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Please contact Greg or Diana if you would like to enroll, make changes or have any questions about Aflac.



Cash-Paying Benefits

Financial security & peace of mind...when you need it most!

CANCER: **Leading cause of death & medical bankruptcy.** Pays large diagnosis cash benefit, hospitalization, chemo & radiation, surgeries, transportation, nursing services and so much more. Reduces your financial exposure with substantial cash benefits –paid directly to you throughout the duration of your battle with cancer... no matter what.

SHORT-TERM DISABILITY (paycheck replacement): Boost your current disability benefit if you get sick or get injured off-the-job. If you can't work...does your household still need your income? Many options to choose from...pick what's best for your family's financial needs.

HEART/STROKE CRITICAL CARE & RECOVERY: Pays a massive cash benefit upon diagnosis of a heart attack, stroke, sudden cardiac arrest, coronary artery bypass surgery, end-stage renal failure, etc. plus large daily hospitalization, ambulance, re-occurrence, etc. Additional daily cash benefits for therapies, continuing care and physician visits once you come home from the hospital.

HOSPITAL , MATERNITY: Concerned about your deductibles and out of pocket when confined in a hospital? Receive cash benefits when hospitalized. Helps with maternity and ER visits as well. The ICU plan pays large daily sums if you're in ICU/Step-down unit for any reason.

DENTAL GAP: Boost your current dental plan an additional **\$1,200.00** per person annual maximum. You can now get more dental work done!
Orthodontics? Add an additional rider to help with out-of-pocket regarding orthodontic services!

LIFE/ WHOLE or TERM: Have a significant cash lump sum to leave your loved ones to help pay off the home, tuition, outstanding debt. Every option available! If you haven't had a recent quote...you're probably paying too much!



AFLAC

- Has been in business for over 60 yrs., created supplemental insurance and is always #1 in quickest claims paid.
- Pays cash benefits directly to you to use as you see fit!
- If you retire or leave employment, you may continue coverage at the same discounted payroll group rate!
- Aflac pays regardless of any other insurance you may have! No coordination of benefits...ever!
- Policies are payroll deducted, pre-taxed and discounted w/the lowest Aflac rates to save you even more!



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AFLAC CANCER CARE

CANCER INDEMNITY INSURANCE

CLASSIC

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



Aflac®

We've got you under our wing.®

AFLAC CANCER CARE

CANCER INDEMNITY INSURANCE

Policy A78300ID



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

BENEFIT NAME

BENEFIT AMOUNT

Cancer Wellness Benefit	\$75 per year, per Covered Person
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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 ²
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 ²
Topical Chemotherapy Benefit	\$150 per prescription, per month up to \$750 max per month for Oral/Topical Benefit ²
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:	
<ul style="list-style-type: none"> Hospitalization for 30 days or less Hospitalization for Days 31+ 	Insured/Spouse: \$200 per day; Dependent Child: \$250 per day; no lifetime max 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

²Up to three different oral/topical chemotherapy medicines per calendar month.

**American Family Life Assurance Company of Columbus
(herein referred to as Aflac)**

Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999
Toll-Free 1.800.99.AFLAC (1.800.992.3522)

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

SPECIFIED-DISEASE INSURANCE

OUTLINE OF COVERAGE FOR POLICY FORM A78300ID

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide furnished by Aflac.

1. Read Your Policy Carefully: This Outline of Coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Aflac. It is, therefore, important that you **READ YOUR POLICY CAREFULLY.**

2. 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. Benefits: 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
- hemocult 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 this policy is in force, subject to Part 2, Limitations and Exclusions, Section C, of the policy.

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

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 anti-nausea 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 anti-nausea 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 anti-nausea 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, which includes

administration, 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, which includes administration, for the treatment of Internal Cancer or an Associated Cancerous Condition as an outpatient in a Physician's office, clinic, Hospital, or Ambulatory Surgical Center. This benefit does not pay for immunoglobulins, Immunotherapy, antihemophilia factors, or colony-stimulating factors. No lifetime maximum.

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.

Laser or Cryosurgery	\$ 35
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Surgeries OTHER THAN Laser or Cryosurgery:

Biopsy	70
Excision of lesion of skin without flap or graft	170
Flap or graft without excision	250
Excision of lesion of skin with flap or graft	400

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.

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

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.

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

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 benefits under Benefit D1 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, benefits under Benefit D1 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 benefits under Benefit D1 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 if 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.

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

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 the material and substantial duties of any job which you are or reasonably become qualified for by reason of education, training, or experience) 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, 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 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 this 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: (Form A78050ID)

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 this 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 this 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 this rider is attached. This benefit will cease to build for each Covered Person on the anniversary date of this 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 this 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 Rider Form A78050ID:

This 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) Internal Cancer or Associated Cancerous Conditions diagnosed during this rider’s 30-day waiting period; (2) the diagnosis of Nonmelanoma Skin Cancer; or (3) claims incurred prior to the Effective Date of this rider. A claim for the Initial Diagnosis Building Benefit is considered incurred on the date the tissue specimen, culture, and/or titer is taken upon which the original distinct diagnosis of Internal Cancer or Associated Cancerous Condition is based.

DEPENDENT CHILD RIDER: (Form A78051ID)

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 this rider is in force.

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

Exceptions, Reductions, and Limitations of Rider Form A78051ID:

This 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 this rider from its beginning and receive a full refund of premium.

The Dependent Child Benefit is not payable for: (1) Internal Cancer or Associated Cancerous Conditions diagnosed during this rider’s 30-day waiting period; (2) the diagnosis of Nonmelanoma Skin Cancer; or (3) claims incurred prior to the Effective Date of this rider. A claim for the Dependent Child Benefit is considered incurred on the date the tissue specimen, culture, and/or titer is taken upon which the original distinct diagnosis of Internal Cancer or an Associated Cancerous Condition is based.

