WOULD YOU LIKE TO FIND OUT MORE ABOUT OUR AFLAC PLANS?

If you would like to hear more, PLEASE TAKE A MINUTE TO READ AND COMPLETE THE FOLLOWING INFORMATION. Our AFLAC representative will be happy to discuss your options.

While major medical will pay the doctor, hospital and/or prescriptions, AFLAC will pay CASH benefits directly to YOU when you need it most in the event of a SERIOUS ILLNESS OR ACCIDENT!

PROTECT YOUR INCOME & ASSETS!

Please rate the AFLAC insurance policies 1-3 that interest you. 1=highest interest and 3=lowest interest

_______ ACCIDENT: Pays case benefits toward a covered accidental injury

_______ CANCER: Provides financial assistance through cash benefits when you’re faced with the treatment and recovery of cancer

_______ CRITICAL CARE and RECOVERY: Provides cash benefits when you’re faced with The treatment and recovery of a covered health event including heart attack, stroke, etc.

Your Name (please print): ____________________________________________________________

Best day/time to meet (on 10/23 or 10/24): __________________________________________

Best way to contact you: [ ]e-mail ______________________ [ ]phone ______________________

PLEASE RETURN THIS FORM TO THE OFFICE OF HUMAN RESOURCES. You will then be contacted for your appointment time.
ACCIDENT INDEMNITY ADVANTAGE 24-HOUR LEVEL TWO - Series A-35200

<table>
<thead>
<tr>
<th>Age</th>
<th>Individual</th>
<th>HUSBAND/WIFE</th>
<th>ONE-PARENT FAMILY</th>
<th>TWO-PARENT FAMILY</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-49</td>
<td>$21.58</td>
<td>$30.55</td>
<td>$34.97</td>
<td>$45.50</td>
</tr>
<tr>
<td>50-70</td>
<td>$21.58</td>
<td>$30.55</td>
<td>$34.97</td>
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</tbody>
</table>

IDR* = Optional Initial Diagnosis Rider (Series A-78050) premium 1-5 units

AFLAC CANCER CARE PLAN CLASSIC - Series A78300

<table>
<thead>
<tr>
<th>Age</th>
<th>Individual</th>
<th>INSURED/SPouse</th>
<th>ONE-PARENT FAMILY</th>
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<tbody>
<tr>
<td>18-75</td>
<td>$31.72</td>
<td>$53.95</td>
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<td>18-75</td>
<td>$53.95</td>
<td>$13.00</td>
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AFLAC CANCER CARE PLAN PREMIER - Series A78400

<table>
<thead>
<tr>
<th>Age</th>
<th>Individual</th>
<th>INSURED/SPouse</th>
<th>ONE-PARENT FAMILY</th>
<th>TWO-PARENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-75</td>
<td>$45.89</td>
<td>$79.95</td>
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<td>$79.95</td>
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<tr>
<td>18-75</td>
<td>$79.95</td>
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<td>$79.95</td>
<td>$13.00</td>
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CRITICAL CARE AND RECOVERY LEVEL TWO - Series A71200

<table>
<thead>
<tr>
<th>Age</th>
<th>Individual (Premium)</th>
<th>FOBBR (First Occurrence Building Benefit Rider)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-35</td>
<td>$16.38</td>
<td>$2.34</td>
<td>$18.72</td>
</tr>
<tr>
<td>36-45</td>
<td>$23.40</td>
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<tr>
<td>46-55</td>
<td>$31.85</td>
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<tr>
<td>56-70</td>
<td>$41.08</td>
<td>$5.59</td>
<td>$46.67</td>
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</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>One Parent Family (Premium)</th>
<th>FOBBR (First Occurrence Building Benefit Rider)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-35</td>
<td>$28.08</td>
<td>$2.47</td>
<td>$30.55</td>
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<tr>
<td>36-45</td>
<td>$33.02</td>
<td>$4.55</td>
<td>$37.57</td>
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<tr>
<td>46-55</td>
<td>$42.51</td>
<td>$5.20</td>
<td>$47.71</td>
</tr>
<tr>
<td>56-70</td>
<td>$55.90</td>
<td>$5.85</td>
<td>$61.75</td>
</tr>
</tbody>
</table>

FOBBR: First Occurrence Building Benefit Rider (Rider Series A71050) ($500)
Peace of Mind \textit{and}
Real Cash Benefits

ACCIDENT INDEMNITY ADVANTAGE®
24-HOUR ACCIDENT-ONLY INSURANCE

Aflac®
We've got you under our wing.
The Need

Accidents happen to all kinds of people every day. In 2009, 38.9 million people—about 1 out of 8—sought medical attention for an injury.*

What would the financial impact of an injury mean to your security? Are you prepared for medical debts in addition to everyday household expenditures and lost wages? Out-of-pocket expenses associated with an accident are unexpected and often burdensome; perhaps the accident itself could not have been prevented, but its impact on your finances and your well-being certainly can be reduced.


Aflac pays cash benefits directly to you, unless you choose otherwise. This means that you will have added financial resources to help with expenses incurred due to an injury, to help with ongoing living expenses, or to help with any purpose you choose. Aflac Accident Indemnity Advantage is designed to provide you with cash benefits throughout the different stages of care, regardless of the severity of the injury.

Aflac enables you to take charge and to help provide for an unpredictable future by paying cash benefits for accidental injuries. Your own peace of mind and the assurance that your family will have help financially are powerful reasons to consider Aflac.

THE ACCIDENT INDEMNITY ADVANTAGE INSURANCE POLICY HAS:

1. No deductibles and no copayments.
2. No lifetime limit—policy won’t terminate based on number or dollar amount of claims paid.
3. No network restrictions—you choose your own medical treatment provider.
4. No coordination of benefits—we pay regardless of any other insurance.

Aflac herein means American Family Life Assurance Company of Columbus.

aflac.com | We’ve got you under our wing.
<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>BENEFIT AMOUNT</th>
<th>ADDITIONAL BENEFIT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>WELLNESS</td>
<td>$60 once per policy, per 12-month period, payable after the policy has been in force for 12 months</td>
<td>Payable if you or any one family member undergoes routine examinations or other preventive testing during the following policy year. Eligible family members are your Spouse and the Dependent Children of either you or your Spouse. Services covered are annual physical examinations, dental examinations, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, ultrasounds, prostate-specific antigen tests (PSAs), and blood screenings. This benefit will become available following each anniversary of the policy’s Effective Date for service received during the following policy year and is payable only once per policy each 12-month period following your policy anniversary date. Service must be under the supervision of or recommended by a physician, received while the policy is in force, and a charge must be incurred.</td>
</tr>
<tr>
<td>ACCIDENT EMERGENCY TREATMENT</td>
<td>$120 once per 24-hour period and only once per covered accident, per Covered Person</td>
<td>Payable when a Covered Person receives treatment for Injuries sustained in a covered accident. This benefit is payable for treatment by a physician or treatment received in a hospital emergency room. Treatment must be received within 72 hours of the accident for benefits to be payable.</td>
</tr>
<tr>
<td>X-RAY</td>
<td>$25 once per covered accident, per Covered Person</td>
<td>Payable when a Covered Person requires an X-ray while receiving emergency treatment in a hospital or a hospital emergency room for Injuries sustained in a covered accident. This benefit is not payable for X-rays received in a physician's office. The X-Ray Benefit is not payable for exams listed in the Major Diagnostic Exams Benefit.</td>
</tr>
<tr>
<td>ACCIDENT FOLLOW-UP TREATMENT</td>
<td>$35 for one treatment per day, up to a maximum of six treatments per covered accident, per Covered Person</td>
<td>Payable when a Covered Person receives emergency treatment for Injuries sustained in a covered accident and later requires additional treatment over and above emergency treatment administered in the first 72 hours following the accident. The treatment must begin within 30 days of the covered accident or discharge from the hospital. Treatments must be furnished by a physician in a physician's office or in a hospital on an outpatient basis. This benefit is payable for acupuncture when furnished by a licensed, certified acupuncturist. The Accident Follow-Up Treatment Benefit is not payable for the same days the Physical Therapy Benefit is paid.</td>
</tr>
<tr>
<td>INITIAL ACCIDENT HOSPITALIZATION</td>
<td>$1,000 once per period of Hospital Confinement or $2,000 once when a Covered Person is admitted directly to an intensive care unit; payable once per calendar year, per Covered Person</td>
<td>Payable when a Covered Person is admitted for a Hospital Confinement of at least 18 hours for treatment of Injuries sustained in a covered accident or if a Covered Person is admitted directly to an intensive care unit of a hospital for treatment of Injuries sustained in a covered accident. Hospital Confinements must start within 30 days of the accident.</td>
</tr>
<tr>
<td>ACCIDENT HOSPITAL CONFINEMENT</td>
<td>$250 per day up to 365 days per covered accident, per Covered Person</td>
<td>Payable when a Covered Person is admitted for a Hospital Confinement of at least 18 hours for treatment of Injuries sustained in a covered accident. Hospital Confinements must start within 30 days of the accident. The Accident Hospital Confinement Benefit and the Rehabilitation Unit Benefit will not be paid on the same day. The highest eligible benefit will be paid.</td>
</tr>
<tr>
<td>INTENSIVE CARE UNIT CONFINEMENT</td>
<td>An additional $400 per day for up to 15 days per covered accident, per Covered Person</td>
<td>Payable for each day a Covered Person receives the Accident Hospital Confinement Benefit, and is confined and charged for a room in an intensive care unit for treatment of Injuries sustained in a covered accident. Hospital Confinements must start within 30 days of the accident.</td>
</tr>
</tbody>
</table>

Aflac will pay the following benefits as applicable if a Covered Person's Accidental Death, dismemberment, or Injury is caused by a covered accident that occurs on or off the job. Accidental Death, dismemberment, or Injury must be independent of Sickness, or the medical or surgical treatment of Sickness, or of any cause other than a covered accident. A covered Accidental Death, dismemberment, or Injury must also occur while coverage is in force and is subject to the limitations and exclusions. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable.
### BENEFIT

