EBS CALL CENTER

1099 Contractor Benefits

2020

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WE'RE HERE TO HELP!

What we offer:

- Netspend Prepaid Cards
- Aflac Insurance Plans
- Tickets at Work

And more to come!

ENROLL TODAY!

Learn About Your Skylight ONE® Card

Use of card and all features is subject to activation and ID verification.*

What is a Skylight ONE Card?

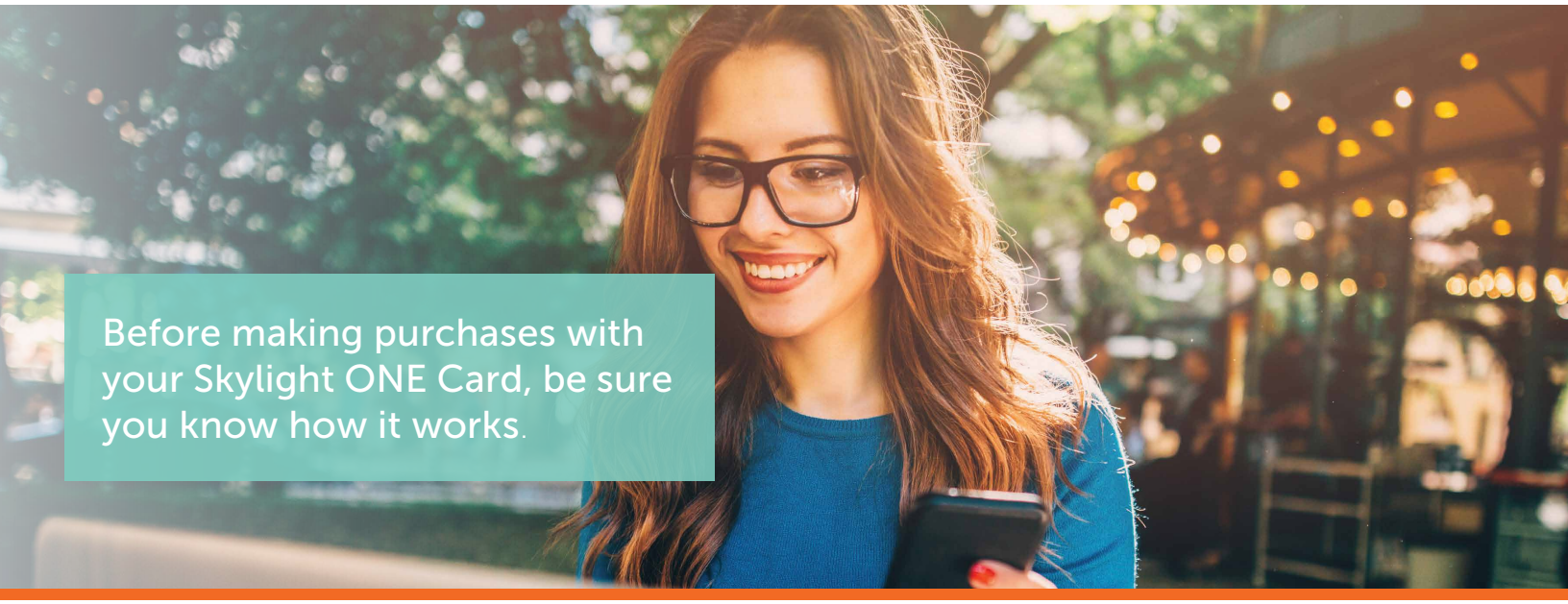
When you get paid, you either have to cash the check or find somewhere to deposit it. With the Skylight ONE Card, you can have your paycheck direct deposited straight to your Skylight Account. It's a convenient way to get paid, each pay period.

Where can I use the card?

You can use it to make purchases wherever Visa® debit or Debit Mastercard® are accepted. That includes in stores, over the phone or online.

Can I get cash from my card?

Sure thing. You can also go to a Visa or Mastercard member bank and withdraw cash from over the counter. Additionally, you can withdraw cash from surcharge-free Allpoint or MoneyPass ATMs at least one time per month or more depending on your program.[1] Go to skylightpaycard.com to find the nearest surcharge-free ATM.



My card came with "Skylight Checks". What is that?

You can use a Skylight Check to withdraw all of the money that is in your Skylight Account. Just follow the instructions that came with the check, and then take it to a participating location. Skylight Checks can be cashed at no cost at any U.S. Bank branch, at participating Walmart locations, and at participating ACE Cash Express locations. Other check cashers set their own policies regarding check acceptance and may charge you a fee to cash Skylight Checks. See the Skylight Checks enclosure for step-by-step instructions.

Does it cost anything to use my card?

There is no cost to sign up, and there are many ways to access your wages at no cost. Some fees may be charged depending on how you use the card. A full list of fees is included in the materials provided with your card.

My card doesn't have my name on it. Can I still use it to make purchases?

In the pack provided by your employer, the first card you get is a temporary card. Once you've activated your card and verified your identity,* you can use it to make purchases wherever Visa debit or Debit Mastercard is accepted. It's just the card you can use to get started. Once you're enrolled, a personalized card with your name on it will be sent to your home mailing address.

What happens if I lose my card?

If you lose your card, contact us immediately so your lost card can be cancelled. That will help minimize the chances that someone else can use the lost card. We'll send a new one to your home mailing address. For lost, stolen or damaged cards, you will receive one replacement card at no cost every 12 months.[2]

Where can I see my transaction history and balance?

There are several ways:

- **Register for Online Account Access** – That way you can log in from a computer or mobile device when it's convenient for you.[w]
- **Sign up for Anytime Alerts™** – You can receive notifications whenever there is a transaction by text or email.[3] You can also text the short code **BAL** to us, and we'll respond with your balance.
- **Download the Mobile App** – The Skylight ONE Mobile App doesn't cost anything to download, and it's available in the App Store or on Google Play.[3]

Download on the App Store | GET IT ON Google Play

I have other questions. How can I contact you?

Call the Customer Service number on the back of your card, and one of our team members can answer any questions you have.[4]

Customer Service hours are:

Monday – Friday: 6am – midnight CT

Saturday – Sunday: 8am – 8pm CT

Bilingual service is available.

* **IMPORTANT INFORMATION FOR OPENING A CARD ACCOUNT:** To help the federal government fight the funding of terrorism and money laundering activities, the USA PATRIOT Act requires us to obtain, verify, and record information that identifies each person who opens a Card Account. **WHAT THIS MEANS FOR YOU:** When you open a Card Account, we will ask for your **name, address, date of birth, and your government ID number.** We may also ask to see your driver's license or other identifying information. Card activation and identity verification required before you can use the Card Account. If your identity is partially verified, full use of the Card Account will be restricted, but you may be able to use the Card for in-store purchase transactions. Restrictions include: no ATM withdrawals, international transactions, account-to-account transfers and additional loads. Use of Card Account also subject to fraud prevention restrictions at any time, with or without notice.

[1] Surcharge-free ATM options will vary by card program. Please see your Cardholder Agreement for surcharge-free options. An ATM Cash Withdrawal Fee applies at ATMs outside the surcharge-free network specified in your Cardholder Agreement. A separate ATM owner fee may also apply.

[2] There may be a cost for additional replacement cards. Consult your Cardholder Agreement and Fee Schedule for details.

[3] No charge for this service, but your wireless carrier may charge for messages or data.

[4] A fee may apply for this call. Consult your Fee Schedule for details.

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NETSPEND

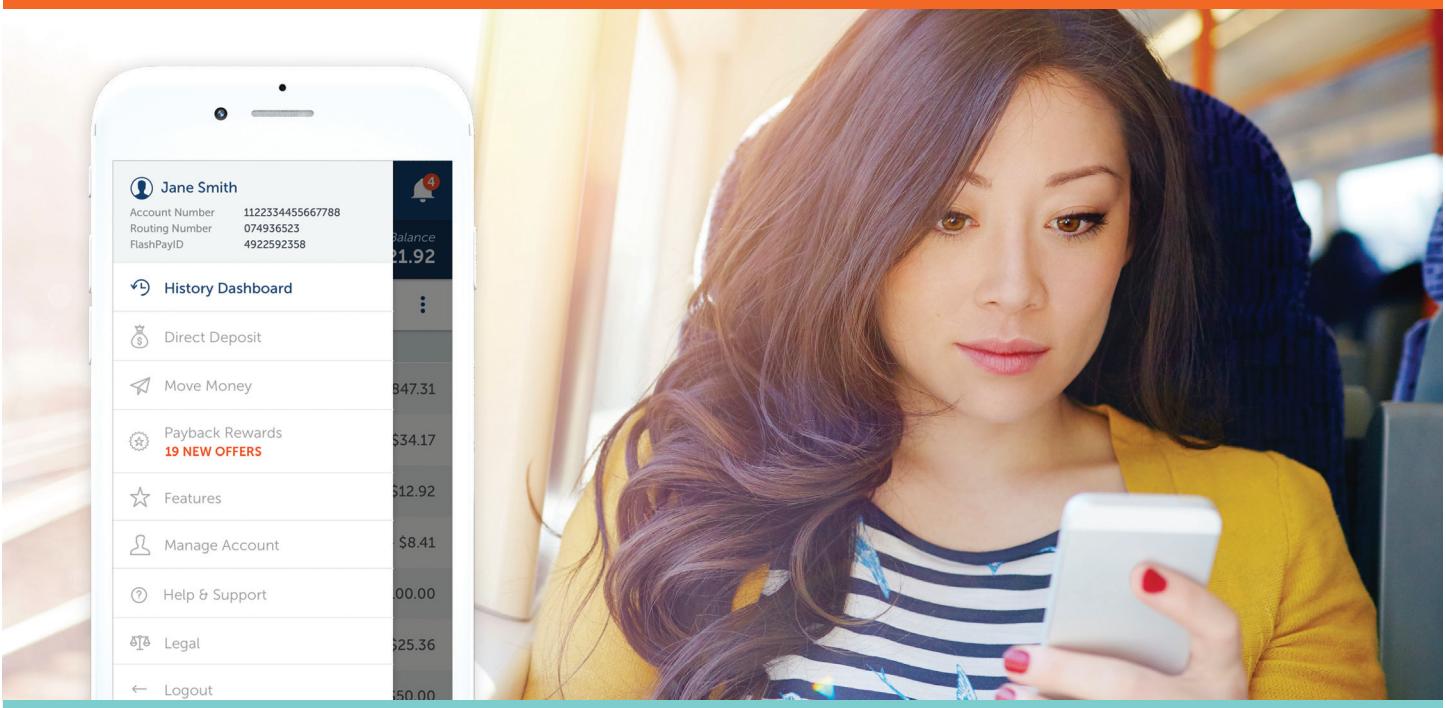
Skylight ONE® Card

Offering a powerful tool to help put you in control of your financial life.

With the Skylight ONE® Visa® Prepaid Card or Skylight ONE® Prepaid Mastercard®, you have a convenient way to receive your pay and manage your money on a prepaid card with features designed with you in mind (upon activation and ID verification).[1]

- Buy groceries, pay bills[2], and shop online anywhere Visa debit or Debit Mastercard is accepted.
- Get rewarded with Payback Rewards℠ on qualifying purchases.[6]
- Access cash with no fees at surcharge-free ATMs[3], point of sale, over-the-counter withdrawals, and with Skylight Checks.[4]
- Keep track of purchases by enrolling in Anytime Alerts.[7]
- Add peace of mind to your purchases by adding your Skylight ONE card to your digital wallet or creating a Virtual Account.[5]
- Easy-to-use budgeting tools to review and set goals on spending by purchase type.

See reverse side for disclosures 1-7.



Manage your money on the go.
Download the Skylight ONE® Mobile App today![7]

Download on the App Store

GET IT ON Google Play

[1] **IMPORTANT INFORMATION FOR OPENING A CARD ACCOUNT:** To help the federal government fight the funding of terrorism and money laundering activities, the USA PATRIOT Act requires us to obtain, verify, and record information that identifies each person who opens a Card Account. **WHAT THIS MEANS FOR YOU:** When you open a Card Account, we will ask for your **name, address, date of birth, and your government ID number.** We may also ask to see your driver's license or other identifying information. Card activation and identity verification required before you can use the Card Account. If your identity is partially verified, full use of the Card Account will be restricted, but you may be able to use the Card for in-store purchase transactions and ATM withdrawals. Restrictions include: no international transactions, account-to-account transfers and additional loads. Use of Card Account also subject to fraud prevention restrictions at any time, with or without notice.

[2] Bill payments may be subject to fees. Details about bill payment methods are available in the Online Account Center.

[3] No ATM-owner surcharge on ATM withdrawals conducted at an Allpoint Network or MoneyPass Network ATMs. Visit your Online Account Center or https://www.allpointnetwork.com/locator.aspx or https://www.moneypass.com/atm-locator.html to find a list of Allpoint Network or MoneyPass Network ATMs. All other ATMs may apply a surcharge assessed by the institution that owns the terminal or network. ATM Withdrawal Fee may apply; please see your Cardholder Agreement for additional details.

[4] Skylight Checks can be cashed at no cost at all US Bank branch locations, at participating Walmart locations, and at participating ACE Cash Express locations. Other check cashers set their own policies regarding check acceptance and may charge you a fee to cash Skylight Checks. See the Skylight Checks for step-by-step instructions.

[5] You may request up to six (6) active virtual accounts for each active Card Account. Virtual Accounts are subject to the same fees, limits, terms, and conditions as your Card Account. See your Cardholder Agreement or Online Account Center for details.

[6] Payback Rewards is an optional program. You may opt-out at any time by visiting the Payback Rewards page in your Online Account Center. Reward offers are based on individual shopping habits. Cash back rewards are credited to your Card Account and are not available in the form of a check or other direct payment method. See the program FAQs and Terms and Conditions in your Online Account Center for additional details about how and when you get rewarded. Program sponsor: Netspend Corporation. Republic Bank & Trust Company and Visa and Mastercard are not affiliated in any way with this program and do not endorse or sponsor this program.

[7] No charge for this service, but your wireless carrier may charge for messages or data.