SPECIFIED-DISEASE BENEFIT RIDER: (Form A78052ID)

Applied for: Yes No

This rider is issued on the basis that the information shown on the application is correct and complete. If answers on your application for this rider are incorrect or incomplete, then this rider may be voided or claims may be denied. If voided, any premiums for this 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 this rider, with any of the covered Specified Diseases, Aflac will pay a benefit of \$1,000. This benefit is payable only once per covered disease per Covered Person. **NO OTHER BENEFITS ARE PAYABLE FOR ANY COVERED SPECIFIED DISEASE NOT PROVIDED FOR IN THIS 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, or other conditions or diseases directly caused, complicated or aggravated by or resulting from the Specified Disease or Specified Disease treatment,, 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, or other conditions or diseases directly caused, complicated or aggravated by or resulting from the Specified Disease or Specified Disease treatment, 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 this 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 this rider’s being in effect for 30 days, benefits for that disease(s) will be paid only for loss incurred after this rider has been in force 31 days.

- 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: (Form A78053)

Applied for: Yes No

Aflac will pay you a cash value based upon the annualized premium paid for this 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 this 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 this rider is added to the policy after the policy has been issued, only the premium paid for the policy after the Effective Date of this 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 this 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: This 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 this 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 this 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, Associated Cancerous Conditions, or other conditions or diseases directly caused, complicated or aggravated by or resulting from Cancer or an Associated Cancerous Condition, including direct extension, metastatic spread, or recurrence. Benefits are not provided for premalignant conditions or conditions with malignant potential (unless specifically covered); or any other disease, sickness, or incapacity.
- B.** This 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 on or after 31 days 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) Internal Cancer or an Associated Cancerous Condition diagnosed during this policy's 30-day waiting period; (2) the diagnosis of Nonmelanoma Skin Cancer; or (3) claims incurred prior to the Effective Date of this policy. A claim for the Initial Diagnosis Benefit is considered incurred on the date the tissue specimen, culture, and/or titer is taken upon which the original distinct diagnosis of Internal Cancer or Associated Cancerous Condition is based.

- 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.

RETAIN FOR YOUR RECORDS.

THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.

THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

TERMS YOU NEED TO KNOW

ASSOCIATED CANCEROUS CONDITION: Myelodysplastic blood disorder, myeloproliferative blood disorder, or internal carcinoma in situ (in the natural or normal place, confined to the site of origin without having invaded neighboring tissue). An Associated Cancerous Condition must receive a Positive Medical Diagnosis. **Premalignant conditions or conditions with malignant potential, other than those specifically named above, are not considered Associated Cancerous Conditions.**

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

- 1. INTERNAL CANCER:** All Cancers other than Nonmelanoma Skin Cancer (see definition of "Nonmelanoma Skin Cancer").
- 2. NONMELANOMA SKIN CANCER:** A Cancer other than a melanoma that begins in the outer part of the skin (epidermis).

Associated Cancerous Conditions, premalignant conditions, or conditions with malignant potential will not be considered Cancer.

COVERED PERSON: Any person insured under the coverage type 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. Newborn adopted children are covered from the moment of birth if placed within 60 days of birth. All other adopted children are covered from the date of placement if added after 60 days 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 60 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. The due date for payment of any additional premium will be 31 days following your receipt of the request for premium. Coverage will include any other Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of intellectual disability or physical disability, 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 born with a congenital anomaly 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.



If Disability Stops Your Pay,
*Will You Have the Ability to
Pay Your Bills?*



SHORT-TERM DISABILITY INSURANCE

DI

Aflac[®]
We've got you under our wing.[®]

SHORT-TERM DISABILITY INSURANCE

Policy A57600IDR; Riders A57650ID, A57651ID

DI

Helping Pay Your Bills, While You Pay Attention to Your Health

Imagine this. One day, not very far in the future, you become disabled. And you can't go to work. It could happen to you. In fact, last year millions of families found themselves in this situation.* How would you pay the mortgage? Buy groceries? Make your car payment? And pay all the other bills that won't go away, just because your paycheck is gone? That's where Aflac's short-term disability insurance policy can help make the difference. The difference that means you will still have a source of income and you will know Aflac is helping take care of your bills while you're taking care of yourself.



Aflac herein means American Family Life Assurance Company of Columbus.

THE FACTS* SAY YOU NEED THE PROTECTION OF AFLAC SHORT-TERM DISABILITY:

3 in **10**

FACT NO. 01

ALMOST ONE-THIRD OF AMERICANS ENTERING THE WORK FORCE TODAY WILL BECOME DISABLED BEFORE THEY RETIRE.

NEARLY

90%

FACT NO. 02

OF DISABILITIES AREN'T WORK-RELATED AND THEREFORE DON'T QUALIFY FOR WORKERS' COMPENSATION BENEFITS.

OVER

10%

FACT NO. 03

OF AMERICANS BETWEEN THE AGES OF 18 AND 64 HAVE A DISABILITY.

100

FACT NO. 04

MILLION AMERICANS ARE NOT PROTECTED BY PRIVATE DISABILITY INSURANCE.

**CDA 2010 Consumer Disability Awareness Study,
Council for Disability Awareness, 2010.

**American Family Life Assurance Company of Columbus
(herein referred to as Aflac)**

Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999
For assistance or information, call 1.800.99.AFLAC (1.800.992.3522).
For claim forms, visit our Web site at aflac.com.

SHORT-TERM DISABILITY COVERAGE

OUTLINE OF COVERAGE FOR POLICY FORM A57600IDR

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the
“Guide to Health Insurance for People With Medicare” available from Aflac.

- 1. Read Your Policy Carefully.** This outline of coverage provides a very brief description 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.** Short-term Disability coverage is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or Sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
- 3. Benefits.** The following benefits are a part of the policy.

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability as a result of pregnancy that began on or before the Effective Date of coverage is not covered except for disability due to Complications of Pregnancy, which will be covered to the same extent as a covered Sickness. The maximum period of Disability allowed for Disability due to childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you while a claim is pending, or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

A. TOTAL DISABILITY BENEFITS:

1. Working Full Time: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Total Disability. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled “Term,” and the definition of “Benefit Period.”

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, or (2) working at any job.

2. Not Working Full Time: If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If you are unable to perform the duties of any occupation for which you are or become qualified by reason of education, training, or experience due to a covered Sickness or Off-the-Job Injury, as certified by a Physician, we will pay you the Daily Disability Benefit for each day you cannot perform such duties. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled “Term,” and the definition of “Benefit Period.”

