Aflac
Group Insurance Plans

CRITICAL ILLNESS / ACCIDENT / HOSPITAL INDEMNITY

Underwritten by Continental American Insurance Company
A proud member of the Aflac family of insurers

AFLAC GROUP CRITICAL ILLNESS INSURANCE

Policy Series C20000

Aflac can help ease the financial stress of surviving a critical illness.

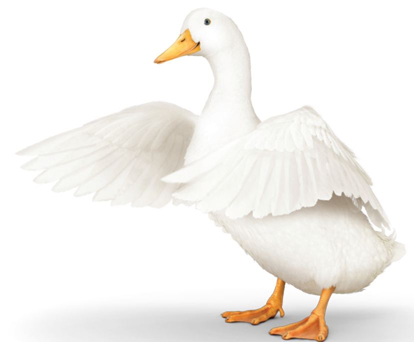
Chances are you may know someone who's been diagnosed with a critical illness. You can't help but notice the strain it's placed on the person's life—both physically and emotionally. What's not so obvious is the impact a critical illness may have on someone's personal finances.

That's because while a major medical plan may pay for a good portion of the costs associated with a critical illness, there are a lot of expenses that just aren't covered. And, during recovery, having to worry about out-of-pocket expenses is the last thing anyone needs.

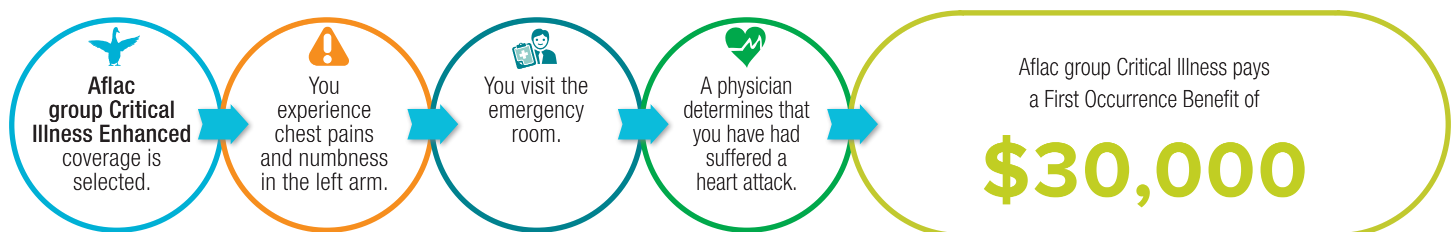
That's the benefit of an Aflac group Critical Illness plan.

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

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



How it works



Amount payable based on $30,000 First Occurrence Benefit.

The plan has limitations and exclusions that may affect benefits payable. This brochure is for illustrative purposes only. Refer to your certificate for complete details, definitions, limitations, and exclusions.

For more information call 1.800.433.3036, or visit aflacgroupinsurance.com.

Benefits Overview

COVERED CRITICAL ILLNESSES:

CANCER (Internal or Invasive)	100%
HEART ATTACK (Myocardial Infarction)	100%
STROKE (Apoplexy or Cerebral Vascular Accident)	100%
CARCINOMA IN SITU (Payment of this benefit will reduce your benefit for cancer by 25%.)	25%

FIRST OCCURRENCE BENEFIT

An insured may receive up to $15,000 or $30,000 (depending on coverage selected) upon the first diagnosis of each covered critical illness; if the date of diagnosis is while coverage is in force, **and** the certificate does not exclude the illness or condition by name or by specific description. We will pay benefits for a critical illness in the order the events occur. We will deduct any previously-paid partial benefits from the appropriate critical illness benefit.

SEPARATE DIAGNOSIS BENEFIT

We will pay benefits for each **different** critical illness after the first when the following conditions are met: the two dates of diagnosis must be separated by at least 6 months, or if the insured is treatment-free from cancer for at least 6 months, and are not caused by or contributed to by a critical illness for which benefits have been paid.

REOCCURRENCE BENEFIT

Once benefits have been paid for a critical illness, we will pay additional benefits for that **same** critical illness when the dates of diagnosis are separated by at least 12 months, or the insured has been treatment-free from cancer for at least 12 months and is currently treatment-free.

Cancer that has metastasized (spread), even though there is a new tumor, is not considered an additional occurrence unless the insured has been treatment-tree for 12 months and is currently treatment-free.

CHILD COVERAGE AT NO ADDITIONAL COST

Each dependent child is covered at 50 percent of the primary insured's benefit amount at no additional charge.

HEALTH SCREENING BENEFIT (Team Member and Spouse/Domestic Partner only)

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

This benefit is only payable for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for the covered Team Member and Spouse/ Domestic Partner.

This benefit is not paid for dependent children.