#### Accident Specific-Sum Injuries

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Benefit Amount</th>
<th>Additional Benefit Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>$35–$12,500 (according to the policy) for:</td>
<td></td>
<td>Payable for treatment performed on a Covered Person for Injuries sustained in a covered accident. We will pay for no more than two dislocations per covered accident, per Covered Person. Benefits are payable for only the first dislocation of a joint. If a dislocation is reduced with local anesthesia or no anesthesia by a physician, we will pay 25 percent of the amount shown for the closed reduction dislocation. Burns must be treated by a physician within 72 hours after a covered accident. If a Covered Person receives one or more skin grafts for a covered burn, we will pay a total of 50 percent of the burn benefit amount that we paid for the burn involved. Lacerations must be repaired within 72 hours after the accident and repaired under the attendance of a physician. We will pay 25 percent of the benefit amount shown for the closed reduction of chip fractures and other fractures not reduced by open or closed reduction. We will pay for no more than two fractures per covered accident, per Covered Person. Emergency dental work does not include false teeth such as dentures, bridges, veneers, partials, crowns, or implants. We will pay for no more than one emergency dental work benefit per covered accident, per Covered Person. The duration of the paralysis must be a minimum of 30 days, and this benefit will be payable once per Covered Person. Coma must last a minimum of seven days. Coma does not include any medically induced coma. Treatment for surgical procedures must be performed within one year of a covered accident. Two or more surgical procedures performed through the same incision will be considered one operation, and benefits will be paid based on the most expensive procedure. Only one miscellaneous surgery benefit is payable per 24-hour period even though more than one surgical procedure may be performed.</td>
</tr>
<tr>
<td>Dislocations</td>
<td></td>
<td></td>
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<tr>
<td>Burns</td>
<td></td>
<td></td>
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<tr>
<td>Skin grafts</td>
<td></td>
<td></td>
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<tr>
<td>Eye injuries</td>
<td></td>
<td></td>
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<tr>
<td>Lacerations</td>
<td></td>
<td></td>
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<tr>
<td>Fractures</td>
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<tr>
<td>Concussions</td>
<td></td>
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<tr>
<td>Coma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paralysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical procedures</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Major Diagnostic Exams

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Benefit Amount</th>
<th>Additional Benefit Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>$200 once per calendar year, per Covered Person</td>
<td></td>
<td>Payable when a Covered Person requires one of the following exams for Injuries sustained in a covered accident and a charge is incurred: computerized tomography (CT scan), computerized axial tomography (CAT), magnetic resonance imaging (MRI), or electroencephalography (EEG). These exams must be performed in a hospital or a physician's office. Exams listed in the Major Diagnostic Exams Benefit are not payable under the X-Ray Benefit. No lifetime maximum.</td>
</tr>
</tbody>
</table>

#### Epidural Pain Management

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Benefit Amount</th>
<th>Additional Benefit Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100 paid no more than twice per covered accident, per Covered Person</td>
<td></td>
<td>Payable when a Covered Person is prescribed, receives, and incurs a charge for an epidural administered for pain management in a hospital or a physician's office for Injuries sustained in a covered accident. This benefit is not payable for an epidural administered during a surgical procedure.</td>
</tr>
</tbody>
</table>

#### Physical Therapy

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Benefit Amount</th>
<th>Additional Benefit Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>$35 per treatment for one treatment per day, up to a maximum of ten treatments per covered accident, per Covered Person</td>
<td></td>
<td>Payable when a Covered Person receives emergency treatment for Injuries sustained in a covered accident and later a physician advises the Covered Person to seek treatment from a licensed physical therapist. Physical therapy must be for Injuries sustained in a covered accident and must start within 30 days of the covered accident or discharge from the hospital. The treatment must take place within six months after the accident. The Physical Therapy Benefit is not payable for the same days that the Accident Follow-Up Treatment Benefit is paid.</td>
</tr>
</tbody>
</table>

#### Rehabilitation Unit

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Benefit Amount</th>
<th>Additional Benefit Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>$150 per day, limited to 30 days for each Covered Person per period of Hospital Confinement and limited to a calendar year maximum of 60 days</td>
<td></td>
<td>Payable when a Covered Person is admitted for a Hospital Confinement and is transferred to a bed in a rehabilitation unit of a hospital for treatment of Injuries sustained in a covered accident and a charge is incurred. The Rehabilitation Unit Benefit will not be payable the same days the Accident Hospital Confinement Benefit is paid. The highest eligible benefit will be paid. No lifetime maximum.</td>
</tr>
</tbody>
</table>

#### Appliances

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Benefit Amount</th>
<th>Additional Benefit Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>$125 once per covered accident, per Covered Person</td>
<td></td>
<td>Payable when a Covered Person receives a medical appliance, prescribed by a physician, as an aid in personal locomotion for Injuries sustained in a covered accident. Benefits are payable for the following types of appliances: a wheelchair, a leg brace, a back brace, a walker, and/or a pair of crutches.</td>
</tr>
</tbody>
</table>

The policy has limitations and exclusions that may affect benefits payable. This brochure is for illustrative purposes only. Refer to the policy for complete details, definitions, limitations, and exclusions.
<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>BENEFIT AMOUNT</th>
<th>ADDITIONAL BENEFIT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthesis</td>
<td>$750 once per covered accident,</td>
<td>Payable when a Covered Person requires use of a prosthetic device as a result of Injuries sustained in a covered accident. This benefit is not payable for repair or replacement of prosthetic devices, hearing aids, wigs, or dental aids, to include false teeth. per Covered Person</td>
</tr>
<tr>
<td>Blood/Plasma/Platelets</td>
<td>$200 once per covered accident,</td>
<td>Payable when a Covered Person receives blood/plasma and/or platelets for the treatment of Injuries sustained in a covered accident. This benefit does not pay for immunoglobulins. per Covered Person</td>
</tr>
<tr>
<td>Ambulance</td>
<td>$200 when a Covered Person requires</td>
<td>Payable when a Covered Person requires ambulance transportation or air ambulance transportation to a hospital for Injuries sustained in a covered accident. Ambulance transportation must be within 72 hours of the covered accident. A licensed professional ambulance company must provide the ambulance service. ambulance transportation.</td>
</tr>
<tr>
<td>Transportation</td>
<td>$600 per round trip, up to three round trips per calendar year, per Covered Person</td>
<td>Payable per round trip to a hospital when a Covered Person requires Hospital Confinement for medical treatment due to an Injury sustained in a covered accident. This benefit is also payable when a covered Dependent Child requires Hospital Confinement for medical treatment due to an Injury sustained in a covered accident if commercial travel (plane, train, or bus) is necessary and such Dependent Child is accompanied by any immediate family member. This benefit is not payable for transportation to any hospital located within a 50-mile radius from the site of the accident or the residence of the Covered Person. The local attending physician must prescribe the treatment requiring Hospital Confinement, and the treatment must not be available locally. This benefit is not payable for transportation by ambulance or air ambulance to the hospital.</td>
</tr>
<tr>
<td>Family Lodging</td>
<td>$125 per night, limited to one motel/hotel room per night, up to 30 days per covered accident</td>
<td>Payable for one motel/hotel room for a member of the immediate family who accompanies a Covered Person who is admitted for a Hospital Confinement for the treatment of Injuries sustained in a covered accident. This benefit is payable only during the same period of time the injured Covered Person is confined to the hospital. The hospital and motel/hotel must be more than 50 miles from the residence of the Covered Person.</td>
</tr>
<tr>
<td>Accidental Death</td>
<td></td>
<td>We will pay the applicable lump sum benefit indicated for the Accidental Death of a Covered Person to the beneficiary named in the application. Accidental Death must occur as a result of an Injury sustained in a covered accident and must occur within 90 days of such accident. Note: We do not recommend that you name a minor child as your beneficiary. If you name a minor child as your beneficiary, any benefits due your minor beneficiary will not be payable until a guardian for the financial estate of the minor is appointed by the court or such beneficiary reaches the age of majority as defined by your state. If there is no beneficiary, Aflac will pay any applicable benefit to your estate.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INSURED</th>
<th>$150,000</th>
<th>$40,000</th>
<th>$10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPOUSE</td>
<td>$150,000</td>
<td>$40,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>CHILD</td>
<td>$25,000</td>
<td>$12,500</td>
<td>$3,125</td>
</tr>
</tbody>
</table>

Please see the Terms You Need to Know section of this brochure for more details about Common-Carrier Accidents, Other Accidents, and Hazardous Activity Accidents.
**BENEFIT** | **BENEFIT AMOUNT** | **ADDITIONAL BENEFIT INFORMATION**
--- | --- | ---
Accidental-Dismemberment | $625–$40,000 | We will pay the applicable lump sum benefit indicated in the policy for dismemberment. Dismemberment must occur as a result of injuries sustained in a covered accident and must occur within 90 days of the accident. Only the highest single benefit per Covered Person will be paid for dismemberment. Benefits will be paid only once per Covered Person, per covered accident. If death and dismemberment result from the same accident, only the Accidental-Death Benefit will be paid. Loss of use does not constitute dismemberment, except for eye injuries resulting in loss of the eye or permanent loss of vision such that central visual acuity cannot be corrected to better than 20/200.

CONTINUATION OF COVERAGE | Waive all monthly premiums for up to two months | We 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) The 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 cease because of your leaving employment; and (5) You re-establish premium payments either through your new employer’s payroll deduction process or direct payment to Aflac. You will again become eligible to receive this benefit after you re-establish your premium payments through payroll deduction for a period of at least six months, and 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.)

**WHAT IS NOT COVERED**

**LIMITATIONS AND EXCLUSIONS**

We will not pay benefits for services rendered by you or a member of the immediate family of a Covered Person. We will not pay benefits for treatment or loss due to Sickness, including (1) any bacterial, viral, or micro-organism infection or infestation, or any condition resulting from insect, arachnid, or other arthropod bites or stings; or (2) an error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure for any Sickness. We 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.

We will not pay benefits for an Injury, treatment, disability, or loss that is caused by or occurs as a result of a Covered Person’s:

- Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a physician and taken according to the physician’s instructions) or while intoxicated (*intoxicated* means that condition as defined by the law of the jurisdiction in which the accident occurred);
- 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;
- 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 type penal institution;
- Intentionally self-inflicting a bodily injury, or committing or attempting suicide, while sane or insane;
- Having cosmetic surgery or other elective procedures that are not medically necessary;
- Having dental treatment except as a result of Injury;
- Being exposed to war or any act of war, declared or undeclared;
- Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve.