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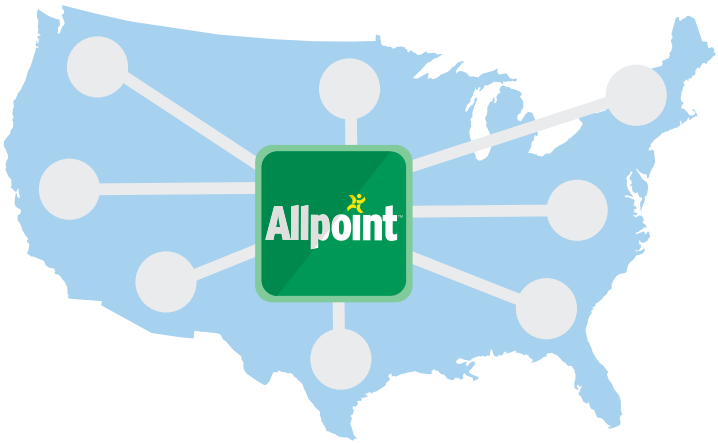
Avoid ATM Fees at Allpoint ATMs

With the Skylight® PayOptions™ Program, you can withdraw money from an ATM with no fee![1] When you go to any of the Allpoint ATMs all over the country, at least 1 ATM withdrawal per month will have no fee, and with some programs, there is no fee on every withdrawal. Check your Cardholder Agreement for details.

For a list of Allpoint ATMs near you, you can:

- Call the number on the back of your card
- Go to skylightpaycard.com and log in to your Online Account Center
- Download the Skylight ONE Mobile App[2] and log in

Download on the App Store | GET IT ON Google Play



The Skylight ONE® Visa® Prepaid Card

The Skylight ONE® Prepaid Mastercard®

Start withdrawing at Allpoint ATMs today!

[1] An ATM Cash Withdrawal Fee applies at ATMs outside the surcharge free network specified in your Cardholder Agreement. A separate ATM owner fee may also apply.

[2] No charge for this service but your wireless carrier may charge for messages or data.

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Card may be used everywhere Debit Mastercard is accepted.

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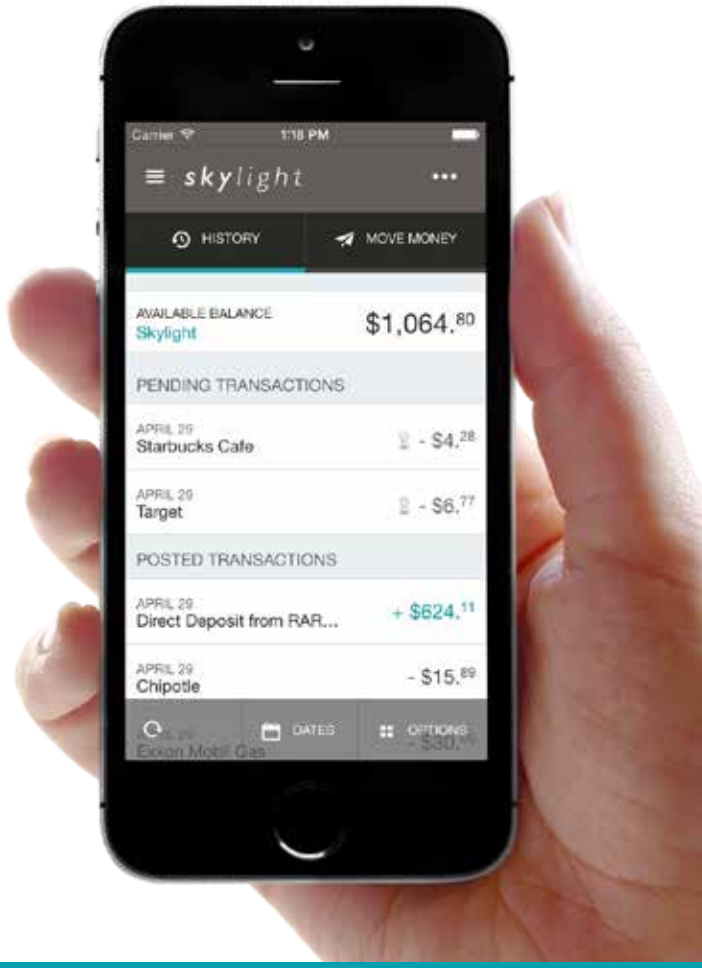
Skylight Mobile Banking App

You're constantly on the go – now your Skylight Account can go with you!

VISA | MasterCard

The Skylight Mobile Banking App – your Skylight Account now conveniently accessed from your phone.

- Download the app for free*
- Surcharge-free ATM location finder
- Send money P2P (if available with your program)
- Obtain Account and Routing numbers to arrange for direct deposits
- View transaction history and account balance
- View Privacy Policy and Cardholder Agreement
- Reset password



Download today!

The Skylight Mobile Banking App is available for Android and iOS/Apple devices. Search "Skylight" on the Google Play and App Store.

ANDROID APP ON Google play

Available on the App Store

**The Skylight Mobile Banking App is free, but your wireless carrier may charge you for data usage.*

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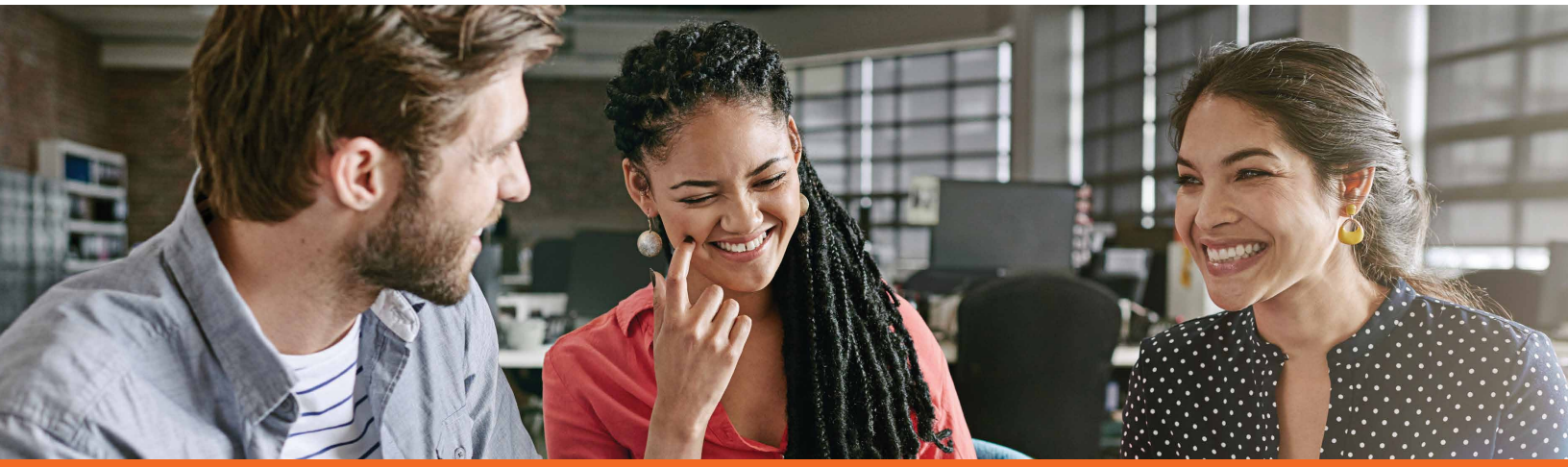
What to Expect on Payday With Your Skylight ONE® Prepaid Card

With your Skylight ONE Card, payday is predictable. Upon activation and verification of identity[1], your payroll will be direct deposited onto your Skylight Account, so you'll be able to use it to make purchases or withdraw cash. Don't need to spend it now? Don't worry because your money is in your Skylight Account when you need it. Here are some tips for getting the most out of your Skylight Account.

Upon activation and verification of identity[1], you can begin using the card and features, such as:

- Make purchases wherever Visa® debit cards or Debit Mastercard® is accepted.
- Withdraw cash from surcharge-free ATMs at Allpoint or MoneyPass ATMs (depending on your program). For a list of surcharge-free ATMs near you, log in to the Online Account Center.[2]
- Make cash withdrawals at no cost at any Visa or Mastercard Member Bank (just look for the Visa or Mastercard logo at the bank).[3]
- Manage your money on the go from the Skylight ONE Mobile App.[4]
- Receive a text or email alert[4] (your choice of one or both) when transactions occur by enrolling in Anytime Alerts™.
- Withdraw 100% of your funds with Skylight Checks enclosure at no cost at certain locations.[5] See the Skylight Checks for step-by-step instructions.



Before you can use your card

- You will need to activate your Skylight Account and verify your identity.[1] To activate, call the number on the back of your card or go to **skylightpaycard.com**.
- Choose a Personal Identification Number (PIN) that you will use to access money at ATMs.
- Register for access to the Online Account Center to monitor and manage your Skylight Account. You can check balances, read statements, review recent transactions, sign up for transaction alerts[4], and manage your Skylight Account features.

[1] **IMPORTANT INFORMATION FOR OPENING A CARD ACCOUNT:** To help the federal government fight the funding of terrorism and money laundering activities, the USA PATRIOT Act requires us to obtain, verify, and record information that identifies each person who opens a Card Account. **WHAT THIS MEANS FOR YOU:** When you open a Card Account, we will ask for your **name, address, date of birth, and your government ID number**. We may also ask to see your driver's license or other identifying information. Card activation and identity verification required before you can use the Card Account. If your identity is partially verified, full use of the Card Account will be restricted, but you may be able to use the Card for in-store purchase transactions. Restrictions include: no ATM withdrawals, international transactions, account-to-account transfers and additional loads. Use of Card Account also subject to fraud prevention restrictions at any time, with or without notice.

[2] Surcharge free ATM options will vary by card program. Please see your Cardholder Agreement for surcharge free options. An ATM Cash Withdrawal Fee applies at ATMs outside the surcharge free network specified in your Cardholder Agreement. A separate ATM owner fee may also apply.

[3] A fee may be assessed by a financial institution that is not a Visa or Mastercard member bank, which is a third-party fee and is subject to change.

[4] No charge for this service, but your wireless carrier may charge you for messages or data.

[5] Skylight Checks can be cashed at no cost at all U.S. Bank branch location, at participating Walmart locations, and at participating ACE Cash Express locations. Other check cashers set their own policies regarding check acceptance and may charge you a fee to cash Skylight Checks. See the Skylight Checks for step-by-step instructions.

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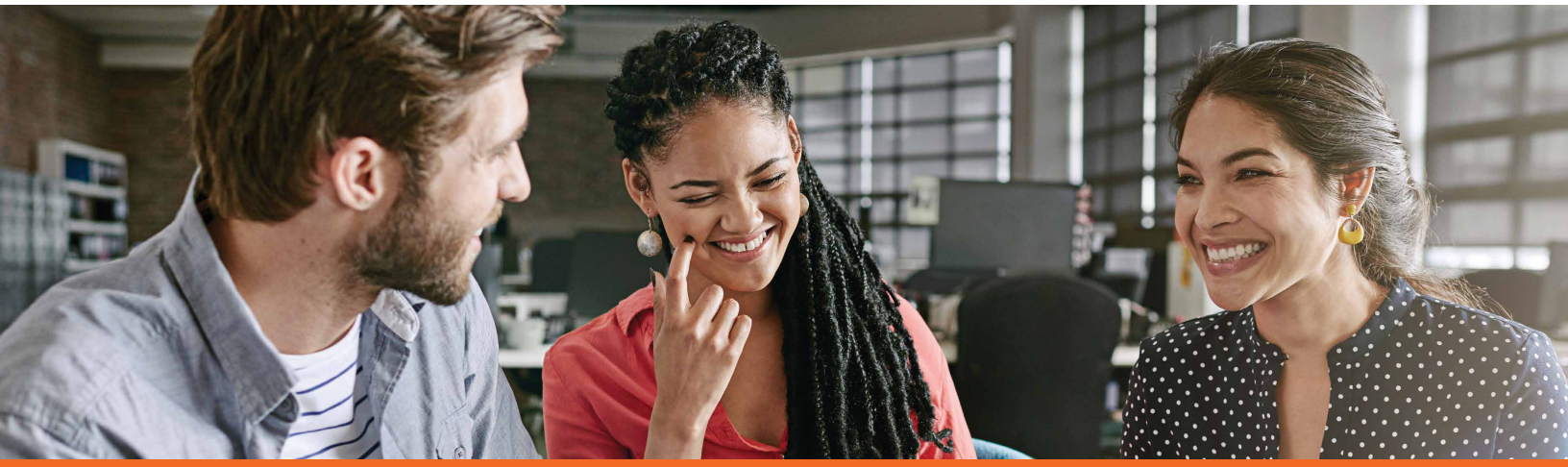
Qué esperar el día de pago con su Tarjeta Prepagada Skylight ONE®

Con su Tarjeta Skylight ONE, el día de pago es predecible. Luego de activar su tarjeta y verificar su identidad[1], su nómina se depositará directamente en su Cuenta Skylight, así que podrá usarla para realizar compras o retirar efectivo. ¿No necesita gastarlo ahora? No se preocupe, su dinero permanecerá en su Cuenta Skylight para cuando lo necesite. A continuación, encontrará algunos consejos para aprovechar al máximo su Cuenta Skylight.

Luego de activar su cuenta y verificar su identidad[1], puede comenzar a usar su tarjeta y sus funciones, como:

- Realizar compras dondequiera que acepten tarjetas de débito Visa® o Debit Mastercard.®
- Retirar dinero sin cargo en los ATM de las redes Allpoint y MoneyPass (según su programa). Ingrese en su Centro de Cuentas en Línea para obtener una lista de los ATM sin cargo en su zona.[2]
- Retirar dinero en efectivo sin costo en cualquier banco miembro de la red Visa o Mastercard (simplemente, busque una sucursal con el logo de Visa o Mastercard).[3]
- Administrar su dinero desde cualquier parte con la aplicación móvil de Skylight ONE.[4]
- Recibir alertas por mensaje de texto o correo electrónico[4] (puede elegir una opción o ambas) cuando se realicen transacciones al suscribirse a Anytime Alerts™.
- Retirar el 100% de sus fondos con Cheques Skylight sin costo en ciertos establecimientos.[5] Consulte los Cheques Skylight para ver instrucciones detalladas.



Antes de que pueda usar su Tarjeta

- Active su Cuenta Skylight y verifique su identidad.[1] Para activarla, llame al número que aparece al dorso de su tarjeta o visite **skylightpaycard.com**.
- Elija un Número de Identificación Personal (“NIP”) que utilizará para acceder a su dinero en ATM.
- Regístrese en el Centro de Cuentas en Línea para monitorear y administrar su Cuenta Skylight. Podrá verificar su saldo, leer sus estados de cuenta, ver sus transacciones recientes, registrarse para obtener alertas por transacciones[4] y administrar todas las funciones de su Cuenta Skylight.