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, (2) working at any job, or (3) Physician no longer being able to certify that you are unable to perform the duties of any occupation for which you are or become qualified by reason of education, training, or experience.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Total Disability Benefit Period, subject to a new Elimination Period.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of three months) and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled “Term,” and the definition of “Benefit Period.”

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, or (2) working at any job earning 80 percent or more of your pre-Disability Annual Income.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum period of three months of Disability under this benefit has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once

the maximum Partial Disability Benefit Period has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Partial Disability Benefit Period (a maximum period of three months), subject to a new Elimination Period.

The Partial Disability Benefit Period is not subject to the Total Disability Benefit Period.

- C. WAIVER OF PREMIUM BENEFIT:** If your covered Sickness or covered Off-the-Job Injury causes your Total Disability or Partial Disability for more than 90 consecutive days (or after the Elimination Period shown in the Policy Schedule, whichever is greater) while this policy is in force, Aflac will waive, from month to month, the premium for the policy and any applicable rider(s) for as long as you remain disabled, up to the applicable Benefit Period shown in the Policy Schedule.

For premiums to be waived, Aflac will require an employer's statement and a Physician's statement certifying your inability to perform said duties or activities, and may each month thereafter require a Physician's statement that your inability to perform said duties or activities continues. Aflac may ask for and use an independent consultant to determine your Disability when this benefit is in force. You must pay all premiums to keep the policy and any applicable rider(s) in force until Aflac approves your claim for this Waiver of Premium Benefit. You must also resume premium payment to keep the policy and any applicable rider(s) in force, beginning with the first premium due after you no longer qualify for Disability benefits.

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

4. OPTIONAL BENEFITS:

Disability Benefit for On-the-Job Injury Rider: (Form A57650ID) Applied For: Yes No

THIS COVERAGE DOES NOT REPLACE WORKERS' COMPENSATION.

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered On-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Injury. **We reserve the right to meet with you while a claim is pending, or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

A. TOTAL DISABILITY BENEFITS:

1. Working Full Time: If you have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Total Disability. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, or (2) working at any job.

2. Not Working Full Time: If you do not have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If you are unable to perform the duties of any occupation for which you are or become qualified by reason of education, training, or experience due to a covered On-the-Job Injury, as certified by a Physician, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day you cannot perform such duties. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, (2) working at any job, or (3) Physician no longer being able to certify that you are unable to perform the duties of any occupation for which you are or become qualified by reason of education, training, or experience.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Total Disability Benefit Period, subject to a new Elimination Period.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of three months) and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled “Term,” and the definition of “Benefit Period.”

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, or (2) working at any job earning 80 percent or more of your pre-Disability Annual Income.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum period of three months of Disability under this benefit has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been

released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Partial Disability Benefit Period has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Partial Disability Benefit Period (a maximum period of three months), subject to a new Elimination Period.

The Partial Disability Benefit Period is not subject to the Total Disability Benefit Period.

C. WAIVER OF PREMIUM BENEFIT: If your covered On-the-Job Injury causes your Total Disability or Partial Disability for more than 90 consecutive days (or after the Elimination Period shown in the Policy Schedule, whichever is greater) while this rider is in force, Aflac will waive, from month to month, the premium for the policy and any applicable rider(s) for as long as you remain disabled, up to the applicable Benefit Period shown in the Policy Schedule.

For premiums to be waived, Aflac will require an employer's statement and a Physician's statement certifying your inability to perform said duties or activities, and may each month thereafter require a Physician's statement that your inability to perform said duties or activities continues. Aflac may ask for and use an independent consultant to determine your Disability when this benefit is in force.

You must pay all premiums to keep the policy and any applicable rider(s) in force until Aflac approves your claim for this Waiver of Premium Benefit. You must also resume premium payment to keep the policy and any applicable rider(s) in force, beginning with the first premium due after you no longer qualify for Disability benefits.

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

Additional Units of Disability Benefit Rider: (Form A57651ID) Applied For: Yes No

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability as a result of pregnancy that began on or before the Effective Date of coverage is not covered except for disability due to Complications of Pregnancy, which will be covered to the same extent as a covered Sickness. The maximum period of Disability allowed for Disability due to childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you while a claim is pending, or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

This benefit will be paid under the same terms as the applicable Total Disability Benefit or Partial Disability Benefit as described in your policy. The additional units of coverage will only be payable for a Disability that begins after the Effective Date of this rider.

A. TOTAL DISABILITY BENEFITS:

1. Working Full Time: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Total Disability. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, or (2) working at any job.

2. Not Working Full Time: If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If you are unable to perform the duties of any occupation for which you are or become qualified by reason of education, training, or experience due to a covered Sickness or Off-the-Job Injury, as certified by a Physician, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day you cannot perform such duties. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled “Term,” and the definition of “Benefit Period.”

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, (2) working at any job, or (3) Physician no longer being able to certify that you are unable to perform the duties of any occupation for which you are or become qualified by reason of education, training, or experience.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Total Disability Benefit Period, subject to a new Elimination Period.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of three months) and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled “Term,” and the definition of “Benefit Period.”

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, or (2) working at any job earning 80 percent or more of your pre-Disability Annual Income.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum period of three months of Disability under this benefit has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Partial Disability Benefit Period has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Partial Disability Benefit Period (a maximum period of three months), subject to a new Elimination Period.

The Partial Disability Benefit Period is not subject to the Total Disability Benefit Period.

IMPORTANT PROVISIONS OF YOUR POLICY LIMITATIONS AND EXCLUSIONS

- A.** Disability caused by a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- B.** Aflac will not pay benefits for a Disability that is being treated outside the territorial limits of the United States.
- C.** 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.
- D. Aflac will not pay benefits for a disability that is caused by or occurs as a result of your:**
1. Pregnancy or childbirth if the pregnancy began prior to the Effective Date of this policy. Complications of such pregnancy will be covered to the same extent as a Sickness;
 2. Elective abortions (An elective abortion means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed);
 3. Alcoholism or drug addiction;
 4. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not (“felony” is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any detention facility or penal institution;
 5. Intentionally self-inflicting a bodily injury, or committing or attempting suicide, while sane or insane;
 6. Having cosmetic surgery or other elective procedures that are not Medically Necessary, except that “cosmetic surgery” shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;
 7. Having dental treatment, except as a result of Injury;
 8. Being exposed to war or any act of war, declared or undeclared;

9. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve; or
10. Mental or emotional disorders, including but not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, or post-partum depression. This policy will pay, however, for covered disabilities resulting from Alzheimer's disease, or similar forms of senility or senile dementia, first manifested while coverage is in force.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury.