COVERED HEALTH SCREENING TESTS INCLUDE:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test, blood test for triglycerides or serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast Cancer)
- CA 125 (blood test for ovarian Cancer)
- CEA (blood test for colon Cancer)
- Chest x-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate Cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Thermograph

COVERED SPECIFIED DISEASES:

Disease	Benefit
COMA	100%
PARALYSIS	100%
LOSS OF SIGHT/HEARING/SPEECH	100%
MAJOR ORGAN TRANSPLANT	100%
END-STAGE RENAL FAILURE	100%
BENIGN BRAIN TUMOR	100%
OCCUPATIONAL HIV This benefit is payable for the initial positive diagnosis of occupational HIV if the diagnosis results from a covered injury. We will pay the indicated percentages of the applicable face amount. Occupational HIV Injuries are payable only once. After the benefit is paid, coverage for that covered person will terminate.	100%
ADVANCED ALZHEIMER'S DISEASE	25%
ADVANCED PARKINSON'S DISEASE	25%
CORONARY ARTERY BYPASS SURGERY (Payment of this benefit will reduce your benefit for heart attack by 25%.)	25%

SPECIFIED DISEASES BENEFIT

We will pay the specified disease benefit if the insured is diagnosed with one of the specified diseases shown in the rider schedule if: the date of diagnosis occurs while the rider is in force; and the specified disease is not excluded by name or specific description in the rider.

We will not pay benefits under the rider if these conditions result from another covered specified disease.

The plan has limitations and exclusions that may affect benefits payable.
This brochure is for illustrative purposes only. Refer to your certificate for complete details, definitions, limitations, and exclusions.

AFLAC GROUP ACCIDENT ADVANTAGE PLUS INSURANCE

GROUP ACCIDENTAL INJURY INSURANCE – HIGH NONOCCUPATIONAL PLAN

Policy Series CAI7800

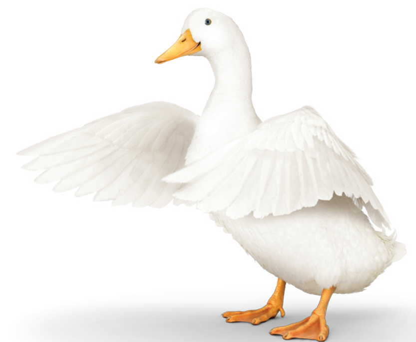
Introducing added protection for life's unexpected moments.

If you're like most people, you don't budget for life's unexpected moments. But at some point, you may make an unexpected trip to your local emergency room. And that could add a set of unexpected bills into the mix.

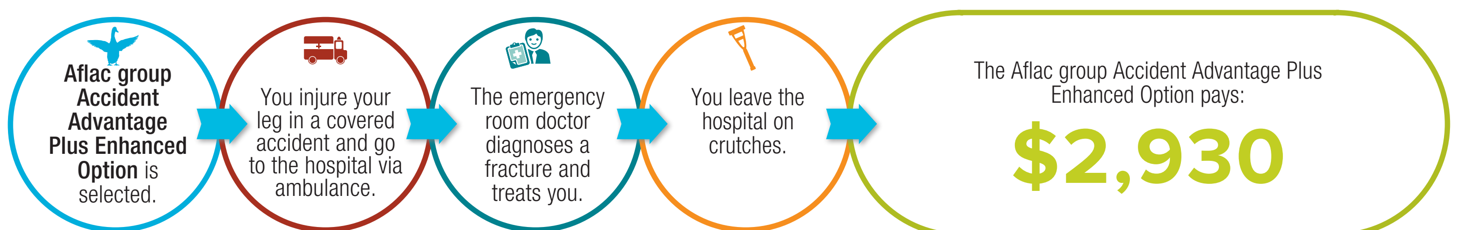
That's the benefit of the Aflac group Accident Advantage Plus plan.

In the event of a covered accident, the plan pays cash benefits fast to help with the costs associated with out-of-pocket expenses and bills—expenses major medical may not take care of, including:

- Ambulance rides.
- Wheelchairs, crutches, and other medical appliances.
- Emergency room visits.
- Surgery and anesthesia.
- Bandages, stitches, and casts.



HOW IT WORKS



Amount payable was generated based on benefit amounts for: Closed-Reduction Leg Fracture ($2,400), Emergency Room Treatment ($200), one Follow-Up Treatment ($30), Ambulance ($200) and Appliance ($100)

The plan has limitations and exclusions that may affect benefits payable. This brochure is for illustrative purposes only. Refer to your certificate for complete details, definitions, limitations, and exclusions.

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Benefits Overview

	BASIC OPTION Team Member/Spouse/ Domestic Partner/Child	ENHANCED OPTION Team Member/Spouse/ Domestic Partner/Child
Hospital Admission We will pay the amount shown, when because of a covered accident, the insured is injured, requires hospital confinement, and is confined to a hospital for at least 24 hours within 6 months after the accident date. We will pay this benefit once per calendar year. We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.	$500	$1,000
Hospital Confinement (per day) We will pay the amount shown when, because of a covered accident, the insured is injured and those injuries cause confinement to a hospital for at least 24 hours within 90 days after the accident date. The maximum period for which you can collect the Hospital Confinement Benefit for the same injury is 365 days. This benefit is payable once per hospital confinement even if the confinement is caused by more than one accidental injury. We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.	$100	$200
Hospital Intensive Care (per day) We will pay the amount shown when, because of a covered accident, the insured is injured, and those injuries cause confinement to a hospital intensive care unit. This benefit is paid up to 30 days per covered accident. Benefits are paid in addition to the Hospital Confinement Benefit.	$200	$400
Medical Fees (for each accident) If an insured is injured in a covered accident and receives treatment within one year after the accident, we will pay up to the applicable amount for doctor services or X-rays. The total amount payable will not exceed the maximum shown per accident. Initial treatment must be received within 72 hours after the accident.	$62.50 / $62.50 / $37.50	$125 / $125 / $75