[1] **INFORMACIÓN IMPORTANTE PARA ABRIR UNA CUENTA DE TARJETA:** Para ayudar al gobierno en la lucha contra el financiamiento de actividades terroristas y el lavado de dinero, la Ley PATRIOTA de EE.UU. exige que obtengamos, verifiquemos y registremos información que identifique a cada persona que abre una Cuenta de Tarjeta. **QUÉ SIGNIFICA ESTO PARA USTED:** Cuando abra una Cuenta de Tarjeta, le preguntaremos su **nombre, domicilio, fecha de nacimiento y número de identificación emitida por el gobierno**. Es posible que también le pidamos que presente su licencia de conducir u otra información de identificación. Se exige la activación de Tarjeta y verificación de identidad antes de comenzar a usar la Cuenta de Tarjeta. Si su identidad se verifica parcialmente, el uso de la Cuenta de Tarjeta será restringido, pero usted podrá utilizar la Tarjeta para realizar compras en comercios. Se incluyen las siguientes restricciones: no se pueden realizar retiros de efectivo por ATM, transacciones internacionales, transferencias entre cuentas, ni cargas adicionales. El uso de la Cuenta de Tarjeta está sujeto a restricciones por prevención de fraude en cualquier momento, con o sin previo aviso.

[2] Las opciones de ATM sin cargo variarán según el programa de tarjeta. Consulte su Acuerdo del Titular de tarjeta para obtener más información sobre las opciones sin cargo. Se aplica un Cargo por retiro de efectivo en los ATM fuera de la red de recarga gratuita especificada en su Acuerdo del Titular de tarjeta. Podría aplicarse un cargo adicional del propietario del ATM.

[3] Podría aplicarse un cargo por parte de una institución financiera que no sea un banco miembro de Visa o Mastercard. Este es un cargo por servicio de terceras partes y está sujeto a cambios.

[4] No se aplican cargos por este servicio, pero su proveedor de servicios de telefonía móvil podría aplicar cargos por mensajes o transferencia de datos.

[5] Puede cobrar cheques Skylight sin costo en cualquier sucursal del U.S. Bank y en los establecimientos participantes de Walmart y ACE Cash Express. Otras instituciones que permiten cobrar cheques tienen políticas distintas para aceptar cheques y podrían aplicar un cargo para cobrar Cheques Skylight. Consulte los Cheques Skylight para ver instrucciones detalladas.

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Aflac Accident Advantage

ACCIDENT-ONLY INSURANCE – OPTION 3

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

Aflac SmartClaim®
One Day Pay℠

AFLAC ACCIDENT ADVANTAGE

ACCIDENT-ONLY INSURANCE – OPTION 3

Policy Series A36000

AA3

Be Prepared for Life's Unexpected Mishaps

Accidents can happen at any time. You could suffer an accidental injury while you are working around the house or walking into work. Or your child may get injured at basketball practice. When an accident happens, it can be costly. Even with major medical insurance, there may be out-of-pocket expenses that you'll have to pay.

In the event of an unexpected injury, Aflac can help protect your personal finances. We provide individuals and families affordable insurance that helps with expenses that may not be covered by major medical insurance. Aflac pays cash benefits directly to you (unless you specify otherwise), so you can use the cash for anything you want. Which means uncovered medical expenses won't break the bank if you are injured.

And since we can process your claim quickly, Aflac helps give you the peace of mind knowing you can spend more time recovering and less time worrying about bills.

The facts say you need the protection of the Aflac Accident Advantage insurance policy:

FACT NO. 1

ABOUT **1 OUT OF 8**

PEOPLE SEEK MEDICAL ATTENTION FOR AN INJURY.[1]

FACT NO. 2

$5,500

THE AVERAGE MEDICAL EXPENSES FOR AN ACCIDENTAL INJURY.[1]

[1]*Injury Facts*, 2014 Edition, National Safety Council.

Aflac herein means American Family Life Assurance Company of Columbus.

Understand the difference Aflac can make in your financial security.

Aflac pays cash benefits for covered accidental injuries directly to you, unless assigned. Your own peace of mind and the assurance that your family will have help financially are powerful reasons to consider Aflac.

The financial impact of an accident is often surprising. Most people have expenses after an accident they never thought of before. From out-of-pocket medical costs to a temporary loss of income, your finances may be strained. If you or a family member suffered an accidental injury, can your finances handle it?

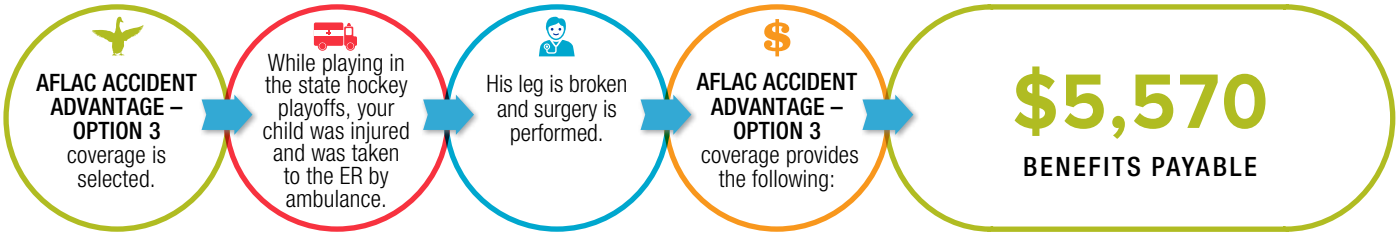
What does the Aflac Accident Advantage policy include?

- A wellness benefit payable for routine medical exams to encourage early detection and prevention.
- Benefits payable for fractures, dislocations, lacerations, concussions, burns, emergency dental work, eye injuries, and surgical procedures.
- Benefits payable for initial treatment, X-rays, major diagnostic exams, and follow-up treatments.
- Benefits payable for physical, speech, and occupational therapy.
- Daily hospitalization benefits payable for hospital stays, and additional daily benefits paid for stays in a hospital intensive care unit.

Why Aflac Accident Advantage may be the right choice for you:

- No underwriting questions to answer[2]
- No coordination of benefits—we pay regardless of any other insurance you may have
- No network restrictions—you choose your own health care provider
- Portable—take the plan with you if you change jobs or retire
- 24-hour accident insurance

How it works



The above example is based on a scenario for the Aflac Accident Advantage – Option 3 that includes the following benefit conditions: Ambulance Benefit of $200 (ground ambulance transportation); Accident Treatment Benefit of $200 (hospital emergency room treatment with X-rays); Accident Specific-Sum Injuries Benefit of $1,750 (fractured leg {femur}–open reduction under anesthesia); Initial Accident Hospitalization Benefit of $1,000; Accident Hospital Confinement Benefit of $250 (hospitalized for 1 day); Major Diagnostic and Imaging Exams Benefit of $200 (CT scan); Appliances Benefit of $300 (wheelchair); Therapy Benefit of $315 (9 physical therapy treatments); Accident Follow-Up Treatment Benefit of $210 (6 follow-up treatments); Family Support Benefit of $20 (hospitalized for 1 day); Family Lodging Benefit of $125 (hospital and motel/hotel more than 50 miles from residence); and Organized Sporting Activity Benefit of $1,000.

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 complete benefit details, definitions, limitations, and exclusions.

[2]Association and associate-only accounts have one underwriting question.

AFLAC ACCIDENT ADVANTAGE – OPTION 3 BENEFIT OVERVIEW

BENEFIT NAME	BENEFIT AMOUNT
INITIAL ACCIDENT HOSPITALIZATION BENEFIT	$1,000 when admitted for a hospital confinement of at least 18 hours or $2,000 when admitted directly to an intensive care unit of a hospital for a covered accident, per calendar year, per covered person
ACCIDENT HOSPITAL CONFINEMENT BENEFIT	$250 per day, up to 365 days per covered accident, per covered person
INTENSIVE CARE UNIT CONFINEMENT BENEFIT	Additional $400 per day for up to 15 days, per covered accident, per covered person
ACCIDENT TREATMENT BENEFIT	Payable once per 24-hour period and only once per covered accident, per covered person Hospital emergency room with X-ray: $200 Hospital emergency room without X-ray: $170 Office or facility (other than a hospital emergency room) with X-ray: $150 Office or facility (other than a hospital emergency room) without X-ray: $120
AMBULANCE BENEFIT	$200 ground ambulance transportation or $1,500 air ambulance transportation
BLOOD/PLASMA/PLATELETS BENEFIT	$200 once per covered accident, per covered person
MAJOR DIAGNOSTIC AND IMAGING EXAMS BENEFIT	$200 per calendar year, per covered person
ACCIDENT FOLLOW-UP TREATMENT BENEFIT	$35 for one treatment per day (up to a max of 6 treatments), per covered accident, per covered person
THERAPY BENEFIT	$35 for one treatment per day (up to a max of 10 treatments), per covered accident, per covered person
APPLIANCES BENEFIT	Benefits are payable for the medical appliances listed below: Back brace: $300 — Wheelchair: $300 — Walker: $100 Body jacket: $300 — Leg brace: $125 — Walking boot: $100 Knee scooter: $300 — Crutches: $100 — Cane: $25 Payable once per covered accident, per covered person
PROSTHESIS BENEFIT	$800 once per covered accident, per covered person
PROSTHESIS REPAIR OR REPLACEMENT BENEFIT	$800 once per covered person, per lifetime
REHABILITATION FACILITY BENEFIT	$150 per day
HOME MODIFICATION BENEFIT	$3,000 once per covered accident, per covered person
ACCIDENT SPECIFIC-SUM INJURIES BENEFITS	Pays benefits for the treatments listed below: DISLOCATIONS ..... $100–$3,750 BURNS ..... $125–$12,500 SKIN GRAFTS ..... 50% of the burns benefit amount paid for the burn involved EYE INJURIES Surgical repair ..... $300 Removal of foreign body by a physician .. $65 LACERATIONS Not requiring sutures ..... $35 Less than 5 centimeters ..... $65 At least 5 cm but not more than 15 cm . $250 Over 15 centimeters ..... $500 FRACTURES ..... $125–$3,500 CONCUSSION (brain) ..... $150 EMERGENCY DENTAL WORK Broken tooth repaired with crown ..... $400 Broken tooth resulting in extraction ..... $130 COMA ..... $12,500 PARALYSIS Quadriplegia ..... $12,500 Paraplegia ..... $6,250 Hemiplegia ..... $4,750 SURGICAL PROCEDURES ..... $200–$1,250 MISCELLANEOUS SURGICAL PROCEDURES ..... $120–$300 PAIN MANAGEMENT (NON-SURGICAL) Epidural $100

ACCIDENTAL-DEATH BENEFIT

	Common-Carrier Accident	Other Accident	Hazardous Activity Accident
INSURED	$150,000	$40,000	$10,000
SPOUSE	$150,000	$40,000	$10,000
CHILD	$25,000	$10,000	$5,000

ACCIDENTAL-DISMEMBERMENT BENEFIT	$300–$40,000
WELLNESS BENEFIT	$60 once per calendar year
FAMILY SUPPORT BENEFIT	$20 per day (up to 30 days), per covered accident
ORGANIZED SPORTING ACTIVITY BENEFIT	Additional 25% of the benefits payable, limited to $1,000 per policy, per calendar year
CONTINUATION OF COVERAGE BENEFIT	Waives all monthly premiums for up to two months, if conditions are met
WAIVER OF PREMIUM BENEFIT	Yes
TRANSPORTATION BENEFIT	$600 per round trip, up to 3 round trips per calendar year, per covered person
FAMILY LODGING BENEFIT	$125 per night, up to 30 days per covered accident

REFER TO THE POLICY FOR COMPLETE BENEFIT DETAILS, DEFINITIONS, LIMITATIONS, AND EXCLUSIONS.

ACCIDENT-ONLY COVERAGE

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

ACCIDENT-ONLY COVERAGE

THE POLICY PROVIDES LIMITED BENEFITS.

BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

1. **Read Your Policy Carefully.** This document provides a very brief description of the important features of the coverage. 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. Accident-Only coverage is designed to provide, to persons insured, coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the policy. **Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.**

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

   HOSPITAL BENEFITS:

   INITIAL ACCIDENT HOSPITALIZATION BENEFIT: Aflac will pay $1,000 when a Covered Person is admitted for a Hospital Confinement of at least 18 hours for treatment of Injuries sustained in a covered accident or Aflac will pay $2,000 if a Covered Person is admitted directly to an Intensive Care Unit of a Hospital for treatment for Injuries sustained in a covered accident. This benefit is payable only once per Period of Hospital Confinement (including Intensive Care Unit confinement) and only once per Calendar Year, per Covered Person. Hospital Confinements must start within 30 days of the accident.

   ACCIDENT HOSPITAL CONFINEMENT BENEFIT: Aflac will pay $250 per day when a Covered Person is admitted for a Hospital Confinement of at least 18 hours for treatment of Injuries sustained in a covered accident. Aflac will pay this benefit up to 365 days per covered accident, per Covered Person. Hospital Confinements must start within 30 days of the accident. **The Accident Hospital Confinement Benefit and the Rehabilitation Facility Benefit will not be paid on the same day. The highest eligible benefit will be paid.**

   INTENSIVE CARE UNIT CONFINEMENT BENEFIT: Aflac will pay an additional $400 for each day a Covered Person receives the Accident Hospital Confinement Benefit and is confined and charged for a room in an Intensive Care Unit for treatment of Injuries sustained in a covered accident. This Intensive Care Unit Confinement Benefit is payable for up to 15 days per covered accident, per Covered Person. Hospital Confinements must start within 30 days of the accident.

   SERVICE BENEFITS:

   ACCIDENT TREATMENT BENEFIT: Aflac will pay the applicable amount shown below when a Covered Person receives treatment for Injuries sustained in a covered accident. This benefit is payable for treatment received under the care of a Physician at a(n):

Hospital Emergency Room with X-Ray	$200
Hospital Emergency Room without X-Ray	$170
Office or facility (other than a Hospital Emergency Room) with X-Ray	$150
Office or facility (other than a Hospital Emergency Room) without X-Ray	$120

   Treatment must be received within 72 hours of the accident for benefits to be payable. This benefit is payable once per 24-hour period and only once per covered accident, per Covered Person.

   AMBULANCE BENEFIT: Aflac will pay $200 when a Covered Person requires ambulance transportation to a Hospital for Injuries sustained in a covered accident. Ambulance transportation must be within 72 hours of the covered accident. Aflac will pay $1,500 when a Covered Person requires transportation provided by an air ambulance for Injuries sustained in a covered accident. A licensed professional ambulance company must provide the ambulance service.

   BLOOD/PLASMA/PLATELETS BENEFIT: Aflac will pay $200 when a Covered Person receives blood/plasma and/or platelets for the treatment of Injuries sustained in a covered accident. This benefit does not pay for immunoglobulins and is payable only one time per covered accident, per Covered Person.

