight**	100%
Limited Benefit Loss of Hearing**	100%
Limited Benefit Loss of Speech**	100%

*This benefit is only payable for burns due to, caused by, and attributed to, a covered accident.

**These benefits are payable for loss due to a covered underlying disease or a covered accident.

These benefits will be paid based on the face amount in effect on the critical illness date of diagnosis.

We will pay the critical illness benefit if the insured is diagnosed with one of the critical illnesses shown if the date of diagnosis occurs while the plan is in force and the critical illness is not excluded by name or specific description in the plan.

Initial Diagnosis
An insured may receive up to 100% of his face amount upon the diagnosis of a covered critical illness.

Additional Diagnosis
Once benefits have been paid for a covered critical illness, we will pay benefits for each different critical illness when the date of diagnosis is separated by at least 6 consecutive months.

Reoccurrence
Once benefits have been paid for a covered critical illness, benefits are payable for that same critical illness when the date of diagnosis is separated by at least 6 consecutive months.

WHAT IS NOT COVERED, LIMITATIONS AND EXCLUSIONS, AND TERMS YOU NEED TO KNOW

All limitations and exclusions that apply to the critical illness plan also apply to these benefits.

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

Date of Diagnosis is defined as follows:

- **Limited Benefit Coma:** The first day of the period for which a doctor/qualified medical professional confirms a limited benefit coma
- that is due to one of the underlying diseases and that has lasted for at least seven consecutive days.
- **Limited Benefit Loss of Sight, Speech, or Hearing:** The date the loss due to one of the underlying diseases is objectively determined by a doctor/qualified medical professional to be total and irreversible.
- **Limited Benefit Paralysis:** The date a doctor/qualified medical professional diagnoses an insured with paralysis due to one of the underlying diseases as specified in this plan, where such diagnosis is based on clinical and/or laboratory findings as supported by the insured's medical records.
- **Severe Burn:** The date the burn takes place.

Critical Illness is one of the illnesses defined below:

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

- Be a full-thickness or third-degree burn, as determined by a doctor/qualified medical professional. A **Full-Thickness Burn** or **Third-Degree Burn** is the destruction of the skin through the entire thickness or depth of the dermis (or possibly into underlying tissues). This results in loss of fluid and sometimes shock.
- Cause cosmetic disfigurement to the body's surface area of at least 35 square inches.
- Be caused solely by or be solely attributed to a covered accident.

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Limited Benefit Coma means a state of continuous, profound unconsciousness, lasting at least seven consecutive days, and characterized by the absence of:

- Spontaneous eye movements,
- Response to painful stimuli, and
- Vocalization.

Limited Benefit Coma does not include a medically-induced coma.

To be payable as an Accident benefit, the limited benefit coma must be caused by a covered accident.

To be considered a critical illness, the limited benefit coma must be caused by one of the following diseases:

- Brain Aneurysm
- Diabetes
- Encephalitis
- Epilepsy
- Hyperglycemia
- Hypoglycemia
- Meningitis

Limited Benefit Paralysis or **Paralyzed** means the permanent, total, and irreversible loss of muscle function to the whole of at least two limbs. To be payable as an Accident benefit, the paralysis must be caused by a covered accident. To be considered a critical illness, paralysis must be caused by one or more of the following diseases:

- Amyotrophic lateral sclerosis
- Cerebral palsy
- Parkinson's disease,
- Poliomyelitis

The diagnosis of paralysis must be supported by neurological evidence.

Limited Benefit Loss of Sight means the total and irreversible loss of all sight in both eyes. To be payable as an Accident benefit, loss of sight must be caused by a covered accident. To be considered a critical illness, loss of sight must be caused by one of the following diseases:

- Retinal disease
- Optic nerve disease
- Hypoxia

Limited Benefit Loss of Speech means the total and permanent loss of the ability to speak. To be payable as an Accident benefit, loss of speech must be caused by a covered accident. To be considered a critical illness, loss of speech must be caused by to one of the following diseases:

- Alzheimer's disease
- Arteriovenous malformation

Limited Benefit Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of hearing does not include hearing loss that can be corrected by the use of a hearing aid or device. To be payable as an Accident benefit, loss of hearing must be caused by a covered accident.