Benefits Overview – *continued*

	BASIC OPTION Team Member/Spouse/ Domestic Partner/Child	ENHANCED OPTION Team Member/Spouse/ Domestic Partner/Child
Paralysis (Lasting 90 days or more and diagnosed by a physician within 90 days)		
Quadriplegia	$5,000	$10,000
Paraplegia	$2,500	$5,000
Paralysis means the permanent loss of movement of two or more limbs. We will pay the appropriate amount shown if, because of a covered accident, the insured is injured, the injury causes paralysis which lasts more than 90 days, and the paralysis is diagnosed by a doctor within 90 days after the accident. The amount paid will be based on the number of limbs paralyzed. If this benefit is paid and the insured later dies as a result of the same covered accident, we will pay the appropriate Death Benefit, less any amounts paid under the Paralysis Benefit.		
ACCIDENTAL DEATH AND DISMEMBERMENT (within 90 days) - See Limitations and Exclusions for a complete explanation.		
Accidental-Death	$25,000/$12,500/$2,500	$50,000/$25,000/$5,000
Accidental Common-Carrier Death (plan, train, boat, or ship)	$50,000/$25,000/$7,500	$100,000/$50,000/$15,000
Single Dismemberment	$6,250/$2,500/$1,250	$12,500/$5,000/$2,500
Double Dismemberment	$12,500/$5,000/$2,500	$25,000/$10,000/$5,000
Loss of One of More Fingers or Toes	$625/$250/$125	$1,250/$500/$250
Partial Amputation of Fingers or Toes (including at least one joint)	$50	$100

- If the Accidental Common-Carrier Death Benefit is paid, we will pay the Accidental-Death Benefit.
- Accidental Injury means bodily injury caused solely by or as the result of a covered accident.
- Covered accident means an accident that occurs on or after the effective date, while the certificate is in force, and that is not specifically excluded.

MAJOR INJURIES (diagnosis and treatment within 90 days)	BASIC OPTION	ENHANCED OPTION
Fractures (closed reduction)		
Hip/Thigh	$2,000	$4,000
Vertebrae (except processes)	$1,800	$3,600
Pelvis	$1,600	$3,200
Skull (depressed)	$1,500	$3,000
Leg	$1,200	$2,400
Forearm/Hand/Wrist	$1,000	$2,000
Foot/Ankle/Knee Cap	$1,000	$2,000
Shoulder Blade/Collar Bone	$800	$1,600
Lower Jaw (mandible)	$800	$1,600
Skull (simple)	$700	$1,400
Upper Arm/Upper Jaw	$700	$1,400
Facial Bones (except teeth)	$600	$1,200
Vertebral Processes	$400	$800
Coccyx/Rib/Finger/Toe	$160	$320

Benefits Overview – *continued*

	BASIC OPTION Team Member/Spouse/ Domestic Partner/Child	ENHANCED OPTION Team Member/Spouse/ Domestic Partner/Child
Dislocations (closed reduction)		
Hip	$1,500	$3,000
Knee (not knee cap)	$975	$1,950
Shoulder	$750	$1,500
Foot/Ankle	$600	$1,200
Hand	$525	$1,050
Lower Jaw	$450	$900
Wrist	$375	$750
Elbow	$300	$600
Finger/Toe	$120	$240
If you have both a fracture and dislocation in the same covered accident, we will pay for both. However, we will pay no more than double the benefit amount for the fractured bone or dislocated joint that has the higher dollar amount. **Please refer to the Limitations and Exclusions section for more detail on fractures and dislocations.***		
SPECIFIC INJURIES		
Ruptured Disc (treatment within 60 days; surgical repair within one year)		
• Injury occurring during the first certificate year	$50	$100
• Injury occurring after the first certificate year	$200	$400
Tendons/Ligaments (treatment within 60 days; surgical repair within one year) If the insured fractures a bone or dislocates a joint, and tears, severs, or ruptures a tendon or ligament in the same accident, we will pay one benefit. We will pay the largest of the scheduled benefit amounts for fractures, dislocations, or tendons and ligaments.	$300 (Multiple) $200 (Single)	$600 (Multiple) $400 (Single)
Torn Knee Cartilage (treatment within 60 days; surgical repair within one year)		
Injury occurring during the first certificate year	$50	$100
Injury occurring after the first certificate year	$200	$400
Eye Injuries		
Treatment and surgical repair within 90 days	$125	$250
Removal of foreign body (no surgery required)	$25	$50
Concussion A head injury resulting in electroencephalogram abnormality	$100	$200
Coma (state of profound unconsciousness lasting 30 days or more)	$5,000	$10,000
Emergency Dental Work (per accident; injury to sound, natural teeth)		
Repaired with crown	$75	$150
Resulting in extraction	$25	$50
BURNS (treatment within 72 hours and based on percent of body surface burned)		
Second-Degree Burns		
Less than 10%	$50	$100
At least 10 %, but less than 25%	$100	$200
At least 25%, but less than 35%	$250	$500
35% or More	$500	$1,000