   MAJOR DIAGNOSTIC AND IMAGING EXAMS BENEFIT: Aflac will pay $200 when a Covered Person requires one of the following exams for Injuries sustained in a covered accident and a charge is incurred: computerized tomography (CT scan), computerized axial tomography (CAT), magnetic resonance imaging (MRI), or electroencephalography (EEG). These exams must be performed in a Hospital, 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.

   AFTER CARE SERVICES:

   ACCIDENT FOLLOW-UP TREATMENT BENEFIT: Aflac will pay $35 per day when a Covered Person receives treatment for Injuries sustained in a covered accident and later requires additional treatment over and above treatment administered in the first 72 hours following the accident. Aflac will pay for one treatment per day for up to a maximum of six treatments per covered accident, per Covered Person. The treatment must begin within 30 days of the covered accident or discharge from the Hospital. Treatments must be received

under the care of a Physician. This benefit is payable for acupuncture when furnished by a licensed certified acupuncturist. **The Accident Follow-Up Benefit is not payable for the same days that the Therapy Benefit is paid.**

THERAPY BENEFIT: Aflac will pay $35 per therapy treatment when a Covered Person receives treatment for Injuries sustained in a covered accident and later a Physician advises the Covered Person to seek treatment from a licensed Occupational, Physical, or Speech Therapist. Occupational, physical, or speech therapy must be for Injuries sustained in a covered accident and must start within 30 days of the covered accident or discharge from the Hospital. Aflac will pay for one treatment per day for up to a maximum of ten treatments per covered accident, per Covered Person. The treatment must take place within six months after the accident. **The Therapy Benefit is not payable for the same days that the Accident Follow-Up Treatment Benefit is paid.**

APPLIANCES BENEFIT: Aflac will pay the applicable amount shown below when a Covered Person receives a medical appliance, prescribed by a Physician, as an aid in personal locomotion, for Injuries sustained in a covered accident. Benefits are payable for the following types of appliances:

Back brace	$300
Body jacket	$300
Knee scooter	$300
Wheelchair	$300
Leg brace	$125
Crutches	$100
Walker	$100
Walking boot	$100
Cane	$25

This benefit is payable once per covered accident, per Covered Person.

PROSTHESIS BENEFIT: Aflac will pay $800 when a Covered Person receives a Prosthetic Device, prescribed by a Physician, as a result of Injuries sustained in a covered accident. This benefit is not payable for repair or replacement of Prosthetic Devices, hearing aids, wigs, or dental aids to include false teeth. This benefit is payable once per covered accident, per Covered Person.

PROSTHESIS REPAIR OR REPLACEMENT BENEFIT: Aflac will pay $800 when:

1. a Covered Person requires replacement of an existing Prosthetic Device for which benefits were previously paid under the Prosthesis Benefit. The replacement must occur 36 months or more after any previously paid Prosthesis Benefit, or
2. a Covered Person sustains damages, as a result of Injuries sustained in a covered accident, which require repair or replacement of an existing Prosthetic Device.

This benefit is not payable for hearing aids, wigs, or dental aids to include false teeth. This benefit is payable once per Covered Person, per lifetime.

REHABILITATION FACILITY BENEFIT: Aflac will pay $150 per day when a Covered Person is admitted for a Hospital Confinement and is transferred to a bed in a Rehabilitation Facility for treatment of Injuries sustained in a covered accident and a charge is incurred. This benefit is limited to 30 days for each Covered Person per Period of Hospital Confinement and is limited to a Calendar Year maximum of 60 days. No lifetime maximum. **The Rehabilitation Facility Benefit will not be payable for the same days that the Accident Hospital Confinement Benefit is paid. The highest eligible benefit will be paid.**

HOME MODIFICATION BENEFIT: Aflac will pay $3,000 for a home modification aid when a Covered Person suffers a Catastrophic Loss in a covered accident. This benefit is payable once per covered accident, per Covered Person.

ACCIDENT SPECIFIC-SUM INJURIES BENEFITS: When a Covered Person receives treatment under the care of a Physician for Injuries sustained in a covered accident, Aflac will pay specified benefits ranging from $35–$12,500 for dislocations, burns, skin grafts, eye injuries, lacerations, fractures, concussion, emergency dental work, coma, paralysis, surgical procedures, miscellaneous surgical procedures and pain management. See policy for specific amounts payable.

ACCIDENTAL-DEATH & DISMEMBERMENT BENEFITS:

ACCIDENTAL-DEATH BENEFIT: Aflac will pay the applicable lump-sum benefit indicated below for an Accidental-Death. Accidental-Death must occur as a result of an Injury sustained in a covered accident and must occur within 90 days of such accident.

Named Insured or Spouse-	
Common-Carrier Accident	$150,000
Other Accident	$40,000
Hazardous Activity Accident	$10,000
Child-	
Common-Carrier Accident	$25,000
Other Accident	$10,000
Hazardous Activity Accident	$5,000

Aflac will pay an additional 25 percent of the Accidental-Death Benefit when two or more Accidental-Deaths occur in the same covered accident. Accidental-Death must occur as a result of an Injury sustained in a covered accident and must occur within 90 days of such accident.

In the event of the Accidental-Death of a covered Spouse or Dependent Child, Aflac will pay you the applicable lump-sum benefit indicated above. If you are disqualified from receiving the benefit by operation of law, then the benefit will be paid to the deceased Covered Person's estate unless Aflac has paid the benefit before receiving notice of your disqualification.

In the event of your Accidental-Death, Aflac will pay the applicable lump-sum benefit indicated above for your Accidental-Death to the beneficiary named in the application for the policy unless you subsequently changed your beneficiary. If you changed your beneficiary, then Aflac will pay this benefit to the beneficiary named in your last change of beneficiary request of record. If any beneficiary is a minor child, then any benefits payable to such minor beneficiary will not be paid until a guardian for the financial estate of the minor is appointed by the court or such beneficiary reaches the age of majority as defined by applicable state law. If any beneficiary is disqualified from receiving the benefit by operation of law, then the benefit will be

paid as though that beneficiary died before you unless Aflac has paid the benefit before receiving notice of the beneficiary's disqualification. If a beneficiary dies before you do, the interest of that beneficiary terminates. If a beneficiary does not survive you by 15 days, then the benefit will be paid as though the beneficiary died before you unless Aflac has paid the benefit before receiving notice of the beneficiary's death. If no beneficiary survives you, Aflac will pay the benefit to your estate.

ACCIDENTAL-DISMEMBERMENT BENEFIT: Aflac will pay the applicable lump-sum benefit indicated below for Dismemberment. Dismemberment must occur as a result of an Injury sustained in a covered accident and must occur within 90 days of such accident. If a Covered Person does not qualify for the Accidental-Dismemberment Benefit but loses (with or without reattachment) at least one joint of a finger or toe, other than the first interphalangeal joint, we will pay the Partial Dismemberment Benefit.

Named Insured or Spouse-	
Dismemberment or complete loss of, with or without reattachment:	
Both arms and both legs	$40,000
Two eyes, feet, hands, arms or legs	$40,000
One eye, foot, hand, arm, or leg	$10,000
One or more fingers and/or one or more toes	$2,000
Partial Dismemberment of finger or toe	$625
Child-	
Dismemberment or complete loss of, with or without reattachment:	
Both arms and both legs	$12,500
Two eyes, feet, hands, arms or legs	$12,500
One eye, foot, hand, arm, or leg	$3,750
One or more fingers and/or one or more toes	$625
Partial Dismemberment of finger or toe	$300

Only the highest single benefit per Covered Person will be paid for Dismemberment. Benefits will be paid only once per Covered Person, per covered accident. If death and Dismemberment result from the same accident, only the Accidental-Death Benefit will be paid.

ADDITIONAL BENEFITS:

WELLNESS BENEFIT (a preventive benefit; the Accidental-Death, Dismemberment, or Injury of a Covered Person is not required for this benefit to be payable): Aflac will pay $60 if you or any one Covered Person undergoes routine examinations or other preventive testing during the Calendar Year. Services covered are annual physical examinations, dental examinations, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, ultrasounds, prostate-specific antigen tests (PSAs), and blood screenings. This benefit is payable only once per policy, per Calendar Year. Service must be under the supervision of or recommended by a Physician, received while your policy is in force, and a charge must be incurred.

FAMILY SUPPORT BENEFIT: Aflac will pay $20 for each day a Covered Person qualifies for benefits under the Accident Hospital Confinement Benefit. Aflac will pay this benefit up to 30 days per covered accident.

ORGANIZED SPORTING ACTIVITY BENEFIT: Aflac will pay an additional 25 percent of the benefits payable when a Covered Person receives treatment for Injuries sustained in a covered accident while participating in an Organized Sporting Activity. This benefit is not payable for Injuries that are caused by or occur as a result of a Covered Person's participating in any sport or sporting activity for wage, compensation, or profit, including officiating or coaching; or racing any type vehicle in an organized event. This benefit is limited to $1,000 per policy, per Calendar Year.

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

1. Your policy has been in force for at least six months;
2. We have received premiums for at least six consecutive months;
3. Your premiums have been paid through payroll deduction and you leave your employer for any reason;
4. You or your employer notifies us in writing within 30 days of the date your premium payments cease because of your leaving employment; and
5. You re-establish premium payments 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.

WAIVER OF PREMIUM BENEFIT:

Employed: If you, due to Injuries sustained in a covered accident, are completely unable to do all of the usual and customary duties of your occupation or any occupation whatsoever, for more than 180 consecutive days while the policy is in force, 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 (or proof of your inability to perform three or more ADLs) and a Physician's statement certifying 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 Injuries sustained in a covered accident, are completely unable to perform three or more of the Activities of Daily Living (ADLs) without Direct Personal Assistance for more than 180 consecutive days while the policy is in force, 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 certifying your inability to perform said activities, and may each month thereafter require a Physician's statement that total inability continues.

This Waiver of Premium Benefit is limited to a total maximum of 36 months per eligibility of the Waiver of Premium Benefit regardless of whether you are employed or not employed.

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

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

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 Waiver of Premium Benefits.

TRANSPORTATION BENEFIT: Aflac will pay $600 per round trip to a Hospital when a Covered Person requires Hospital Confinement for medical treatment due to an Injury sustained in a covered accident.

Aflac will also pay $600 per round trip when a covered Dependent Child requires Hospital Confinement for medical treatment due to an Injury sustained in a covered accident if commercial travel (plane, train, or bus) is necessary and such Dependent Child is accompanied by any Immediate Family member.

This benefit is not payable for transportation to any Hospital located within a 50-mile radius of the site of the accident or residence of the Covered Person. The local attending Physician must prescribe the treatment requiring Hospital Confinement, and the treatment must not be available locally. This benefit is payable for up to three round trips per Calendar Year, per Covered Person. This benefit is not payable for transportation by ambulance or air ambulance to the Hospital.

FAMILY LODGING BENEFIT: Aflac will pay $125 per night for one motel/hotel room for a member(s) of the Immediate Family that accompanies a Covered Person who is admitted for a Hospital Confinement for the treatment of Injuries sustained in a covered accident. This benefit is payable only during the same period of time the injured Covered Person is confined to the Hospital. The Hospital and motel/hotel must be more than 50 miles from the residence of the Covered Person. This benefit is limited to one motel/hotel room per night and is payable up to 30 days per covered accident.

4. Optional Benefit

Additional Accidental-Death Benefit Rider:
(Series A36050) Applied For: ☐Yes ☐No

EXCEPTIONS, REDUCTIONS AND LIMITATIONS OF THE RIDER: Aflac will not pay benefits under the rider for an Accidental-Death that is caused by or occurs as a result of a Hazardous Activity Accident. Refer to your policy for additional Limitations and Exclusions.

ACCIDENTAL-DEATH BENEFIT: Aflac will pay the applicable lump-sum benefit indicated below for an Accidental-Death. Accidental-Death must occur as a result of an Injury sustained in a covered accident and must occur within 90 days of such accident.

	Named Insured	Spouse	Child
Common-Carrier Accident	$35,000	$35,000	$7,000
Other Accident	35,000	35,000	7,000

Aflac will pay an additional 25 percent of the Accidental-Death Benefit when two or more Accidental-Deaths occur in the same covered accident. Accidental-Death must occur as a result of an Injury sustained in a covered accident and must occur within 90 days of such accident.

In the event of the Accidental-Death of a covered Spouse or Dependent Child, Aflac will pay you the applicable lump-sum benefit indicated above. If you are disqualified from receiving the benefit by operation of law, then the benefit will be paid to the deceased Covered Person's estate unless Aflac has paid the benefit before receiving notice of your disqualification.

In the event of your Accidental-Death, Aflac will pay the applicable lump-sum benefit indicated above for your Accidental-Death to the beneficiary named in the application for the policy unless you subsequently changed your beneficiary. If you changed your beneficiary, then Aflac will pay this benefit to the beneficiary named in your last change of beneficiary request of record. If any beneficiary is a minor child, then any benefits payable to such minor beneficiary will not be paid until a guardian for the financial estate of the minor is appointed by the court or such beneficiary reaches the age of majority as defined by applicable state law. If any beneficiary is disqualified from receiving the benefit by operation of law, then the benefit will be paid as though that beneficiary died before you unless Aflac has paid the benefit before receiving notice of the beneficiary's disqualification. If a beneficiary dies before you do, the interest of that beneficiary terminates. If a beneficiary does not survive you by 15 days, then the benefit will be paid as though the beneficiary died before you unless Aflac has paid the benefit before receiving notice of the beneficiary's death. If no beneficiary survives you, Aflac will pay the benefit to your estate.

The rider will terminate upon the earlier of the termination of the policy to which it is attached, your failure to pay premiums for the rider, or your death.

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5. Exceptions, Reductions and Limitations of the Policy:

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

For any benefit to be payable, the Injury, treatment, or loss must occur on or after the Effective Date of coverage and while coverage is in force.

Aflac will not pay benefits for treatment or loss due to Sickness including (1) any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings; or (2) an error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure for any Sickness.

Aflac will not pay benefits whenever coverage provided by the policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

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

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

- Actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve;
- Being intoxicated or under the influence of any narcotic, unless administered on the advice of a Physician and taken according to the Physician's instructions (the term "intoxicated" refers to

that condition as defined by the law of the jurisdiction in which the cause of the loss occurred);

- Using any narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions) or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;
- Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any detention facility or penal institution;
- Intentionally self-inflicting a bodily injury, or committing or attempting suicide, while sane or insane;
- Having cosmetic surgery or other elective procedures that are not Medically Necessary. Cosmetic surgery does not include reconstructive surgery because of congenital disease or anomaly of a covered Dependent Child which has resulted in a functional defect; or
- Having dental treatment except as a result of Injury.