To be considered a critical illness, loss of hearing must be caused by one of the following diseases:

- Alport syndrome
- Autoimmune inner ear disease
- Chicken pox
- Diabetes
- Goldenhar syndrome
- Meniere's disease
- Meningitis
- Mumps

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.

GROUP CRITICAL ILLNESS ADVANTAGE INSURANCE

HEART PROCEDURE RIDER SUMMARY PAGE

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WHAT WE WILL PAY

Surgeries and Procedures Covered Under Plan	Percentage of Maximum Benefit
Category 1- Specified Surgeries of the Heart	
Mitral Valve Replacement or Repair	100%
Aortic Valve Replacement or Repair	100%
Surgical Treatment of Abdominal aortic aneurysm	100%
Coronary Artery Bypass Surgery	75%*
Category 2- Invasive Procedures and Techniques of the Heart	
AngioJet Clot Busting	10%
Balloon Angioplasty (or Balloon valvuloplasty)	10%
Laser Angioplasty	10%
Atherectomy	10%
Stent Implantation	10%
Cardiac Catheterization	10%
Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD)	10%
Pacemakers	10%

These benefits will be paid based on the face amount in effect on the critical illness date of diagnosis.

*The 75% benefit available in the rider, combined with the partial benefit available in the certificate, equals a 100% benefit for coronary artery bypass surgery.

Benefits are payable for the specified surgeries and procedures listed above when caused by a defined underlying disease, treatment is recommended by a doctor/qualifed medical professional, and is not excluded by name or specific description. Benefits from each category are payable once per calendar year, per insured. If multiple procedures are performed at the same time, benefits will be payable only at the highest benefit level and will not exceed the percentage shown above.

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WHAT IS NOT COVERED, LIMITATIONS AND EXCLUSIONS, AND TERMS YOU NEED TO KNOW

All limitations and exclusions that apply to the critical illness plan also apply to this rider unless amended by the rider.

COVERED HEART PROCEDURE is one of the Category I or Category II procedures defined below:

CATEGORY I – SPECIFIED SURGERIES OF THE HEART

Specified Surgeries of the Heart (Open Heart Surgery) refers to open chest surgery, where the heart is exposed and/or manipulated for open cardiothoracic situations. We will pay benefits for the following open heart surgery procedures when they are performed as a direct result of one of the following: acute coronary syndrome, atherosclerosis, coronary artery disease, cardiomyopathy, or valvular heart disease.

- **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. A blood vessel 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 the rider.
- **Mitral Valve Replacement** or **Repair** is a surgical procedure in which a patient's mitral valve is repaired or replaced by a different valve.
- **Aortic Valve Replacement** or **Repair** is a surgical procedure in which a patient's aortic valve is repaired or replaced by a different valve.
- **Surgical Treatment of Abdominal Aortic Aneurysm** involves opening the abdomen and repairing or removing an abdominal aortic aneurysm.

CATEGORY II – INVASIVE PROCEDURES AND TECHNIQUES OF THE HEART

We will pay Category II benefits for the following invasive procedures and techniques of the heart when they are performed as a result of one of the following: acute coronary syndrome, atherosclerosis, coronary artery disease, cardiomyopathy, or valvular heart disease.

- **AngioJet Clot Busting** clears 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)** opens 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** uses a laser tip to burn/break down plaque in the clogged blood vessel.
- **Atherectomy** opens blocked coronary arteries or clears bypass grafts by using a device on the end of a catheter to cut or shave away atherosclerotic plaque.
- **Stent Implantation** is the implantation of a stainless steel mesh coil in a narrowed part of an artery to keep it propped open.
- **Cardiac Catheterization** (also **Heart Catheterization**) is a diagnostic and occasionally therapeutic procedure that allows a comprehensive examination of the heart and surrounding blood vessels.
- **Automatic Implantable** (or **Internal**) **Cardioverter Defibrillator (AICD**) refers to the initial placement of the AICD. AICDs are used for treating irregular heartbeats. The defibrillator is surgically placed inside the patient's chest where it monitors the heart's rhythm. When it identifies a serious arrhythmia, it produces an electrical shock to disrupt the arrhythmia.
- **Pacemaker Placement** refers to the initial placement/ implantation of a pacemaker, which sends electrical signals to make the heart beat when a person'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.

Valvular Heart Disease is a disease characterized by damage to or a defect in one of the four heart valves.