Benefits Overview – *continued*

	BASIC OPTION Team Member/Spouse/ Domestic Partner/Child	ENHANCED OPTION Team Member/Spouse/ Domestic Partner/Child
Third-Degree Burns		
Less than 10%	$500	$1,000
At least 10 %, but less than 25%	$2,500	$5,000
At least 25%, but less than 35%	$5,000	$10,000
35% or More	$10,000	$20,000
First-Degree burns are not covered.		
Lacerations (treatment and repair within 72 hours)		
Under 2" long	$25	$50
2" to 6" long	$100	$200
Over 6" long	$200	$400
Lacerations not requiring stitches	$12.50	$25
Multiple Lacerations: We will pay for the largest single laceration requiring stitches.		

ADDITIONAL BENEFITS

	BASIC OPTION	ENHANCED OPTION
Emergency Room Treatment We will pay the amount shown for injuries received in a covered accident if the insured receives treatment in a hospital emergency room and receives initial treatment within 72 hours after the covered accident. This benefit is payable only once per 24-hour period and only once per covered accident. We will not pay the Accident Emergency Room Treatment Benefit and the Medical Fees Benefit for the same covered accident. We will pay the highest eligible benefit amount.	$100	$200
Emergency Room Observation We will pay the amount shown for injuries received in a covered accident if the insured receives treatment in a hospital emergency room, and is held in a hospital for observation for at least 24 hours, and receives initial treatment within 72 hours after the accident. This benefit is payable only once per 24-hour period and only once per covered accident. This benefit would be paid in addition to Accident Emergency Room Treatment Benefit.	$50	$100
Major Diagnostic Testing We will pay the amount shown if, because of injuries sustained in a covered accident, you require one of the following exams, and a charge is incurred: computerized tomography (CT scan); computerized axial tomography (CAT); magnetic resonance imaging (MRI); electroencephalography (EEG). These exams must be performed in a hospital or a doctor's office. This benefit is limited to one payment per Covered Accident.	$100	$200

Benefits Overview – *continued*

	BASIC OPTION Team Member/Spouse/ Domestic Partner/Child	ENHANCED OPTION Team Member/Spouse/ Domestic Partner/Child
Post-Traumatic Stress Disorder Diagnosis Post-traumatic Stress Disorder (PTSD) is a mental health condition triggered by a covered accident. We will pay the amount shown if the insured is diagnosed with Post-traumatic Stress Disorder. The insured must meet the diagnostic criteria for PTSD, stipulated in the Diagnostic and Statistical Manual of Mental disorders IV (DSM IV-TR), and be under the active care of either a psychiatrist or Ph.D.-level psychologist. This benefit is payable only once per covered accident.	$100	$200
Ambulance **Air Ambulance** If an insured requires transportation to a hospital by a professional ambulance or air ambulance service within 90 days after a covered accident, we will pay the amount shown.	$100 $500	$200 $1,000
Blood/Plasma If the insured receives blood or plasma within 90 days following a covered accident, we will pay the amount shown.	$50	$100
Appliances We will pay this benefit for use of a medical appliance due to injuries received in a covered accident. Benefits are payable for crutches, wheelchairs, leg braces, back braces, and walkers.	$50	$100
Internal Injuries (resulting in open abdominal or thoracic surgery)	$500	$1,000
Accident Follow-Up Treatment We will pay this benefit for up to six treatments (one per day) per covered accident, per insured for follow-up treatment. The insured must have received initial treatment within 72 hours of the accident, and the follow-up treatment must begin within 30 days of the covered accident or discharge from the hospital. This benefit is not payable for the same visit that the Physical Therapy Benefit is paid.	$15	$30
Exploratory Surgery [without repair (i.e., arthroscopy)]	$125	$250
Prosthesis If an insured requires the use of a prosthetic device due to injuries received in a covered accident, we will pay this benefit. Hearing aids, wigs, dental aids, and false teeth are not covered.	$250	$500