A hospital does not include any institution or part thereof used as 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; 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 or a physical therapist does not include you or a member of your immediate family.
**Accidental Death:** death caused by a covered Injury. See the Limitations and Exclusions section for Injuries not covered by the policy.

**Common-Carrier Accident:** an accident, occurring on or after the Effective Date of coverage and while coverage is in force, directly involving a common-carrier vehicle in which a Covered Person is a Passenger at the time of the accident. A common-carrier vehicle is limited to only an airplane, train, bus, trolley, or boat that is duly licensed by a proper authority to transport persons for a fee, holds itself out as a public conveyance, and is operating on a posted regularly scheduled basis between predetermined points or cities at the time of the accident. A Passenger is a person aboard or riding in a common-carrier vehicle other than (1) a pilot, driver, operator, officer, or member of the crew of such vehicle; (2) a person having any duties aboard such vehicle; or (3) a person giving or receiving any kind of training or instruction. A Common-Carrier Accident does not include any Hazardous Activity Accident or any accident directly involving private, on demand, or chartered transportation in which a Covered Person is a Passenger at the time of the accident.

**Covered Person:** any person insured under the coverage type you applied for: 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. Newborn children are automatically covered under the terms of the policy from the moment of birth. If coverage is for individual or named insured/Spouse only, and you desire uninterrupted coverage for a newborn child, you must notify Aflac in writing within 31 days of the birth of your child, and Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due. Coverage will 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 (including children placed for adoption) 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. The Effective Date is not the date you signed the application for coverage.

**Guaranteed-Renewable:** the right to renew the policy by payment of the premium due on or before the renewal date. The policy is Guaranteed-Renewable for your lifetime, subject to Aflac’s right to change premiums by class upon any renewal date.

**Hazardous Activity Accident:** an accident that occurs on or after the Effective Date of coverage, while coverage is in force, and while a Covered Person is participating in sky diving, scuba diving, hang gliding, motorized vehicle racing, cave exploration, bungee jumping, parachuting, or mountain or rock climbing, or while a Covered Person is a pilot, an officer, or a member of the crew of an aircraft and has any duties aboard an aircraft, or while giving or receiving any kind of training or instruction aboard an aircraft. A Hazardous Activity Accident does not include any Common-Carrier Accidents.

**Hospital Confinement:** a stay of a Covered Person confined to a bed in a hospital for which a room charge is made. The Hospital Confinement must be on the advice of a physician, medically necessary, and the result of a covered Injury. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable.

**Injury:** a bodily injury caused directly by an accident, independent of Sickness, disease, bodily infirmity, or any other cause, occurring on or after the Effective Date of coverage and while coverage is in force. See the Limitations and Exclusions section for Injuries not covered by the policy.

**Other Accident:** an accident occurring on or after the Effective Date of coverage and while coverage is in force that is not classified as either a Common-Carrier Accident or a Hazardous Activity Accident and that is not specifically excluded in the Limitations and Exclusions section.

**Sickness:** an illness, disease, infection, or any other abnormal physical condition, independent of Injury, occurring on or after the Effective Date of coverage and while coverage is in force.
We’ve got you under our wing.®

aflac.com/social  1.800.99.AFLAC (1.800.992.3522)
Accident Specific-Sum Injuries Benefit Amounts
Plan 2 – 24-Hour Coverage

Aflac will pay $35–$12,500 for the following:

- Dislocations
- Eye Injuries
- Broken Teeth
- Burns
- Lacerations
- Comas
- Skin Grafts
- Fractures
- Paralysis
- Surgical Procedures
- Eye Injuries
- Lacerations
- Fractures
- Skin Grafts
- Surgical Procedures
- Comas
- Brain Concussions

If a covered person receives treatment for injuries sustained in a covered accident, we will pay the following benefit for the treatment listed:

1. Dislocations (reduced under general anesthesia): Must be diagnosed by a physician within 72 hours after the date of the injury and require correction by a physician. We will pay for no more than two dislocations per covered accident, per covered person. Benefits are payable for only the first dislocation of a joint. If a dislocation is reduced with local anesthesia or no anesthesia by a physician, we will pay 25 percent of the amount shown for the closed reduction dislocation.

<table>
<thead>
<tr>
<th>Open Reduction</th>
<th>Closed Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Hip</td>
<td>$2,500</td>
</tr>
<tr>
<td>b. Knee or shoulder</td>
<td>625</td>
</tr>
<tr>
<td>c. Collar bone</td>
<td>1,000</td>
</tr>
<tr>
<td>d. Ankle or foot (excluding toes)</td>
<td>625</td>
</tr>
<tr>
<td>e. Lower jaw</td>
<td>625</td>
</tr>
<tr>
<td>f. Wrist or elbow</td>
<td>500</td>
</tr>
<tr>
<td>g. Toe or finger</td>
<td>125</td>
</tr>
</tbody>
</table>

2. Burns (treated by a physician within 72 hours after a covered accident), based on size of the body surface burned:

<table>
<thead>
<tr>
<th>2nd Degree</th>
<th>3rd Degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Less than 20 square centimeters</td>
<td>$125</td>
</tr>
<tr>
<td>b. More than 20 but less than 40 square centimeters</td>
<td>250</td>
</tr>
<tr>
<td>c. More than 40 but less than 65 square centimeters</td>
<td>500</td>
</tr>
<tr>
<td>d. More than 65 but less than 160 square centimeters</td>
<td>750</td>
</tr>
<tr>
<td>e. More than 160 but less than 225 square centimeters</td>
<td>1,000</td>
</tr>
<tr>
<td>f. More than 225 square centimeters</td>
<td>1,250</td>
</tr>
</tbody>
</table>

3. Skin Grafts: If a covered person receives one or more skin grafts for a covered burn, we will pay a total of 50 percent of the Burn Benefit amount we paid for the burn involved.

4. Eye Injuries:
   - Surgical repair: $300
   - Removal of foreign body by a physician: 65

5. Lacerations (must be repaired within 72 hours after the accident and repaired under the attendance of a physician):

<table>
<thead>
<tr>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Laceration(s) not requiring sutures and treated by a physician (total of all lacerations)</td>
</tr>
<tr>
<td>b. Lacerations less than 5 centimeters (total of all lacerations)</td>
</tr>
<tr>
<td>c. Lacerations at least 5 centimeters but not more than 15 centimeters (total of all lacerations)</td>
</tr>
<tr>
<td>d. Lacerations over 15 centimeters (total of all lacerations)</td>
</tr>
</tbody>
</table>
6. **Fractures:** Must be diagnosed by a physician within 14 days after the date of the injury and require correction by a physician. We will pay for no more than two fractures per covered accident, per covered person. For the closed reduction of chip fractures and other fractures not reduced by open or closed reduction, we will pay 25 percent of the benefit amount shown.

<table>
<thead>
<tr>
<th>Open Reduction</th>
<th>Closed Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Hip</td>
<td>$2,500</td>
</tr>
<tr>
<td>b. Leg</td>
<td>1,250</td>
</tr>
<tr>
<td>c. Hand (excluding fingers)</td>
<td>625</td>
</tr>
<tr>
<td>d. Foot (excluding toes/heel)</td>
<td>625</td>
</tr>
<tr>
<td>e. Wrist, elbow, ankle, or kneecap</td>
<td>625</td>
</tr>
<tr>
<td>f. Shoulder blade or forearm</td>
<td>625</td>
</tr>
<tr>
<td>g. Lower jaw</td>
<td>625</td>
</tr>
<tr>
<td>h. Vertebrae (body of), pelvis (excluding coccyx), or sternum</td>
<td>1,250</td>
</tr>
<tr>
<td>i. Upper jaw, upper arm, or face (excluding nose)</td>
<td>750</td>
</tr>
<tr>
<td>j. Rib</td>
<td>1,250</td>
</tr>
<tr>
<td>k. Nose, heel, or finger</td>
<td>625</td>
</tr>
<tr>
<td>l. Cockey</td>
<td>250</td>
</tr>
<tr>
<td>m. Toe</td>
<td>250</td>
</tr>
<tr>
<td>n. Vertebral processes</td>
<td>1,250</td>
</tr>
<tr>
<td>o. Skull (depressed $1,875; simple $625)</td>
<td></td>
</tr>
</tbody>
</table>

7. **Concussion (brain):** Benefit $50

8. **Emergency dental work:** We will pay for no more than one emergency dental work benefit per covered accident, per covered person. Emergency dental work does not include false teeth such as dentures, bridges, veneers, partials, crowns, or implants.

<table>
<thead>
<tr>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Broken teeth repaired with crowns</td>
</tr>
<tr>
<td>b. Broken teeth resulting in extractions</td>
</tr>
</tbody>
</table>

9. **Coma (duration of at least 7 days):** The condition must require intubation for respiratory assistance. The term coma does not include any medically induced coma. Benefit $12,500

10. **Paralysis (duration minimum of 30 days):** This benefit will be payable once per covered person and must be confirmed by your attending physician. Benefit $12,500

<table>
<thead>
<tr>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Quadruplegia (paralysis of four limbs)</td>
</tr>
<tr>
<td>b. Paraplegia (paralysis of lower limbs)</td>
</tr>
<tr>
<td>c. Hemiplegia (paralysis of one side of the body)</td>
</tr>
</tbody>
</table>

11. **Surgical Procedures:** Treatment must be performed within one year of a covered accident. Two or more surgical procedures performed through the same incision will be considered one operation, and benefits will be paid based on the most expensive procedure.

