

# Aflac Cancer Protection Assurance

CANCER INDEMNITY INSURANCE – OPTION 2

We've been dedicated to helping provide peace of mind and financial security for more than 60 years.



**The policy is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.**

**Aflac** SmartClaim®  
**One Day Pay**™

# AFLAC CANCER PROTECTION ASSURANCE

## CANCER INDEMNITY INSURANCE – OPTION 2

Policy Series B70000



### Aflac Cancer Protection Assurance: real coverage when you need it most.

Cancer treatment is changing—and Aflac is proud to be changing with it. Thanks to advances in science and treatment, more and more Americans today are living with cancer.<sup>1</sup> Aflac Cancer Protection Assurance helps cover these innovative treatments with benefits that really care for you as a whole person.

From prevention to recovery, Aflac is with you every step of the way. Our benefits are built to see you all the way through cancer treatment and they'll stay with you for life after cancer.<sup>2</sup>



#### CANCER STATS YOU NEED TO KNOW

##### FACT NO. 1



LIFETIME RISK OF DEVELOPING CANCER IN  
THE UNITED STATES.<sup>3</sup>

##### FACT NO. 2



LIFETIME RISK OF DEVELOPING CANCER IN  
THE UNITED STATES.<sup>3</sup>

Of course, four-in-four hope they'll never get it. But for many—and for certain types of cancer—advances in science and treatment have transformed cancer into an illness that can be managed over a lifetime. **In fact: 89% of women who are diagnosed with breast cancer will survive it and 98% of men who develop prostate cancer will live with it for five years—or more.**<sup>4</sup> Some cancer patients, even with insurance, spend about a third of their household income on out-of-pocket health care costs outside of insurance premiums.<sup>5</sup>

<sup>1</sup>Progress Against Cancer – 2019 Annual Plan, National Cancer Institute. <https://www.cancer.gov/about-nci/budget/plan/progress>. Accessed: November 13, 2017. <sup>2</sup>Coverage remains in force as long as premiums are paid. <sup>3</sup>Cancer Facts & Figures 2017, American Cancer Society. <sup>4</sup>National Cancer Institute, Surveillance, Epidemiology and End Results (SEER) Program. See: <https://seer.cancer.gov/statfacts/html/breast.html> and <https://seer.cancer.gov/statfacts/html/prost.html>. SEER Cancer Statistics Review, 1975-2014, National Cancer Institute. Bethesda, MD, [https://seer.cancer.gov/csr/1975\\_2014/](https://seer.cancer.gov/csr/1975_2014/), based on November 2016 SEER data submission, posted to the SEER web site, April 2017. Accessed: December 13, 2017.

<sup>5</sup>Widowed Early, A Cancer Doctor Writes About the Harm of Medical Debt, NPR, August, 10 2018. <https://www.npr.org/sections/health-shots/2017/08/10/542589232/widowed-early-a-cancer-doctor-writes-about-the-harm-of-medical-debt>. Accessed: December 14, 2017.

**Understand the difference Aflac makes in your financial security.**

Aflac pays cash benefits directly to you, unless you choose otherwise. This means that you can have added financial resources to help with expenses incurred due to medical treatment, ongoing living expenses or any purpose you choose.

## **We're With You: Aflac Cancer Protection Assurance Stays with You for Life.**

Aflac Cancer Protection Assurance pays cash benefits directly to you, unless assigned, when you need them most. If you're ever diagnosed with a covered cancer, these benefits are more important than ever. Why? Because cancer treatment is expensive—today, cancer costs patients and families more than any other chronic illness.<sup>6</sup>

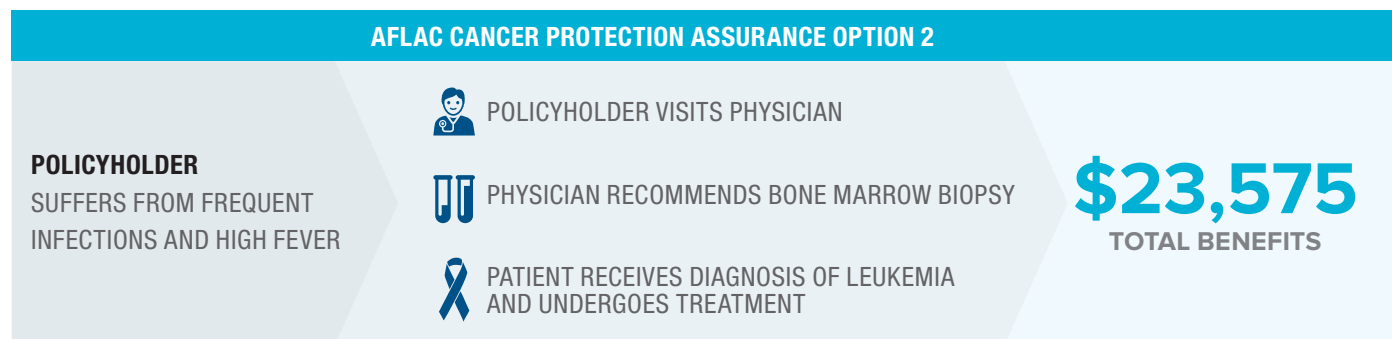
Major medical may not cover the cost of things like deductibles, co-pays, lost work time, or even travel. Aflac Cancer Protection Assurance can help with cancer-associated costs like these. It helps support you through the physical, emotional, and financial costs of cancer—and stays with you for life. Here's how it works:

**We're with you, even when you're well.** We pay a benefit for early detection and preventative care, like mammograms, PSA blood tests, and many other kinds of cancer screenings, too. Why? Because when cancer is found and treated early you're more likely to survive it.<sup>7</sup>

**We'll see you all the way through treatment.** If you're diagnosed with cancer, we offer benefits that you can count on—and thanks to One Day Pay<sup>SM</sup>, your claim can be processed in just one day. You'll receive a benefit upon initial diagnosis of a covered cancer and our support doesn't end there.

**We give you the freedom to choose the best care for you.** You and your doctor decide on a treatment plan together; we help provide you with financial support for every month that you're undergoing that treatment. Want a second opinion? We provide a benefit for that, too.

### **HOW IT WORKS**



The above example is based on a scenario for Aflac Cancer Protection Assurance – Option 2 that includes the following benefit conditions: Bone Marrow Biopsy (Cancer Screening Benefit) of \$75, Initial Diagnosis Benefit of \$4,000, IV Chemotherapy for 3 months (Physician-Administered Radiation Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy Benefit) of \$3,600, Immunotherapy (Physician-Administered Radiation Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy Benefit) for 6 months of \$7,200, Antinausea Benefit (9 months) of \$900, Stem Cell Transplant Benefit of \$7,000, Hospital Confinement Benefit (4 days) of \$800.

Benefits and/or premiums may vary based on state and benefit option selected. Riders are available for an additional premium. The policy has limitations and exclusions that may affect benefits payable. This brochure is for illustrative purposes only. Refer to the policy for complete benefit details, definitions, limitations and exclusions.

<sup>6</sup>National Institutes of Health, Discussing Health Care Expenses in the Oncology Clinic: Analysis of Cost Conversations in Outpatient Encounters, November 2017 <https://www.ncbi.nlm.nih.gov/pubmed/28834684>. Accessed: December 13, 2017. <sup>7</sup>National Cancer Institute, Cancer Trends Progress Report. See <https://progressreport.cancer.gov/detection>. Published: January 2017. Accessed: December 13, 2017.

## Coverage Options

### Choose the Policy and Riders that Fit Your Needs

BENEFIT	DESCRIPTION
CANCER SCREENING	One \$75 benefit per calendar year, per covered person Benefit increases to three screenings per calendar year after the diagnosis for internal cancer or an associated cancerous condition
PROPHYLACTIC SURGERY (DUE TO A POSITIVE GENETIC TEST RESULT)	\$250 per covered person, per lifetime
INITIAL DIAGNOSIS	Named Insured or Spouse: \$4,000 Dependent Child: \$8,000 Payable once per covered person, per lifetime
ADDITIONAL OPINION	\$300 per covered person, per lifetime
RADIATION THERAPY, CHEMOTHERAPY, IMMUNOTHERAPY OR EXPERIMENTAL CHEMOTHERAPY	Self-Administered: \$250 per calendar month Physician Administered: \$1,200 per calendar month This benefit is limited to one self-administered treatment and one physician-administered treatment per calendar month.
HORMONAL THERAPY	\$25 once per calendar month
TOPICAL CHEMOTHERAPY	\$150 once per calendar month
ANTINAUSEA	\$100 once per calendar month
STEM CELL AND BONE MARROW TRANSPLANTATION	\$7,000; lifetime maximum of \$7,000 per covered person Donor Benefit: \$100 for stem cell donation, or \$750 for bone marrow donation Payable one time per covered person
BLOOD AND PLASMA	Inpatient: \$50 times the number of days paid under the Hospital Confinement Benefit, per covered person Outpatient: \$175 per day, per covered person
SURGERY/ANESTHESIA	\$100-\$3,400 Anesthesia: additional 25% of the Surgery Benefit Maximum daily benefit will not exceed \$4,250; no lifetime maximum on the number of operations
SKIN CANCER SURGERY	Laser or Cryosurgery: \$35 Excision of lesion of skin without flap or graft: \$170 Flap or graft without excision: \$250 Excision of lesion of skin with flap or graft: \$400 Maximum daily benefit will not exceed \$400. No lifetime maximum on the number of operations
PROPHYLACTIC SURGERY (WITH CORRELATING INTERNAL CANCER DIAGNOSIS)	\$250 per covered person, per lifetime
HOSPITALIZATION CONFINEMENT FOR 30 DAYS OR LESS	Named Insured or Spouse: \$200 Dependent Child: \$250
HOSPITALIZATION CONFINEMENT FOR 31 DAYS OR MORE	Named Insured or Spouse: \$400 Dependent Child: \$500
OUTPATIENT HOSPITAL SURGICAL ROOM CHARGE	\$200 per day, per covered person