6. **Renewability.** The policy is guaranteed-renewable for your lifetime by the payment of premiums within the grace period at the rate in effect at the beginning of each term. However, subject to the Time Limit on Certain Defenses provision, we may discontinue or terminate the policy if you have performed an act or practice that constitutes fraud, or have made an intentional misrepresentation of material fact, relating in any way to the policy, including claims for benefits under the policy. Premium rates may be changed only if changed on all policies of the same form number and class in force in your state.

RETAIN FOR YOUR RECORDS.
THIS IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.
REFER TO THE POLICY AND RIDER(S) FOR COMPLETE DEFINITIONS, DETAILS, LIMITATIONS AND EXCLUSIONS.

TERMS YOU NEED TO KNOW

ACCIDENTAL-DEATH: Death of a covered person caused by a covered injury. See the limitations and exclusions for injuries not covered by the policy.

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

The ADLs are:

- Bathing: Washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower;
- Maintaining continence: Controlling urination and bowel movements, including your ability to use ostomy supplies or other devices such as catheters;
- Transferring: Moving between a bed and a chair, or a bed and a wheelchair;
- Dressing: Putting on and taking off all necessary items of clothing;
- Toileting: Getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene; and
- Eating: Performing all major tasks of getting food into your body.

CATASTROPHIC LOSS: An injury that results in total and permanent or irrevocable loss of: the sight of one eye; the use of one hand/arm; or the use of one foot/leg.

COMMON-CARRIER ACCIDENT: An accident directly involving a common-carrier vehicle in which a covered person is a passenger at the time of the accident. A common-carrier vehicle is limited to only an airplane, train, bus, trolley, or boat that is duly licensed by a proper authority to transport persons for a fee, holds itself out as a public conveyance, and is operating on a posted regularly scheduled basis between predetermined points or cities at the time of the accident. A passenger is a person aboard or riding in a common-carrier vehicle other than (1) a pilot, driver, operator, officer, or member of the crew of such vehicle; (2) a person having any duties aboard such vehicle; or (3) a person giving or receiving any kind of training or instruction. A common-carrier accident does not include any hazardous activity accident or any accident directly involving private, on demand, or chartered transportation in which a covered person is a passenger at the time of the accident.

COVERED PERSON: Any person insured under the coverage type you applied for 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 covered under the terms of the policy from the moment of birth. If individual or named insured/spouse only coverage is in force and you desire uninterrupted coverage for a newborn child, you must notify Aflac in writing within 31 days of the child's birth. Upon notification, Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due, if any. Coverage provided under any one-parent family or two-parent family policy will continue to include any other dependent child, regardless of age, who (1) is incapable of self-sustaining employment by reason of mental retardation or physical handicap, (2) is chiefly dependent upon the policyholder or subscriber for support and maintenance, and (3) became so incapacitated prior to age 26. Dependent children are your natural children, stepchildren, legally adopted or foster children who are under age 26. This includes your dependent children whom you must provide medical support under a court or administrative order. Children born to your dependent children or children born to the dependent children of your spouse are not covered under the policy. A dependent child (including persons incapable of self-sustaining employment by reason of mental retardation or physical handicap and is chiefly dependent upon the policyholder or subscriber for support and maintenance) must be under age 26 at the time of application to be eligible for coverage.

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

HAZARDOUS ACTIVITY ACCIDENT: An accident while a covered person is participating in sky diving, scuba diving, hang gliding, motorized vehicle racing, cave exploration, bungee jumping, parachuting, or mountain or rock climbing; or while a pilot, officer, or member of the crew of an aircraft, having any duties aboard an aircraft, or giving or receiving any kind of training or instruction aboard an aircraft. A hazardous activity accident does not include any common-carrier accidents.

HOSPITAL CONFINEMENT: A stay of a covered person confined to a bed in a hospital for which a room charge is made. The hospital confinement must be on the advice of a physician, medically necessary, and the result of a covered injury. Confinement in a U.S. government hospital does not require a charge for benefits to be payable.

INJURY: A bodily injury caused directly by an accident, independent of sickness, disease, bodily infirmity, or any other cause. See the limitations and exclusions for injuries not covered by the policy.

ORGANIZED SPORTING ACTIVITY: A competition or supervised organized practice for a competition. The competition must be governed by a set of written rules, be officiated by someone certified to act in that capacity, and overseen by a legal entity such as a public school system or sports conference. The legal entity must have a set of bylaws and competition must be on a regulation playing surface. Participation must be on an amateur basis. The organized sporting activity benefit is not payable for injuries that are caused by or occur as a result of a covered person's participating in any sport or sporting activity for wage, compensation, or profit, including officiating or coaching; or racing any type vehicle in an organized event.

OTHER ACCIDENT: An accident that is not classified as either a common-carrier accident or a hazardous activity accident and that is not specifically excluded in the limitations and exclusions.

SICKNESS: An illness, disease, infection, disorder, or condition not caused by an injury, occurring on or after the effective date of coverage and while coverage is in force.

Refer to the policy for complete benefit details, definitions, limitations, and exclusions.

ADDITIONAL INFORMATION

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

The term hospital does not include any institution or part thereof used as a rehabilitation facility; 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; an extended-care facility; a skilled nursing facility; a psychiatric unit; 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.

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

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.

A physician, occupational therapist, physical therapist, or speech therapist does not include you or a member of your immediate family.

Burns must be treated by a physician within 72 hours after a covered accident. If a covered person receives one or more skin grafts for a covered burn, we will pay a total of 50 percent of the burns benefit amount that we paid for the burn involved.

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

Coma must have a duration of at least seven days. The condition must require intubation for respiratory assistance. Coma does not include any medically induced coma.

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

Fractures must be diagnosed by a physician within 14 days after the date of the injury and require correction by a physician. It can be corrected by open or closed reduction. We will pay for no more than two fractures per covered accident, per covered person. For the closed reduction for chip fractures and other fractures not reduced by open or closed reduction, we will pay 25 percent of the benefit amount shown in the policy.

Lacerations must be repaired within 72 hours after the accident and repaired under the attendance of a physician. A laceration resulting from an open fracture will not be payable under the laceration benefit.

Paralysis must be confirmed by the attending physician. The duration of the paralysis must be a minimum of 30 days. This benefit will be payable once per covered person.

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

A miscellaneous surgical procedures benefit is only payable for one miscellaneous surgical procedure, per 24-hour period, even though more than one surgical procedure may be performed.

When a covered person is prescribed, receives, and incurs a charge for an epidural administered into the spine for pain management in a hospital or a physician's office for injuries sustained in a covered accident, we will pay a pain management benefit amount. This benefit is not payable for an epidural administered during a surgical procedure. This benefit is payable no more than twice per covered accident, per covered person.

Aflac®

Refer to the policy for complete benefit details, definitions, limitations, and exclusions.

Aflac SmartClaim®

One Day Pay℠

aflac.com | **1.800.99.AFLAC** (1.800.992.3522)

One Day Pay℠ available for most properly-documented, individual Accident claims submitted online through Aflac SmartClaim® by 3 p.m. ET. Aflac SmartClaim® not available on the following: Aflac Plus Rider. Processing time is based on business days after all required documentation needed to render a decision is received and no further validation and/or research is required. Individual Company Statistic, 2015.

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

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MeMD

Wave goodbye to the waiting room

With MeMD, care is just a click away

Not feeling so great? Avoid the waiting room and get care right where you are — from your phone or computer. Introducing MeMD, brought to you by Aflac.

With MeMD telehealth services, you can connect to a board-certified, U.S.-licensed medical provider, or licensed behavioral health specialist, from almost any location. Day and night. Weekends and holidays. All using your phone or computer. You'll get a confidential diagnosis along with a personalized treatment plan, including prescriptions* for common medications when medically necessary. Best of all, your family members can use the program as well.

Activate and log in to your account
at **www.MeMD.me/AflacStandard,** using your email address for the member ID and email fields.

Consult a physician, PA, nurse practitioner or licensed behavioral health specialist
in real time by video or phone, using the MeMD app. Visit fee varies by service type.

Prescription for common medicines,
if medically necessary, will be submitted electronically by MeMD to your pharmacy of choice.*

Connect with a board-certified, U.S.-licensed medical provider or behavioral health specialist.

Aflac | Value-Added Services

Aflac has entered into a marketing alliance with MeMD whereby MeMD may provide telehealth services from MeMD to individuals who are employees of accounts that choose to make MeMD available to them. Other than this marketing alliance, Aflac and MeMD are not affiliated in any way. Aflac makes no representations or warranties regarding MeMD's products or services, and is not responsible for any products or services provided by MeMD. If you have questions regarding MeMD's products or services, please contact MeMD by calling 855-636-3669 or emailing solutions@memd.me. The complimentary telehealth services provided by MeMD is not available to employees of Aflac accounts located in ID, MN or NY. Telehealth services are not available to residents of ID or MN. Additional state restrictions may apply and benefits may vary by state. Customers will be responsible for a visit fee at time of each telehealth visit.

*When medically necessary, MeMD's providers (except therapists) can submit a prescription electronically for purchase and pick-up at your local participating pharmacy; however, MeMD providers cannot prescribe elective medications, narcotic pain relievers, or controlled substances. MeMD's providers are each licensed by the appropriate licensing board for the state in which they are providing services and all have prescriptive authority for each of the states in which they are licensed.

Aflac herein means American Family Life Assurance Company of Columbus. WWHQ | 1932 Wynnton Road | Columbus, GA 31999.

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EXP 2/21

MeMD®

Use your phone or computer to get treatment for:

- Abrasions, bruises, minor headaches, arthritic pains.
- Allergies, hives, skin infections, bites and stings.
- Colds, fever, sore throat, cough, congestion.
- Diarrhea, vomiting, nausea, urinary tract infections.
- Eye infections, conjunctivitis, body aches.
- Medication refills (short-term)* and more.
- Addiction, anxiety, bipolar disorder, depression, divorce and more.
- Telepsychiatry, Talk Therapy Services, and Teen Therapy.†

Download the MeMD app

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It's even easier to get on-demand access to U.S.-licensed, board-certified medical providers with MeMD's app. After activating your online account, search MeMD in the app store to download it on your Android or Apple device today.**

Avoid the waiting room. Call on MeMD.

Call: 855.636.3669 or Visit: www.MeMD.me/AflacStandard.

**If you have already created a MeMD® account and are being charged an incorrect price, call MeMD's care coordination team at 1-855-636-3669 to update.

† Service availability and age restrictions vary by state.

Aflac

Cancer Protection Assurance

CANCER INDEMNITY INSURANCE – OPTION 2

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

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

Aflac SmartClaim®
One Day Pay℠

AFLAC CANCER PROTECTION ASSURANCE

CANCER INDEMNITY INSURANCE – OPTION 2

Policy Series B70000

C²

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

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

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

CANCER STATS YOU NEED TO KNOW

FACT NO. 1

MEN HAVE A SLIGHTLY LESS THAN **1 IN 2**

LIFETIME RISK OF DEVELOPING CANCER IN THE UNITED STATES.[3]

FACT NO. 2

WOMEN HAVE A SLIGHTLY MORE THAN **1 IN 3**

LIFETIME RISK OF DEVELOPING CANCER IN THE UNITED STATES.[3]

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

[1]Progress Against Cancer – 2019 Annual Plan, National Cancer Institute. https://www.cancer.gov/about-nci/budget/plan/progress. Accessed: November 13, 2017. [2]Coverage remains in force as long as premiums are paid. [3]Cancer Facts & Figures 2017, American Cancer Society. [4]National Cancer Institute, Surveillance, Epidemiology and End Results (SEER) Program. See:https://seer.cancer.gov/statfacts/html/breast.html and https://seer.cancer.gov/statfacts/html/prost.html. SEER Cancer Statistics Review, 1975-2014, National Cancer Institute. Bethesda, MD, https://seer.cancer.gov/csr/1975_2014/, based on November 2016 SEER data submission, posted to the SEER web site, April 2017. Accessed: December 13, 2017. [5]Widowed Early, A Cancer Doctor Writes About the Harm of Medical Debt, NPR, August, 10 2018. https://www.npr.org/sections/health-shots/2017/08/10/542589232/widowed-early-a-cancer-doctor-writes-about-the-harm-of-medical-debt. Accessed: December 14, 2017.

Understand the difference Aflac makes in your financial security.

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

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

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

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

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

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

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

HOW IT WORKS

AFLAC CANCER PROTECTION ASSURANCE OPTION 2

POLICYHOLDER
SUFFERS FROM FREQUENT INFECTIONS AND HIGH FEVER

- POLICYHOLDER VISITS PHYSICIAN
- PHYSICIAN RECOMMENDS BONE MARROW BIOPSY
- PATIENT RECEIVES DIAGNOSIS OF LEUKEMIA AND UNDERGOES TREATMENT

$23,575
TOTAL BENEFITS

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

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

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

Coverage Options

Choose the Policy and Riders that Fit Your Needs

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

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

OPTIONAL RIDERS	**DESCRIPTION**		
INITIAL DIAGNOSIS BUILDING BENEFIT RIDER	This benefit will increase the amount of your Initial Diagnosis Benefit, as shown in the policy, by $100 for each unit purchased, up to five units, for each covered person on the anniversary date of coverage, while coverage remains in force.		
SPECIFIED-DISEASE BENEFIT RIDER	When a covered person is diagnosed with any of the diseases listed in the Specified-Disease Rider:		
	Initial diagnosis	Hospitalization	
	$2,000	30 days or less: $400 per day	31 days or more: $800 per day
DEPENDENT CHILD RIDER	$10,000 when a covered dependent child is diagnosed as having internal cancer or an associated cancerous condition; payable only once for each covered dependent child		

REFER TO THE FOLLOWING PAGES FOR BENEFIT DETAILS, LIMITATIONS AND EXCLUSIONS.

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

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

LIMITED BENEFIT, SPECIFIED DISEASE INSURANCE
Policy Form Series B70200

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

2. **Cancer Insurance Coverage** is designed to supplement a Covered Person's existing accident and sickness coverage only when certain losses occur as a result of the disease of Cancer or an Associated Cancerous Condition. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

3. **Benefits:** Aflac will pay the following benefits, as applicable, while coverage is in force, subject to all other limitations and exclusions, conditions, and provisions of the policy, unless indicated otherwise. All treatments listed below must be National Cancer Institute (NCI) or Food and Drug Administration (FDA) approved for the treatment of Cancer or an Associated Cancerous Condition, as applicable.