PRE-EXISTING CONDITION LIMITATIONS: A "Pre-existing Condition" is an illness, disease, infection, disorder, condition, 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. Disability caused by a Pre-existing Condition, including deliveries for children conceived prior to the Effective Date of coverage, will not be covered unless it begins more than 12 months after the Effective Date of coverage.

Renewability. The policy is guaranteed-renewable to age 75 by payment of the premium in effect at the beginning of each renewal period. Premium rates may be changed only if changed on all policies of the same form number and class in force in your state, except that we may discontinue or terminate the policy if you have performed an act or practice that constitutes fraud, or have made an intentional misrepresentation of material fact, relating in any way to the policy, including claims for benefits under the policy.

RETAIN FOR YOUR RECORDS.

THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF YOUR POLICY.

THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

TERMS YOU NEED TO KNOW

DAILY DISABILITY BENEFIT: one-thirtieth of the applicable monthly disability benefit shown in the Policy Schedule.

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

FULL-TIME JOB: one job at which you work 19 or more hours per week for one employer for pay or benefits.

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.

OFF-THE-JOB INJURY: an Injury that occurs while you are not working at any job for pay or benefits.

ON-THE-JOB INJURY: an Injury that occurs while you are working at any job for pay or benefits. This coverage does not replace Workers' Compensation.

PARTIAL DISABILITY: being under the care and attendance of a Physician due to a condition that causes you to be unable to perform the material and substantial duties of your Full-Time Job, but able to work at any job earning less than 80 percent of your Annual Income of your Full-Time Job at the time you became disabled.

SICKNESS: an illness, disease, infection, or any other abnormal physical condition, independent of Injury, that is first manifested and first treated after the Effective Date of coverage and while coverage is in force.

TOTAL DISABILITY: being under the care and attendance of a Physician due to a condition that causes you to be unable to perform the material and substantial duties of your Full-Time Job, and not working at any job.

A Physician does not include you or a member of your Immediate Family.

The term *Complications of Pregnancy* does not include premature delivery without incidence, multiple gestation pregnancy, false labor, occasional spotting, prescribed rest during pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy not constituting a classifiably distinct pregnancy complication.

Aflac shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician.

Why Aflac Short-Term Disability may be the best choice for you

Aflac is a market leader with over 50 years of experience in the insurance industry. We've been there before for others, and we'll be there for you when you need us. Aflac helps you choose what best fits your individual needs.

- Aflac short-term disability is sold on an individual basis. So you actually choose the plan that's right for you. We'll give you what you need based on your financial needs and income.
- We now offer the option of guaranteed-issue short-term disability coverage. That means **no medical questionnaire is required**. That should help give you some peace of mind.
- Your Aflac plan stays with you even when you change or leave your job. You don't get that kind of portability everywhere else.
- We pay you a cash benefit for each day you are disabled.**
- Aflac does not coordinate benefits. Regardless of any other disability insurance benefits you may have, including Social Security, we will pay you directly.
- Aflac provides benefits for both Total and Partial Disability. Even if you're able to work, Partial Disability Benefits may be available to help compensate for lost income.
- Premiums may be waived when you have a prolonged disability.**

***Subject to your benefit period and elimination period.*

COVERAGE OPTIONS

Choose the Policy You Need

- **Monthly Benefit: \$500–\$6,000 (subject to income requirements)**
- **Total Disability Benefit Periods: 6, 12, 18, or 24 months**
- **Partial Disability Benefit Period: 3 months**
- **Elimination Periods (Injury/Sickness): 0/7, 0/14, 7/7, 7/14, 14/14, 0/30, 30/30, 60/60, 90/90, 180/180**
- **Optional rider available for on-the-job injuries.**

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.

Aflac Critical Care and Recovery

SPECIFIED HEALTH EVENT INSURANCE – PLAN 1

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



Aflac®

We've got you under our wing.®

CRITICAL CARE AND RECOVERY

SPECIFIED HEALTH EVENT INSURANCE – PLAN 1

Policy A71100ID

CCR¹

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:

FACT NO. 1

ABOUT EVERY **34** SECONDS

SOMEONE SUFFERS A HEART ATTACK.¹

FACT NO. 2

ABOUT EVERY **40** SECONDS

SOMEONE SUFFERS A STROKE.¹

¹Heart Disease and Stroke Statistics, 2012 Update, American Heart Association.

Understand the difference Aflac makes in your financial security.

Aflac pays cash benefits directly to you, unless you choose otherwise. Aflac Critical Care and Recovery is designed to provide you with cash benefits if you experience a catastrophic event, such as a heart attack or stroke. This means that you will have added financial resources to help with expenses incurred due to a serious health event, to help with ongoing living expenses, or to help with any purpose you choose.

An illness or injury can happen to anyone, anytime—and when it does, everyday expenses may suddenly seem 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.