<b>EXTENDED-CARE FACILITY</b>	\$100 per day; limited to 30 days in each calendar year, per covered person
<b>HOME HEALTH CARE</b>	\$100 per day; limited to 10 days per hospitalization, per covered person; and 30 days per calendar year, per covered person
<b>HOSPICE CARE</b>	\$1,000 for first day; \$50 per day thereafter; \$12,000 lifetime maximum per covered person
<b>NURSING SERVICES</b>	\$100 per day; payable for only the number of days the Hospital Confinement Benefit is payable
<b>SURGICAL PROSTHESIS</b>	\$2,000; lifetime maximum of \$4,000 per covered person
<b>NONSURGICAL PROSTHESIS</b>	\$175 per occurrence, per covered person; lifetime maximum of \$350 per covered person
<b>BREAST RECONSTRUCTION</b>	Breast Tissue/Muscle Reconstruction Flap Procedures: \$2,000 Breast Reconstruction (occurring within 5 years of breast cancer diagnosis): \$500 Breast Symmetry (on the nondiseased breast occurring within 5 years of breast reconstruction): \$220 Permanent Areola Repigmentation (on the diseased breast): \$100 Maximum daily benefit will not exceed \$2,000
<b>OTHER RECONSTRUCTIVE SURGERY</b>	Facial Reconstruction: \$500 Anesthesia: additional 25% of the Other Reconstructive Surgery Benefit Maximum daily benefit will not exceed \$500
<b>EGG HARVESTING, STORAGE (CRYOPRESERVATION) AND IMPLANTATION</b>	\$1,000 for a covered person to have oocytes extracted and harvested \$200 for the storage of a covered person's oocyte(s) or sperm \$200 for embryo transfer Lifetime maximum of \$1,400 per covered person
<b>ANNUAL CARE</b>	\$200 on the anniversary date of diagnosis; lifetime maximum of five annual \$200 payments per covered person
<b>AMBULANCE</b>	\$250 ground \$2,000 air ambulance
<b>TRANSPORTATION</b>	\$.40 cents per mile for transportation; payable up to a combined maximum of \$2,400, per round trip
<b>LODGING</b>	\$65 per day; limited to 90 days per calendar year
<b>WAIVER OF PREMIUM</b>	Yes
<b>CONTINUATION OF COVERAGE</b>	Yes

<b>OPTIONAL RIDERS</b>	<b>DESCRIPTION</b>						
<b>INITIAL DIAGNOSIS BUILDING BENEFIT RIDER</b>	This benefit will increase the amount of your Initial Diagnosis Benefit, as shown in the policy, by \$100 for each unit purchased, up to five units, for each covered person on the anniversary date of coverage, while coverage remains in force.						
<b>SPECIFIED-DISEASE BENEFIT RIDER</b>	When a covered person is diagnosed with any of the diseases listed in the Specified-Disease Rider: <table border="1" data-bbox="490 1747 1524 1887"> <thead> <tr> <th>Initial diagnosis</th> <th colspan="2">Hospitalization</th> </tr> </thead> <tbody> <tr> <td>\$2,000</td> <td>30 days or less: \$400 per day</td> <td>31 days or more: \$800 per day</td> </tr> </tbody> </table>	Initial diagnosis	Hospitalization		\$2,000	30 days or less: \$400 per day	31 days or more: \$800 per day
Initial diagnosis	Hospitalization						
\$2,000	30 days or less: \$400 per day	31 days or more: \$800 per day					
<b>DEPENDENT CHILD RIDER</b>	\$10,000 when a covered dependent child is diagnosed as having internal cancer or an associated cancerous condition; payable only once for each covered dependent child						

REFER TO THE OUTLINE OF COVERAGE FOR BENEFIT DETAILS, LIMITATIONS AND EXCLUSIONS.

**American Family Life Assurance Company of Columbus**  
(herein referred to as Aflac)  
Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999  
Toll-Free 1.800.99.AFLAC (1.800.992.3522)

**The policy described in this Outline of Coverage provides supplemental coverage  
and will be issued only to supplement insurance already in force.**

**LIMITED BENEFIT, SPECIFIED DISEASE INSURANCE**  
**Outline of Coverage for Policy Form Series B70200**  
**THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.**

**If you are eligible for Medicare, review the “Guide to Health Insurance for People with Medicare” furnished by Aflac.**

- (1) Read Your Policy Carefully:** This Outline of Coverage provides a very brief description of some of the important features of the policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Aflac. It is, therefore, important that you READ YOUR POLICY CAREFULLY.
- (2) Cancer Insurance Coverage** is designed to supplement a Covered Person’s existing accident and sickness coverage only when certain losses occur as a result of the disease of Cancer or an Associated Cancerous Condition. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
- (3) Benefits:** Aflac will pay the following benefits, as applicable, while coverage is in force, subject to all other limitations and exclusions, conditions, and provisions of the policy, unless indicated otherwise. All treatments listed below must be National Cancer Institute (NCI) or Food and Drug Administration (FDA) approved for the treatment of Cancer or an Associated Cancerous Condition, as applicable.

**CANCER SCREENING BENEFIT:** Aflac will pay \$75 per Calendar Year when a Covered Person receives one of the following:

- mammogram • breast ultrasound • breast MRI • thermography
- CA15-3 (blood test for breast cancer) • CA 125 (blood test for ovarian cancer) • Pap smear/ThinPrep • PSA (blood test for prostate cancer) • CEA (blood test for colon cancer) • P32 uptake serum protein electrophoresis (blood test for multiple myeloma) • testicular ultrasound • transrectal ultrasound • abdominal ultrasound • flexible sigmoidoscopy • colonoscopy • virtual colonoscopy • cystoscopy • colposcopy • bronchoscopy • mediastinoscopy • esophagoscopy • sigmoidoscopy • proctosigmoidoscopy • gastroscopy • laryngoscopy • chest X-ray • computerized tomography (CT or CAT scan) • magnetic resonance imaging (MRI) • bone scan • thyroid scan • multiple gated acquisition (MUGA) scan • positron emission tomography (PET) scan • biopsy • hemoccult stool specimen (lab confirmed)
- Genetic Testing • bone marrow donor screening • cancer vaccine

This benefit is limited to one \$75 payment per Calendar Year, per Covered Person, with no Positive Medical Diagnosis. If a Covered Person receives a Positive Medical Diagnosis for Internal Cancer or an Associated Cancerous Condition, this benefit will pay up to a total of three \$75 payments per Calendar Year for screenings performed on such Covered Person. Screenings must be administered by licensed medical personnel. Except for Genetic Testing, bone marrow donor screening, and cancer vaccine, the screening must be performed for the purpose of determining whether Cancer or an Associated Cancerous Condition exists in a Covered Person. No lifetime maximum.

**PROPHYLACTIC SURGERY BENEFIT (DUE TO A POSITIVE GENETIC TEST RESULT):** Aflac will pay \$250 when a Covered Person has surgery due to a positive test result received for a genetic alteration or mutation associated with a hereditary Cancer syndrome and such surgery is recommended by a Physician. The Genetic Testing must be performed while coverage is in force.

**This benefit is payable once per Covered Person, per lifetime.**

**CANCER DIAGNOSIS BENEFITS:**

**INITIAL DIAGNOSIS BENEFIT:** Aflac will pay the amount listed below when a Covered Person is diagnosed as having Internal Cancer or an Associated Cancerous Condition while the policy is in force, subject to the Limitations and Exclusions.

Named Insured or Spouse	\$4,000
Dependent Child	\$8,000

**This benefit is payable once per Covered Person, per lifetime.** In addition to the Positive Medical Diagnosis, we may require additional information from the attending Physician and Hospital.

**ADDITIONAL OPINION BENEFIT:** Aflac will pay \$300 when a charge is incurred for an additional surgical opinion from a Physician or an evaluation or consultation with a Physician for the purpose of determining the appropriate course of treatment for a covered Internal Cancer or Associated Cancerous

Condition. **This benefit is payable once per Covered Person, per lifetime.**

**CANCER TREATMENT BENEFITS:**

**NONSURGICAL TREATMENT BENEFITS:**

**RADIATION THERAPY, CHEMOTHERAPY, IMMUNOTHERAPY, OR EXPERIMENTAL CHEMOTHERAPY BENEFIT:**

**SELF-ADMINISTERED:** Aflac will pay \$250 once per Calendar Month for which a Covered Person receives and incurs a charge for self-administered Physician-prescribed Chemotherapy, Immunotherapy, or Experimental Chemotherapy as part of a treatment regimen for Cancer or an Associated Cancerous Condition.

**PHYSICIAN-ADMINISTERED:** Aflac will pay \$1,200 once per Calendar Month for which a Covered Person is prescribed, receives, and incurs a charge for Radiation Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy administered by a member of the medical profession in a Medical Facility as part of a treatment regimen for Cancer or an Associated Cancerous Condition.

This benefit is limited to one self-administered treatment and one physician-administered treatment per Calendar Month. After this benefit has been paid for 12 Calendar Months, Aflac will require annual documentation from the attending Physician certifying that the Cancer or Associated Cancerous Condition is still detectable and active in the body and is not in remission in order for this benefit to continue to be payable.

**HORMONAL THERAPY BENEFIT:** Aflac will pay \$25 once per Calendar Month for which a Covered Person is prescribed, receives, and incurs a charge for Hormonal Therapy as part of a treatment regimen for Cancer or an Associated Cancerous Condition.

**TOPICAL CHEMOTHERAPY BENEFIT:** Aflac will pay \$150 once per Calendar Month for which a Covered Person is prescribed, receives, and incurs a charge for a Topical Chemotherapy for the treatment of Cancer or an Associated Cancerous Condition.

See the Payment of Nonsurgical Treatment Benefits section for additional information.

**INDIRECT/ADDITIONAL THERAPY BENEFITS:**

**ANTINAUSEA BENEFIT:** Aflac will pay \$100 once per Calendar Month for which a Covered Person receives and incurs a charge for anti-nausea drugs that are prescribed in conjunction with Radiation Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy. This benefit is payable only once per Calendar Month and is limited to the Calendar Month in which a person receives Radiation Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy, the Calendar Month prior to such treatment, and the Calendar Month following such treatment. No lifetime maximum.

**STEM CELL AND BONE MARROW TRANSPLANTATION**

**BENEFIT:** Aflac will pay \$7,000 when a Covered Person receives and incurs a charge for a peripheral Stem Cell Transplantation or a Bone Marrow Transplantation for the treatment of Internal Cancer or an Associated Cancerous Condition. Lifetime maximum of \$7,000 per Covered Person. In addition, Aflac will pay the Covered Person's donor an indemnity amount for his or her expenses as a result of the donation procedure as follows: \$100 for stem cell donation, or \$750 for bone marrow donation. This benefit is payable one time per Covered Person.

**BLOOD AND PLASMA BENEFIT:** Aflac will pay \$50 times the number of days paid under the Hospital Confinement Benefit when a Covered Person receives and incurs a charge for blood and/or plasma transfusions for the treatment of Internal Cancer or an Associated Cancerous Condition during a covered Hospital confinement. Aflac will pay \$175 for each day a Covered Person receives and incurs a charge for blood and/or plasma transfusions for the treatment of Internal Cancer or an Associated Cancerous Condition as an outpatient in a Physician's office, clinic, Hospital, or Ambulatory Surgical Center. This benefit does not pay for immunoglobulins, Immunotherapy, antihemophilia factors, or colony-stimulating factors. No lifetime maximum.

**SURGICAL TREATMENT BENEFITS:**

**SURGERY/ANESTHESIA BENEFIT:** Aflac will pay according to the benefits in the Schedule of Operations in the policy when a Covered Person has a surgical procedure performed for the direct treatment of a covered Internal Cancer or Associated Cancerous Condition and a charge is incurred for such surgical procedure. If any surgical procedure for the treatment of Internal Cancer or an Associated Cancerous Condition is performed other than those listed, Aflac will pay an amount comparable to the amount shown in the Schedule of Operations for the surgical procedure most nearly similar in severity and gravity.