<table>
<thead>
<tr>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Repair of:</td>
</tr>
<tr>
<td>* Tendons and/or ligaments</td>
</tr>
<tr>
<td>* Torn rotator cuffs</td>
</tr>
<tr>
<td>* Ruptured discs</td>
</tr>
<tr>
<td>* Torn knee cartilages</td>
</tr>
<tr>
<td>b. Arthroscopy without surgical repair</td>
</tr>
<tr>
<td>c. Open abdominal (including exploratory laparotomy)</td>
</tr>
<tr>
<td>d. Cranial</td>
</tr>
<tr>
<td>e. Hernia</td>
</tr>
<tr>
<td>f. Thoracic surgery</td>
</tr>
</tbody>
</table>

12. **Miscellaneous Surgical Procedures:** Miscellaneous surgery that is not covered by any other specific-sum injury benefit. Only one miscellaneous surgery benefit is payable per 24-hour period even though more than one surgical procedure may be performed.

<table>
<thead>
<tr>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Miscellaneous surgery with general anesthesia</td>
</tr>
<tr>
<td>b. Other miscellaneous surgery with conscious sedation</td>
</tr>
</tbody>
</table>

Refer to the policy and the accompanying brochure for complete details, limitations, and exclusions.

American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters • Columbus, Georgia 31999
AFLAC CANCER CARE
CANCER INDEMNITY INSURANCE
CLASSIC
We’ve been dedicated to helping provide peace of mind and financial security for nearly 60 years.
Added Protection for You and Your Family

Chances are you know someone who’s been affected, directly or indirectly, by cancer. You also know the toll it’s taken on them—physically, emotionally, and financially. That’s why we’ve developed the Aflac Cancer Care insurance policy. The plan pays a cash benefit upon initial diagnosis of a covered cancer, with a variety of other benefits payable throughout cancer treatment. You can use these cash benefits to help pay out-of-pocket medical expenses, the rent or mortgage, groceries, or utility bills—the choice is yours.

And while you can’t always predict the future, here at Aflac we believe it’s good to be prepared. The Aflac Cancer Care plan is here to help you and your family better cope financially—and emotionally—if a positive diagnosis of cancer ever occurs. That way you can worry less about what may be ahead.

HOW IT WORKS

The above example is based on a scenario for Aflac Cancer Care – Classic that includes the following benefit conditions: Physician visit (Cancer Wellness Benefit) of $75, bone marrow biopsy (Surgical/Anesthesia Benefit) of $125, NCI Evaluation/Consultation Benefit of $500, Initial Diagnosis Benefit of $4,000, venous port (Surgical/Anesthesia Benefit) of $125, Injected Chemotherapy Benefit (10 weeks) of $6,000, Immunotherapy Benefit (3 months) of $1,050, Antinausea Benefit (3 months) of $300, Hospital Confinement Benefit (10-week hospitalization) of $22,000, Blood/Plasma Benefit (10 transfusions) of $1,000.

THE FACTS SAY YOU NEED THE PROTECTION OF AFLAC’S CANCER CARE PLAN:

FACT NO. 01

IN THE UNITED STATES, MEN HAVE SLIGHTLY LESS THAN A

1-in-2

LIFETIME RISK OF DEVELOPING CANCER.¹

FACT NO. 02

IN THE UNITED STATES, WOMEN HAVE SLIGHTLY MORE THAN A

1-in-3

LIFETIME RISK OF DEVELOPING CANCER.¹

¹Cancer Facts & Figures 2012, American Cancer Society.

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 herein means American Family Life Assurance Company of Columbus.
# Classic Cancer Care Benefit Overview

<table>
<thead>
<tr>
<th>BENEFIT NAME</th>
<th>BENEFIT AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancer Wellness Benefit</strong></td>
<td>$75 per year, per Covered Person</td>
</tr>
</tbody>
</table>

| **Cancer Diagnosis Benefits:**                   |                                                                                                                                                   |
| Initial Diagnosis Benefit                        | Insured/Spouse: $4,000; Dependent Child: $8,000; payable once per Covered Person                                                                 |
| Medical Imaging With Diagnosis Benefit           | $135; two payments per year, per Covered Person; no lifetime max                                                                            |
| NCI Evaluation/Consultation Benefit              | $500 payable only once per Covered Person                                                                                                       |

| **Cancer Treatment Benefits:**                   |                                                                                                                                                   |
| Injected Chemotherapy Benefit                     | $600 per week; no lifetime max                                                                                                                  |
| Nonhormonal Oral Chemotherapy Benefit            | $250 per prescription, per month up to $750 max per month for Oral/Topical Benefit**                                                            |
| Hormonal Oral Chemotherapy Benefit               | $250 per prescription, per month up to 24 months; after 24 months $75 per month up to $750 max per month for Oral/Topical Benefit**            |
| Topical Chemotherapy Benefit                      | $150 per prescription, per month up to $750 max per month for Oral/Topical Benefit**                                                            |
| Radiation Therapy Benefit                         | $350 per week; no lifetime max                                                                                                                  |
| Experimental Treatment Benefit                    | $350 per week if charged; $100 per week if no charge; no lifetime max                                                                            |
| Immunotherapy Benefit                             | $350 once per month; $1,750 lifetime max per Covered Person                                                                                     |
| Antinausea Benefit                                | $100 per month; no lifetime max                                                                                                                  |
| Stem Cell Transplantation Benefit                 | $7,000; lifetime max $7,000 per Covered Person                                                                                                   |
| Bone Marrow Transplantation Benefit              | $7,000; $7,000 lifetime max per Covered Person; $750 to donor                                                                                   |
| Blood and Plasma Benefit                          | Inpatient: $100 times the number of days paid under the Hospital Confinement Benefit; Outpatient: $175 per day; no lifetime max               |
| Surgical/Anesthesia Benefit                       | $100–$3,400 (Anesthesia: additional 25% of Surgical Benefit); maximum daily benefit not to exceed $4,250; no lifetime max on number of operations |
| Skin Cancer Surgery Benefit                       | $35–$400; no lifetime max on number of operations                                                                                                 |
| Additional Surgical Opinion Benefit               | $200 per day; no lifetime max                                                                                                                  |

| **Hospitalization Benefits:**                     |                                                                                                                                                   |
| Hospital Confinement Benefit                       |                                                                                                                                                   |
| • Hospitalization for 30 days or less             | Insured/Spouse: $200 per day; Dependent Child: $250 per day; no lifetime max                                                                   |
| • Hospitalization for Days 31+                    | Insured/Spouse: $400 per day; Dependent Child: $500 per day; no lifetime max                                                                   |
| Outpatient Hospital Surgical Room Charge Benefit   | $200 (payable in addition to Surgical/Anesthesia Benefit); no lifetime max on number of operations                                              |

| **Continuing Care Benefits:**                     |                                                                                                                                                   |
| Extended-Care Facility Benefit                     | $100 a day, limited to 30 days per year, per Covered Person                                                                                      |
| Home Health Care Benefit                           | $100 per day; limited to 30 days per year, per Covered Person                                                                                   |
| Hospice Care Benefit                               | $1,000 for the 1st day; $50 per day thereafter; $12,000 lifetime max per Covered Person                                                        |
| Nursing Services Benefit                           | $100 per day; no lifetime max                                                                                                                   |
| Surgical Prosthesis Benefit                        | $2,000; lifetime max $4,000 per Covered Person                                                                                                   |
| Nonsurgical Prosthesis Benefit                     | $175 per occurrence; lifetime max $350 per Covered Person                                                                                      |
| Reconstructive Surgery Benefit                     | $220–$2,000 (Anesthesia: 25% of Reconstructive Surgery Benefit); no lifetime max on number of operations                                           |
| Egg Harvesting and Storage (Cryopreservation) Benefit | $1,000 to have oocytes extracted; $350 for storage; $1,350 lifetime max per Covered Person                                                 |

| **Ambulance, Transportation, Lodging, and Other Benefits:** |                                                                                                                                                   |
| Ambulance Benefit                                    | $250 ground or $2,000 air; no lifetime max                                                                                                       |
| Transportation Benefit                               | $.40 per mile; max $1,200 per round trip; no lifetime max                                                                                       |
| Lodging Benefit                                      | $65 per day; limited to 90 days per year                                                                                                         |
| Bone Marrow Donor Screening Benefit                  | $40; limited to one benefit per Covered Person, per lifetime                                                                                     |

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Up to three different oral/topical chemotherapy medicines per calendar month.

REFER TO THE FOLLOWING PAGES FOR BENEFIT DETAILS, DEFINITIONS, LIMITATIONS, AND EXCLUSIONS.
American Family Life Assurance Company of Columbus
( herein referred to as Aflac)

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

LIMITED BENEFIT

CANCER/SPECIFIED-
DISEASE INSURANCE

POLICY SERIES A78300

Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999
Toll-Free 1.800.99.AFLAC (1.800.992.3522)
1. **Read Your Policy Carefully:** This document 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. **Cancer Insurance Coverage** is designed to supplement your 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 provided for the benefits outlined in Part (3). The benefits described in Part (3) may be limited by Part (5).

3. All treatments listed below must be NCI or Food and Drug Administration approved for the treatment of Cancer or an Associated Cancerous Condition, as applicable.

### A. Cancer Wellness Benefits:

1. **Cancer Wellness:** Aflac will pay $75 per Calendar Year when a Covered Person receives one of the following:
   - mammogram
   - breast ultrasound
   - breast MRI
   - CA15-3 (blood test for breast Cancer tumor)
   - Pap smear
   - ThinPrep
   - biopsy
   - flexible sigmoidoscopy
   - hemoccult stool specimen (lab confirmed)
   - chest X-ray
   - CEA (blood test for colon Cancer)
   - CA 125 (blood test for ovarian Cancer)
   - PSA (blood test for prostate Cancer)
   - testicular ultrasound
   - thermography
   - colonoscopy
   - virtual colonoscopy

   This benefit is limited to one payment per Calendar Year, per Covered Person. These tests must be performed to determine whether Cancer or an Associated Cancerous Condition exists in a Covered Person and must be administered by licensed medical personnel. No lifetime maximum.

2. **Bone Marrow Donor Screening:** Aflac will pay $40 when a Covered Person provides documentation of participation in a screening test as a potential bone marrow donor. This benefit is limited to one benefit per Covered Person per lifetime.

### B. Cancer Diagnosis Benefits:

1. **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 Part 2, Limitations and Exclusions, Section C, of the policy.