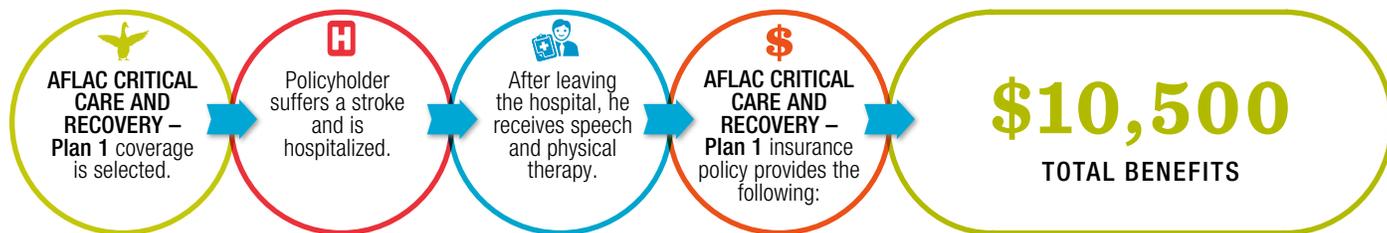
The Critical Care and Recovery insurance policy:

- 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—as long as premiums are paid, the policy cannot be canceled.
- 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

HOW IT WORKS - POLICY A71100ID



The above example is based on a scenario for Aflac Critical Care and Recovery – Plan 1 that includes the following benefit conditions: Stroke (First-Occurrence Benefit) of \$5,000, 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 1 Critical Care and Recovery Benefit Overview

BENEFIT NAME	BENEFIT AMOUNT
FIRST-OCCURRENCE BENEFIT: <ul style="list-style-type: none"> • NAMED INSURED/SPOUSE • DEPENDENT CHILDREN 	\$5,000; lifetime max \$5,000 per covered person \$7,500; lifetime max \$7,500 per covered person
REOCCURRENCE BENEFIT	\$2,500; no lifetime max
SECONDARY SPECIFIED HEALTH EVENT BENEFIT	\$250; no lifetime max
HOSPITAL CONFINEMENT BENEFIT	\$300 per day; no lifetime max
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 OUTLINE OF COVERAGE FOR BENEFIT DETAILS, DEFINITIONS, LIMITATIONS, AND EXCLUSIONS.

**American Family Life Assurance Company of Columbus
(herein referred to as Aflac)**

Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999
Toll-Free 1.800.99.AFLAC (1.800.992.3522)

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

SPECIFIED HEALTH EVENT INSURANCE POLICY

**SUPPLEMENTAL HEALTH INSURANCE COVERAGE
OUTLINE OF COVERAGE FOR POLICY FORM A71100ID**

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

**If you are eligible for Medicare, review the *Medicare Supplement
Buyer's Guide* furnished by Aflac.**

1. Read Your Policy Carefully: This Outline of Coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Aflac. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

2. Specified Health Event Insurance Coverage is designed to supplement your existing accident and Sickness coverage only when certain losses occur as a result of Specified Health Events. Primary Specified Health Events are: 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 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).

3. Benefits: Subject to the Pre-existing Condition Limitations provision, 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.

A. 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.

B. REOCCURRENCE BENEFIT: If benefits have been paid to a covered person under A 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 B to be payable, the Primary Specified Health Event must occur more than 180 days after the date Benefit A or Benefit B became payable. No lifetime maximum.

C. 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.

Benefits are not payable on the same day as the Continuing Care Benefit (D). If the Hospital Confinement Benefit (C) and the Continuing Care Benefit (D) are payable on the same day, only the highest eligible benefit will be paid.

Benefits D through G 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.

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

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.

Benefits are not payable on the same day as the Hospital Confinement Benefit (C). If the Hospital Confinement Benefit (C) and the Continuing Care Benefit (D) are payable on the same day, only the highest eligible benefit will be paid. No lifetime maximum.

E. AMBULANCE BENEFIT: If, due to a covered Primary Specified Health Event, 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, 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. **Ambulance Benefits are not payable beyond the 180th day following the occurrence of a covered Primary Specified Health Event.** No lifetime maximum.

F. 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.

G. 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 for 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.

H. 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.

I. WAIVER OF PREMIUM BENEFIT:

Employed: If you, due to a Primary Specified Health Event (as defined in Part 1, Item R 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 R of the policy), are completely unable to perform the material and substantial duties of any job for which you are or reasonably become qualified for by reason of education, training, or experience 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.

J. 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. Your policy has been in force for at least six months;
2. We have received premiums for at least six consecutive months;
3. Your premiums have been paid through payroll deduction;
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:
(Form A71050) 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 this 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 this 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 this 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 this rider after the payment of benefits.)

PRIMARY SPECIFIED HEALTH EVENT RECOVERY BENEFIT RIDER: (Form A71051ID) 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, Paralysis, or Sudden Cardiac Arrest occurring after the Effective Date of this 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 CONDITION LIMITATIONS: 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 RIDER FORM A71051ID ONLY:

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

1. Alcoholism or drug addiction.
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.

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

A. 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.

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

1. Alcoholism or drug addiction.
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.

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.

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.

RETAIN FOR YOUR RECORDS.

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

TERMS YOU NEED TO KNOW

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.

CONGENITAL ANOMALY: a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. The term significant deviation is defined to be a deviation which impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital anomalies.

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. Newborn adopted children are covered from the moment of birth if placed within 60 days of birth. All other adopted children are covered from the date of placement if added after 60 days 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 60 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. The due date for payment of any additional premium will be thirty-one days following your receipt of the request for premium. Coverage will include any other dependent child, regardless of age, who is incapable of self-sustaining employment by reason of intellectual disability or physical disability, 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 born with a congenital anomaly, who are under age 26. A dependent child (including persons incapable of self-sustaining employment by reason of intellectual disability or physical disability) 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.

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

Aflac shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.



We've got you under our wing.*

AFLAC HOSPITAL ADVANTAGE

HOSPITAL CONFINEMENT INDEMNITY INSURANCE

POLICY SERIES A49000

SELECT 3000

This brochure is for a hospital confinement indemnity policy providing limited benefits.
Benefits provided are supplemental and are not intended to cover all medical expenses.