**EXCEPTIONS: Prophylactic Surgery and procedures payable under the Cancer Screening Benefit, Skin Cancer Surgery Benefit, or Reconstructive Surgery Benefit will not be payable under the Surgery/Anesthesia Benefit.**

**The Surgery/Anesthesia Benefit is only payable one time per 24-hour period, even though more than one surgical procedure may be performed. The highest eligible benefit will be paid.**

Aflac will pay an indemnity benefit equal to 25% of the amount shown in the Schedule of Operations for the administration of anesthesia during a covered surgical operation.

The maximum daily benefit will not exceed \$4,250. No lifetime maximum on the number of operations.

**SKIN CANCER SURGERY BENEFIT:** When a surgical operation is performed on a Covered Person for a diagnosed skin Cancer, including melanoma or Nonmelanoma Skin

Cancer, Aflac will pay the amount listed below when a charge is incurred for the specific procedure. The amount listed below includes anesthesia services. The maximum daily benefit will not exceed \$400. No lifetime maximum on the number of operations.

Laser or Cryosurgery \$ 35

**Surgeries OTHER THAN Laser or Cryosurgery:**

Excision of lesion of skin without flap or graft 170  
 Flap or graft without excision 250  
 Excision of lesion of skin with flap or graft 400

**PROPHYLACTIC SURGERY BENEFIT (WITH CORRELATING INTERNAL CANCER DIAGNOSIS):** Aflac will pay \$250 when, as recommended by a Physician due to a covered diagnosis of Internal Cancer or an Associated Cancerous Condition, one of the Prophylactic Surgeries shown below is performed on a Covered Person:

1. mastectomy due to a covered diagnosis of Internal Cancer other than breast Cancer;
2. oophorectomy due to a covered diagnosis of Internal Cancer other than ovarian Cancer; or
3. orchiectomy due to a covered diagnosis of Internal Cancer other than testicular Cancer.

**This benefit is payable once per Covered Person, per lifetime.**

**HOSPITALIZATION BENEFITS:**

**HOSPITAL CONFINEMENT BENEFITS:**

**HOSPITALIZATION FOR 30 DAYS OR LESS:** When a Covered Person is confined to a Hospital for treatment of Cancer or an Associated Cancerous Condition for 30 days or less, Aflac will pay the amount listed below for each day the Covered Person is charged for a room as an inpatient. No lifetime maximum.

Named Insured or Spouse \$200  
 Dependent Child \$250

**HOSPITALIZATION FOR 31 DAYS OR MORE:** During any continuous period of Hospital confinement of a Covered Person for treatment of Cancer or an Associated Cancerous Condition for 31 days or more, Aflac will pay benefits as described above for the first 30 days. Beginning with the 31st day of such continuous Hospital confinement, Aflac will pay the amount listed below for each day the Covered Person is charged for a room as an inpatient. No lifetime maximum.

Named Insured or Spouse \$400  
 Dependent Child \$500

**OUTPATIENT HOSPITAL SURGICAL ROOM CHARGE**

**BENEFIT:** When a surgical operation is performed on a Covered Person for treatment of a diagnosed Internal Cancer or Associated Cancerous Condition, and a surgical room charge is

incurred, Aflac will pay \$200. For this benefit to be paid, surgeries must be performed on an outpatient basis in a Hospital or an Ambulatory Surgical Center. This benefit is payable once per day and is not payable on the same day the Hospital Confinement Benefit is payable. This benefit is payable in addition to the Surgery/Anesthesia Benefit. The maximum daily benefit will not exceed \$200. No lifetime maximum on number of operations.

**This benefit is also payable for Nonmelanoma Skin Cancer surgery involving a flap or graft. It is not payable for the procedures listed in the Cancer Screening Benefit or any surgery performed in a Physician's office.**

**CONTINUING CARE BENEFITS:**

**EXTENDED-CARE FACILITY BENEFIT:** When a Covered Person is hospitalized and receives Hospital Confinement Benefits and is later confined, within 30 days of the covered Hospital confinement, to an extended-care facility, a skilled nursing facility, a rehabilitation unit or facility, a transitional care unit or any bed designated as a swing bed, or to a section of the Hospital used as such, (collectively referred to as "Extended-Care Facility"), Aflac will pay \$100 per day when a charge is incurred for such continued confinement. For each day this benefit is payable, Hospital Confinement Benefits are NOT payable. Benefits are limited to 30 days in each Calendar Year per Covered Person.

If more than 30 days separates confinements in an Extended-Care Facility, benefits are not payable for the second confinement unless the Covered Person again receives Hospital Confinement Benefits and is confined as an inpatient to the Extended-Care Facility within 30 days of that confinement.

**HOME HEALTH CARE BENEFIT:** When a Covered Person is hospitalized for the treatment of Internal Cancer or an Associated Cancerous Condition and then has either home health care or health supportive services provided on his or her behalf, Aflac will pay \$100 per day when a charge is incurred for each such visit, subject to the following conditions:

1. The home health care or health supportive services must begin within seven days of release from the Hospital.
2. This benefit is limited to ten days per hospitalization for each Covered Person.
3. This benefit is limited to 30 days in any Calendar Year for each Covered Person.
4. This benefit will not be payable unless the attending Physician prescribes such services to be performed in the home of the Covered Person and certifies that if these services were not available, the Covered Person would have to be hospitalized to receive the necessary care, treatment, and services.



- Home health care and health supportive services must be performed by a person, other than a member of your Immediate Family, who is licensed, certified, or otherwise duly qualified to perform such services on the same basis as if the services had been performed in a health care facility.

**This benefit is not payable the same day the Hospice Care Benefit is payable.**

**HOSPICE CARE BENEFIT:** When a Covered Person is diagnosed with Internal Cancer or an Associated Cancerous Condition and therapeutic intervention directed toward the cure of the disease is medically determined to be no longer appropriate, and if the Covered Person's medical prognosis is one in which there is a life expectancy of six months or less as the direct result of Internal Cancer or an Associated Cancerous Condition (hereinafter referred to as "Terminally Ill"), Aflac will pay a one-time benefit of \$1,000 for the first day the Covered Person receives Hospice care and \$50 per day thereafter for Hospice care. For this benefit to be payable, Aflac must be furnished: (1) a written statement from the attending Physician that the Covered Person is Terminally Ill, and (2) a written statement from the Hospice certifying the days services were provided. Lifetime maximum for each Covered Person is \$12,000.

**This benefit is not payable the same day the Home Health Care Benefit is payable.**

**NURSING SERVICES BENEFIT:** While confined in a Hospital for the treatment of Cancer or an Associated Cancerous Condition, if a Covered Person requires and is charged for private nurses and their services other than those regularly furnished by the Hospital, Aflac will pay \$100 per day for full-time private care and attendance provided by such nurses (registered graduate nurses, licensed practical nurses, or licensed vocational nurses). These services must be required and authorized by the attending Physician. This benefit is not payable for private nurses who are members of your Immediate Family. This benefit is payable for only the number of days the Hospital Confinement Benefit is payable. No lifetime maximum.

**SURGICAL PROSTHESIS BENEFIT:** Aflac will pay \$2,000 when a charge is incurred for surgically implanted prosthetic devices that are prescribed as a direct result of surgery for Internal Cancer or an Associated Cancerous Condition treatment. Lifetime maximum of \$4,000 per Covered Person.

**The Surgical Prosthesis Benefit does not include coverage for tissue expanders or a Breast Transverse Rectus Abdominis Myocutaneous (TRAM) Flap.**

**NONSURGICAL PROSTHESIS BENEFIT:** Aflac will pay \$175 per occurrence, per Covered Person when a charge is incurred for nonsurgically implanted prosthetic devices that are prescribed as a direct result of treatment for Internal Cancer or an Associated Cancerous Condition. Examples of nonsurgically implanted prosthetic devices include voice boxes, hair pieces,

and removable breast prostheses. Lifetime maximum of \$350 per Covered Person.

**RECONSTRUCTIVE SURGERY BENEFIT:**

**BREAST RECONSTRUCTION:** Aflac will pay the amount listed below when a charge is incurred for a reconstructive surgical operation that is performed on a Covered Person as a result of treatment of Cancer or an Associated Cancerous Condition. The maximum daily benefit will not exceed \$2,000.

Breast Tissue/Muscle Reconstruction Flap Procedures	\$2,000
Breast Reconstruction (occurring within five years of breast Cancer diagnosis)	500
Breast Symmetry (on the nondiseased breast occurring within five years of breast reconstruction)	220
Permanent Areola Repigmentation	100

**OTHER RECONSTRUCTIVE SURGERY:** Aflac will pay the amount listed below when a charge is incurred for a reconstructive surgical operation that is performed on a Covered Person as a result of treatment of Cancer or an Associated Cancerous Condition. The maximum daily benefit will not exceed \$500.

Facial Reconstruction	\$ 500
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Aflac will pay an indemnity benefit equal to 25% of the amount shown above for the administration of anesthesia during a covered reconstructive surgical operation.

If any reconstructive surgery is performed other than those listed, Aflac will pay an amount comparable to the amount shown above for the operation most nearly similar in severity and gravity. No lifetime maximum on number of operations.

**EGG HARVESTING, STORAGE (CRYOPRESERVATION), AND IMPLANTATION BENEFIT:** Aflac will pay \$1,000 for a Covered Person to have oocytes extracted and harvested due to a positive diagnosis of Internal Cancer or an Associated Cancerous Condition. In addition, Aflac will pay, one time per Covered Person, \$200 for the storage of a Covered Person's oocyte(s) or sperm when a charge is incurred to store with a licensed reproductive tissue bank or similarly licensed facility. Any such extraction, harvesting, or storage must occur prior to Chemotherapy or radiation treatment that has been prescribed for the Covered Person's treatment of Cancer or an Associated Cancerous Condition. Aflac will also pay \$200 for embryo transfer resulting from such stored oocyte(s) or sperm of a Covered Person. Lifetime maximum of \$1,400 per Covered Person.

**ANNUAL CARE BENEFIT:** Aflac will pay \$200 on the anniversary date of a Covered Person's diagnosis of a covered Internal Cancer or Associated Cancerous Condition for care other than the direct treatment of Cancer or an Associated Cancerous Condition to meet the Covered Person's physical,

emotional, spiritual, or social needs. Lifetime maximum of five annual \$200 payments per Covered Person.