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Named Insured or Spouse</td>
<td>$4,000</td>
</tr>
<tr>
<td>Dependent Child</td>
<td>$8,000</td>
</tr>
</tbody>
</table>

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

2. **Medical Imaging with Diagnosis Benefit:** Aflac will pay $135 when a charge is incurred for a Covered Person who receives an initial diagnosis or follow-up evaluation of Internal Cancer or an Associated Cancerous Condition, using one of the following medical imaging exams: CT scans, MRIs, bone scans, thyroid scans, multiple gated acquisition (MUGA) scans, positron emission tomography (PET) scans, transrectal ultrasounds, or abdominal ultrasounds. This benefit is limited to two payments per Calendar Year, per Covered Person. No lifetime maximum.

3. **National Cancer Institute Evaluation/Consultation Benefit:** Aflac will pay $500 when a Covered Person seeks evaluation or consultation at an NCI-Designated Cancer Center as a result of receiving a diagnosis of Internal Cancer or an Associated Cancerous Condition. The purpose of the evaluation/consultation must be to determine the appropriate course of treatment. This benefit is not payable the same day the Additional Surgical Opinion Benefit is payable. This benefit is also payable at the Aflac Cancer Center & Blood Disorders Service of Children’s Healthcare of Atlanta. This benefit is payable only once per Covered Person.

### C. Cancer Treatment Benefits:

1. **Direct Nonsurgical Treatment Benefits:** All benefits listed below are not payable based on the number, duration, or frequency of the medication(s), therapy, or treatment received by the Covered Person (except as provided in Benefit C1b). Benefits will not be paid under the Experimental Treatment Benefit or Immunotherapy Benefit for any medications or treatment paid under the Injected Chemotherapy Benefit, the Oral/Topical Chemotherapy Benefits, or the Radiation Therapy Benefit.

   a. **Injected Chemotherapy Benefit:** Aflac will pay $600 once per Calendar Week during which a Covered Person receives and incurs a charge for Physician-prescribed Injected Chemotherapy. The Surgical/Anesthesia Benefit provides amounts payable for insertion and removal of a pump. Benefits will not be paid for each week of continuous infusion of medications dispensed by a pump, implant, or patch. This benefit is limited to the Calendar Week in which the charge for the medication(s) or treatment is incurred. No lifetime maximum.

   b. **Oral/Topical Chemotherapy Benefits:**

      (1) **Nonhormonal Oral Chemotherapy Benefit:** Aflac will pay $250 per Calendar Month during which a Covered Person is prescribed, receives, and incurs a charge for Nonhormonal Oral Chemotherapy for the treatment of Cancer or an Associated Cancerous Condition.
(2) HORMONAL ORAL CHEMOTHERAPY BENEFIT: Aflac will pay $250 per Calendar Month for up to 24 months during which a Covered Person is prescribed, receives, and incurs a charge for Hormonal Oral Chemotherapy for the treatment of Cancer or an Associated Cancerous Condition. After 24 months of paid benefits of Hormonal Oral Chemotherapy for a Covered Person, Aflac will pay $75 per Calendar Month during which a Covered Person is prescribed, receives, and incurs a charge for Hormonal Oral Chemotherapy for the treatment of Cancer or an Associated Cancerous Condition. Examples of Hormonal Oral Chemotherapy treatments include but are not limited to Nolvadex, Arimidex, Femara, and Lupron and their generic versions, such as tamoxifen.

(3) TOPICAL CHEMOTHERAPY BENEFIT: Aflac will pay $150 per Calendar Month during 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.

Oral/Topical Chemotherapy benefits are limited to the Calendar Month in which the charge for the medication(s) or treatment is incurred. If the prescription is for more than one month, the benefit is limited to the Calendar Month in which the charge is incurred. Total benefits are payable for up to three different Oral/Topical Chemotherapy medicines per Calendar Month, up to a maximum of $750 per Calendar Month. Refills of the same prescription within the same Calendar Month are not considered a different Chemotherapy medicine. No lifetime maximum.

c. RADIATION THERAPY BENEFIT: Aflac will pay $350 once per Calendar Week during which a Covered Person receives and incurs a charge for Radiation Therapy for the treatment of Cancer or an Associated Cancerous Condition. This benefit will not be paid for each week a radium implant or radioisotope remains in the body. This benefit is limited to the Calendar Week in which the charge for the therapy is incurred. No lifetime maximum.

d. EXPERIMENTAL TREATMENT BENEFIT: Aflac will pay $350 once per Calendar Week during which a Covered Person receives and incurs a charge for Physician-prescribed experimental Cancer chemotherapy medications. Aflac will pay $100 once per Calendar Week during which a Covered Person receives Physician-prescribed experimental Cancer chemotherapy medications as part of a clinical trial that does not charge patients for such medications. Chemotherapy medications must be approved by the NCI as a viable experimental treatment for Cancer. This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, Immunotherapy, colony-stimulating factors, and therapeutic devices or other procedures related to these experimental treatments. Benefits will not be paid for each week of continuous infusion of medications dispensed by a pump, implant, or patch. This benefit is limited to the Calendar Week in which the charge for the chemotherapy medications is incurred. No lifetime maximum.

Benefits will not be paid under the Experimental Treatment Benefit for any medications paid under the Immunotherapy Benefit.

2. INDIRECT/ADDITIONAL THERAPY BENEFITS: The following benefits are not payable based on the number, duration, or frequency of Immunotherapy or antinausea drugs received by the Covered Person.

a. IMMUNOTHERAPY BENEFIT: Aflac will pay $350 per Calendar Month during which a Covered Person receives and incurs a charge for Physician-prescribed Immunotherapy as part of a treatment regimen for Internal Cancer or an Associated Cancerous Condition. This benefit is payable only once per Calendar Month. It is limited to the Calendar Month in which the charge for Immunotherapy is incurred. Lifetime maximum of $1,750 per Covered Person.

Benefits will not be paid under the Immunotherapy Benefit for any medications paid under the Experimental Treatment Benefit.

b. ANTINAUSEA BENEFIT: Aflac will pay $100 per Calendar Month during which a Covered Person receives and incurs a charge for antinausea drugs that are prescribed in conjunction with Radiation Therapy Benefits, Injected Chemotherapy Benefits, Oral/Topical Chemotherapy Benefits, or Experimental Treatment Benefits. This benefit is payable only once per Calendar Month and is limited to the Calendar Month in which the charge for antinausea drugs is incurred. No lifetime maximum.

c. STEM CELL TRANSPLANTATION BENEFIT: Aflac will pay $7,000 when a Covered Person receives and incurs a charge for a peripheral Stem Cell Transplantation for the treatment of Internal Cancer or an Associated Cancerous Condition. This benefit is payable once per Covered Person. Lifetime maximum of $7,000 per Covered Person.

d. BONE MARROW TRANSPLANTATION BENEFIT: (1) Aflac will pay $7,000 when a Covered Person receives and incurs a charge for a Bone Marrow Transplantation for the treatment of Internal Cancer or an Associated Cancerous Condition. (2) Aflac will pay the Covered Person’s bone marrow donor an indemnity of $750 for his or her expenses incurred as a result of the transplantation procedure. Lifetime maximum of $7,000 per Covered Person.

e. BLOOD AND PLASMA BENEFIT: Aflac will pay $100 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 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, anthemophilia factors, or colony-stimulating factors. No lifetime maximum.

3. SURGICAL TREATMENT BENEFITS:

a. SURGICAL/ANESTHESIA BENEFIT: When a surgical operation is performed on a Covered Person for a diagnosed Internal Cancer or Associated Cancerous Condition, Aflac will pay the indemnity listed in the Schedule of Operations for the specific procedure when a charge is incurred. If any operation 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 operation most nearly similar in severity and gravity.

EXCEPTIONS: Surgery for Skin Cancer will be payable under Benefit C3b. Reconstructive Surgery will be payable under Benefit E7.

Two or more surgical procedures performed through the same incision will be considered one operation, and benefits will be paid based upon the highest eligible benefit.

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.

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

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laser or Cryosurgery</td>
<td>$35</td>
</tr>
<tr>
<td>Surgeries OTHER THAN Laser or Cryosurgery:</td>
<td></td>
</tr>
<tr>
<td>Biopsy</td>
<td>$70</td>
</tr>
<tr>
<td>Excision of lesion of skin without flap or graft</td>
<td>$170</td>
</tr>
<tr>
<td>Flap or graft without excision</td>
<td>$250</td>
</tr>
<tr>
<td>Excision of lesion of skin with flap or graft</td>
<td>$400</td>
</tr>
</tbody>
</table>

c. ADDITIONAL SURGICAL OPINION BENEFIT: Aflac will pay $200 per day when a charge is incurred for an additional surgical opinion, by a Physician, concerning surgery for a diagnosed Cancer or an Associated Cancerous Condition. This benefit is not payable on the same day the NCI Evaluation/Consultation Benefit is payable. No lifetime maximum.

D. HOSPITALIZATION BENEFITS:

1. HOSPITAL CONFINEMENT BENEFITS:

a. 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 per day for each day a Covered Person is charged for a room as an inpatient. No lifetime maximum.

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Named Insured or Spouse</td>
<td>$200</td>
</tr>
<tr>
<td>Dependent Child</td>
<td>$250</td>
</tr>
</tbody>
</table>

b. 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 in Benefit D1a above for the first 30 days. Beginning with the 31st day of such continuous Hospital confinement, Aflac will pay the amount listed below per day for each day a Covered Person is charged for a room as an inpatient. No lifetime maximum.

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Named Insured or Spouse</td>
<td>$400</td>
</tr>
<tr>
<td>Dependent Child</td>
<td>$500</td>
</tr>
</tbody>
</table>

2. 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 Surgical/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 any surgery performed in a Physician’s office.

E. CONTINUING CARE BENEFITS:

1. 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.

2. 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:
   a. The home health care or health supportive services must begin within seven days of release from the Hospital.
   b. This benefit is limited to ten days per hospitalization for each Covered Person.
   c. This benefit is limited to 30 days in any Calendar Year for each Covered Person.
   d. 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 these services were not available, the Covered Person would have to be hospitalized to receive the necessary care, treatment, and services.
   e. 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.

3. 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. This benefit is not payable the same day the Home Health Care Benefit is payable. Lifetime maximum for each Covered Person is $12,000.