Aflac Hospital Advantage

HOSPITAL CONFINEMENT INDEMNITY INSURANCE

Policies A49100ID through A49400ID

OPTION 1 BENEFITS

HOSPITAL CONFINEMENT	\$3,000 PER COVERED PERSON
REHABILITATION FACILITY	\$100 PER DAY
HOSPITAL EMERGENCY ROOM	\$100 UP TO 2 TIMES PER YEAR, PER POLICY
HOSPITAL SHORT-STAY	\$100 UP TO 2 TIMES PER YEAR, PER POLICY
WAIVER OF PREMIUM	YES
CONTINUATION OF COVERAGE	YES

OPTION 2 BENEFITS

ALL BENEFITS OF OPTION 1 PLUS THE FOLLOWING

PHYSICIAN VISIT	\$25 PER VISIT
MEDICAL DIAGNOSTIC & IMAGING	\$150 ONCE PER YEAR, PER COVERED PERSON
AMBULANCE	\$100 – GROUND, \$1,000 – AIR UP TO 2 TRIPS PER YEAR, PER COVERED PERSON

OPTION 3 BENEFITS

ALL BENEFITS OF OPTIONS 1 & 2 PLUS THE FOLLOWING

SURGICAL	\$50-\$1,000 SURGICAL SCHEDULE ONE BENEFIT PER 24-HOUR PERIOD
INVASIVE DIAGNOSTIC EXAMS	\$100 ONE EXAM PER COVERED PERSON, PER 24-HOUR PERIOD

OPTION 4 BENEFITS

ALL BENEFITS OF OPTIONS 1, 2, & 3 PLUS THE FOLLOWING

DAILY HOSPITAL CONFINEMENT	\$100 PER DAY UP TO 365 DAYS IN ADDITION TO THE HOSPITAL CONFINEMENT BENEFIT
HOSPITAL INTENSIVE CARE UNIT CONFINEMENT	\$100 PER DAY UP TO 30 DAYS IN ADDITION TO HOSPITAL CONFINEMENT & DAILY HOSPITAL CONFINEMENT BENEFITS

The policy has limitations and exclusions that may affect benefits payable. This schedule is for illustrative purposes only. Refer to the policy for benefit details, definitions, limitations, and exclusions.

Aflac will pay the following benefits, as applicable, for a covered sickness or injury that occurs while coverage is in force. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable.

BENEFIT	BENEFIT AMOUNT	ADDITIONAL BENEFIT INFORMATION
OPTION 1 HOSPITAL CONFINEMENT	\$3,000	<p>Aflac will pay a Hospital Confinement Benefit of \$3,000 when a covered person requires hospital confinement for 23 or more hours for a covered sickness or injury and a charge is incurred. This benefit is payable once per period of hospital confinement, per covered person. Confinements must be separated by a minimum of 90 days from the previous covered hospital confinement for this benefit to be payable. No lifetime maximum.</p>
REHABILITATION FACILITY	\$100 per day	<p>Aflac will pay \$100 per day when a covered person is confined in a hospital and is transferred to a bed in a rehabilitation facility for a covered sickness or injury and a charge is incurred. This benefit is limited to 15 days per period of hospital confinement and is limited to a calendar year maximum of 30 days per covered person. No lifetime maximum.</p>
HOSPITAL EMERGENCY ROOM	\$100	<p>Aflac will pay \$100 when a covered person receives treatment for a covered sickness or injury in a hospital emergency room, including triage, and a charge is incurred. This benefit is payable twice per calendar year, per policy. The Hospital Emergency Room Benefit and the Hospital Short-Stay Benefit are not payable on the same day. No lifetime maximum.</p>
HOSPITAL SHORT-STAY	\$100	<p>Aflac will pay \$100 when a covered person receives treatment for a covered sickness or injury in a hospital, including an observation room or an ambulatory surgical center, for a period of less than 23 hours and a charge is incurred. This benefit is not payable for treatment received in a hospital emergency room. This benefit is payable twice per calendar year, per policy. The Hospital Short-Stay Benefit and the Hospital Emergency Room Benefit are not payable on the same day. No lifetime maximum.</p>
WAIVER OF PREMIUM	<p>Upon written notice, Aflac will waive from month to month any premium(s) falling due during a continued period of hospital confinement for the named insured only. This benefit will begin after the period of hospital confinement for the named insured has exceeded 30 consecutive days. When such continued period of hospital confinement has ended, premium payments must be resumed. Once premium payments are resumed, any new period of hospital confinement must again satisfy the 30-day continued confinement for premiums to be waived.</p>	
CONTINUATION OF COVERAGE	<p>Aflac will waive all monthly premiums due for the policy and riders, if any, for up to two months if you meet all of the following conditions:</p> <ul style="list-style-type: none"> • The policy was in force for at least six months. • We received premiums for at least six consecutive months. • Your premiums were paid through payroll deduction, and you left your employer for any reason. • You or your employer notified us in writing within 30 days of the date your premium payments ceased because of leaving employment. • You re-establish premium payments with Aflac. <p>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.</p>	
OPTION 2 <i>All benefits of Option 1 plus the following</i> PHYSICIAN VISIT	\$25	<p>Aflac will pay \$25 when a covered person incurs a charge for a physician visit. Services must be under the supervision of a physician. If the type of coverage for the policy is individual, the benefit is limited to three visits per calendar year, per policy. If the type of coverage is named insured/spouse only, one-parent family, or two-parent family, the benefit is limited to a total of six visits per calendar year, per policy.</p> <p>The sickness or injury of a covered person is not required for this benefit to be payable. Covered physician visits include but are not limited to eye exams, well-baby visits, immunizations, periodic health exams, and routine physicals. This benefit is not subject to the Pre-existing Condition Limitations or to the Limitations and Exclusions. No lifetime maximum.</p>