**AMBULANCE, TRANSPORTATION, AND LODGING BENEFITS:**

**AMBULANCE BENEFIT:** Aflac will pay \$250 when a charge is incurred for ambulance transportation of a Covered Person to or from a Hospital where the Covered Person receives treatment for Cancer or an Associated Cancerous Condition. Aflac will pay \$2,000 when a charge is incurred for air ambulance transportation of a Covered Person to or from a Hospital where the Covered Person receives treatment for Cancer or an Associated Cancerous Condition. This benefit is limited to two trips per confinement. The ambulance service must be performed by a licensed professional ambulance company. No lifetime maximum.

**TRANSPORTATION BENEFIT:** Aflac will pay 40 cents per mile for transportation, up to a combined maximum of \$2,400, if a Covered Person requires treatment that has been prescribed by the attending Physician for Cancer or an Associated Cancerous Condition.

This benefit includes:

1. Personal vehicle transportation of the Covered Person limited to the distance of miles between the Hospital or Medical Facility and the residence of the Covered Person.
2. Commercial transportation (in a vehicle licensed to carry passengers for a fee) of the Covered Person and no more than one additional adult to travel with the Covered Person. If the treatment is for a covered Dependent Child and commercial transportation is necessary, Aflac will pay for up to two adults to travel with the covered Dependent Child. This benefit is limited to the distance of miles between the Hospital or Medical Facility and the residence of the Covered Person.

This benefit is payable up to a maximum of \$2,400 per round trip for all travelers and modes of transportation combined. No lifetime maximum.

**THIS BENEFIT IS NOT PAYABLE FOR TRANSPORTATION TO ANY HOSPITAL/FACILITY LOCATED WITHIN A 50-MILE RADIUS OF THE RESIDENCE OF THE COVERED PERSON OR FOR TRANSPORTATION BY AMBULANCE TO OR FROM ANY HOSPITAL.**

In the state of Hawaii, travel to Oahu from any other Hawaiian Island shall satisfy the 50-mile requirement.

**LODGING BENEFIT:** Aflac will pay \$65 per day when a charge is incurred for lodging, in a room in a motel, hotel, or other commercial accommodation, for you or any one adult family member when a Covered Person receives treatment for Cancer or an Associated Cancerous Condition at a Hospital or Medical Facility more than 50 miles from the Covered Person's

residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. This benefit is limited to 90 days per Calendar Year.

**PREMIUM WAIVER AND RELATED BENEFITS:**

**WAIVER OF PREMIUM BENEFIT:** If you, due to having Cancer or an Associated Cancerous Condition, are completely unable to perform all of the usual and customary duties of your occupation [if you are not employed: are completely unable to perform two or more Activities of Daily Living (ADLs) without the assistance of another person] for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require an employer's statement (if applicable) and a Physician's statement of your inability to perform said duties or activities, and may each month thereafter require a Physician's statement that total inability continues.

If you die and your Spouse, civil union partner or Reciprocal Beneficiary becomes the new Named Insured, premiums will resume and be payable on the first premium due date after the change. The new Named Insured will then be eligible for this benefit if the need arises.

Aflac may ask for and use an independent consultant to determine whether you can perform an ADL when this benefit is in force.

Aflac will also waive, from month to month, any premiums falling due while you are receiving Hospice Benefits.

**CONTINUATION OF COVERAGE BENEFIT:** Aflac will waive all monthly premiums due for the policy and riders for up to two months if you meet all of the following conditions:

1. Your policy has been in force for at least six months;
2. We have received premiums for at least six consecutive months;
3. Your premiums have been paid through payroll deduction, and you leave your employer for any reason;
4. You or your employer notifies us in writing within 30 days of the date your premium payments ceased because of your leaving employment; and
5. You re-establish premium payments through:
  - (1) your new employer's payroll deduction process, or
  - (2) direct payment to Aflac.

You will again become eligible to receive this benefit after:

1. You re-establish your premium payments through payroll deduction for a period of at least six months, and

2. We receive premiums for at least six consecutive months.

**“Payroll deduction” means your premium is remitted to Aflac for you by your employer through a payroll deduction process or any other method agreed to by Aflac and the employer.**

**(4) Optional Benefits:**

**INITIAL DIAGNOSIS BUILDING BENEFIT RIDER: (SERIES B70050) Applied for  Yes  No**

**INITIAL DIAGNOSIS BUILDING BENEFIT:** This benefit can be purchased in units of \$100 each, up to a maximum of five units or \$500. **If more than one unit has been purchased, the number of units purchased must be multiplied by \$100.** The number of units you purchased is shown in both the Policy Schedule and the attached application.

The **INITIAL DIAGNOSIS BUILDING BENEFIT** will increase the amount of your Initial Diagnosis Benefit, as shown in the policy, by \$100 for each unit purchased for each Covered Person on the anniversary date of their coverage, while coverage remains in force. (The amount of the monthly increase will be determined on a pro rata basis.) This benefit will be paid under the same terms as the Initial Diagnosis Benefit in the policy to which the rider is attached. This benefit will cease to build for each Covered Person on the anniversary date of the rider following the Covered Person’s 65th birthday or at the time Internal Cancer or an Associated Cancerous Condition is diagnosed for that Covered Person, whichever occurs first. However, regardless of the age of the Covered Person on the Effective Date of coverage, this benefit will accrue for a period of at least five years, unless Internal Cancer or an Associated Cancerous Condition is diagnosed prior to the fifth year of coverage.

**Exceptions, Reductions, and Limitations of Rider Series B70050:**

The rider contains a 30-day waiting period. If a Covered Person has Internal Cancer or an Associated Cancerous Condition diagnosed before his or her coverage has been in force 30 days, you may, at your option, elect to void the rider from its beginning and receive a full refund of premium paid for the rider, less any benefits paid under the rider.

The Initial Diagnosis Building Benefit is not payable for: (1) any Internal Cancer or Associated Cancerous Condition diagnosed or treated before the Effective Date of coverage under the rider and the subsequent recurrence, extension, or metastatic spread of such Internal Cancer or Associated Cancerous Condition; (2) Internal Cancer or Associated Cancerous Conditions diagnosed during the rider’s 30-day waiting period; or (3) the diagnosis of Nonmelanoma Skin Cancer. **Any Covered Person who has had a previous diagnosis of Internal Cancer or an Associated Cancerous Condition will NOT be eligible for an Initial Diagnosis Building Benefit**

**under the rider for a recurrence, extension, or metastatic spread of that same Internal Cancer or Associated Cancerous Condition.**

**DEPENDENT CHILD RIDER: (SERIES B70051) Applied for  Yes  No**

**DEPENDENT CHILD BENEFIT:** Aflac will pay \$10,000 when a covered Dependent Child is diagnosed as having Internal Cancer or an Associated Cancerous Condition while the rider is in force.

This benefit is payable under the rider only once for each covered Dependent Child. In addition to the Positive Medical Diagnosis, we may require additional information from the attending Physician and Hospital.

**Exceptions, Reductions, and Limitations of Rider Series B70051:**

The rider contains a 30-day waiting period. If a covered Dependent Child has Internal Cancer or an Associated Cancerous Condition diagnosed before his or her coverage has been in force 30 days, you may, at your option, elect to void the rider from its beginning and receive a full refund of premium paid for the rider, less any benefits paid under the rider.

The Dependent Child Benefit is not payable for: (1) any Internal Cancer or Associated Cancerous Condition diagnosed or treated before the Effective Date of the rider and the subsequent recurrence, extension, or metastatic spread of such Internal Cancer or Associated Cancerous Condition; (2) Internal Cancer or Associated Cancerous Conditions diagnosed during the rider’s 30-day waiting period; or (3) the diagnosis of Nonmelanoma Skin Cancer. **Any Dependent Child who has had a previous diagnosis of Internal Cancer or an Associated Cancerous Condition will NOT be eligible for any benefit under the rider for a recurrence, extension, or metastatic spread of that same Internal Cancer or Associated Cancerous Condition.**

**SPECIFIED-DISEASE BENEFIT RIDER: (SERIES B70052) Applied for  Yes  No**

**SPECIFIED-DISEASE INITIAL BENEFIT:** While coverage is in force, if a Covered Person is first diagnosed, after the Effective Date of coverage under the rider, with any of the covered Specified Diseases, Aflac will pay a benefit of \$2,000. This benefit is payable only once per Specified Disease per Covered Person. **NO OTHER BENEFITS ARE PAYABLE FOR ANY COVERED SPECIFIED DISEASE NOT PROVIDED FOR IN THE RIDER.**

**HOSPITAL CONFINEMENT BENEFITS:**

**HOSPITALIZATION FOR 30 DAYS OR LESS:** When a Covered Person is confined to a Hospital for a covered Specified Disease for 30 days or less, Aflac will pay \$400 for each day the Covered Person is charged for a room as an inpatient.

**HOSPITALIZATION FOR 31 DAYS OR MORE:** During any continuous period of Hospital confinement of 31 days or more for a covered Specified Disease, Aflac will pay benefits as described above for the first 30 days, and beginning with the 31st day of such continuous Hospital confinement, Aflac will pay \$800 for each day the Covered Person is charged for a room as an inpatient.

**Exceptions, Reductions, and Limitations of Rider Series B70052:**

Specified diseases must be first diagnosed by a Physician 30 days following the Effective Date of coverage under the rider for benefits to be paid. The diagnosis must be made by and upon a tissue specimen, culture(s), and/or titer(s). If a Covered Person has a Specified Disease diagnosed before his or her coverage has been in force 30 days, benefits for treatment of that Specified Disease will apply only to treatment occurring after two years from the Effective Date of such person's coverage. At your option, you may elect to void the rider from its beginning and receive a full refund of premium paid for the rider, less any benefits paid under the rider.

**(5) Payment of Nonsurgical Treatment Benefits:**

If an initial prescription of Hormonal Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy medication instructs a Covered Person to take the medication orally for a period of thirty days or less, then the payment under the applicable Nonsurgical Treatment Benefit is limited to the Calendar Month in which the medication was prescribed, received, and the Covered Person incurred a charge.

If a prescription of Hormonal Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy medication which instructs a Covered Person to take the medication orally for a period of thirty days or less is refilled during a Calendar Month in which the stated amount under the applicable Nonsurgical Treatment Benefit has previously been paid, then we will pay the stated amount under the applicable Nonsurgical Treatment Benefit in advance for one additional Calendar Month for which it has not previously been paid without requiring proof a Covered Person incurred a charge for the medication during that additional Calendar Month. Otherwise, if the prescription is refilled during a Calendar Month in which the stated amount under the applicable Nonsurgical Treatment Benefit has not been previously paid, then the benefit is limited to the Calendar Month in which the medication was prescribed, received, and the Covered Person incurred a charge.

If an initial prescription of Hormonal Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy medication instructs a Covered Person to take the medication orally for a period of more than thirty days but less than 61 days, then we will pay the stated amount under the applicable Nonsurgical Treatment Benefit in advance for one additional, consecutive Calendar Month without requiring proof a Covered Person

incurred a charge for the medication during the additional, consecutive Calendar Month.