4. 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.

5. 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 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.

6. 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.

7. RECONSTRUCTIVE SURGERY BENEFIT: Aflac will pay the specified indemnity 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 treatment of an Associated Cancerous Condition. The maximum daily benefit will not exceed $2,000. No lifetime maximum on number of operations.

<table>
<thead>
<tr>
<th>Description</th>
<th>Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Tissue/Muscle Reconstruction Flap Procedures</td>
<td>$2,000</td>
</tr>
<tr>
<td>Breast Reconstruction (occurring within five years of breast cancer diagnosis)</td>
<td>500</td>
</tr>
<tr>
<td>Breast Symmetry (on the nondiseased breast occurring within five years of breast reconstruction)</td>
<td>220</td>
</tr>
<tr>
<td>Facial Reconstruction</td>
<td>500</td>
</tr>
</tbody>
</table>

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.
8. EGG HARVESTING AND STORAGE (CRYOPRESERVATION)

**Benefit:** Aflac will pay $1,000 for a Covered Person to have oocytes extracted and harvested. In addition, Aflac will pay, one time per Covered Person, $350 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. Lifetime maximum of $1,350 per Covered Person.

F. AMBULANCE, TRANSPORTATION, AND LODGING BENEFITS:

1. **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 of 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.

2. **Transportation Benefit:** Aflac will pay 40 cents per mile for transportation, up to a combined maximum of $1,200, if a Covered Person requires treatment that has been prescribed by the attending Physician for Cancer or an Associated Cancerous Condition. This benefit includes:

   a. 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.

   b. 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 $1,200 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.**

3. **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.

G. PREMIUM WAIVER AND RELATED BENEFITS:

1. **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 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.

2. **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:

   a. Your policy has been in force for at least six months;

   b. We have received premiums for at least six consecutive months;

   c. Your premiums have been paid through payroll deduction, and you leave your employer for any reason;

   d. You or your employer notifies us in writing within 30 days of the date your premium payments ceased because of your leaving employment; and

   e. 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:

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

b. 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 A78000)
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. All amounts cited in the rider are for one unit of coverage. If more than one unit has been purchased, the amounts listed must be multiplied by the number of units in force. The number of units you purchased is shown in both the Policy Schedule and the attached application.

The INITIAL DIAGNOSIS BENEFIT, as shown in the policy, will be increased by $100 for each unit purchased 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 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 the rider, 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 the Initial Diagnosis Building Benefit Rider:

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

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 the rider and the subsequent recurrence, extension, or metastatic spread of that same 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 78000)
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 the Dependent Child Rider:

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

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 A78000)
Applied for:  □ Yes  □ No

The rider is issued on the basis that the information shown on the application is correct and complete. If answers on your application for the rider are incorrect or incomplete, then the rider may be voided or claims may be denied. If voided, any premiums for the rider, less any claims paid, will be refunded to you.

SPECIFIED-DISEASE INITIAL BENEFIT: While coverage is in force, if a Covered Person is first diagnosed, after the Effective Date of the rider, with any of the covered Specified Diseases, Aflac will pay a benefit of $1,000. This benefit is payable only once per covered
NO OTHER BENEFITS ARE PAYABLE FOR ANY COVERED SPECIFIED DISEASE NOT PROVIDED FOR IN THE RIDER.

A. HOSPITAL CONFINEMENT BENEFITS:

1. HOSPITALIZATION FOR 30 DAYS OR LESS: When a Covered Person is confined to a Hospital for 30 days or less, for a covered Specified Disease, Aflac will pay $200 per day.

2. 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 in Section A1 above for the first 30 days, and beginning with the 31st day of such continuous Hospital confinement, Aflac will pay $500 per day.

“Specified Disease,” as used under this benefit, means one or more of the diseases listed below. These diseases must be first diagnosed by a Physician 30 days following the Effective Date of 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 any of these diseases are diagnosed prior to the rider’s being in effect for 30 days, benefits for that disease(s) will be paid only for loss incurred after the rider has been in force two years.

- adrenal hypofunction (Addison’s disease)
- amyotrophic lateral sclerosis (ALS or Lou Gehrig’s disease)
- botulism
- bubonic plague
- cerebral palsy
- cholera
- cystic fibrosis
- diphtheria
- encephalitis (including encephalitis contracted from West Nile virus)
- Huntington’s chorea
- Lyme disease
- malaria
- meningitis (bacterial)
- multiple sclerosis
- muscular dystrophy
- myasthenia gravis
- necrotizing fasciitis
- osteomyelitis
- polio
- rabies
- Reye’s syndrome
- scleroderma
- sickle cell anemia
- systemic lupus
- tetanus
- toxic shock syndrome
- tuberculosis
- tularemia
- typhoid fever
- variant Creutzfeldt-Jakob disease (mad cow disease)
- yellow fever

RETURN OF PREMIUM BENEFIT: (Series A78000)

Applied for:  □ Yes  □ No

Aflac will pay you a cash value based upon the annualized premium paid for the rider, the policy, and any other attached benefit riders (premium paid for the policy and other attached benefit riders will be calculated at the original premium in effect on the rider Effective Date and will not include premium increases that may occur for the policy or other such riders). All Return of Premium Benefits/cash values paid will be less any claims paid. If you surrender the rider for its cash value after Cancer or an Associated Cancerous Condition is diagnosed but before claims are submitted, we will reduce subsequent claim payment(s) by the amount of the cash value paid. Both the policy and the rider must remain in force for 20 consecutive years for you to obtain a maximum refund of premiums paid. If the rider is added to the policy after the policy has been issued, only the premium paid for the policy after the Effective Date of the rider will be returned. When the rider is issued after the Effective Date of the policy, the 20-year period begins for both the policy and the rider on the rider Effective Date.

The cash value for premium paid for the policy and rider begins on the fifth rider anniversary date.

Your cash value is based upon annualized premium of $_____. If you surrender the rider after its fifth anniversary and such surrender occurs between rider anniversaries, a prorated amount for the partial year will be paid. The proration will be calculated by taking the cash value difference between the last and next anniversary dates, dividing by 12, and multiplying by the number of months that premiums were earned in the partial year at the time of surrender. This proration will then be added to the cash value on the last rider anniversary date, and this will be the cash value paid.

IMPORTANT! READ CAREFULLY: The rider will terminate on the earlier of: its 20th anniversary date and payment of the cash value; your surrender of it for its cash value between the fifth and 20th anniversary dates; your death prior to its 20th anniversary date, in which case the cash value (if any) will be paid to your estate; your failure to pay the premium for the rider, in which case any cash values due will be paid; the policy’s termination, in which case any cash values due will be paid; or the time that claims paid equal or exceed the cash value that would be paid on the 20th policy anniversary. When the rider terminates (is no longer in force), no further premium will be charged for it.
5. Exceptions, Reductions, and Limitations of the Policy (This is not a daily hospital expense plan):

A. We pay only for treatment of Cancer and 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.

B. 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 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.

C. 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.

D. 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.

E. Aflac will not pay benefits whenever fraud is committed in making a claim under this coverage or any prior claim under any other Aflac coverage for which you received benefits that were not lawfully due and that fraudulently induced payment.

6. Renewability: The policy is guaranteed-renewable for life by payment of the premium in effect at the beginning of each renewal period. Premium rates may change only if changed on all policies of the same form number and class in force in your state.

The policy has limitations that may affect benefits payable.

This brochure is for illustration purposes only.

Refer to the policy and riders for complete definitions, details, limitations, and exclusions.
**TERMS YOU NEED TO KNOW**

**ACTIVITIES OF DAILY LIVING (ADLs):**

**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:** These conditions are not considered Associated Cancerous Conditions and must receive a Positive Medical Diagnosis.

**COVERED PERSON:** Any person insured under the coverage type you applied for: 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. Newborn children are automatically insured from the moment of birth. If coverage is for individual or named insured/Spouse only and you desire uninterrupted coverage for a newborn child, you must notify Aflac in writing within 31 days of the birth of your child, and Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due. Coverage will 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 (including children placed for adoption) who are under age 26.

**EFFECTIVE DATE:** The date coverage begins, as shown in the Policy Schedule. The Effective Date is not the date you signed the application for coverage.

**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.

**ADDITIONAL INFORMATION**

An Ambulatory Surgical Center does not include a doctor’s or dentist’s office, clinic, or other such location.

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 Bone Marrow Transplantation does not include Stem Cell Transplantations.

A Stem Cell Transplantation does not include Bone Marrow Transplantations.

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, the benefits listed in the policy will not require a charge for them to be payable.
We’ve got you under our wing.®

aflac.com  1.800.99.AFLAC (1.800.992.3522)

Underwritten by:
American Family Life Assurance Company of Columbus
Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999
Aflac
Critical Care and Recovery
SPECIFIED HEALTH EVENT INSURANCE – PLAN 2

We’ve been dedicated to helping provide peace of mind and financial security for nearly 60 years.
Added Protection for You and Your Family

Like many people, you probably have insurance to cover burglaries, fires, auto accidents, and standard hospital bills. But what would happen to your family’s finances if you experienced a catastrophic event, such as a heart attack or stroke—an event that knocked you off your feet or even changed your life forever?

You may think you’re already protected by major medical insurance. Think again. Major medical coverage pays doctor and hospital bills, not out-of-pocket expenses. Nor does it pay cash benefits that can be used to help with expenses, such as car payments, the mortgage or rent, and utility bills—bills that would be difficult, if not impossible to pay if your income suddenly stopped due to illness or injury. Aflac’s specified health event insurance policy complements your major medical coverage and helps provide the peace of mind that comes from knowing you and your family are protected.

THE FACTS SAY YOU NEED THE PROTECTION OF THE AFLAC CRITICAL CARE AND RECOVERY PLAN:

<table>
<thead>
<tr>
<th>FACT NO. 1</th>
<th>FACT NO. 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABOUT EVERY 34 SECONDS</td>
<td>ABOUT EVERY 40 SECONDS</td>
</tr>
<tr>
<td>SOMEONE SUFFERS A HEART ATTACK.¹</td>
<td>SOMEONE SUFFERS A STROKE.¹</td>
</tr>
</tbody>
</table>

¹Heart Disease and Stroke Statistics, 2012 Update, American Heart Association.
An illness or injury can happen to anyone, anytime—and when it does, everyday expenses may suddenly seem insurmountable. Fortunately, Aflac’s specified health event insurance policy can help with those everyday expenses, so all you have to focus on is getting well.