Benefits Overview *– continued*

	BASIC OPTION Team Member/Spouse/ Domestic Partner/Child	ENHANCED OPTION Team Member/Spouse/ Domestic Partner/Child
Physical Therapy We will pay this benefit for up to six treatments per covered accident, per insured for treatment from a physical therapist. The insured must have received initial treatment within 72 hours of the accident, and physical therapy must begin within 30 days of the covered accident or discharge from the hospital. Treatment must take place within six months after the accident. This benefit is not payable for the same visit that the Accident Follow-Up Treatment Benefit is paid.	$15	$30
Transportation If hospital treatment or diagnostic study is recommended by the insured's physician and is not available in the insured's city of residence, we will pay the amount shown. Transportation must begin within 90 days from the date of the covered accident. The distance to the hospital must be greater than 50 miles from your residence.	$150 (train/plane) $75 (bus)	$300 (train/plane) $150 (bus)
Family Lodging Benefit (per night) If an insured is required to travel more than 100 miles from his or her home for inpatient treatment of injuries received in a covered accident, we will pay this benefit for an immediate adult family member's lodging. Benefits are payable up to 30 days per accident and only while the insured is confined to the hospital. The treatment must be prescribed by the insured's local physician.	$50	$100
Rehabilitation Unit Benefit (per 12-month period) We will pay the amount shown for injuries received in a covered accident if the insured: is admitted for a hospital confinement, is transferred to a bed in a rehabilitation unit of a hospital for treatment, and incur a charge. This benefit is limited to 30 days per period of hospital confinement. This benefit is also limited to a calendar year maximum of 60 days. We will not pay the Rehabilitation Unit Benefit for the same days that the Accident Hospital Confinement Benefit is paid. We will pay the highest eligible benefit.	$37.50	$75

AFLAC GROUP HOSPITAL INDEMNITY

INSURANCE PLAN

Policy Series CA8500-MP

HI G

The plan that can help cover expenses and protect your savings.

Does your major medical insurance cover all of your bills?

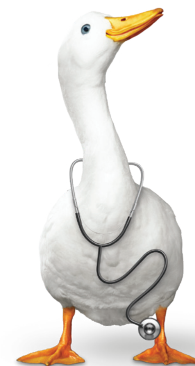
Even a minor trip to the hospital can present you with unexpected expenses and medical bills. And though you may have major medical insurance, your plan may only pay a portion of what your entire stay entails.

That's how the Aflac group supplemental hospital indemnity insurance plan can help.

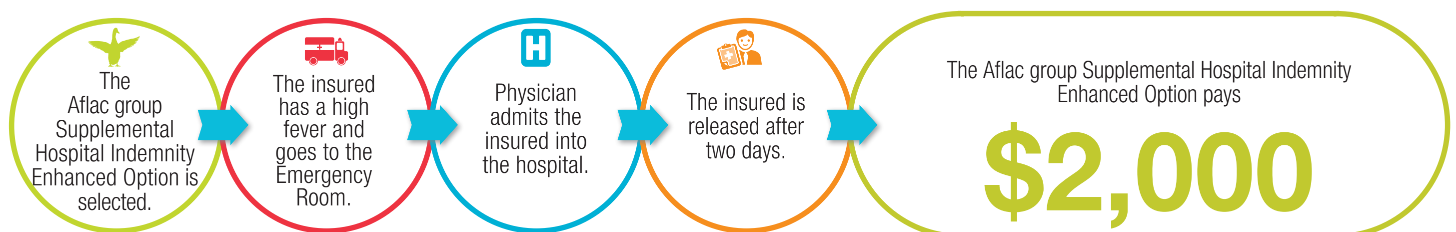
It provides financial assistance to enhance your current coverage. So you can avoid dipping into savings, or having to borrow to cover out-of-pocket-expenses health insurance was never intended to cover. Like transportation and meals for family members, help with child care or time away from work, for instance.

In addition to providing you with cash benefits (unless otherwise assigned) during a covered hospitalization, Aflac's group supplemental hospital indemnity plan has been designed with much more in mind, such as:

- **No deductibles.**
- **No networks, which means you can be treated at the hospital of your choice.**
- **No precertification.**



How it works



Amount payable was generated based on benefit amounts for: Hospital Admission ($1,500), and Hospital Confinement ($250 per day).

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For more information call 1.800.433.3036, or visit aflacgroupinsurance.com.

Benefits Overview

	BASIC OPTION	ENHANCED OPTION
HOSPITAL ADMISSION This benefit is paid when a Covered person is admitted to a hospital and confined as a resident bed patient because of injuries received in a covered accident or because of a covered sickness. To receive this benefit for injuries received in a covered accident, an insured must be admitted to a hospital within six months of the date of the covered accident. We will not pay benefits for confinement to an observation unit, for emergency room treatment, or for outpatient treatment. We will pay this benefit once for a period of confinement. We will pay this benefit only once for each covered accident or covered sickness. If an insured is confined to the hospital because of the same or related injury or sickness, we will not pay this benefit again. Residents of Massachusetts are not eligible for Hospital Admission Benefit amounts in excess of $500.	**$1,000** per admission	**$1,500** per admission
HOSPITAL CONFINEMENT (up to 180 days per confinement) This benefit is paid when a Covered Person is confined to a hospital as a resident bed patient because of a Covered Sickness or as the result of injuries received in a Covered Accident. To receive this benefit for Injuries received in a Covered Accident, the Covered Person must be confined to a hospital within six months of the date of the Covered Accident. This benefit is payable for only one hospital confinement at a time even if caused by more than one Covered Accident, more than one Covered Sickness, or a Covered Accident and a Covered Sickness.	**$150** per day	**$250** per day
HOSPITAL INTENSIVE CARE (30 day maximum for any one period of confinement.) This benefit is paid when a Covered Person is confined in a hospital intensive care unit because of a Covered Sickness or due to an Injury received from a Covered Accident. To receive this benefit for injuries received in a Covered Accident, the Covered Person must be admitted to a hospital intensive care unit within six months of the date of the Covered Accident. We will pay benefits for only one confinement in a hospital intensive care unit at a time, even if it is caused by more than one Covered Accident, more than one Covered Sickness, or a Covered Accident and a Covered Sickness. If we pay benefits for confinement in a hospital intensive care unit and a Covered Person becomes confined to a hospital intensive care unit again within six months because of the same or related condition, we will treat this confinement as the same period of confinement.	**$150** per day	**$250** per day