If an initial prescription of Hormonal Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy medication instructs a Covered Person to take the medication orally for a period of more than sixty days but less than 91 days, then we will pay the stated amount under the applicable Nonsurgical Treatment Benefit in advance for two additional, consecutive Calendar Months without requiring proof a Covered Person incurred a charge for the medication during the additional, consecutive Calendar Months.

If a prescription of Hormonal Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy medication which instructs a Covered Person to take the medication orally for a period of more than thirty days is refilled during a Calendar Month in which the payment under the applicable Nonsurgical Treatment Benefit has previously been paid, then we will pay the stated amount under the applicable Nonsurgical Treatment Benefit in advance for up to three additional, consecutive Calendar Months for which it has not previously been paid without requiring proof a Covered Person incurred a charge for the medication during the three additional, consecutive Calendar Months. Otherwise, if the prescription is refilled during a Calendar Month in which the payment under the applicable Nonsurgical Treatment Benefit has not been previously paid, then, so long as the Covered Person incurred a charge during the first Calendar Month of the prescription, for refills instructing a Covered Person to take the medication orally for a period of more than thirty days but less than 61 days, we will pay the stated amount under the applicable Nonsurgical Treatment Benefit in advance for one additional, consecutive Calendar Month without requiring proof a Covered Person incurred a charge for the medication during the additional, consecutive Calendar Month, and for refills instructing a Covered Person to take the medication orally for a period of more than sixty days but less than 91 days, we will pay the stated amount under the applicable Nonsurgical Treatment Benefit in advance for two additional, consecutive Calendar Months without requiring proof a Covered Person incurred a charge for the medication during the additional, consecutive Calendar Months.

For injected treatment, the stated amount under the applicable Radiation Therapy, Chemotherapy, Immunotherapy, Or Experimental Chemotherapy Benefit is payable one time per prescribed injection, but not more than one time per Calendar Month. The Surgical/Anesthesia Benefit provides amounts payable for insertion and removal of a pump. Benefits will not be paid for each month of continuous infusion of medications dispensed by a pump, implant, or patch.

If only Experimental Chemotherapy is payable during any Calendar Month, the benefit amount will be reduced 50% for Experimental Chemotherapy for which no charge is incurred. If a Covered Person received the stated amount under the

applicable Radiation Therapy, Chemotherapy, Immunotherapy, Or Experimental Chemotherapy Benefit at the reduced 50% amount and, later in the same Calendar Month, receives Radiation Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy where a charge is incurred, we will pay the difference between the 50% previously received and the Radiation Therapy, Chemotherapy, Immunotherapy, or Experimental Therapy Benefit.

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**(6) Exceptions, Reductions, and Limitations of the Policy (policy is not a daily hospital expense plan):**

Except as specifically provided in the Benefits section of the policy, Aflac will pay only for treatment of Cancer or Associated Cancerous Conditions, including direct extension, metastatic spread, or recurrence. Benefits are not provided for premalignant conditions or conditions with malignant potential (unless specifically covered); complications of either Cancer or an Associated Cancerous Condition; or any other disease, sickness, or incapacity.

The policy contains a 30-day waiting period. If a Covered Person has Cancer or an Associated Cancerous Condition diagnosed before his or her coverage has been in force 30 days, benefits for treatment of that Cancer or Associated Cancerous Condition, or any recurrence, extension, or metastatic spread of that same Cancer or Associated Cancerous Condition will apply only to treatment occurring after two years from the Effective Date of such person's coverage. At your option, you may elect to void the coverage and receive a full refund of premium.

The Initial Diagnosis Benefit is not payable for: (1) any Internal Cancer or Associated Cancerous Condition diagnosed or treated before the Effective Date of the policy and the subsequent recurrence, extension, or metastatic spread of such Internal Cancer or Associated Cancerous Condition; (2) Internal Cancer or an Associated Cancerous Condition

diagnosed during the policy's 30-day waiting period; or (3) the diagnosis of Nonmelanoma Skin Cancer. **Any Covered Person who has had a previous diagnosis of Internal Cancer or an Associated Cancerous Condition will NOT be eligible for an Initial Diagnosis Benefit under the policy for a recurrence, extension, or metastatic spread of that same Internal Cancer or Associated Cancerous Condition.**

Aflac will not pay benefits whenever coverage provided by the policy 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.

Aflac will not pay benefits for any loss that is diagnosed or treated outside the territorial limits of the United States or its possessions.

Aflac may void the policy and will not pay benefits whenever: (1) material facts or circumstances have been concealed or misrepresented in making a claim under the policy; or (2) fraud is committed or attempted in connection with any matter relating to the policy. If you have received benefits that were not contractually due under the policy, then Aflac reserves the right to offset any benefits payable under the policy up to the amount of benefits you received that were not contractually due.

- (7) Renewability:** The policy is guaranteed renewable for your lifetime as long as you pay the premiums when they are due or within the grace period. We may discontinue or terminate the policy if you have performed an act or practice that constitutes fraud, or have made an intentional misrepresentation of material fact, relating in any way to the policy, including claims for benefits under the policy. We may change the premium we charge, but not specific to any one person. Any premium change will be made for all policies of the same form number and premium classification in the state where the policy was issued that are then in force.

**RETAIN FOR YOUR RECORDS.  
THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.  
THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE  
GOVERNING CONTRACTUAL PROVISIONS.**

## TERMS YOU NEED TO KNOW

**ACTIVITIES OF DAILY LIVING (ADLs):** Activities used in measuring your levels of personal functioning capacity. Normally, these activities are performed without direct personal assistance, allowing you personal independence in everyday living. The ADLs are BATHING: washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower; MAINTAINING CONTINENCE: controlling urination and bowel movements, including your ability to use ostomy supplies or other devices such as catheters; TRANSFERRING: moving between a bed and a chair, or a bed and a wheelchair; DRESSING: putting on and taking off all necessary items of clothing; TOILETING: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene; EATING: performing all major tasks of getting food into your body.

**ASSOCIATED CANCEROUS CONDITION:** Myelodysplastic blood disorder, myeloproliferative blood disorder, or internal carcinoma in situ (in the natural or normal place, confined to the site of origin without having invaded neighboring tissue). An associated cancerous condition must receive a positive medical diagnosis. **Premalignant conditions or conditions with malignant potential, other than those specifically named above, are not considered associated cancerous conditions.**

**CANCER:** Disease manifested by the presence of a malignant tumor and characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Cancer also includes but is not limited to leukemia, Hodgkin's disease and melanoma. Cancer must receive a positive medical diagnosis.

**1. INTERNAL CANCER:** all cancers other than nonmelanoma skin cancer (see definition of nonmelanoma skin cancer).

**2. NONMELANOMA SKIN CANCER:** a cancer other than a melanoma that begins in the outer part of the skin (epidermis).

**Associated cancerous conditions, premalignant conditions or conditions with malignant potential will not be considered cancer.**

**COVERED PERSON:** Any person insured under the coverage type that you applied for on the application: individual (named insured listed in the Policy Schedule), named insured/spouse only (named insured and spouse), one-parent family (named insured and dependent children), or two-parent family (named insured, spouse and dependent children). Spouse is defined as the person to whom you are legally married and who is listed on your application. This includes a civil union or reciprocal beneficiary relationship. Newborn children are automatically insured for 30 days from the moment of birth. If coverage is for individual or named insured/spouse only and you desire uninterrupted coverage for a newborn child beyond the first 30 days, you must notify Aflac in writing within 31 days of the child's birth and Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due, if any. Coverage will include any other dependent child, regardless of age, who is incapable of self-sustaining employment by reason of intellectual or physical disability and who became so disabled prior to age 26 and while covered under the policy. Dependent children are your natural children, stepchildren or legally adopted children who are under age 26. Children born to your dependent children or children born to the dependent children of your spouse are not covered under the policy.

**EFFECTIVE DATE:** The date(s) coverage begins as shown in the Policy Schedule or any attached endorsements or riders. The effective date is not the date you signed the application for coverage.

## ADDITIONAL INFORMATION

An ambulatory surgical center does not include a physician's or dentist's office, a clinic or other such location.

Experimental chemotherapy does not include laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, therapeutic devices, or other procedures related to these experimental treatments.

The term hospital does not include any institution or part thereof used as an emergency room; an observation unit; a rehabilitation unit; a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a psychiatric unit; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

A physician does not include you or a member of your immediate family.

A stem cell transplantation does not include the bone marrow transplantation.

The diagnosis date is not the date the diagnosis is communicated to the covered person.

If nonmelanoma skin cancer is diagnosed during hospitalization, benefits will be limited to the day(s) the covered person actually received treatment for nonmelanoma skin cancer.

If treatment for cancer or an associated cancerous condition is received in a U.S. government hospital, Aflac will not require a covered person to be charged for such services for benefits to be payable.



Aflac SmartClaim®  
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One Day Pay<sup>SM</sup> is available for certain individual claims submitted online through the Aflac SmartClaim<sup>®</sup> process. Claims may be eligible for One Day Pay processing if submitted online through Aflac SmartClaim, including all required documentation, by 3 p.m. ET. Documentation requirements vary by type of claim; please review requirements for your claim(s) carefully. Aflac SmartClaim is available for claims on most individual Accident, Cancer, Hospital, Specified Health, and Intensive Care policies. Processing time is based on business days after all required documentation needed to render a decision is received and no further validation and/or research is required. Individual Company Statistic, 2017.

Underwritten by:  
American Family Life Assurance Company of Columbus  
Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999





# Aflac Critical Care Protection

SPECIFIED HEALTH EVENT INSURANCE – OPTION 2

We've been dedicated to helping provide peace of mind and financial security for nearly 60 years.



# AFLAC CRITICAL CARE PROTECTION SPECIFIED HEALTH EVENT INSURANCE – OPTION 2

Policy Series A74000

# CCP<sup>2</sup>

## Critical care for you. Added financial protection for your family.

Aflac's Critical Care Protection policy helps provide financial peace of mind if you experience a serious health event, such as a heart attack or stroke. You will receive a lump sum benefit upon diagnosis of a covered event with additional benefits to be paid for things such as a hospital confinement, intensive care unit confinement, ambulance, transportation, lodging, and therapy.

All benefits are paid directly to you, unless otherwise assigned, and can be used for any out-of-pocket expenses you have such as car payments, mortgage or rent payments, or utility bills. Aflac Critical Care Protection allows you to help protect the things you love the most from the things you expect the least.



### Get the facts:

#### FACT NO. 1

ABOUT  
EVERY

**34** SECONDS

AN AMERICAN SUFFERS A HEART ATTACK.<sup>1</sup>

#### FACT NO. 2

ABOUT  
EVERY

**40** SECONDS

SOMEONE IN THE UNITED STATES HAS A STROKE.<sup>1</sup>

<sup>1</sup>Heart Disease and Stroke Statistics, 2014 Update, American Heart Association.