The Critical Care and Recovery insurance policy:

• Pays a lump-sum benefit upon diagnosis of having had a primary specified health event, which increases for dependent children.
• Pays benefits for hospital confinement, continuing care, transportation, and lodging.
• Is guaranteed-renewable for your lifetime with some benefits reduced at age 70.
• Has no deductibles, copayments, or network restrictions—you choose your own medical treatment provider.

Primary specified health events covered by the Critical Care and Recovery policy include:

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

The above example is based on a scenario for Aflac Critical Care and Recovery – Plan 2 that includes the following benefit conditions: Stroke (First-Occurrence Benefit) of $5,000, Hospital Intensive Care Unit Benefit (3 days) of $2,100, Hospital Confinement Benefit (5 days) of $1,500, Continuing Care Benefit (30 days) of $3,750, ground ambulance transportation (Ambulance Benefit) of $250.

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.
# Plan 2 Critical Care and Recovery Benefit Overview

## First-Occurrence Benefit:
- **Named Insured/Spouse**
- **Dependent Children**

<table>
<thead>
<tr>
<th>Benefit Name</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$5,000; lifetime max $5,000 per covered person</td>
</tr>
<tr>
<td></td>
<td>$7,500; lifetime max $7,500 per covered person</td>
</tr>
</tbody>
</table>

## Readmission Benefit
- $2,500; no lifetime max

## Secondary Specified Health Event Benefit
- $250; no lifetime max

## Hospital Confinement Benefit
- $300 per day; no lifetime max

## Hospital Intensive Care Unit Benefit:
- **Confinement in a Hospital Intensive Care Unit**

<table>
<thead>
<tr>
<th>Sickness/Injury</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days 1-7:</td>
<td>$700 per day</td>
</tr>
<tr>
<td>Days 8-15:</td>
<td>$1,200 per day</td>
</tr>
<tr>
<td>Days 16-30:</td>
<td>$350 per day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Infection/Injury</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days 1-7:</td>
<td>$800 per day</td>
</tr>
<tr>
<td>Days 8-15:</td>
<td>$1,300 per day</td>
</tr>
<tr>
<td>Days 16-30:</td>
<td>$350 per day</td>
</tr>
</tbody>
</table>

Limited to 15 days per period of confinement; no lifetime max

- **Confinement in a Step-Down Intensive Care Unit**

<table>
<thead>
<tr>
<th>Sickness/Injury</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days 1-15:</td>
<td>$350 per day</td>
</tr>
</tbody>
</table>

Limited to 15 days per period of confinement; no lifetime max

## Major Human Organ Transplant Benefit
- $25,000; limited to one procedure per 180-day period; no lifetime max

## Progressive Benefit for Hospital Intensive Care Unit/Step-Down Intensive Care Unit Confinement
- A $2 indemnity benefit will accumulate for the named insured/spouse for each month the policy remains in force

## Continuing Care Benefit
- $125 each day for up to 75 days; no lifetime max

## Ambulance Benefit
- $250 ground or $2,000 air; no lifetime max

## Transportation Benefit
- $.50 per mile; up to $1,500 per occurrence; no lifetime max

## Lodging Benefit
- Up to $75 per day; limited to 15 days per occurrence; no lifetime max

Refer to the following pages for benefit details, definitions, limitations, and exclusions.
American Family Life Assurance Company of Columbus
(herin referred to as Aflac)

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

SPECIFIED HEALTH EVENT INSURANCE
SUPPLEMENTAL HEALTH INSURANCE COVERAGE
POLICY SERIES A71200

Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999
Toll-Free 1.800.99.AFLAC (1.800.992.3522)
1. **Read Your Policy Carefully:** This document 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. Primary Specified Health Events are: Heart Attack, Stroke, Coronary Artery Bypass Surgery, End-Stage Renal Failure, Major Human Organ Transplant, Persistent Vegetative State, Coma, Paralysis, or Sudden Cardiac Arrest occurring after the Effective Date of coverage. Secondary Specified Health Events are: Coronary Angioplasty, with or without stents, occurring after the Effective Date of coverage. Coverage is provided for the benefits outlined in Part (3). The benefits described in Part (3) may be limited by the provisions in Part (5).

Form A92398

3. **Benefits:** Subject to the Pre-existing Conditions provision, if applicable, Limitations and Exclusions, and all other policy provisions, we will pay the following benefits for a covered Specified Health Event that occurs while coverage is in force.

**IMPORTANT:** BENEFITS A, B, and J REDUCE BY ONE-HALF FOR LOSSES INCURRED ON OR AFTER THE POLICY ANNIVERSARY DATE FOLLOWING THE 70TH BIRTHDAY OF A COVERED PERSON.

Subject to Part 2, Limitations and Exclusions, and all other policy provisions, we will pay the following benefits to a covered person, as applicable:

**BENEFITS FOR HOSPITAL 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 or a Step-Down Intensive Care Unit for a covered Sickness or Injury:

1. **Confinement in a Hospital Intensive Care Unit:**

<table>
<thead>
<tr>
<th>Sickness</th>
<th>Injury</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1–7</td>
</tr>
<tr>
<td>$1,200 per day</td>
<td>$1,300 per day</td>
<td>8–15</td>
</tr>
</tbody>
</table>

**B. PROGRESSIVE BENEFIT FOR HOSPITAL INTENSIVE CARE UNIT/STEP-DOWN INTENSIVE CARE UNIT CONFINEMENT:** Two dollars indemnity will accumulate for the Named Insured and the covered spouse for each calendar month the policy remains in force after the Effective Date. This accumulated indemnity, if any, will be paid in addition to the Hospital Intensive Care Unit Benefit A1 and A2 for each day of Hospital Intensive Care Unit confinement for which benefits under A1 or A2 are payable. This Progressive Benefit will cease to build on 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 70th 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 70th 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 the policy.** 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 PRIMARY SPECIFIED HEALTH EVENTS:

Subject to the Pre-Existing Conditions provision, Limitations and Exclusions, and all other policy provisions, Benefits F through H will be paid for care received within 180 days following the occurrence of a covered Primary Specified Health Event. Benefits are payable for only one covered Primary Specified Health Event at a time per covered person. If a covered person is eligible to receive benefits for more than one covered Primary Specified Health Event, we will pay benefits only for care received within the 180 days following the occurrence of the most recent event.

C. 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 Primary Specified Health Event:

- **Named Insured/Spouse**
  - $5,000 (Lifetime maximum $5,000 per covered person)

- **Dependent Children**
  - $7,500 (Lifetime maximum $7,500 per covered person)

This benefit is payable only once for each covered person and will be paid in addition to any other benefit in the policy.

D. REOCCURRENCE BENEFIT: If benefits have been paid to a covered person under C above, Aflac will pay $2,500 (two thousand five hundred dollars) if such covered person is later diagnosed as having had a subsequent Primary Specified Health Event.

For Benefit D to be payable, the Primary Specified Health Event must occur more than 180 days after the date Benefit C or Benefit D became payable. No lifetime maximum.

E. HOSPITAL CONFINEMENT BENEFIT (includes confinement in a U.S. government Hospital):

When a covered person requires Hospital Confinement for the treatment of a covered Primary Specified Health Event, Aflac will pay $300 (three hundred dollars) 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 Primary Specified Health Event that occur within 500 days following the occurrence of the most recent covered Primary Specified Health Event. No lifetime maximum.

Hospital Confinement Benefits are payable for only one covered Primary Specified Health Event at a time per covered person. Treatment or confinement in a U.S. government Hospital does not require a charge for benefits to be payable.

F. CONTINUING CARE BENEFIT: If, as the result of a covered Primary Specified Health Event, a covered person receives any of the following treatments from a licensed Physician, Aflac will pay $125 (one hundred twenty-five dollars) each day a covered person is charged:

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

Treatment is limited to 75 days for continuing care commencing within 180 days following the occurrence of the most recent covered Primary Specified Health Event. Daily maximum for this benefit is $125 (one hundred twenty-five dollars) regardless of the number of treatments received.

G. TRANSPORTATION BENEFIT: If a covered person requires special medical treatment that has been prescribed by the local attending Physician for a covered Primary Specified Health Event, Aflac will pay 50 cents (fifty 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 $1,500 (one thousand five hundred dollars) per occurrence of a covered Primary Specified Health Event. Transportation Benefits are not payable beyond the 180th day following the occurrence of a covered Primary Specified Health Event. 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.

H. LODGING BENEFIT: Aflac will pay the charges incurred up to $75 (seventy-five dollars) per day for lodging for you or any one adult family member when a covered person receives special medical treatment for a covered Primary Specified Health Event 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 lodging occurring more than 24 hours following treatment. This benefit is limited to 15 days per occurrence of a covered Primary Specified Health Event. LODGING BENEFITS ARE NOT PAYABLE BEYOND THE 180TH DAY FOLLOWING THE OCCURRENCE OF A COVERED PRIMARY SPECIFIED HEALTH EVENT. No lifetime maximum.

BENEFIT FOR SECONDARY SPECIFIED HEALTH EVENTS:
Subject to the Pre-existing Conditions provision, Limitations and Exclusions, and all other policy provisions, we will pay the following benefits to a covered person, as applicable:

I. SECONDARY SPECIFIED HEALTH EVENT BENEFIT: Aflac will pay $250 (two hundred fifty dollars) for each covered person under the policy when he or she has a Coronary Angioplasty, with or without stents. THIS BENEFIT IS LIMITED TO ONE CORONARY ANGIOPLASTY PER 30-DAY PERIOD. No lifetime maximum.