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.

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GROUP CRITICAL ILLNESS ADVANTAGE INSURANCE

OPTIONAL BENEFITS RIDER SUMMARY PAGE

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WHAT WE WILL PAY

COVERED OPTIONAL BENEFITS

Illnesses Covered Under Plan	Percentage of Maximum Benefit
Limited Benefit Benign Brain Tumor	100%
Advanced Alzheimer's Disease	25%
Advanced Parkinson's Disease	25%

These benefits will be paid based on the face amount in effect on the critical illness date of diagnosis.

We will pay the optional benefit if the insured is diagnosed with one of the conditions listed in the rider schedule if the date of diagnosis is while the rider is in force.

WHAT IS NOT COVERED, LIMITATIONS AND EXCLUSIONS, AND TERMS YOU NEED TO KNOW

All limitations and exclusions that apply to the critical illness plan also apply to the rider unless amended by the rider.

Date of Diagnosis is defined as follows:

- **Advanced Alzheimer's Disease:** The date a doctor/qualified medical professional diagnoses the insured as incapacitated due to Alzheimer's disease.
- **Advanced Parkinson's Disease:** The date a doctor/qualified medical professional diagnoses the insured as incapacitated due to Parkinson's disease.
- **Limited Benefit Benign Brain Tumor:** The date a doctor/qualified medical professional determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

Optional Benefit is one of the illnesses defined below and shown in the rider schedule:

Advanced Alzheimer's Disease means Alzheimer's disease, a progressive degenerative disease of the brain, which has been diagnosed by a doctor/qualified medical professional as having progressed to a stage which causes the insured to be incapacitated.

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To be incapacitated due to Alzheimer's disease, a doctor/qualified medical professional must determine that the insured exhibits a loss of intellectual capacity resulting in an impairment of memory and judgment, as well as a significant reduction in mental and social functioning, to the extent that the insured requires permanent daily personal supervision. Diagnosis of Advanced Alzheimer's Disease requires proof, made in writing, by a psychiatrist, neurologist, neuropsychologist, or other qualified medical professional of the following:

- Formal neuropsychological testing performed by a neuropsychologist confirming dementia;
- Completed laboratory tests which rule out causes other than Alzheimer's Disease; **and**
- Magnetic resonance imaging, computerized tomography or other imaging techniques which rule out causes other than Alzheimer's disease.

Advanced Parkinson's Disease means Parkinson's disease which has been diagnosed by a doctor/qualified medical professional as having progressed to classification of Stage 4 or greater and which causes the insured to be incapacitated. Diagnosis of Advanced Parkinson's Disease must be made by a neurologist or other qualified medical professional based upon abnormal results from a neurological examination, cognitive testing, and imaging studies. To be incapacitated due to Parkinson's disease, the insured must exhibit permanent clinical impairment of **at least two** of the following manifestations:

- Muscle rigidity
- Tremor
- Bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses).

Limited Benefit Benign Brain Tumor is a mass or growth of abnormal, noncancerous cells in the brain. The tumor is composed of similar cells that do not follow normal cell division and growth patterns and develop into a mass of cells that microscopically do not have the characteristic appearance of a Cancer. Benign Brain Tumor must be caused by Multiple Endocrine Neoplasia, Neurofibromatosis, or Von Hippel-Lindau Syndrome.

- Multiple Endocrine Neoplasia is a genetic disease in which one or more of the endocrine glands are overactive or form a tumor.
- Neurofibromatosis is a genetic disease in which the nerve tissue grows tumors that may be benign and may cause serious damage by compressing nerves and other tissue.
- Von Hippel-Lindau Syndrome is a genetic disease that predisposes a person to have benign or malignant tumors.
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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.

AFLAC GROUP CHILDHOOD CONDITIONS RIDER

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CHILDHOOD CONDITIONS RIDER BENEFIT

CHILDHOOD CONDITIONS RIDER	Percentage of Employee Face Amount
CYSTIC FIBROSIS	50%
CEREBRAL PALSY	50%
CLEFT LIP OR CLEFT PALATE	50%
DOWN SYNDROME	50%
PHENYLALANINE HYDROXYLASE DEFICIENCY DISEASE (PKU)	50%
SPINA BIFIDA	50%
TYPE 1 DIABETES	50%
	One-time Benefit Amount
AUTISM SPECTRUM DISORDER	$3,000

Benefits are payable if a dependent child is diagnosed with one of the conditions listed and the date of diagnosis is while the rider is in force. (In Indiana, diagnosis must not be specifically excluded by the plan.)