## Understand the difference Aflac can make in your financial security.

Aflac pays cash benefits directly to you, unless you choose otherwise. Aflac Critical Care Protection is designed to provide you with cash benefits if you experience a specified health event, such as sudden cardiac arrest or end-stage renal failure. This means that you will have added financial resources to help with expenses incurred due to a serious health event, to help with ongoing living expenses, or to help with any purpose you choose.

An illness or injury can happen to anyone, anytime—and when it does, everyday expenses may suddenly seem overwhelming. Fortunately, Aflac’s Critical Care Protection can help with those everyday expenses, so all you have to focus on is getting well.

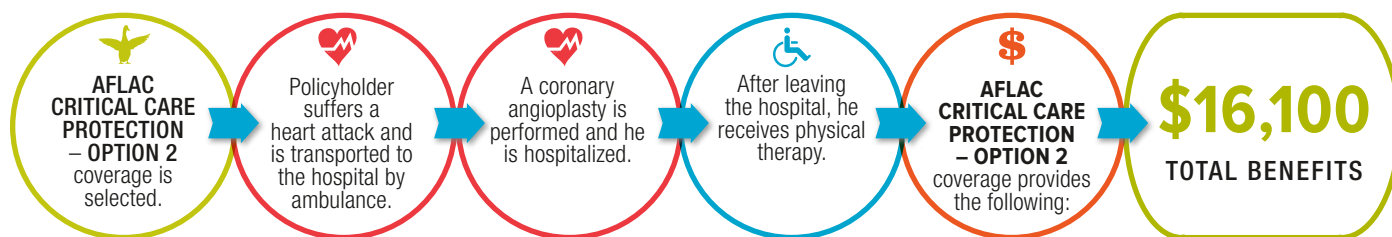
### Aflac Critical Care Protection offers more types of benefits compared to other critical illness coverage on the market:

- Pays \$7,500 upon diagnosis of having had a specified health event, which increases to \$10,000 for dependent children
- Pays \$300 per day for covered hospital stays
- Daily benefits payable for covered hospital intensive care unit and step-down intensive care unit confinements
- Pays benefits for physical therapy, speech therapy, rehabilitation therapy, home health care, and many more
- Transportation and lodging benefits payable for travel to receive treatment
- Guaranteed-renewable for your lifetime with some benefits reduced at age 70—as long as premiums are paid, the policy cannot be canceled

### Specified health events covered by the Critical Care Protection policy include:

- Heart Attack
- Stroke
- Coronary Artery Bypass Graft Surgery (CABG)
- Sudden Cardiac Arrest
- Third-Degree Burns
- Coma
- Paralysis
- Major Human Organ Transplant
- End-Stage Renal Failure
- Persistent Vegetative State

### How it works



The above example is based on a scenario for Aflac Critical Care Protection – Option 2 that includes the following benefit conditions: First-Occurrence Benefit (heart attack) of \$7,500, Ambulance Benefit (ground ambulance transportation) of \$250, Coronary Angioplasty Benefit of \$1,000, Hospital Intensive Care Unit Benefit (3 days) of \$2,400, Hospital Confinement Benefit (4 days) of \$1,200, and Continuing Care Benefit (30 days) of \$3,750.

The policy has limitations and exclusions that may affect benefits payable. For costs and complete details of the coverage, contact your Aflac insurance agent/producer. This brochure is for illustrative purposes only. Refer to the policy for benefit details, definitions, limitations, and exclusions.

## Aflac Critical Care Protection – Option 2 Benefit Overview

BENEFIT NAME	BENEFIT AMOUNT
<b>HOSPITAL INTENSIVE CARE UNIT BENEFIT</b>	Days 1–7: \$800 per day Days 8–15: \$1,300 per day Limited to 15 days per period of confinement; no lifetime maximum
<b>STEP-DOWN INTENSIVE CARE UNIT BENEFIT</b>	\$500 per day Limited to 15 days per period of confinement; no lifetime maximum
<b>PROGRESSIVE BENEFIT FOR HOSPITAL INTENSIVE CARE UNIT/STEP-DOWN INTENSIVE CARE UNIT CONFINEMENT</b>	An indemnity of \$2 will accumulate for the named insured and the covered spouse for each calendar month the policy remains in force after the effective date
<b>FIRST-OCCURRENCE BENEFIT:</b>  Named Insured/Spouse Dependent Children	\$7,500; lifetime maximum \$7,500 per covered person \$10,000; lifetime maximum \$10,000 per covered person
<b>SUBSEQUENT SPECIFIED HEALTH EVENT BENEFIT</b>	\$3,500 Subsequent occurrence limitations apply. No lifetime maximum.
<b>CORONARY ANGIOPLASTY BENEFIT</b>	\$1,000 Payable only once per covered person, per lifetime
<b>HOSPITAL CONFINEMENT BENEFIT</b>	\$300 per day No lifetime maximum
<b>CONTINUING CARE BENEFIT</b>	\$125 each day when a covered person is charged for any of the following treatments: <ul style="list-style-type: none"> <li>• Rehabilitation Therapy</li> <li>• Physical Therapy</li> <li>• Speech Therapy</li> <li>• Occupational Therapy</li> <li>• Respiratory Therapy</li> <li>• Dietary Therapy/Consultation</li> <li>• Home Health Care</li> <li>• Dialysis</li> <li>• Hospice Care</li> <li>• Extended Care</li> <li>• Physician Visits</li> <li>• Nursing Home Care</li> </ul> Treatment is limited to 75 days for continuing care received within 180 days following the occurrence of the most recent covered specified health event or coronary angioplasty. No lifetime maximum.
<b>AMBULANCE BENEFIT</b>	\$250 ground or \$2,000 air No lifetime maximum
<b>TRANSPORTATION BENEFIT</b>	\$.50 per mile, per covered person whom special treatment is prescribed, for a covered loss Limited to \$3,000 per occurrence; no lifetime maximum
<b>LODGING BENEFIT</b>	Up to \$75 per day, for covered lodging charges Limited to 15 days per occurrence; no lifetime maximum
<b>WAIVER OF PREMIUM BENEFIT</b>	Premium waived, from month to month, during total inability (after 180 continuous days)
<b>CONTINUATION OF COVERAGE BENEFIT</b>	Waives all monthly premiums for up to 2 months, when all conditions for this benefit are met

REFER TO THE FOLLOWING OUTLINE OF COVERAGE FOR BENEFIT DETAILS, DEFINITIONS, LIMITATIONS, AND EXCLUSIONS.

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LIMITED BENEFIT

**AFLAC CRITICAL  
CARE PROTECTION**

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**American Family Life Assurance Company of Columbus**  
(herein referred to as Aflac)  
Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999  
Toll-Free 1.800.99.AFLAC (1.800.992.3522)

The policy described in this Outline of Coverage provides supplemental coverage  
and will be issued only to supplement insurance already in force.

**SPECIFIED HEALTH EVENT INSURANCE**  
Supplemental Health Insurance Coverage  
Outline of Coverage for Policy Form Series A74200

**THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.**

If you are eligible for Medicare, review the “Guide to Health Insurance for People with Medicare” furnished by Aflac.

- (1) **Read Your Policy Carefully:** This Outline of Coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Aflac. It is, therefore, important that you READ YOUR POLICY CAREFULLY.
- (2) **Specified Health Event Insurance Coverage** is designed to supplement your existing accident and sickness coverage only when certain losses occur as a result of Specified Health Events or other conditions as specified. Specified Health Events are: Heart Attack, Stroke, End-Stage Renal Failure, Major Human Organ Transplant, Third-Degree Burns, Persistent Vegetative State, Coma, Paralysis, Coronary Artery Bypass Graft Surgery (CABG), or Sudden Cardiac Arrest. Coverage is provided for the benefits outlined in (3) **Benefits**. The benefits described in (3) **Benefits** may be limited by (5) **Exceptions, Reductions, and Limitations of the Policy**.

(3) **Benefits:**

**IMPORTANT: BENEFITS FOR INTENSIVE CARE UNIT CONFINEMENTS REDUCE BY ONE-HALF FOR LOSSES INCURRED ON OR AFTER THE POLICY ANNIVERSARY DATE FOLLOWING THE 70TH BIRTHDAY OF A COVERED PERSON.**

While coverage is in force, Aflac will pay the following benefits, as applicable, subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions. The term “Hospital Confinement” does not include emergency rooms. Treatment or confinement in a U.S. government Hospital does not require a charge for benefits to be payable.

**BENEFITS FOR INTENSIVE CARE UNIT CONFINEMENTS:**

- A. **HOSPITAL INTENSIVE CARE UNIT BENEFIT:** Aflac will pay the following benefits when a Covered Person incurs a charge for confinement in a Hospital Intensive Care Unit for a covered Sickness or Injury:

**Days 1 – 7:**

**Sickness/Injury**  
\$800 per day

**Days 8 – 15:**

**Sickness/Injury**  
\$1,300 per day

This benefit is limited to 15 days per Period of Confinement.

**The Hospital Intensive Care Unit Benefit is not payable on the same day as the Step-Down Intensive Care Unit Benefit. If a Covered Person is charged for both on the same day, only the highest eligible benefit will be paid. Confinement in a U.S. government Hospital does not require a charge for benefits to be payable. No lifetime maximum.**

- B. **STEP-DOWN INTENSIVE CARE UNIT BENEFIT:** Aflac will pay \$500 per day when a Covered Person incurs a charge for confinement in a Step-Down Intensive Care Unit for a covered Sickness or Injury.

This benefit is limited to 15 days per Period of Confinement and is also payable for confinement in a Hospital Intensive Care Unit after exhaustion of benefits payable under the Hospital Intensive Care Unit Benefit.

**The Step-Down Intensive Care Unit Benefit is not payable on the same day as the Hospital Intensive Care Unit Benefit. If a Covered Person is charged for both on the same day, only the highest eligible benefit will be paid. Confinement in a U.S. government Hospital does not require a charge for benefits to be payable. No lifetime maximum.**

- C. **PROGRESSIVE BENEFIT FOR HOSPITAL INTENSIVE CARE UNIT/STEP-DOWN INTENSIVE CARE UNIT CONFINEMENT:** An indemnity of two dollars will accumulate for the Named Insured and the covered Spouse for each calendar month coverage remains in force after the Effective Date. This accumulated indemnity, if any, will be paid in addition to the Hospital Intensive Care Unit Benefit and Step-Down Intensive Care Unit Benefit for each day of a Period of Confinement for which benefits are payable. This Progressive Benefit will continue to build, regardless of claims paid, until the policy anniversary date following the 65th birthday of a Covered Person. Any amount accrued at the time this benefit ceases to build for a Covered Person will continue to be added to the benefit

amount for all Hospital Intensive Care Unit/Step-Down Hospital Intensive Care Unit confinements commencing prior to the policy anniversary date following the 70<sup>th</sup> birthday of the Covered Person. **THIS ACCUMULATED BENEFIT REDUCES AT AGE 70.** This accumulated benefit will be reduced by one-half for Hospital Intensive Care Unit/Step-Down Intensive Care Unit confinements commencing on or after the policy anniversary date following the 70<sup>th</sup> birthday of a Covered Person. **This benefit is not applicable and will not accrue to any Covered Person who has attained age 65 prior to the Effective Date of coverage.** The Named Insured and covered Spouse, if any, are the only persons eligible for this benefit if One-Parent Family or Two-Parent Family coverage is in force. Dependent Children do not qualify for this benefit. When a Spouse is added to an existing policy, this benefit will begin to accrue from the endorsement date adding such Spouse, provided the Spouse has not yet attained age 65.