What you need, when you need it.

Group supplemental hospital indemnity insurance pays cash benefits that you can use any way you see fit.

The plan has limitations and exclusions that may affect benefits payable. This brochure is for illustrative purposes only. Refer to the plan for complete details, definitions, limitations, and exclusions.

LIMITATIONS AND EXCLUSIONS

CRITICAL ILLNESS

The applicable benefit amount will be paid if the date of diagnosis occurs while the insured's coverage is in force; and the cause of the illness is not excluded by name or specific description.

Pre-existing Condition is a sickness or physical condition that existed within the 12-month period before the insured's effective date. For this pre-existing condition, a medical professional must have advised, diagnosed, or treated the insured.

We will **not** pay benefits for any critical illness resulting from or affected by a pre-existing condition if the critical illness was diagnosed within the12-month period after the insured's effective date.

We will not reduce or deny a claim for benefits for any critical illness that was diagnosed more than 12 months after the insured's effective date.

*Benefits are payable for the reoccurrence of a previously diagnosed cancer and/or carcinoma in situ as long as the insured:

- Has been free from signs or symptoms of that cancer for a consecutive 12-month period before the date of diagnosis (for the reoccurrence) **and**
- Has been treatment-free from that cancer for the 12 consecutive months before the date of diagnosis (for the reoccurrence).

We will not pay for loss due to any of the following:

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured
- **Suicide** – committing or attempting to commit suicide, while sane or insane
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job
- **Participation in Aggressive Conflict** of any kind, including:
  - War (declared or undeclared) or military conflicts
  - Insurrection or riot
  - Civil commotion or civil state of belligerence
- **Illegal substance abuse, which includes the following:**
  - Abuse of legally-obtained prescription medication
  - Illegal use of non-prescription drugs

Specified Disease Benefit Exclusions:

Pre-existing Condition is a sickness or physical condition that existed within the 12-month period before the Insured's effective date. For this pre-existing condition, a medical professional must have advised, diagnosed, or treated the insured.

We will not pay benefits for any specified diseases resulting from or affected by a pre-existing condition if the specified diseases was diagnosed within the 12-month period after the insured's effective date.

We will not reduce or deny a claim for benefits for any specified disease that was diagnosed more than 12 months after the effective date of the rider.

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

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

Benefits are not payable under for loss if these conditions result from another covered specified critical illness.

Occupational HIV Exclusions:

1. We will not pay for loss due to any of the following:

Occupational HIV that occurred before this Rider's Effective Date and that resulted from:

- A needle stick
- A sharp injury
- A mucous membrane exposure to blood
- Bloodstained bodily fluids

No benefits will be paid for HIV contracted outside the United States.

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

Benefits are not payable for loss if these conditions result from another covered specified disease.

TERMS YOU NEED TO KNOW

Acute Coronary Syndrome means an obstruction of the coronary arteries that occurs as a result of ST elevation Myocardial Infarction, non ST elevation Myocardial Infarction, or unstable angina.

Acute Coronary Syndrome does not include stable angina.

Cancer (internal or invasive) is defined as an illness meeting either of the following definitions:

- A malignant tumor characterized by:
  - The uncontrolled growth and spread of malignant cells and
  - The invasion of distant tissue.
- A disease meeting the diagnosis criteria of malignancy, as established by the American Board of Pathology. The doctor must have studied the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen.

Cancer includes leukemia and melanoma.

The following are not internal or invasive cancers:

- Pre-malignant tumors or polyps
- Carcinoma in Situ
- Any skin cancers (except melanomas)
- Basal cell carcinoma and squamous cell carcinoma of the skin
- Melanoma that is diagnosed as
  - Clark's Level I or II or
  - Breslow less than .77mm

Carcinoma in Situ is non-invasive cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

Cancer and/or Carcinoma in Situ must be diagnosed in one of two ways:
1. **Pathological Diagnosis** is a Diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This diagnosis must be made by a certified pathologist whose malignancy diagnosis conforms to the American Board of Pathology standards; 2. **Clinical Diagnosis** is based only on the study of symptoms. The company will accept a clinical diagnosis only if:

- A doctor cannot make a pathological diagnosis because it is medically inappropriate or life-threatening,
- Medical evidence exists to support the diagnosis, and
- A doctor is treating the insured for cancer or carcinoma in situ.