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

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

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

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

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

   CANCER DIAGNOSIS BENEFITS:

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

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

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

   ADDITIONAL OPINION BENEFIT: Aflac will pay $300 when a charge is incurred for an additional surgical opinion from a Physician or an evaluation or consultation with a Physician for the purpose of determining the appropriate course of treatment for a covered Internal Cancer or Associated Cancerous Condition. **This benefit is payable once per Covered Person, per lifetime.**

   CANCER TREATMENT BENEFITS:

   NONSURGICAL TREATMENT BENEFITS:

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

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

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

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

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

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

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

INDIRECT/ADDITIONAL THERAPY BENEFITS:

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

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

BLOOD AND PLASMA BENEFIT: Aflac will pay the actual charges incurred up to $50 multiplied by 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, including charges for administration, for the treatment of Internal Cancer or an Associated Cancerous Condition during a covered Hospital confinement. Aflac will pay the actual charges incurred up to $175 for each day a Covered Person receives and incurs a charge for blood and/or plasma transfusions, including charges for 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.

SURGICAL TREATMENT BENEFITS:

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

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

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

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

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

SKIN CANCER SURGERY BENEFIT: When a surgical operation is performed on a Covered Person for a diagnosed skin Cancer, including melanoma or Nonmelanoma Skin Cancer, Aflac will pay the amount listed below when a charge is incurred for the specific procedure. The amount listed below includes anesthesia services. The maximum daily benefit will not exceed $400. No lifetime maximum on the number of operations.

Laser or Cryosurgery	$ 35

<u>Surgeries OTHER THAN Laser or Cryosurgery:</u>

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

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

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

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

<u>HOSPITALIZATION BENEFITS:</u>

HOSPITAL CONFINEMENT BENEFITS:

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

Named Insured or Spouse	$200
Dependent Child	$250

HOSPITALIZATION FOR 31 DAYS OR MORE: During any continuous period of Hospital confinement of a Covered Person for treatment of Cancer or an Associated Cancerous Condition for 31 days or more, Aflac will pay benefits as described above for the first 30 days. Beginning with the 31st day of such continuous Hospital confinement,

Aflac will pay the amount listed below for each day the Covered Person is charged for a room as an inpatient. No lifetime maximum.

Named Insured or Spouse	$400
Dependent Child	$500

OUTPATIENT HOSPITAL SURGICAL ROOM CHARGE BENEFIT: When a surgical operation is performed on a Covered Person for treatment of a diagnosed Internal Cancer or Associated Cancerous Condition, and a surgical room charge is incurred, Aflac will pay $200. For this benefit to be paid, surgeries must be performed on an outpatient basis in a Hospital or an Ambulatory Surgical Center. This benefit is payable once per day and is not payable on the same day the Hospital Confinement Benefit is payable. This benefit is payable in addition to the Surgery/Anesthesia Benefit. The maximum daily benefit will not exceed $200. No lifetime maximum on number of operations.

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

CONTINUING CARE BENEFITS:

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

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

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

1. The home health care or health supportive services must begin within seven days of release from the Hospital.
2. This benefit is limited to ten days per hospitalization for each Covered Person.
3. This benefit is limited to 30 days in any Calendar Year for each Covered Person.
4. This benefit will not be payable unless the attending Physician prescribes such services to be performed in the home of the Covered Person and certifies that if these services were not available, the Covered Person would have to be hospitalized to receive the necessary care, treatment, and services.
5. Home health care and health supportive services must be performed by a person, other than a member of your Immediate Family, who is licensed, certified, or otherwise duly qualified to perform such services on the same basis as if the services had been performed in a health care facility.

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

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

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

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

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

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

NONSURGICAL PROSTHESIS BENEFIT: Aflac will pay $175 per occurrence, per Covered Person when a charge is incurred for nonsurgically implanted prosthetic devices that are prescribed as a direct result of treatment for Internal Cancer or an Associated Cancerous Condition. Examples of nonsurgically implanted prosthetic devices include voice boxes, hair pieces, and removable breast prostheses. Lifetime maximum of $350 per Covered Person.

RECONSTRUCTIVE SURGERY BENEFIT:

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

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

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

Facial Reconstruction	$ 500

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

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

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

ANNUAL CARE BENEFIT: Aflac will pay $200 on the anniversary date of a Covered Person's diagnosis of a covered Internal Cancer or Associated Cancerous Condition for care other than the direct treatment of Cancer or an Associated Cancerous Condition to meet the Covered Person's physical, emotional, spiritual, or social needs. Lifetime maximum of five annual $200 payments per Covered Person.

AMBULANCE, TRANSPORTATION, AND LODGING BENEFITS:

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

TRANSPORTATION BENEFIT: Aflac will pay 40 cents per mile for transportation, up to a combined maximum of $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:

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

This benefit is payable up to a maximum of $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.

LODGING BENEFIT: Aflac will pay $65 per day when a charge is incurred for lodging, in a room in a motel, hotel, or other commercial accommodation, for you or any one adult family member when a Covered Person receives treatment for Cancer or an Associated Cancerous Condition at a Hospital or Medical Facility more than 50 miles from the Covered Person's residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. This benefit is limited to 90 days per Calendar Year.

PREMIUM WAIVER AND RELATED BENEFITS:

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

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

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

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

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

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

You will again become eligible to receive this benefit after:

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

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

4. Optional Benefits:

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

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

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

Exceptions, Reductions, and Limitations of Rider Series B70050:

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

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

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

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

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

Exceptions, Reductions, and Limitations of Rider Series B70051:

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

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

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

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

HOSPITAL CONFINEMENT BENEFITS:

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

HOSPITALIZATION FOR 31 DAYS OR MORE: During any continuous period of Hospital confinement of 31 days or more for a covered Specified Disease, Aflac will pay benefits as described above for the first 30 days, and beginning with the

31st day of such continuous Hospital confinement, Aflac will pay $800 for each day the Covered Person is charged for a room as an inpatient.

Exceptions, Reductions, and Limitations of Rider Series B70052:

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

5. Payment of Nonsurgical Treatment Benefits:

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

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

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

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

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

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

If only Experimental Chemotherapy is payable during any Calendar Month, the benefit amount will be reduced 50% for Experimental Chemotherapy for which no charge is incurred. If a Covered Person received the stated amount under the applicable Radiation Therapy, Chemotherapy, Immunotherapy, Or Experimental Chemotherapy Benefit at the reduced 50% amount and, later in the same Calendar Month, receives Radiation Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy where a charge is incurred, we will pay the difference between the 50% previously received and the Radiation Therapy, Chemotherapy, Immunotherapy, or Experimental Therapy Benefit.

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

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

The policy contains a 30-day Waiting Period. If a Covered Person has Cancer or an Associated Cancerous Condition diagnosed before his or her coverage has been in force 30 days, benefits for treatment of that Cancer or Associated Cancerous Condition, or any recurrence, extension, or metastatic spread of that same Cancer or Associated Cancerous Condition will apply only to treatment occurring after one year from the Effective Date of such person's coverage. At your

option, you may elect to void the coverage and receive a full refund of premium.

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

Aflac will not pay benefits whenever coverage provided by the policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

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

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

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

NO RECOVERY FOR PRE-EXISTING DIAGNOSED CANCER — READ CAREFULLY. No benefits will be provided during the first 12 months of the policy for Cancer diagnosed before the 30th day after the Effective Date shown in the policy schedule. This policy contains a 30-day Waiting Period. See the Limitations and Exclusions section for conditions not covered by this policy.

RETAIN FOR YOUR RECORDS.
THIS IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.
REFER TO THE POLICY AND RIDER(S) FOR COMPLETE DEFINITIONS, DETAILS, LIMITATIONS AND EXCLUSIONS.

TERMS YOU NEED TO KNOW

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

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

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

1. **INTERNAL CANCER:** all cancers other than nonmelanoma skin cancer (see definition of nonmelanoma skin cancer).
2. **NONMELANOMA SKIN CANCER:** a cancer other than a melanoma that begins in the outer part of the skin (epidermis).

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

COVERED PERSON: Any person insured under the coverage type that you applied for on the application: individual (named insured listed in the Policy Schedule), named insured/spouse only (named insured and spouse), one-parent family (named insured and dependent children), or two-parent family (named insured, spouse and dependent children). Spouse is defined as the person to whom you are legally married and who is listed on your application. Newborn children are automatically insured for 30 days from the moment of birth. If coverage is for individual or named insured/spouse only and you desire uninterrupted coverage for a newborn child beyond the first 30 days, you must notify Aflac in writing within 31 days of the child's birth and Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due, if any. Coverage will include any other dependent child, regardless of age, who (1) is incapable of self-sustaining employment by reason of intellectual or physical disability, (2) is chiefly dependent upon the policyholder or subscriber for support and maintenance, and (3) became so disabled prior to age 26 and while covered under the policy. Dependent children are your natural children, stepchildren, legally adopted, or foster children who are under age 26. Children born to your dependent children or children born to the dependent children of your spouse are not covered under the policy.

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

PRE-EXISTING CONDITION: Means those conditions for which medical advice, diagnosis, care, or treatment was recommended or received from a physician within the 12-month period immediately preceding the effective date of coverage.

WAITING PERIOD: The number of days from the effective date of coverage before benefits are payable for loss due to cancer or an associated cancerous condition.

ADDITIONAL INFORMATION

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

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

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

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

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

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

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

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

Aflac®

Aflac SmartClaim®

One Day Pay℠

aflac.com || **1.800.99.AFLAC** (1.800.992.3522)

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

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

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Aflac

Critical Care Protection

SPECIFIED HEALTH EVENT INSURANCE – OPTION 1

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

Aflac®

AFLAC CRITICAL CARE PROTECTION

SPECIFIED HEALTH EVENT INSURANCE – OPTION 1

Policy Series A74000

CCP[1]

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

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

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

Get the facts:

FACT NO. 1

ABOUT EVERY **34** SECONDS

AN AMERICAN SUFFERS A HEART ATTACK.[1]

FACT NO. 2

ABOUT EVERY **40** SECONDS

SOMEONE IN THE UNITED STATES HAS A STROKE.[1]

[1]*Heart Disease and Stroke Statistics,* 2014 Update, American Heart Association.

Aflac herein means American Family Life Assurance Company of Columbus.

Understand the difference Aflac can make in your financial security.

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

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

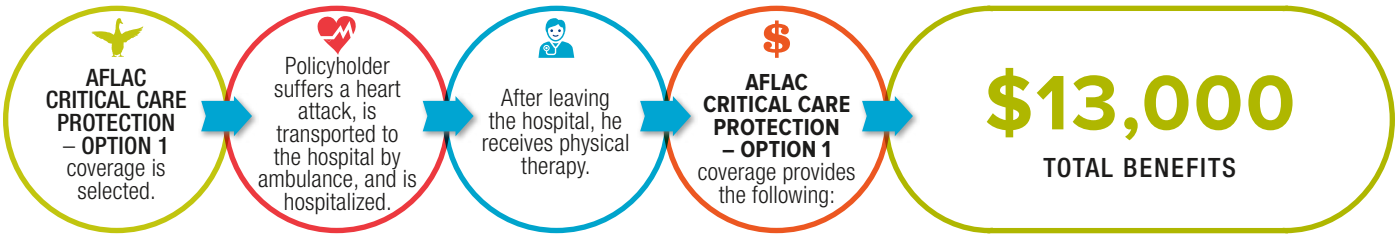
Aflac Critical Care Protection offers more types of benefits compared to other critical illness coverage on the market:

- Pays $7,500 upon diagnosis of having had a specified health event, which increases to $10,000 for dependent children
- Pays $300 per day for covered hospital stays
- Pays benefits for physical therapy, speech therapy, rehabilitation therapy, home health care, and many more
- Transportation and lodging benefits payable for travel to receive treatment
- Guaranteed-renewable–as long as premiums are paid, the policy cannot be canceled

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

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

How it works



The above example is based on a scenario for Aflac Critical Care Protection – Option 1 that includes the following benefit conditions: First-Occurrence Benefit (heart attack) of $7,500, Ambulance Benefit (ground ambulance transportation) of $250, Hospital Confinement Benefit (5 days) of $1,500, and Continuing Care Benefit (30 days) of $3,750.

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

Aflac Critical Care Protection – Option 1 Benefit Overview

BENEFIT NAME	BENEFIT AMOUNT
FIRST-OCCURRENCE BENEFIT: Named Insured/Spouse Dependent Children	 $7,500; lifetime maximum $7,500 per covered person $10,000; lifetime maximum $10,000 per covered person
SUBSEQUENT SPECIFIED HEALTH EVENT BENEFIT	$3,500 Subsequent occurrence limitations apply. No lifetime maximum.
CORONARY ANGIOPLASTY BENEFIT	$1,000 Payable only once per covered person, per lifetime
HOSPITAL CONFINEMENT BENEFIT	$300 per day No lifetime maximum
AMBULANCE BENEFIT	$250 ground or $2,000 air No lifetime maximum
CONTINUING CARE BENEFIT	$125 each day when a covered person is charged for any of the following treatments: • Rehabilitation Therapy • Physical Therapy • Speech Therapy • Occupational Therapy • Respiratory Therapy • Dietary Therapy/Consultation • Home Health Care • Dialysis • Hospice Care • Extended Care • Physician Visits • Nursing Home Care Treatment is limited to 75 days for continuing care received within 180 days following the occurrence of the most recent covered loss. No lifetime maximum.
TRANSPORTATION BENEFIT	$.50 per mile, per covered person whom special treatment is prescribed, for a covered loss Limited to $1,500 per occurrence; no lifetime maximum
LODGING BENEFIT	Up to $75 per day, for covered lodging charges Limited to 15 days per occurrence; no lifetime maximum
WAIVER OF PREMIUM BENEFIT	Premium waived, from month to month, during total inability (after 180 continuous days)
CONTINUATION OF COVERAGE BENEFIT	Waives all monthly premiums for up to 2 months, when all conditions for this benefit are met

REFER TO THE FOLLOWING PAGES FOR BENEFIT DETAILS, DEFINITIONS, LIMITATIONS, AND EXCLUSIONS.

LIMITED BENEFIT

AFLAC CRITICAL CARE PROTECTION

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 provides supplemental coverage and will be issued only to supplement insurance already in force.