**BENEFITS FOR SPECIFIED HEALTH EVENTS AND/OR CORONARY ANGIOPLASTY:**

**D. FIRST-OCCURRENCE BENEFIT:** Aflac will pay the following benefit amount for each Covered Person when he or she is first diagnosed as having had a Specified Health Event:

**Named Insured/Spouse**

\$7,500 (Lifetime maximum \$7,500 per Covered Person)

**Dependent Children**

\$10,000 (Lifetime maximum \$10,000 per Covered Person)

**This benefit is payable only once per Covered Person, per lifetime.**

**E. SUBSEQUENT SPECIFIED HEALTH EVENT BENEFIT:** If benefits have been paid to a Covered Person under the First-Occurrence Benefit above, Aflac will pay \$3,500 if such Covered Person is later diagnosed as having had a subsequent Specified Health Event.

**For the Subsequent Specified Health Event Benefit to be payable, the subsequent Specified Health Event must occur 180 days or more after the occurrence of any previously paid Specified Health Event for such Covered Person. No lifetime maximum.**

**F. CORONARY ANGIOPLASTY BENEFIT:** Aflac will pay \$1,000 when a Covered Person has a Coronary Angioplasty, with or without stents.

**This benefit is payable only once per Covered Person, per lifetime.**

**G. HOSPITAL CONFINEMENT BENEFIT (includes confinement in a U.S. government Hospital):** When a Covered Person requires Hospital Confinement for the

treatment of a covered Specified Health Event or Coronary Angioplasty, Aflac will pay \$300 per day for each day a Covered Person is charged as an inpatient. **This benefit is limited to confinements for the treatment of a covered Specified Health Event or Coronary Angioplasty that occur within 500 days following the occurrence of the most recent covered Specified Health Event or Coronary Angioplasty. No lifetime maximum.**

Hospital Confinement Benefits are payable for only one covered Specified Health Event or Coronary Angioplasty at a time per Covered Person. Confinement in a U.S. government Hospital does not require a charge for benefits to be payable.

**This benefit is not payable on the same day as the Continuing Care Benefit. The highest eligible benefit will be paid.**

**H. CONTINUING CARE BENEFIT:** If, as the result of a covered Specified Health Event or Coronary Angioplasty, a Covered Person receives any of the following treatments from a licensed Physician, Aflac will pay \$125 each day a Covered Person is charged:

- |                                 |                       |
|---------------------------------|-----------------------|
| 1. rehabilitation therapy       | 7. home health care   |
| 2. physical therapy             | 8. dialysis           |
| 3. speech therapy               | 9. hospice care       |
| 4. occupational therapy         | 10. extended care     |
| 5. respiratory therapy          | 11. Physician visits  |
| 6. dietary therapy/consultation | 12. nursing home care |

This benefit is payable for only one covered Specified Health Event or Coronary Angioplasty at a time per Covered Person and is limited to 75 days for continuing care received within 180 days following the occurrence of the most recent covered Specified Health Event or Coronary Angioplasty. Daily maximum for this benefit is \$125 regardless of the number of treatments received.

**This benefit is not payable on the same day as the Hospital Confinement Benefit. The highest eligible benefit will be paid. No lifetime maximum.**

**OTHER BENEFITS:**

**I. AMBULANCE BENEFIT:** If, due to a covered Loss, a Covered Person requires ground ambulance transportation to or from a Hospital, Aflac will pay \$250. If air ambulance transportation is required due to a covered Loss, we will pay \$2,000. A licensed professional ambulance company must provide the ambulance service. This benefit will not be paid for more than two times per occurrence of a Loss.

**This benefit is not payable beyond the 180th day following the occurrence of a covered Loss. No lifetime maximum.**



The Transportation and Lodging Benefits will be paid for care received within 180 days following the occurrence of a covered Loss. Benefits are payable for only one covered Loss at a time per Covered Person. If a Covered Person is eligible to receive benefits for more than one covered Loss, we will pay benefits only for care received within the 180 days following the occurrence of the most recent covered Loss.

**J. TRANSPORTATION BENEFIT:** If a Covered Person requires special medical treatment that has been prescribed by the local attending Physician for a covered Loss, Aflac will pay 50 cents per mile for noncommercial travel or the costs incurred for commercial travel (coach class plane, train, or bus fare) for transportation of a Covered Person for the round-trip distance between the Hospital or medical facility and the residence of the Covered Person. This benefit is not payable for transportation by ambulance or air ambulance to the Hospital. Reimbursement will be made only for the method of transportation actually taken. This benefit will be paid only for the Covered Person for whom the special treatment is prescribed. If the special treatment is for a Dependent Child and commercial travel is necessary, we will pay this benefit for up to two adults to accompany the Dependent Child. The benefit amount payable is limited to \$3,000 per occurrence of a covered Loss. **Transportation Benefits are not payable beyond the 180th day following the occurrence of a covered Loss. THIS BENEFIT IS NOT PAYABLE FOR TRANSPORTATION TO ANY HOSPITAL LOCATED WITHIN A 50-MILE RADIUS OF THE RESIDENCE OF THE COVERED PERSON. No lifetime maximum.**

In the state of Hawaii, travel to Oahu from any other Hawaiian Island shall satisfy the 50-mile radius requirement.

**K. LODGING BENEFIT:** Aflac will pay the charges incurred up to \$75 per day for lodging, in a room in a motel, hotel, or other commercial accommodation, for you or any one adult family member when a Covered Person receives special medical treatment for a covered Loss at a Hospital or medical facility. The Hospital, medical facility, and lodging must be more than 50 miles from the Covered Person's residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. This benefit is limited to 15 days per occurrence of a covered Loss.

**This benefit is not payable beyond the 180th day following the occurrence of a covered Loss. No lifetime maximum.**

**L. WAIVER OF PREMIUM BENEFIT:**

**Employed:** If you, due to a covered Specified Health Event, are completely unable to do all of the usual and customary duties of your occupation for a period of 180 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require an employer's statement and a Physician's statement of your inability to perform said duties, and may each month thereafter require a Physician's statement that total inability continues.

**Not Employed:** If you, due to a covered Specified Health Event, are completely unable to perform three or more of the Activities of Daily Living (ADLs) without Direct Personal Assistance for a period of 180 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require a Physician's statement of your inability to perform said activities, and may each month thereafter require a Physician's statement that total inability continues.

If you die and your Spouse, civil union partner or Reciprocal Beneficiary becomes the new Named Insured, premiums will start again and be due on the first premium due date after the change. The new Named Insured will then be eligible for this benefit if the need arises.

While this benefit is being paid, Aflac may ask for and use an independent consultant to determine whether you can perform an ADL.

**M. CONTINUATION OF COVERAGE BENEFIT:** Aflac will waive all monthly premiums due for the policy and riders, if any, for up to two months if you meet all of the following conditions:

1. Your policy has been in force for at least six months;
2. We have received premiums for at least six consecutive months;
3. Your premiums have been paid through payroll deduction, and you leave your employer for any reason;
4. You or your employer has notified us in writing within 30 days of the date your premium payments ceased due to your leaving employment; and
5. You re-establish premium payments through:
  - a. your new employer's payroll deduction process, or
  - b. direct payment to Aflac.

You will again become eligible to receive this benefit after:

1. You re-establish your premium payments through payroll deduction for a period of at least six months, and

2. We receive premiums for at least six consecutive months.

**“Payroll deduction” means your premium is remitted to Aflac for you by your employer through a payroll deduction process or any other method agreed to by Aflac and the employer.**

**(4) Optional Benefits:**

**FIRST-OCCURRENCE BUILDING BENEFIT RIDER:  
(Series A74050) Applied for  Yes  No**

The First-Occurrence Benefit, as defined in the policy, will be increased by \$500 on each rider anniversary date while the rider remains in force. (The amount of the monthly increase will be determined on a pro rata basis.) This benefit will be paid under the same terms as the First-Occurrence Benefit. This benefit will cease to build for each Covered Person on the anniversary date of the rider following the Covered Person’s 65th birthday or at the time of a Specified Health Event, subject to the Limitations and Exclusions of the policy, for that Covered Person, whichever occurs first. However, regardless of the age of the Covered Person on the Effective Date of the rider, this benefit will accrue for a period of at least five years unless a Specified Health Event is diagnosed prior to the fifth year of coverage. (If the rider is Individual coverage, no further premium will be billed for the rider after the payment of benefits.)

**SPECIFIED HEALTH EVENT RECOVERY BENEFIT RIDER:  
(Series A74051) Applied for  Yes  No**

**SPECIFIED HEALTH EVENT RECOVERY:** A Covered Person will be considered in Specified Health Event Recovery if he or she continues to be under the active care and treatment by a Physician for a covered Specified Health Event OR he or she is unable to engage in the duties of his or her regular occupation due to a covered Specified Health Event. “Specified Health Event” includes Heart Attack, Stroke, End-Stage Renal Failure, Major Human Organ Transplant, Third-Degree Burns, Persistent Vegetative State, Coma, Paralysis, Coronary Artery Bypass Graft Surgery (CABG), or Sudden Cardiac Arrest occurring on or after the Effective Date of coverage under the rider. (If the rider is Individual coverage, no further premium will be billed for the rider after the payment of lifetime maximum benefits.)

**SPECIFIED HEALTH EVENT RECOVERY BENEFIT:** Aflac will pay \$500 per month while a Covered Person remains in Specified Health Event Recovery upon receipt of written proof of Loss from that person’s Physician.

Lifetime maximum of six months per Covered Person.

**(5) Exceptions, Reductions, and Limitations of the Policy (not a daily hospital expense plan):**

- A. The Benefits for Intensive Care Unit Confinements will be reduced by one-half for confinements that begin on or

after the policy anniversary date following the 70th birthday of a Covered Person.