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

These benefits will be paid based on the face amount in effect on the critical illness date of diagnosis.

WHAT IS NOT COVERED, LIMITATIONS AND EXCLUSIONS, AND TERMS YOU NEED TO KNOW

All limitations and exclusions that apply to the critical illness plan also apply to these benefits. No benefits will be paid for loss which occurred prior to the effective date of the plan.

Date of Diagnosis is defined as follows:

- Cystic Fibrosis: The date a doctor/qualified medical professional diagnoses a dependent child as having Cystic Fibrosis and where such diagnosis is supported by medical records.
- Cerebral Palsy: The date a doctor/qualified medical professional diagnoses a dependent child as having Cerebral Palsy and where such diagnosis is supported by medical records.
- Cleft Lip or Cleft Palate: The date a doctor/qualified medical professional diagnoses a dependent child as having Cleft Lip or Cleft Palate and where such diagnosis is supported by medical records.
- Down Syndrome: The date a doctor/qualified medical professional diagnoses a dependent child as having Down Syndrome and where such diagnosis is supported by medical records.
- Phenylalanine Hydroxylase Deficiency Disease (PKU): The date a doctor/qualified medical professional diagnoses a dependent child as having PKU and where such diagnosis is supported by medical records.
- Spina Bifida: The date a doctor/qualified medical professional diagnoses a dependent child as having Spina Bifida and where such diagnosis is supported by medical records.
- Type I Diabetes: The date a doctor/qualified medical professional diagnoses a dependent child as having Type I Diabetes and where such diagnosis is supported by medical records.
- Autism Spectrum Disorder: The date a doctor/qualified medical professional diagnoses a dependent child as having Autism Spectrum Disorder and where such diagnosis is supported by medical records.

If a dependent child has both a Cleft Lip and Cleft Palate or has one on each side of the face, we will pay this benefit only once.

A doctor/qualified medical professional must diagnose Phenylalanine Hydroxylase Deficiency Disease (PKU) based on a PKU test.

A doctor/qualified medical professional must diagnose Type I Diabetes based on one of the following diagnostic tests:

- Glycated hemoglobin (A1C) test
- Random blood sugar test
- Fasting blood sugar test

A doctor/qualified medical professional must diagnose Autism Spectrum Disorder based on DSM-V diagnostic criteria.

In California, coverage is underwritten by Continental American Life Insurance Company.

For a complete list of limitations and exclusions please refer to the brochure.

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. For groups situsedin California, group coverage is underwritten by Continental American Life Insurance Company. This piece is intended to be used in conjunction with the C21000 Critical Illness product brochure and is subject to the terms, conditions, and limitations of Policy Series C21000.

Continental American Insurance Company • Columbia, South Carolina

GROUP CRITICAL ILLNESS ADVANTAGE INSURANCE

PROGRESSIVE DISEASES RIDER SUMMARY PAGE

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WHAT WE WILL PAY

COVERED PROGRESSIVE DISEASES

Illnesses Covered Under Plan	Percentage of Maximum Benefit
Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease)	100%
Sustained Multiple Sclerosis	100%

This benefit is paid based on your selected Progressive Disease Benefit amount.

We will pay the benefit shown upon diagnosis of one of the covered diseases if the date of diagnosis is while the rider is in force.

WHAT IS NOT COVERED, LIMITATIONS AND EXCLUSIONS, AND TERMS YOU NEED TO KNOW

All limitations and exclusions that apply to the critical illness plan also apply to the rider unless amended by the rider.

Date of Diagnosis is defined for each specified critical illness as follows:

- **Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease):** The date a doctor/qualified medical professional Diagnoses an Insured as having ALS and where such Diagnosis is supported by medical records.
- **Sustained Multiple Sclerosis:** The date a doctor/qualified medical professional Diagnoses an Insured as having Multiple Sclerosis and where such Diagnosis is supported by medical records.

Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease) means a chronic, progressive motor neuron disease occurring when nerve cells in the brain and spinal cord that control voluntary movement degenerate, causing muscle weakness and atrophy, eventually leading to paralysis.