SPECIFIED HEALTH EVENT INSURANCE
Supplemental Health Insurance Coverage
Policy Form Series A74100

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

2. **Specified Health Event Insurance Coverage** is designed to supplement your existing accident and sickness coverage only when certain losses occur as a result of Specified Health Events or other conditions as specified. Specified Health Events are: Heart Attack, Stroke, End-Stage Renal Failure, Major Human Organ Transplant, Third-Degree Burns, Persistent Vegetative State, Coma, Paralysis, Coronary Artery Bypass Graft Surgery (CABG), or Sudden Cardiac Arrest. Coverage is provided for the benefits outlined in **(3) Benefits.** The benefits described in **(3) Benefits** may be limited by **(5) Exceptions, Reductions, and Limitations of the Policy.**

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

   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 Specified Health Event:

      Named Insured/Spouse
      $7,500 (Lifetime maximum $7,500 per Covered Person)

      Dependent Children
      $10,000 (Lifetime maximum $10,000 per Covered Person)

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

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

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

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

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

   D. **HOSPITAL CONFINEMENT BENEFIT (includes confinement in a U.S. government Hospital):** When a Covered Person requires Hospital Confinement for the treatment of a covered Loss, Aflac will pay $300 per day for each day a Covered Person is charged as an inpatient. **This benefit is limited to confinements for the treatment of a covered Loss that occur within 500 days following the occurrence of the most recent covered Loss. No lifetime maximum.**

      Hospital Confinement Benefits are payable for only one covered Loss at a time per Covered Person. Confinement in a U.S. government Hospital does not require a charge for benefits to be payable.

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

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

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

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

   F. **CONTINUING CARE BENEFIT:** If, as the result of a covered Loss, a Covered Person receives any of the following treatments from a licensed Physician, Aflac will pay $125 each day a Covered Person is charged:

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

Treatment is limited to 75 days for continuing care received within 180 days following the occurrence of the most recent covered Loss. Daily maximum for this benefit is $125 regardless of the number of treatments received.

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

G. **TRANSPORTATION BENEFIT:** If a Covered Person requires special medical treatment that has been prescribed by the local attending Physician for a covered Loss, Aflac will pay 50 cents per mile for noncommercial travel or the costs incurred for commercial travel (coach class plane, train, or bus fare) for transportation of a Covered Person for the round-trip distance between the Hospital or medical facility and the residence of the Covered Person. This benefit is not payable for transportation by ambulance or air ambulance to the Hospital. Reimbursement will be made only for the method of transportation actually taken. This benefit will be paid only for the Covered Person for whom the special treatment is prescribed. If the special treatment is for a Dependent Child and commercial travel is necessary, we will pay this benefit for up to two adults to accompany the Dependent Child. The benefit amount payable is limited to $1,500 per occurrence of a covered Loss. **Transportation Benefits are not payable beyond the 180th day following the occurrence of a covered Loss. THIS BENEFIT IS NOT PAYABLE FOR TRANSPORTATION TO ANY HOSPITAL LOCATED WITHIN A 50-MILE RADIUS OF THE RESIDENCE OF THE COVERED PERSON. No lifetime maximum.**

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

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

I. **WAIVER OF PREMIUM BENEFIT:**

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

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

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

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

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

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

You will again become eligible to receive this benefit after:

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

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

4. **Optional Benefits:**

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

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

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

SPECIFIED HEALTH EVENT RECOVERY: A Covered Person will be considered in Specified Health Event Recovery if he or she continues to be under the active care and treatment by a Physician for a

covered Specified Health Event OR he or she is unable to engage in the duties of his or her regular occupation due to a covered Specified Health Event. "Specified Health Event" includes Heart Attack, Stroke, End-Stage Renal Failure, Major Human Organ Transplant, Third-Degree Burns, Persistent Vegetative State, Coma, Paralysis, Coronary Artery Bypass Graft Surgery (CABG), or Sudden Cardiac Arrest occurring on or after the Effective Date of coverage under the rider. (If the rider is Individual coverage, no further premium will be billed for the rider after the payment of lifetime maximum benefits.)

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

Lifetime maximum of six months per Covered Person.

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

   A. Aflac will not pay benefits for any Loss that is caused by a Pre-existing Condition unless the Loss occurs more than 12 months after the Effective Date of coverage.

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

   C. 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.

   D. For any benefit to be payable, the Loss must occur on or after the Effective Date of coverage and while coverage is in force. If more than one Specified Health Event per Covered Person occurs on the same day, only the highest eligible benefit will be paid.

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

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

   1. Being intoxicated or under the influence of any narcotic, unless administered on the advice of a Physician and taken according to the Physician's instructions (the term "intoxicated" refers to that condition as defined by the law of the jurisdiction in which the cause of the Loss occurred);
   2. Using any narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions), or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;
   3. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place), or being incarcerated in any detention facility or penal institution;
   4. Participating in any sport or sporting activity for wage, compensation, or profit, including officiating or coaching; or racing any type vehicle in an organized event;
   5. Intentionally self-inflicting a bodily Injury or committing or attempting suicide, while sane or insane;
   6. Having elective surgery that is not Medically Necessary within the first 12 months of the Effective Date of coverage; or
   7. Actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve.

PRE-EXISTING CONDITION LIMITATIONS: A "Pre-existing Condition" is covered under the policy 12 months after the Effective Date of coverage. Pre-existing Condition means those conditions for which medical advice, diagnosis, care or treatment was recommended or received from a Physician within the one-year period immediately preceding the Effective Date of the Covered Person's coverage.

6. **Renewability:** The policy is guaranteed-renewable for your lifetime by the payment of premiums within the grace period at the rate in effect at the beginning of each term. However, subject to the Time Limit on Certain Defenses provision in the policy, we may discontinue or terminate the policy if you have performed an act or practice that constitutes fraud or have made an intentional misrepresentation of material fact relating in any way to the policy, including claims for benefits under the policy. Premium rates may change only if changed on all policies of the same form number and class in force in your state.

RETAIN FOR YOUR RECORDS.
THIS IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.
REFER TO THE POLICY FOR COMPLETE DEFINITIONS, DETAILS, LIMITATIONS AND EXCLUSIONS.

TERMS YOU NEED TO KNOW

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

The ADLs are:

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

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

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

CORONARY ARTERY BYPASS GRAFT SURGERY (CABG): open-heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as but not limited to coronary angioplasty, valve replacement surgery, stent placement, laser relief, or other surgical or nonsurgical procedures.

COVERED PERSON: any person insured under the coverage type that you applied for on the application: individual (named insured listed in the Policy Schedule), named insured/spouse only (named insured and spouse), one-parent family (named insured and dependent children), or two-parent family (named insured, spouse, and dependent children). Spouse is defined as the person to whom you are legally married and who is listed on your application. Newborn children are automatically covered under the terms of the policy from the moment of birth. If individual or named insured/spouse only coverage is in force and you desire uninterrupted coverage for a newborn child, you must notify Aflac in writing within 31 days of the child's birth. Upon notification, Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due, if any. One-parent family or two-parent family coverage will continue to include any other dependent child, regardless of age, who (1) is incapable of self-sustaining employment by reason of mental retardation or physical handicap, (2) is chiefly dependent upon the policyholder or subscriber for support and maintenance, and (3) became so incapacitated prior to age 26. Dependent children are your natural children, stepchildren, adopted or foster children who are under age 26. A dependent child (including persons incapable of self-sustaining employment by reason of mental retardation or physical handicap and are chiefly dependent upon the policyholder or subscriber for support and maintenance) must be under age 26 at the time of application to be eligible for coverage. This includes your dependent children whom you must provide medical support under a court or administrative order.

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

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

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

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

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

LOSS: a specified health event or coronary angioplasty occurring on or after the effective date of coverage and while coverage is in force.

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

PARALYSIS: complete and total loss of use of two or more limbs (paraplegia, quadriplegia, or hemiplegia) for a continuous period of at

least 30 days as the result of a spinal cord injury. The paralysis must be confirmed by the attending physician. The spinal cord injury causing the paralysis must occur on or after the effective date of coverage and while coverage is in force for benefits to be payable.

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

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

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

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

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

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

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

Aflac®

aflac.com || **1.800.99.AFLAC** (1.800.992.3522)

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

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Aflac Choice

HOSPITAL CONFINEMENT INDEMNITY INSURANCE – OPTION 1

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

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

Aflac SmartClaim®
One Day Pay℠

AFLAC CHOICE

HOSPITAL CONFINEMENT INDEMNITY INSURANCE – OPTION 1

Policy Series B40000

HC

Life is full of tough choices, but this isn't one of them.

Aflac Choice makes selecting the right coverage easier and less stressful. With your trusted Aflac agent you can tailor Aflac Choice to meet your specific needs and enhance your existing coverage. Choose the options you want and ignore the rest.

Here's how we can help

Aflac Choice offers our best selection of hospital-related benefits to help with the expenses that may not be covered by major medical, which can help prevent high deductibles and out-of-pocket expenses from derailing your life plans.

If choosing the right coverage has given you one giant headache in the past, don't worry. We're here to help.

Why Aflac Choice may be the right policy for you

- It's customizable. You choose the plan that's right for you based on your specific needs. It also works well with our other products.
- Guaranteed-issue options available—that means there is no medical questionnaire required.
- We pay cash directly to you (unless you tell us otherwise)—not the doctor or hospital.

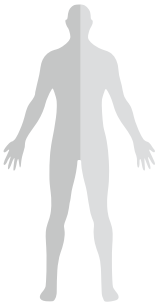
Aflac herein means American Family Life Assurance Company of Columbus.

Understand the difference Aflac makes in your financial security.

Aflac pays cash benefits directly to you, unless otherwise assigned, for covered hospital expenses. We provide you with financial resources to help you overcome some of the unexpected expenses associated with a visit to the hospital, giving you less to worry about so you can focus your energy on getting better.

How it works

POLICYHOLDER
FEELS A SHARP PAIN IN HIS RIGHT SIDE.
Decides to visit his urgent care clinic for care.



DOCTOR DIAGNOSES APPENDICITIS,
sends patient to hospital by ambulance.

PATIENT HAS LAB TEST
& diagnostic exam in hospital ER. Undergoes surgery and released after 3 days.

Choice 1	Choice 2	Choice 3	Choice 4
$1,600	**$2,200**	**$2,010**	**$2,610**
Aflac Choice Policy	**Policy + Hospital Stay and Surgical Care Rider**	**Policy + Extended Benefits Rider**	**Policy + Both Riders**

The above example is based on four scenarios. **Choice 1 Scenario:** Policyholder has the Aflac Choice policy only; includes a Hospital Confinement Benefit of $1,500 and a Hospital Emergency Room Benefit of $100. **Choice 2 Scenario:** Policyholder has the Aflac Choice policy plus the Hospital Stay and Surgical Care Rider; includes the benefit amounts from Choice 1 Scenario (shown above), plus an Initial Assistance Benefit of $100, a Surgery Benefit (appendectomy) of $200, and a Daily Hospital Confinement Benefit of $300 (hospitalized for 3 days). **Choice 3 Scenario:** Policyholder has the Aflac Choice policy plus the Extended Benefits Rider; includes the benefit amounts from Choice 1 Scenario (shown above), plus a Physician Visit Benefit of $25, a Laboratory Test and X-Ray Benefit of $35, a Medical Diagnostic and Imaging Exams Benefit of $150, and an Ambulance Benefit of $200 (ground). **Choice 4 Scenario:** Policyholder has the Aflac Choice policy plus both the Extended Benefits Rider and the Hospital Stay and Surgical Care Rider; includes the benefit amounts from Choice 1 Scenario (shown above), plus a Physician Visit Benefit of $25, a Laboratory Test and X-Ray Benefit of $35, a Medical Diagnostic and Imaging Exams Benefit of $150, an Ambulance Benefit of $200 (ground), an Initial Assistance Benefit of $100, a Surgery Benefit (appendectomy) of $200, and a Daily Hospital Confinement Benefit of $300 (hospitalized for 3 days). Benefits may vary by state and benefit option selected. The policy has limitations and exclusions that may affect benefits payable. This brochure is for illustrative purposes only. Refer to the policy for benefit details, definitions, limitations, and exclusions.

Coverage Options

Choose the Policy and Riders that Fit Your Needs

BENEFIT	DESCRIPTION
HOSPITAL CONFINEMENT	Pays $500; $1,000; $1,500; or $2,000. You choose the benefit amount at the time of application. Payable once per calendar year, per covered person.
REHABILITATION FACILITY	Pays $100 per day; limited to 15 days per confinement. Limited to 30 days per calendar year, per covered person.
HOSPITAL EMERGENCY ROOM	Pays $100 for treatment in a hospital emergency room. Limited to 2 payments per calendar year, per covered person.
HOSPITAL SHORT-STAY	Pays $100 for hospital stays of less than 23 hours. Limited to 2 payments per calendar year, per policy.
WAIVER OF PREMIUM	Yes
CONTINUATION OF COVERAGE	Yes

OPTIONAL RIDERS	DESCRIPTION
EXTENDED BENEFITS RIDER	**Physician Visit Benefit:** Pays $25 for visits (including telemedicine) to a physician, psychologist or urgent care center. **Individual Coverage:** Limited to 3 visits per calendar year, per policy. **Insured/Spouse & Family Coverage:** Limited to 6 visits per calendar year, per policy. **Laboratory Test and X-Ray Benefit:** Pays $35; limited to 2 payments per covered person, per calendar year. **Medical Diagnostic and Imaging Exams Benefit:** Pays $150 for a covered exam, limited to 2 exams per covered person, per calendar year. Benefits payable for a variety of medical diagnostic and imaging exams, including sleep studies. **Ambulance Benefit:** Pays $200 (ground) or $2,000 (air) for transportation to or from a hospital. The benefit is limited to two trips, per calendar year, per covered person.
HOSPITAL STAY AND SURGICAL CARE RIDER	**Initial Assistance Benefit:** Pays $100 once per calendar year, per rider, when a covered person requires a hospital admission. **Surgery Benefit:** Pays $50-$1,000 for a covered surgery. Limited to one payment per 24-hour period, per covered person. **Invasive Diagnostic Exams Benefit:** Pays $100 per day for one covered exam, per covered person, per 24-hour period. **Hospital Intensive Care Unit Confinement Benefit:** Pays $500 per day, per covered person, for up to 30 days. **Daily Hospital Confinement Benefit:** Pays $100 per day, per covered person, for up to 365 days. **Second Surgical Opinion Benefit:** Pays $50 once per covered person, per calendar year.
AFLAC PLUS RIDER	Ask your Aflac agent about the Aflac Plus Rider!

REFER TO THE FOLLOWING PAGES AND POLICY FOR COMPLETE BENEFIT DETAILS, DEFINITIONS, LIMITATIONS AND EXCLUSIONS.