Coronary Artery Bypass means open heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts and where such narrowing or blockage is attributable to Coronary Artery Disease or Acute Coronary Syndrome. This excludes any non-surgical procedure, such as, but not limited to, balloon angioplasty, laser relief, or stents.

Coronary Artery Disease means a disease that occurs when the coronary arteries become diseased or damaged due to acute coronary occlusion, coronary atherosclerosis, aneurysm and dissection of the heart, and coronary atherosclerosis due to lipid rich plaque.

Critical Illness is a sickness or disease that first manifests while the insured's coverage is in force. Any loss due to critical illness must begin while the insured's coverage is in force. Critical illness includes only the following:
- Cancer
- Heart Attack due to coronary artery disease or acute coronary syndrome
- Stroke
  - Ischemic Stroke due to advanced arteriosclerosis of the arteries of the neck or brain
  - Hemorrhagic Stroke due to uncontrolled high blood pressure, malignant hypertension, brain aneurysm, or arteriovenous malformation

Date of Diagnosis is defined for each critical illness as follows:
- Cancer and/or Carcinoma in Situ: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or carcinoma in situ is based on such specimens). This includes the recurrence of a previously diagnosed cancer as long as the insured:
  - Is free from any signs or symptoms for a consecutive 12-month period before the date of diagnosis (for the reoccurrence),
  - Is currently treatment-free from that cancer, and
- Has been treatment-free from that cancer for 12 consecutive months.
  Heart Attack: The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the heart attack definition.
- Ischemic or Hemorrhagic Stroke: The date the stroke occurs (based on documented neurological deficits and neuroimaging studies).

Dependent means the Spouse/Domestic Partner of an Team Member or the dependent child of an Team Member.

Dependent Children are an Team Member's or an Team Member's Spouse/ Domestic Partner's natural children, step-children, legally adopted children, or children placed for adoption who are younger than age 26.

Children Placed for Adoption are children for whom the Team Member has entered a decree of adoption or for whom the Team Member has instituted adoption proceedings. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. The Team Member must continue to have custody pursuant to the decree of the court.

There is an exception to the age-26 limit listed above. This limit will not apply to any child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. The Team Member or the Team Member's Spouse/Domestic Partner must furnish proof of this incapacity and dependency to the company within 31 days following the child's 26th birthday.

Diagnosis (also Diagnosed) refers to the definitive and certain identification of an illness that:
- Is made by a doctor and
- Is based on clinical or laboratory investigations, as supported by the insured's medical records.

The illness must meet the requirements outlined in this plan for the particular critical illness being diagnosed.

Diagnosis must be made and treatment must be received in the United States.

Doctor is defined as a person who is:
- Legally qualified to practice medicine,
- Licensed as a doctor by the state where treatment is received, and
- Licensed to treat the type of condition for which a claim is made.

A Doctor does not include the insured or the insured's family member.

Team Member is a person who meets eligibility requirements under Section I – Eligibility of the certificate, and who is covered under this plan. The Team Member is the primary Insured under this plan.

Family Member includes the Team Member's Spouse (who is defined as an Team Member's legal wife or husband) or Domestic Partner as well as the following members of the insured's immediate family: son, daughter, mother, father, sister, or brother.

This includes Step-Family Members and Family-Members-in-law.

Heart Attack (Myocardial Infarction) is the death of a portion of the heart muscle (myocardium) caused by a blockage of one or more coronary arteries due to coronary artery disease or acute coronary syndrome.

Heart Attack does not include:
- Any other disease or injury involving the cardiovascular system.
- Cardiac Arrest not caused by a myocardial infarction.

Diagnosis of a heart attack must include all of the following:
- New and serial electrocardiographic (EKG) findings consistent with myocardial infarction;
- Elevation of cardiac enzymes above generally accepted laboratory levels of normal (in the case of creatine physphokinase {CPK}, a CPK-MB measurement must be used); and
- Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms.

Kidney Failure (Renal Failure) means end-stage renal failure caused by Chronic Kidney Disease, which results in the chronic, irreversible failure of both kidneys to function.

Kidney Failure is covered only if one of the following occurs:
- Regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) are necessary to treat the Kidney Failure; or
- The Kidney Failure results in kidney transplantation.

Chronic Kidney Disease means a disease characterized by the gradual loss in renal function over time due to diabetes mellitus, hypertension , or glomerulonephritis.

Maintenance Drug Therapy is a course of systemic medication given to a patient after a cancer goes into full remission because of primary treatment. Maintenance drug therapy includes ongoing hormonal therapy, immunotherapy, or chemo-prevention therapy. Maintenance drug therapy is meant to decrease the risk of cancer recurrence; it is not meant to treat or suppress a cancer that is still present.