BENEFIT	BENEFIT AMOUNT	ADDITIONAL BENEFIT INFORMATION
MEDICAL DIAGNOSTIC AND IMAGING	\$150	Aflac will pay \$150 per calendar year when a covered person requires one of the following exams and a charge is incurred: CT scan, MRI (magnetic resonance imaging), EEG (electroencephalogram), thallium stress test, myelogram, angiogram, or arteriogram. These exams must be performed in a hospital, a medical diagnostic imaging center, a physician's office, or an ambulatory surgical center. This benefit is limited to one payment per calendar year, per covered person. No lifetime maximum.
AMBULANCE	\$100 – ground ambulance \$1,000 – air ambulance	Aflac will pay the amount shown at left if, due to a covered sickness or injury, a covered person requires ground ambulance transportation or air ambulance transportation to or from a hospital due to a covered sickness or injury and a charge is incurred. A licensed professional ambulance company must provide the ambulance service. The Ambulance Benefit is limited to two trips per calendar year, per covered person. No lifetime maximum.
OPTION 3 <i>All benefits of Options 1 & 2 plus the following</i> SURGICAL	\$50–\$1,000 (based on the Schedule of Operations listed in the policy)	Aflac will pay according to the benefits listed in the Schedule of Operations in the policy when, due to a covered sickness or injury, a covered person has a surgical operation, including a vaginal or cesarean delivery, performed in a hospital or an ambulatory surgical center and a charge is incurred. If any operation for the treatment of the covered sickness or injury 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. Only one benefit is payable per 24-hour period for surgery, even though more than one surgical procedure may be performed. The highest eligible benefit will be paid. Exams covered under the Invasive Diagnostic Exams Benefit are not payable under this benefit. The Surgical Benefit and the Invasive Diagnostic Exams Benefit are not payable on the same day. The highest eligible benefit will be paid. No lifetime maximum. IMPORTANT: Surgical Benefits are not payable for surgery performed in a physician's or dentist's office, a clinic, or other such location.
INVASIVE DIAGNOSTIC EXAMS	\$100	Aflac will pay \$100 when a covered person requires one of the following exams, with or without biopsy, and a charge is incurred: arthroscopy, bronchoscopy, colonoscopy, cystoscopy, gastroscopy, laparoscopy, laryngoscopy, sigmoidoscopy, or esophagoscopy. These exams must be performed in a hospital or an ambulatory surgical center. This benefit is limited to one exam per covered person, per 24-hour period. The Invasive Diagnostic Exams Benefit and the Surgical Benefit are not payable on the same day. The highest eligible benefit will be paid. No lifetime maximum.
OPTION 4 <i>All benefits of Options 1, 2, & 3 plus the following</i> DAILY HOSPITAL CONFINEMENT	\$100 per day	Aflac will pay \$100 per day for the period of hospital confinement when a covered person requires hospital confinement for a covered sickness or injury and a charge is incurred. This benefit is payable in addition to the Hospital Confinement Benefit. The maximum benefit period for any one period of hospital confinement is 365 days. No lifetime maximum.
HOSPITAL INTENSIVE CARE UNIT CONFINEMENT	\$100 per day	Aflac will pay \$100 per day when a covered person incurs a charge for a period of hospital intensive care unit confinement for a covered sickness or injury. This benefit is payable in addition to the Hospital Confinement Benefit and the Daily Hospital Confinement Benefit. Confinements must be separated by a minimum of 90 days from the previous covered period of hospital intensive care unit confinement for this benefit to be payable. The maximum benefit period for any one period of hospital intensive care unit confinement is 30 days. No lifetime maximum.

WHAT IS NOT COVERED

LIMITATIONS AND EXCLUSIONS

Aflac will not pay benefits for care or treatment that is: (1) caused by a pre-existing condition, unless it begins more than 12 months after the effective date of coverage, or (2) received prior to the effective date of coverage.

Aflac will pay benefits for elective surgery that is not medically necessary after the first 12 months of the effective date of coverage.

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

- Being pregnant or giving birth if the pregnancy is in existence on the effective date of coverage. When conception occurs after the Effective Date of coverage, involuntary complications of pregnancy will be covered to the same extent as a sickness;
- Elective abortions (an elective abortion means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed);
- Alcoholism or drug addiction;
- Receiving routine nursing or routine well-baby care for a newborn child (other than provided by the Physician Visit Benefit). Policy benefits will be paid for a newborn's sickness or injury, including congenital anomaly;
- Participating in a felony, whether charged or not (*felony* is as defined by the law of the jurisdiction in which the activity takes place);
- Intentionally self-inflicting a bodily injury, or committing or attempting suicide, while sane or insane;
- Having dental treatment except as a result of injury or having cosmetic surgery that is not medically necessary, except that *cosmetic surgery* shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital anomaly or disease of the covered dependent child;

The term *hospital* does not include any institution or part thereof used as an emergency room; a rehabilitation facility; 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. Benefits for confinement in a rehabilitation facility are payable under the Rehabilitation Facility Benefit.

The term *hospital emergency room* does not include urgent care centers.

Benefits are not payable for confinement in a hospital intensive care unit under the Hospital Intensive Care Unit Confinement Benefit 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; beds, wards, or private or semiprivate rooms with or without telemetry monitoring equipment; emergency rooms; labor or delivery rooms; step-down intensive care units, or other facilities that do not meet the standards for a hospital intensive care unit.

- 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; or
- Having mental or emotional disorders, including but not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, or post-partum depression. The policy will pay, however, for covered losses resulting from Alzheimer's disease, or similar forms of senility or senile dementia, first manifested while coverage is in force.

Aflac shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

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

Involuntary complications of pregnancy do not include any of the following: premature delivery, multiple gestation pregnancy, false labor, occasional spotting, prescribed rest during pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy not constituting a classifiably distinct pregnancy complication.

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

The term *rehabilitation facility* does not include 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.

PRE-EXISTING CONDITION LIMITATIONS: A *pre-existing condition* is an illness, disease, infection, disorder, condition, or injury for which, within the six-month period before the effective date of coverage, prescription medication was taken or medical testing, medical advice, consultation, or treatment was recommended or received from a physician. Care or treatment caused by a pre-existing condition, including deliveries for children if the pregnancy is in existence on the effective date of coverage, will not be covered unless it begins more than 12 months after the effective date of coverage.

TERMS YOU NEED TO KNOW

CONGENITAL ANOMALY: a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. The term significant deviation is defined to be a deviation which impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital anomalies.

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. Newborn adopted children are covered from the moment of birth if placed within 60 days of birth. All other adopted children are covered from the date of placement if added after 60 days 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 60 days of the child's birth, and Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due. The due date for payment of any additional premium will be 31 days following your receipt of the request of premium. Coverage will include any other dependent child, regardless of age, who is incapable of self-sustaining employment by reason of intellectual disability or physical disability, 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 born with a congenital anomaly, who are under age 26.

EFFECTIVE DATE: the date(s) coverage begins as shown in the Policy Schedule or on any attached endorsements or riders. 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.

HOSPITAL CONFINEMENT: a stay of a covered person confined to a bed in a hospital for 23 or more hours 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 sickness or injury. The term *hospital confinement* does not include emergency rooms.

INJURY: a bodily injury caused directly by an accident, independent of sickness, 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.