AFLAC CHOICE COVERAGE

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 provides supplemental coverage and will be issued only to supplement insurance already in force.

LIMITED BENEFIT, HOSPITAL CONFINEMENT INDEMNITY INSURANCE
Policy Form Series B40100

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

2. **Hospital Confinement Indemnity Coverage:** The policy provides coverage in the form of a fixed benefit during periods of hospitalization or care resulting from Sickness or Injury, subject to any limitations set forth in your policy. It does not provide any benefits other than the fixed indemnity for Hospital Confinement and any additional benefits described below.

3. **Benefits:** Aflac will pay the following benefits, as applicable, for a covered Sickness or Injury that occurs while coverage is in force, subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions, unless indicated otherwise. Pregnancy and Complications of Pregnancy will be covered to the same extent as a Sickness. The term "Hospital Confinement" does not include emergency rooms. Treatment or confinement in a U.S. government Hospital does not require a charge for benefits to be payable.

   A. **HOSPITAL CONFINEMENT BENEFIT:** Aflac will pay $[_____] when a Covered Person requires Hospital Confinement for 23 or more hours for a covered Sickness or Injury and a room charge is incurred. This benefit is payable once per Calendar Year, per Covered Person. No lifetime maximum.

   B. **REHABILITATION FACILITY BENEFIT:** Aflac will pay $100 per day when a Covered Person is confined in a Hospital and is transferred to a room in a Rehabilitation Facility for treatment of a covered Sickness or Injury and a charge is incurred each day for such treatment. 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.

   C. **HOSPITAL EMERGENCY ROOM BENEFIT:** 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 for such treatment. This benefit is payable twice per Calendar Year, per Covered Person. No lifetime maximum.

   The Hospital Emergency Room Benefit and the Hospital Short-Stay Benefit are not payable on the same day.

   D. **HOSPITAL SHORT-STAY BENEFIT:** 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 for such treatment. This benefit is not payable for treatment received in a Hospital Emergency Room or Urgent Care Center. This benefit is payable twice per Calendar Year, per policy. No lifetime maximum.

   The Hospital Short-Stay Benefit and the Hospital Emergency Room Benefit are not payable on the same day.

   E. **WAIVER OF PREMIUM BENEFIT:** 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.

   If you die and your Spouse becomes the new Named Insured, premiums will start again at the appropriate rate and will 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.

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

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

      You will again become eligible to receive this benefit after:

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

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

4. **Optional Benefits:**

EXTENDED BENEFITS RIDER: (SERIES B40050)
Applied for ❑ Yes ❑ No

Aflac will pay the following benefits, as applicable, for a covered Sickness or Injury that occurs while coverage is in force, subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions, unless indicated otherwise. The term "Hospital Confinement" does not include emergency rooms. Treatment or confinement in a U.S. government Hospital does not require a charge for benefits to be payable.

A. **PHYSICIAN VISIT BENEFIT:** Aflac will pay $25 when a Covered Person incurs a charge for a visit (including a Telemedicine Visit) to a Physician, Psychologist, or Urgent Care Center. Services must be under the supervision of a Physician or Psychologist. 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. No lifetime maximum.

The Sickness or Injury of a Covered Person is not required for the Physician Visit Benefit to be payable. This benefit is not subject to the Pre-existing Condition Limitations or Limitations and Exclusions section of the policy. No lifetime maximum.

B. **LABORATORY TEST AND X-RAY BENEFIT:** Aflac will pay $35 when a Covered Person requires, and incurs a charge for, a laboratory test or an X-ray. The laboratory test or X-ray must be performed in a Hospital, Medical Diagnostic Imaging Center, Physician's office, an Urgent Care Center, or an Ambulatory Surgical Center. This benefit is limited to two payments per Covered Person, per Calendar Year. **The Laboratory Test and X-Ray Benefit is not payable for exams listed in the Medical Diagnostic and Imaging Exams Benefit.** No lifetime maximum.

The Sickness or Injury of a Covered Person is not required for the Laboratory Test and X-ray Benefit to be payable. This benefit is not subject to the Pre-existing Condition Limitations or Limitations and Exclusions section of the policy. No lifetime maximum.

C. **MEDICAL DIAGNOSTIC AND IMAGING EXAMS BENEFIT:** Aflac will pay $150 when a Covered Person requires, and incurs a charge for, one of the following exams: computerized tomography (CT or CAT scan), magnetic resonance imaging (MRI), electroencephalogram (EEG), Sleep Study, thallium stress test, myelogram, angiogram, or arteriogram. These exams must be performed in a Hospital, Medical Diagnostic Imaging Center, Physician's office, Sleep Center, an Urgent Care Center, or an Ambulatory Surgical Center. This benefit is limited to two payments per Calendar Year, per Covered Person. No lifetime maximum.

D. **AMBULANCE BENEFIT:** Aflac will pay $200 if, due to a covered Sickness or Injury, a Covered Person requires, and incurs a charge for, ground ambulance transportation to or from a Hospital. If a Covered Person requires, and incurs a charge for, air ambulance transportation to or from a Hospital due to a covered Sickness or Injury, Aflac will pay $2,000. 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.

HOSPITAL STAY AND SURGICAL CARE RIDER: (SERIES B40051)
Applied for ❑ Yes ❑ No

Aflac will pay the following benefits, as applicable, for a covered Sickness or Injury that occurs while coverage is in force, subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions, unless indicated otherwise. Pregnancy and Complications of Pregnancy will be covered to the same extent as a Sickness. The term "Hospital Confinement" does not include emergency rooms. Treatment or confinement in a U.S. government Hospital does not require a charge for benefits to be payable.

A. **INITIAL ASSISTANCE BENEFIT:** Aflac will pay $100 when a Covered Person requires a Hospital Admission. This benefit is payable once per Calendar Year, per rider. No lifetime maximum. This benefit is not subject to the Pre-existing Condition Limitations or the Limitations and Exclusions section of the policy. **Payment of this benefit is based solely on a Covered Person's Hospital Admission, as defined in the rider. Any additional benefits that may be due as a result of a Hospital Admission remain subject to the terms of the policy, including any limitations and/or exclusions.**

B. **SURGERY BENEFIT:** Aflac will pay according to the benefits in the Schedule of Operations in the rider when, due to a covered Sickness or Injury, a Covered Person has a surgical procedure, including a vaginal or cesarean delivery, performed in a Hospital or an Ambulatory Surgical Center and a charge is incurred for such surgical procedure. If any surgical procedure 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 surgical procedure most nearly similar in severity and gravity. **The Surgery Benefit is only payable one time per 24-hour period, even though more than one surgical procedure may be performed. The highest eligible benefit will be paid. Exams covered under the Invasive Diagnostic Exams Benefit are not payable under this benefit. The Surgery 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: The Surgery Benefit is not payable for surgical procedures performed in a Physician's or dentist's office, a clinic, or other such location.

C. **INVASIVE DIAGNOSTIC EXAMS BENEFIT:** Aflac will pay $100 per day when a Covered Person requires one of the following exams, with or without biopsy, and a charge is incurred: arthroscopy, bronchoscopy, colonoscopy, cystoscopy, endoscopy, 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. No lifetime maximum.

The Invasive Diagnostic Exams Benefit and the Surgery Benefit are not payable on the same day. The highest eligible benefit will be paid.

D. HOSPITAL INTENSIVE CARE UNIT CONFINEMENT BENEFIT: Aflac will pay $500 per day when a Covered Person incurs a room 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. The maximum benefit period for any one Period of Hospital Intensive Care Unit Confinement is 30 days. No lifetime maximum.

E. DAILY HOSPITAL CONFINEMENT BENEFIT: 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 room 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.

F. SECOND SURGICAL OPINION BENEFIT: Aflac will pay $50 when a charge is incurred for a second surgical opinion by a Physician concerning surgery for a covered Sickness or Injury. This benefit is payable once per Calendar Year, per Covered Person. No lifetime maximum.

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

A. 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.

B. Aflac will not pay benefits for any condition that is medically evaluated, diagnosed, or treated by a Physician before coverage has been in force 30 days from the Effective Date, unless the loss begins more than 30 days after the Effective Date of coverage.

C. Benefits for a covered Sickness for all persons added to the policy (excluding newborns, adopted or foster children) are subject to a 30-day Waiting Period.

D. Aflac will not pay benefits whenever coverage provided by the policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

E. Aflac will not pay benefits whenever fraud is committed in making a claim under the coverage. If you have received benefits that were not contractually due under the coverage, then Aflac reserves the right to offset any benefits payable under the coverage up to the amount of benefits you received that were not contractually due.

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

1. Pregnancy in existence prior to the Effective Date of coverage. Complications of Pregnancy are covered to the same extent as a Sickness;
2. Receiving routine nursing or routine well-baby care for a newborn child;
3. Using any narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions), or voluntarily taking any type of poison or inhaling any type of gas or fumes;
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 detained in any detention facility or penal institution;
5. Being intoxicated or under the influence of any narcotic, unless administered on the advice of a Physician and taken according to the Physician's instructions (the term "intoxicated" refers to that condition as defined by the law of the jurisdiction in which the cause of the loss occurred);
6. Intentionally self-inflicting a bodily injury, or committing or attempting suicide, while sane or insane;
7. Having dental treatment, except as a result of Injury;
8. Having cosmetic surgery that is not Medically Necessary. Costmetic surgery does not include reconstructive surgery because of congenital disease or anomaly of a covered Dependent Child which has resulted in a functional defect;
9. Having elective surgery that is not Medically Necessary within the first 12 months of the Effective Date of coverage;
10. Being exposed to war or any act of war, declared, or actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;
11. Actively participating in a riot, insurrection, or terrorist activity;
12. Donating an organ within the first 12 months of the Effective Date of coverage; or
13. 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, bereavement, situational depression, 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, which made itself known while coverage is in force.

PRE-EXISTING CONDITION LIMITATIONS

A "Pre-existing Condition" is covered under the policy 12 months after the Effective Date of coverage. Pre-existing Condition means those conditions for which medical advice, diagnosis, care or treatment was recommended or received from a Physician within the one-year period preceding the Effective Date of the Covered Person's coverage. **The policy has a 30-day Waiting Period for Sickness. Please see the definition of Sickness**.

6. **Renewability:** The policy is guaranteed-renewable for your lifetime by the timely payment of premiums within the grace period at the rate in effect at the beginning of each term. However, subject to the Time Limit on Certain Defenses provision, 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. Aflac may change the established premium rate, but only if the rate is changed for all policies of the same form number and premium classification in the state where the policy was issued that are then in force. The established premium rate is guaranteed to remain the same for a minimum of 12 months.

RETAIN FOR YOUR RECORDS.
THIS IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.
REFER TO THE POLICY AND RIDER(S) FOR COMPLETE DEFINITIONS, DETAILS, LIMITATIONS AND EXCLUSIONS.

TERMS YOU NEED TO KNOW

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 for 30 days from the moment of birth. If coverage is for individual or named insured/spouse only and you desire uninterrupted coverage for a newborn child beyond the first 30 days, you must notify Aflac in writing within 31 days of the child's birth and Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due, if any. Coverage will include any other dependent child, regardless of age, who (1) is incapable of self-sustaining employment by reason of mental or physical disability, (2) is chiefly dependent upon the policyholder or subscriber for support and maintenance, and (3) who became so disabled prior to age 26. Dependent children are your natural children, stepchildren, adopted, or foster children who are under age 26. This includes your dependent children whom you must provide medical support under a court or administrative order. Children born to your dependent children or children born to the dependent children of your spouse are not covered under the policy.

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

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. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable.

INJURY: A bodily injury caused directly by an accident, independent of sickness, disease, bodily infirmity or any other cause. An injury must occur on or after the effective date of coverage and while coverage is in force for benefits to be payable. 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 room in a hospital. Confinements must begin while coverage under the policy is in force. 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 room in a hospital intensive care unit. Confinements must begin while coverage under the rider is in force. 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, disorder, pregnancy, or condition not caused by an injury, medically evaluated, diagnosed or treated by a physician more than 30 days after the effective date of coverage and while coverage is in force. **Pregnancy and complications of pregnancy will be covered to the same extent as a sickness. All sicknesses are subject to the Pre-existing Condition Limitations.**

ADDITIONAL INFORMATION

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

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

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

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 or treatment for persons suffering from mental disease or disorders, care for the aged or care for persons addicted to drugs or alcohol.

The term urgent care center does not include hospital emergency rooms.

Admissions into the emergency room of a hospital, admissions for same day surgical procedures or admissions for observation are not considered a hospital admission.

A physician or psychologist is not you or a member of your immediate family.

The policy does not cover losses caused by or resulting from pregnancy in existence prior to the effective date of coverage. Complications of pregnancy are covered to the same extent as a sickness. 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. Elective cesarean deliveries are not considered complications of pregnancy. Complications of pregnancy are covered to the same extent as a sickness, subject to the Limitations and Exclusions.

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One Day Pay℠ available for most properly-documented, individual Hospital claims submitted online through Aflac SmartClaim® by 3 p.m. ET. Aflac SmartClaim® not available on all products. Processing time is based on business days after all required documentation needed to render a decision is received and no further validation and/or research is required. Individual Company Statistic, 2016.

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What is TicketsatWork?

This cost-free benefit provides you access to thousands of exclusive discounts on:

- shopping
- services
- travel
- entertainment
- and more!

How Do I Become a Member?

- Visit ticketsatwork.com and click *Become a Member*.
- Use your company code or work email to create an account.

Not by a computer? Use your phone camera or QR scanning app to access the site:

Company Code EBSCALLCENTER

There's something for everyone with savings on:

April Highlights

- Blue Apron: Get $25 off each of your first 4 boxes - $100 in total savings
- Dell: Get an additional 5% off sitewide
- Try Disney+ for FREE for 7 days
- Sign up for ESPN+ and stream live sports for just $4.99 per month
- H&R Block: Save 25% on online tax filing products
- HP: Save up to 50% on select products
- Instacart: Get free delivery on your first order of $35+
- Laithwaite's Wine: Top 6 Reds + 3 Bonus Bottles for just $39.99
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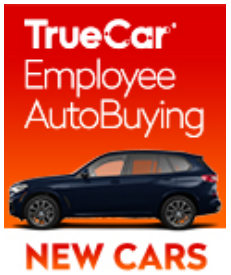

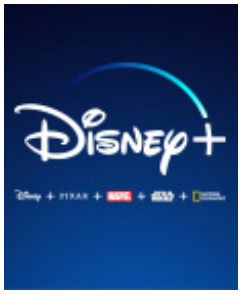

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