J. MAJOR HUMAN ORGAN TRANSPLANT BENEFIT: Aflac will pay $25,000 (twenty-five thousand dollars) as a result of a Major Human Organ Transplant procedure when a covered person is confined in a Hospital and receives one or more of the following human organs: kidney, liver, heart, lung, or pancreas. Transplant procedures involving more than one major organ will be considered to be one organ transplant procedure. THIS BENEFIT IS NOT PAYABLE FOR TRANSPLANTS INVOLVING MECHANICAL OR NONHUMAN ORGANS AND IS LIMITED TO ONE PROEDURE PER 180-DAY PERIOD. No lifetime maximum.

K. AMBULANCE BENEFIT: If, due to a covered Primary Specified Health Event or confinement in a Hospital Intensive Care Unit or Step-Down Intensive Care Unit for a covered Sickness or Injury, a covered person requires ground ambulance transportation to or from a Hospital, Aflac will pay $250 (two hundred fifty dollars). If air ambulance transportation is required due to a covered Primary Specified Health Event for a covered Sickness or Injury, or confinement in a Hospital Intensive Care Unit or Step-Down Intensive Care Unit, we will pay $2,000 (two thousand dollars). A licensed professional or licensed volunteer ambulance company must provide the ambulance service. This benefit will not be paid for more than two times per occurrence of a Primary Specified Health Event or confinement in a Hospital Intensive Care Unit or Step-Down Intensive Care Unit for a covered Sickness or Injury. AMBULANCE BENEFITS ARE NOT PAYABLE BEYOND THE 180TH DAY FOLLOWING THE OCCURRENCE OF A COVERED PRIMARY SPECIFIED HEALTH EVENT. No lifetime maximum.

L. WAIVER OF PREMIUM BENEFIT:
Employed: If you, due to a Primary Specified Health Event (as defined in Part 1, Item T of the policy), are completely unable to do all of the usual and customary duties of your occupation 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 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 Primary Specified Health Event (as defined in Part 1, Item T of the policy), are completely unable to perform three or more of the 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 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 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 for two months if you meet all of the following conditions:

1. The 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;
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.

4. Optional Benefits:

FIRST-OCCURRENCE BUILDING BENEFIT RIDER: (Series A71000) Applied for: ☐ Yes ☐ No

The First-Occurrence Building Benefit as defined in the policy, will be increased by $500 (five hundred dollars) 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 Primary Specified Health Event, subject to Part 2 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 Primary Specified Health Event is diagnosed prior to the fifth year of coverage. (If this is Individual coverage, no further premium will be billed for the rider after the payment of benefits.)

PRIMARY SPECIFIED HEALTH EVENT RECOVERY BENEFIT RIDER: (Series A71000) Applied for: ☐ Yes ☐ No

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 Primary Specified Health Event OR if he or she is unable to engage in the duties of his or her regular occupation due to a covered Primary Specified Health Event. “Primary Specified Health Event” includes Heart Attack, Stroke, Coronary Artery Bypass Surgery, End-Stage Renal Failure, Major Human Organ Transplant, Major Third-Degree Burns, Persistent Vegetative State, Coma, or Paralysis occurring after the Effective Date of the rider.

Aflac will pay $500 per month while a covered person remains in Primary Specified Health Event Recovery upon receipt of written proof of loss from that person’s Physician.

For Periods of Primary Specified Health Event Recovery less than one month, we will pay a pro rata benefit. Lifetime maximum of six months per covered person.

PRE-EXISTING CONDITIONS: Benefits for a Primary Specified Health Event that is caused by a Pre-existing Condition will not be covered unless the Primary Specified Health Event occurs more than 30 days after the Effective Date of the rider. Any reoccurrence of a
Primary Specified Health Event occurring more than 30 days after the Effective Date will be covered.

**LIMITATIONS AND EXCLUSIONS FOR THE PRIMARY SPECIFIED HEALTH EVENT RECOVERY BENEFIT RIDER:**

A. Benefits for a Primary Specified Health Event that is caused by a Pre-Existing Condition will not be covered unless the Primary Specified Health Event occurs more than 30 days after the Effective Date. Benefits are payable for only one covered Primary Specified Health Event at a time per covered person.

B. The rider does not cover losses or confinements caused by or resulting from:

1. Any loss sustained or contracted due, directly or indirectly, to a covered person’s 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 Injury or cause of the loss occurred).
2. Participating in any sport or sporting activity for wage, compensation, or profit.
3. Intentionally self-inflicting bodily Injury or attempting suicide.
4. 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.

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

A. Benefits payable under Part 5, A, B, and J of the policy will be reduced by one-half for losses that begin on or after the policy anniversary date following the 70th birthday of a covered person.

B. Children born within 270 days of the Effective Date of the policy will not be covered for any losses or confinements payable under Part 5, A or J of the policy, that occur or begin during the first 28 days of life.

C. Benefits are not payable under part 5, A1 and B, Hospital Intensive Care Unit, for confinement in 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, or other facilities that do not meet the standards for a Hospital Intensive Care Unit. Benefits are not payable under Part 5, A2 and B, Step-Down Intensive Care Unit, for confinement in units such as telemetry or surgical recovery rooms; postanesthesia care units; beds, wards, or private or semiprivate rooms with or without telemetry monitoring equipment; observation units located in emergency rooms or outpatient surgery units; emergency rooms; labor or delivery rooms; or other facilities that do not meet the standards for a Step-Down Intensive Care Unit.

D. Benefits are not payable for losses or confinements that begin or occur before the policy Effective Date or after termination of the policy.

E. Benefits for a Primary or Secondary Specified Health Event that is caused by a Pre-Existing Condition will not be covered unless the Primary or Secondary Specified Health Event occurs more than 30 days after the Effective Date. Benefits are payable for only one covered Primary or Secondary Specified Health Event at a time per covered person.

F. The policy does not cover losses or confinements caused by or resulting from:

1. Participating in any sport or sporting activity for wage, compensation, or profit. This exclusion does not apply to Part 5, Benefits A, B, or J of the policy.
2. Intentionally self-inflicting bodily Injury or attempting suicide.
3. 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.
4. Participating in or attempting to participate in any illegal activity that is classified as a felony, whether charged or not (the term “felony” is as defined by the law of the jurisdiction in which the activity takes place).
5. Having treatment for a mental or nervous disorder or disease.
6. Any loss sustained or contracted due, directly or indirectly, to a covered person’s 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 injury or cause of the loss occurred).

A “Pre-Existing Condition” is an illness, disease, disorder, or injury for which, within the six-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received from a Physician. Benefits for a Primary or Secondary Specified Health Event that is caused by a Pre-Existing Condition will not be covered unless the Primary or Secondary Specified Health Event occurs more than 30 days after the Effective Date. Any reoccurrence of a Primary or Secondary Specified Health Event occurring more than 30 days after the Effective Date will be covered. The Pre-Existing Condition DOES NOT apply to any Hospital Intensive Care benefits under the policy.

6. **Renewability**: The policy is guaranteed-renewable for life, with some benefits reduced at age 70, by payment of the premium in effect at the beginning of each renewal period. Premium rates may change only if changed on all policies of the same form number and class in force in your state.

The policy has limitations that may affect benefits payable.

This brochure is for illustration purposes only.

Refer to the policy and riders for complete definitions, details, limitations, and exclusions.
**TERMS YOU NEED TO KNOW**

**COMA:** a continuous state of profound unconsciousness, diagnosed or treated after the effective date of the policy, lasting for a period of seven or more consecutive days, 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.

**CORONARY ANGIoplasty:** a medical procedure in which a balloon is used to open narrowed or blocked blood vessels of the heart (coronary arteries). A coronary angioplasty may be performed to treat persistent chest pain (angina) blockage of one or more coronary arteries, or residual obstruction in a coronary artery during or after a heart attack. These procedures may be performed with or without stents.

**CORONARY ARTERY BYPASS SURGERY:** open-heart surgery, performed after the effective date of the policy, 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, laser relief, or other nonsurgical procedures. This does not include valve replacement surgery.

**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. Newborn children are automatically insured from the moment of birth. If coverage is for individual or named insured/spouse only and you desire uninterrupted coverage for a newborn child, you must notify Aflac within 31 days of the birth of your child, and Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due. Coverage will 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 (including children placed for adoption) 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. 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, requiring dialysis or a kidney transplant to maintain life.

**HEART ATTACK:** a myocardial infarction, coronary thrombosis, or coronary occlusion that is diagnosed or treated after the effective date of the policy. 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, or any other dysfunction of the cardiovascular system.

**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. It does not include transplants involving mechanical or nonhuman organs.

**MAJOR 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.

**PARALYSIS:** spinal cord injuries occurring after the effective date of coverage resulting in complete and total loss of use of two or more limbs (paraplegia, quadriplegia, or hemiplegia) for a continuous period of at least 30 days. The paralysis must be confirmed by your attending physician.

**PERSISTENT VEGETATIVE STATE:** a state of severe mental impairment in which only involuntary bodily functions are present 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.

**PRIMARY SPECIFIED HEALTH EVENT:** heart attack, stroke, coronary artery bypass surgery, end-stage renal failure, major human organ transplant, major third-degree burns, persistent vegetative state, coma, paralysis, or sudden cardiac arrest.
occurring after the effective date of coverage.

SECONDARY SPECIFIED HEALTH EVENT: coronary angioplasty, with or without stents, occurring after the effective date of coverage.

STROKE: apoplexy due to rupture or acute occlusion of a cerebral artery that is diagnosed or treated after the effective date of the policy. 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), or cerebrovascular insufficiency.

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.
ADDITIONAL INFORMATION

A 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.

Benefits are not payable for confinement in a hospital intensive care unit under the Hospital Intensive Care Unit Benefit and the Progressive Benefit for Hospital Intensive Care Unit/Step-Down Intensive Care Unit Confinement for confinements in units such as telemetry or surgical recovery 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.

Benefits are not payable for confinement in a step-down intensive care unit under the Hospital Intensive Care Unit Benefit and the Progressive Benefit for Hospital Intensive Care Unit/Step-Down Intensive Care Unit Confinement for confinements in units such as telemetry or surgical recovery rooms; observation units located in emergency rooms or outpatient surgery units; postanesthesia care units; beds, wards, or private or semiprivate rooms with or without telemetry monitoring equipment; emergency rooms; labor or delivery rooms; or other facilities that do not meet the standards for a step-down intensive care unit.

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