PERIOD OF HOSPITAL CONFINEMENT: the number of days a covered person is assigned to and incurs a charge for a bed in a hospital. Confinements must begin while coverage under the policy is in force. Covered confinements not separated by 90 days or more from a previously covered confinement are considered a continuation of the previous period of hospital confinement. Hospitalization that begins prior to the end of one calendar year and continues into the next calendar year will be considered one confinement.

PERIOD OF HOSPITAL INTENSIVE CARE UNIT CONFINEMENT: the number of days a covered person is assigned to and incurs a charge for a bed in a hospital intensive care unit. Confinements must begin while coverage under the policy is in force. Covered confinements not separated by 90 days or more from a previously covered confinement are considered a continuation of the previous period of hospital intensive care unit confinement. Hospitalization that begins prior to the end of one calendar year and continues into the next calendar year will be considered one confinement.

SICKNESS: an illness, disease, infection, or disorder, independent of injury, medically evaluated, diagnosed, or treated by a physician after the effective date of coverage and while coverage is in force.

Peace of Mind *and*
Real Cash Benefits



DENTAL INSURANCE

DE^E

Aflac[®]

We've got you under our wing.[®]

DENTAL INSURANCE

Policy A82100RID

This brochure accompanies Schedule of Dental Procedures A82ES75SCHID.

Smile. We've got you under our wing.[®]

Millions of people believe a smile is the most important physical attribute—more so than hair, eyes, or figure.¹ The best way to maintain or improve your smile is to brush and floss your teeth daily, visit your dentist, and apply for an Aflac Dental insurance policy.

Aflac Dental provides benefits for periodic checkups and cleanings, X-rays, fillings, crowns, and much more. It's your smile and your policy; Aflac Dental gives you control.

- **You choose your dentist.** Because Aflac doesn't use a network of dentists, you can go to any dentist you choose.
- **You and your dentist choose the best treatment for you.** Aflac Dental doesn't have precertification requirements. If the treatment is covered by your policy, you don't need Aflac's permission to receive it.²

Aflac Dental is different from many other dental plans you may have seen.

- **You know what you're getting with Aflac Dental.** The plan spells out the benefits for both wellness and other diagnostic/treatment services. There are no gray areas. Each covered procedure has a specific benefit amount.
- **Aflac Dental doesn't have an annual deductible.** Other dental plans may require you to meet an annual deductible before benefits are payable.
- **Aflac Dental pays benefits regardless of any other plan.** Even if you have other coverage, you'll receive your full Aflac benefit amount.³

With Aflac Dental's **Annual Maximum Building Benefit**, you can receive even more benefits. Aflac will increase each Covered Person's Policy Year Maximum by \$100 after each 12 consecutive months the policy is in force up to a maximum of \$500 per Covered Person.

¹"The Public Speaks Up on Oral Health Care: An ADA and Crest/Oral-B Survey," American Dental Association, October 2008.

²Subject to applicable Waiting Periods.

³If the applicant retains existing dental coverage with another company, only the Essentials plan can be offered.

Aflac Dental pays benefits for seven categories of dental treatments and hundreds of procedures. The benefit amounts within each category vary based on the procedure received and are subject to a Policy Year Maximum. Benefit amounts and the Policy Year Maximum are per Covered Person.

BENEFIT CATEGORIES	WAITING PERIOD	BENEFIT AMOUNTS
Preventive (Wellness and X-Ray)	None	\$15-\$25
Fillings and Basic Services	3 Months	\$10-\$225
Pain Management and Adjunctive Services	3 Months	\$25-\$120
Other Preventive Services	6 Months	\$15-\$100
Oral Surgery, Gum Treatments, and Prosthetic Repair	6 Months	\$20-\$750
Crowns and Major Services	12 Months	\$15-\$350
Major Prosthetic Services	24 Months	\$40-\$450
POLICY YEAR MAXIMUM		\$1,200

THIS BROCHURE IS FOR ILLUSTRATIVE PURPOSES ONLY.
 REFER TO THE POLICY FOR COMPLETE DEFINITIONS, DETAILS, LIMITATIONS, AND EXCLUSIONS.
 FOR MORE INFORMATION ABOUT THE BENEFITS AVAILABLE, PLEASE SEE THE SCHEDULE OF DENTAL PROCEDURES.
 AFLAC HEREIN MEANS AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS.



OVER
90%
OF SYSTEMIC DISEASES,
including heart disease, have oral symptoms.⁴

TERMS YOU NEED TO KNOW

COVERED PERSON: *Covered Person* includes any person insured under the coverage type you applied for.

Please see the Schedule of Dental Procedures for a complete and comprehensive definition.

GUARANTEED-RENEWABLE: The policy is Guaranteed-Renewable for your lifetime, subject to Aflac's right to change premiums by class upon any renewal date.

POLICY YEAR MAXIMUM: The *Policy Year Maximum* is the total dollar amount of benefits payable per policy year, per Covered Person.

WAITING PERIOD: The *Waiting Period* is the period after the Effective Date of coverage for which benefits are not payable. If the policy is reinstated, all Covered Persons will be subject to new Waiting Periods beginning with the date of reinstatement. If a dependent is added by endorsement, the Waiting Period for such dependent will begin on the Effective Date of the addition. The Waiting Period will vary based on the benefit category.

WHAT IS NOT COVERED

Aflac will not pay benefits for losses caused by or resulting from any procedure not shown on the Schedule of Dental Procedures; services that are not recommended by a dentist or denturist, or that are not required for the preservation or restoration of oral health; repairs to dental work within six months of the initial work; treatment received while outside the territorial limits of the United States or, if outside the United States, the territorial limits of the place where your policy was issued; or treatment received prior to the Effective Date of coverage or treatment received during a benefit's Waiting Period.

No benefits will be paid for replacement of teeth missing before the Effective Date of coverage.

Aflac will not pay benefits for services rendered by you or a member of the immediate family of a Covered Person.

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.

Please see the Schedule of Dental Procedures for procedure-specific limitations and exclusions.

⁴"Warning Signs in the Mouth Can Save Lives," Academy of General Dentistry, October 2008.

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under our wing.®**

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