- B. The Benefits for Intensive Care Unit Confinements are not payable for confinement in units such as telemetry or surgical recovery rooms, postanesthesia care units, private monitored rooms, observation units located in emergency room or outpatient surgery units, or other facilities that do not meet the standards for a Hospital Intensive Care Unit or Step-Down Intensive Care Unit. The Hospital Intensive Care Unit Benefit is not payable for confinement in progressive care units or intermediate care units.
- C. Aflac will not pay benefits for any Loss that is caused by a Pre-existing Condition unless the Loss occurs more than 12 months after the Effective Date of coverage.
- D. Aflac will not pay benefits for any Loss that is diagnosed or treated outside the territorial limits of the United States or its possessions.
- E. Aflac will not pay benefits for any newborn’s Loss or confinement that occurs or begins during the first 28 days following birth when conception occurred prior to the Effective Date of coverage.
- F. Aflac will not pay benefits whenever coverage provided by the policy 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.
- G. For any benefit to be payable, the Loss must occur on or after the Effective Date of coverage and while coverage is in force. If more than one Specified Health Event per Covered Person occurs on the same day, only the highest eligible benefit will be paid.
- H. Aflac will not pay benefits whenever fraud is committed in making a claim under the coverage or any prior claim under any other Aflac coverage for which benefits were received that were not lawfully due and that fraudulently induced payment.
- I. **The policy does not cover Losses or confinements caused by or resulting from:**
  1. Being intoxicated or under the influence of alcohol, drugs, or any narcotic, unless administered on the advice of a Physician and taken according to the Physician’s instructions (the term “intoxicated” refers to that condition as defined by the law of the jurisdiction in which the cause of the Loss occurred);
  2. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician’s instructions), or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;

3. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place), or being incarcerated in any detention facility or penal institution;
4. Participating in any sport or sporting activity for wage, compensation, or profit, including officiating or coaching; or racing any type vehicle in an organized event;
5. Intentionally self-inflicting a bodily Injury or committing or attempting suicide, while sane or insane;
6. Having elective surgery that is not Medically Necessary within the first 12 months of the Effective Date of coverage; or
7. Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve.

**PRE-EXISTING CONDITION LIMITATIONS:** A "Pre-existing Condition" is an illness, disease, infection, disorder, or Injury for which, within the 12-month period before the Effective Date of coverage, prescription medication was taken or medical testing, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Benefits will not be payable for any Loss that is caused by a Pre-existing Condition unless the Loss occurs more than 12 months after the Effective Date of coverage.

- (6) Renewability:** The policy is guaranteed-renewable for your lifetime by the timely payment of premiums at the rate in effect at the beginning of each term, with some benefits reduced beginning at age 70, except that we may discontinue or terminate the policy if you have performed an act or practice that constitutes fraud or have made an intentional misrepresentation of material fact relating in any way to the policy, including claims for benefits under the policy. Premium rates may change only if changed on all policies of the same form number and class in force in your state.

**RETAIN FOR YOUR RECORDS.**

**THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.  
THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.**



## TERMS YOU NEED TO KNOW

**ACTIVITIES OF DAILY LIVING (ADLs):** activities used in measuring your levels of personal functioning capacity. Normally, these activities are performed without direct personal assistance, allowing you personal independence in everyday living.

The ADLs are:

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

**COMA:** a continuous state of profound unconsciousness lasting for a period of seven or more consecutive days and characterized by the absence of: (1) spontaneous eye movements, (2) response to painful stimuli, and (3) vocalization. The condition must require intubation for respiratory assistance. The term coma does not include any medically induced coma. The coma must begin on or after the effective date of coverage and while coverage is in force for benefits to be payable.

**CORONARY ANGIOPLASTY:** a medical procedure in which a balloon is used to open narrowed or blocked blood vessels of the heart (coronary arteries). This procedure may be performed with or without stents.

**CORONARY ARTERY BYPASS GRAFT SURGERY (CABG):** 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 coronary angioplasty, valve replacement surgery, stent placement, laser relief, or other surgical or nonsurgical procedures.

**COVERED PERSON:** any person insured under the coverage type that you applied for on the application: individual (named insured listed in the Policy Schedule), named insured/spouse only (named insured and spouse), one-parent family (named insured and dependent children), or two-parent family (named insured, spouse, and dependent children). Spouse is defined as the person to whom you are legally married and who is listed on your application. This includes a civil union and reciprocal beneficiary relationship. Newborn children are automatically covered under the terms of the policy from the moment of birth. If individual or named insured/spouse only coverage is in force and you desire uninterrupted coverage for a newborn child, you must notify Aflac in writing within 31 days of the child's birth. Upon notification, Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due, if any. One-parent family or two-parent family coverage will continue to include any other dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and who became so incapacitated prior to age 26 and while covered under the policy. Dependent children are your natural children, stepchildren, or legally adopted children who are under age 26. A dependent child (including

persons incapable of self-sustaining employment by reason of mental retardation or physical handicap) must be under age 26 at the time of application to be eligible for coverage.

**EFFECTIVE DATE:** the date(s) coverage begins as shown in the Policy Schedule or any attached endorsements or riders. The effective date **is not** the date you signed the application for coverage.

**END-STAGE RENAL FAILURE:** permanent and irreversible kidney failure, not of an acute nature.

**HEART ATTACK:** a myocardial infarction. The attack must be positively diagnosed by a physician and must be evidenced by electrocardiographic findings or clinical findings together with blood enzyme findings. The definition of heart attack shall not be construed to mean congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease, cardiac arrest, or any other dysfunction of the cardiovascular system. The heart attack must occur on or after the effective date of coverage and while coverage is in force for benefits to be payable. Sudden cardiac arrest is not a heart attack.

**HOSPITAL:** a legally operated institution licensed by the state in which it is located that maintains and uses a laboratory, X-ray equipment, and an operating room on its premises or in facilities available to it on a prearranged, written, contractual basis. The institution must also have permanent and full-time facilities for the care of overnight-resident bed patients under the supervision of one or more licensed physicians, provide 24-hour-a-day nursing service by or under the supervision of a registered professional nurse, and maintain the patients' written histories and medical records on the premises. The term hospital also includes ambulatory surgical centers. The term hospital does not include any institution or part thereof used as an emergency room; a rehabilitation unit; a hospice unit, including any bed designated as a hospice bed or a swing bed; a transitional care unit; a convalescent home; a rest or nursing facility; a psychiatric unit; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

**HOSPITAL CONFINEMENT:** a stay of a covered person confined to a bed in a hospital for a period of 23 hours or more for which a room charge is made. The hospital confinement must be on the advice of a physician and medically necessary. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable.

**HOSPITAL INTENSIVE CARE UNIT:** specifically designated facility of the hospital that provides the highest level of medical care and that is restricted to those patients who are critically ill or injured. Such facilities must be separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement. The hospital intensive care unit must be permanently equipped with special lifesaving equipment for the care of the critically ill or injured, and the patients must be under constant and continual observation by nursing staffs assigned exclusively to the hospital intensive care unit on a full-time basis. These units must be listed as hospital intensive care units in the current edition of the American Hospital Association Guide or be eligible to be listed therein. This guide lists three types of facilities that meet this definition: (1) Hospital intensive care unit, (2) Cardiac intensive care unit, and (3) Infant (neonatal) intensive care unit. **Hospital**

**intensive care unit does not include units such as:** telemetry or surgical recovery rooms, postanesthesia care units, progressive care units, intermediate care units, private monitored rooms, observation units located in emergency rooms or outpatient surgery units, step-down intensive care units, or other facilities that do not meet the standards for a hospital intensive care unit.

**LOSS:** a specified health event, coronary angioplasty, or confinement in a hospital intensive care unit or step-down intensive care unit occurring or beginning on or after the effective date of coverage and while coverage is in force.

**MAJOR HUMAN ORGAN TRANSPLANT:** a surgery in which a covered person receives, as a result of a surgical transplant, one or more of the following human organs: kidney, liver, heart, lung, or pancreas. **This does not include transplants involving mechanical or nonhuman organs.**

**PARALYSIS:** complete and total loss of use of two or more limbs (paraplegia, quadriplegia, or hemiplegia) for a continuous period of at least 30 days as the result of a spinal cord injury. The paralysis must be confirmed by the attending physician. The spinal cord injury causing the paralysis must occur on or after the effective date of coverage and while coverage is in force for benefits to be payable.

**PERIOD OF CONFINEMENT:** the number of days a covered person is assigned to and incurs a charge for a bed in a hospital intensive care unit or a step-down intensive care unit. Confinements must begin on or after the effective date of coverage and while coverage is in force. **Covered confinements not separated by 30 days or more from a previously covered confinement are considered a continuation of the previous period of confinement.**

**PERSISTENT VEGETATIVE STATE:** a state of severe mental impairment in which only involuntary bodily functions are present for a continuous period of at least 30 days and for which there exists no reasonable expectation of regaining significant cognitive function. The procedure for establishing a persistent vegetative state is as follows: two physicians, one of whom must be the attending physician, who, after personally examining the covered person, shall certify in writing, based upon conditions found during the course of their examination, that:

1. The covered person's cognitive function has been substantially impaired; and
2. There exists no reasonable expectation that the covered person will regain significant cognitive function.

**PHYSICIAN:** a person legally qualified to practice medicine, other than you or a member of your immediate family, who is licensed as a physician by the state where treatment is received to treat the type of condition for which a claim is made.

**SPECIFIED HEALTH EVENT:** heart attack, stroke, end-stage renal failure, major human organ transplant, third-degree burns, persistent vegetative state, coma, paralysis, coronary artery bypass graft surgery (CABG), or sudden cardiac arrest.

**STEP-DOWN INTENSIVE CARE UNIT:** specifically designated facility of the hospital that provides a level of medical care below the highest level of acute medical care available at the hospital, but above the level of medical care in a regular private or semiprivate room or ward. The facility must also be separate and apart from other hospital areas, permanently equipped with telemetry equipment, and under constant and continual observation by specially trained nursing staff assigned exclusively to that area. **A step-down intensive care unit does not include:** telemetry or surgical recovery rooms; observation units located in emergency rooms or outpatient surgery units; postanesthesia care units; beds, wards, or private or semiprivate room with or without telemetry monitoring equipment; emergency rooms; or labor or delivery rooms.

**STROKE:** apoplexy due to rupture or acute occlusion of a cerebral artery. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. The stroke must be positively diagnosed by a physician based upon documented neurological deficits and confirmatory neuroimaging studies. Stroke does not mean head injury, transient ischemic attack (TIA), cerebrovascular insufficiency, or lacunar infarction (LACI).

**SUDDEN CARDIAC ARREST:** sudden, unexpected loss of heart function in which the heart abruptly and without warning stops working as a result of an internal electrical system malfunction of the heart. Any death where the sole cause of death shown on the death certificate is cardiovascular collapse, sudden cardiac arrest, cardiac arrest, or sudden cardiac death shall be deemed to be sudden cardiac arrest for purposes of the policy. Sudden cardiac arrest is not a heart attack.

**THIRD-DEGREE BURNS:** an area of tissue damage in which there is destruction of the entire epidermis and underlying dermis and that covers more than 10 percent of total body surface. The damage must be caused by heat, electricity, radiation, or chemicals. This does not include skin abrasions caused by falling on and scraping skin on asphalt, concrete, or any other surface.







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