Sustained Multiple Sclerosis means a chronic degenerative disease of the central nervous system in which gradual destruction of myelin occurs in the brain or spinal cord or both, interfering with the nerve pathways. Sustained Multiple Sclerosis results in one of the following symptoms for at least 90 consecutive days:

- **Muscular weakness,**
- **Loss of coordination,**
- **Speech disturbances, or**
- **Visual disturbances.**

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.

This insert is subject to the terms, conditions, and limitations of Form Number C21303CA.

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AFLAC GROUP SPECIFIED DISEASE RIDER

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COVERED SPECIFIED DISEASES	Percentage of Face Amount
ADRENAL HYPOFUNCTION (ADDISON'S DISEASE)	25%
CEREBROSPINAL MENINGITIS	25%
DIPHTHERIA	25%
HUNTINGTON'S CHOREA	25%
LEGIONNAIRE'S DISEASE	25%
MALARIA	25%
MUSCULAR DYSTROPHY	25%
MYASTHENIA GRAVIS	25%
NECROTIZING FASCIITIS	25%
OSTEOMYELITIS	25%
POLIOMYELITIS (POLIO)	25%
RABIES	25%
SICKLE CELL ANEMIA	25%
SYSTEMIC LUPUS	25%
SYSTEMIC SCLEROSIS (SCLERODERMA)	25%
TETANUS	25%
TUBERCULOSIS	25%

WHAT IS NOT COVERED, LIMITATIONS AND EXCLUSIONS, AND TERMS YOU NEED TO KNOW

These benefits will be paid based on the face amount in effect on the specified disease date of diagnosis. All limitations and exclusions that apply to the critical illness plan also apply to the rider unless amended by the rider.

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

Date of diagnosis is defined for each specified disease as follows:

- Adrenal Hypofunction (Addison's Disease): The date a doctor diagnoses an insured as having Adrenal Hypofunction and where such diagnosis is supported by medical records.
- Cerebrospinal Meningitis: The date a doctor diagnoses an insured as having Cerebrospinal Meningitis and where such diagnosis is supported by medical records.
- Diphtheria: The date a doctor diagnoses an insured as having Diphtheria based on clinical and/or laboratory findings as supported by medical records.
- Huntington's Chorea: The date a doctor diagnoses an insured as having Huntington's Chorea based on clinical findings as supported by medical records.
- Legionnaire's Disease: The date a doctor diagnoses an insured as having Legionnaire's Disease by finding Legionella bacteria in a clinical specimen taken from the insured.
- Malaria: The date a doctor diagnoses an insured as having Malaria and where such diagnosis is supported by medical records.
- Muscular Dystrophy: The date a doctor diagnoses an insured as having Muscular Dystrophy and where such diagnosis is supported by medical records.
- Myasthenia Gravis: The date a doctor diagnoses an insured as having Myasthenia Gravis and where such diagnosis is supported by medical records.
- Necrotizing Fasciitis: The date a doctor diagnoses an insured as having Necrotizing Fasciitis and where such diagnosis is supported by medical records.
- Osteomyelitis: The date a doctor diagnoses an insured as having Osteomyelitis and where such diagnosis is supported by medical records.
- Poliomyelitis: The date a doctor diagnoses an insured as having Poliomyelitis and where such diagnosis is supported by medical records.
- Rabies: The date a doctor diagnoses an insured as having Rabies and where such diagnosis is supported by medical records.
- Sickle Cell Anemia: The date a doctor diagnoses an insured as having Sickle Cell Anemia and where such diagnosis is supported by medical records.
- Systemic Lupus: The date a doctor diagnoses an insured as having Systemic Lupus and where such diagnosis is supported by medical records.
- Systemic Sclerosis (Scleroderma): The date a doctor diagnoses an insured as having Systemic Sclerosis and where such diagnosis is supported by medical records.
- Tetanus: The date a doctor diagnoses an insured as having Tetanus by finding Clostridium tetani bacteria in a clinical specimen taken from the insured.
- Tuberculosis: The date a doctor diagnoses an insured as having Tuberculosis by finding Mycobacterium tuberculosis bacteria in a clinical specimen taken from the insured.

Adrenal Hypofunction does not include secondary and tertiary adrenal insufficiency.

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