Major Organ Transplant means undergoing surgery as a recipient of a covered transplant of a human heart, lung, liver, kidney, or pancreas. A Transplant must be caused by one or more of the following diseases:
- Bronchiectasis, which is a lung disease state defined by localized, irreversible dilation of the bronchial tree caused by destruction of the muscle and elastic tissue.
- Cancer
- Cardiomyopathy, which is a heart disease characterized by the measurable deterioration of the function of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid.
- Cirrhosis, which is a liver disease characterized by replacement of liver tissue by fibrosis, scar tissue, and regenerative nodules, leading to loss of liver function.
- Chronic Kidney Disease
- Chronic obstructive pulmonary disease, which is a lung disease

characterized by persistently poor airflow as a result of breakdown of lung tissue and dysfunction of the small airways.
- Congenital Heart Disease, which is heart disease characterized by abnormalities in cardiovascular structures that occur before birth.
- Coronary Artery Disease
- Cystic fibrosis, which is a hereditary disease of the exocrine glands, affects the pancreas, respiratory system, and sweat glands, and is characterized by the production of abnormally viscous mucus by the affected glands.
- Hepatitis, which is a disease caused by the hepatitis A, B, or C virus and is characterized by the inflammation of the liver.
- Interstitial lung disease, which is a lung disease that affects the interstitium of the lungs.
- Lymphangioleiomyomatosis, which is a lung disease characterized by smooth muscle growth throughout the lungs, resulting in the obstruction of small airways, leading to pulmonary cyst formation and pneumothorax, and of lymphatics.
- Polycystic liver disease, which is characterized by multiple variably-sized cysts lined by cuboidal epithelium.
- Pulmonary fibrosis, which is a lung disease where the lung tissue becomes thickened, stiff, and scarred due to chronic inflammation.
- Pulmonary hypertension, which is a disease characterized by increased pressure in the pulmonary artery and results in the thickening of the pulmonary arteries and the narrowing of these blood vessels, which causes the right side of the heart to become enlarged.
- Sarcoidosis, which is a disease characterized by the growth of granulomatous lesions that appear in the body.
- Valvular heart disease, which is a disease of the heart valves.

Pathologist is a doctor who is licensed:
- To practice medicine and
- By the American Board of Pathology to practice pathologic anatomy.

A pathologist also includes an osteopathic pathologist who is certified by the Osteopathic Board of Pathology. Pathologist does not include the insured or a family member.

Signs and/or Symptoms are the evidence of disease or physical disturbance observed by a doctor or other medical professional. The doctor (or other medical professional) must observe these signs while acting within the scope of his license.

Stroke means the death of a portion of the brain producing neurological sequelae, including infarction of brain tissue, hemorrhage, and embolization from an extra-cranial source. There must be evidence of permanent neurological deficit.

Stroke must be either:
- Ischemic Stroke due to advanced arteriosclerosis of the arteries of the neck or brain, or
- Hemorrhagic Stroke due to uncontrolled high blood pressure, malignant hypertension, brain aneurysm, or arteriovenous malformation.

Stroke does not include:
- Transient ischemic attacks (TIAs).
- Head injury.
- Chronic cerebrovascular insufficiency.
- Reversible ischemic neurological deficits.

Stroke will be covered only if the Insured submits evidence of the permanent neurological damage by providing:
- Computed Axial Tomography (CAT scan) images or
- Magnetic Resonance Imaging (MRI).

Successor Insured means that if an Team Member dies while covered under a certificate, then his surviving Spouse/Domestic Partner becomes the primary insured if that Spouse/Domestic Partner is also insured under this plan. If the certificate does not cover a surviving Spouse/Domestic Partner, the certificate will terminate on the next premium due date.

Total Disability or Totally Disabled means the insured is:
- Unable to work (defined later in this section),
- Not working at any job for pay or benefits, and
- Under the care of a doctor for the treatment of a covered critical illness.

Treatment or Medical Treatment is the consultation, care, or services provided by a doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

Treatment-Free From Cancer refers to the period of time without the consultation, care, or services provided by a doctor. This includes receiving diagnostic measures and taking prescribed drugs and medicines. Treatment does not include maintenance drug therapy or routine follow-up visits to verify whether cancer or carcinoma in situ has returned.

Unable to Work means either:
- During the first 365 days of total disability, the insured is unable to work at the occupation he was performing when his total disability began; or
- After the first 365 days of total disability, the insured is unable to work at any gainful occupation for which he is suited by education, training, or experience.

Activities of Daily Living (ADLs) are activities used in measuring levels of personal functioning capacity. These activities are normally performed without assistance, allowing personal independence in everyday living. For the purposes of this policy, ADLs include the following:
- Maintaining continence – controlling urination and bowel movements, including the 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 the body.
- Bathing – washing oneself by sponge bath or in either a tub or shower, including getting into or out of the tub or shower.

Covered Accident means an unforeseen and unexpected traumatic event resulting in bodily injury. An event meets the qualifications of covered accident if it:
- Occurs on or after the plan's effective date,
- Occurs while coverage is in force, and
- Is not specifically excluded.

Date of Diagnosis is defined for each specified disease as follows:
- Advanced Alzheimer's Disease – The date a doctor diagnoses you as incapacitated due to Alzheimer's disease.
- Advanced Parkinson's Disease: The date a doctor diagnoses you as incapacitated due to Parkinson's disease.
- Benign Brain Tumor: The date a doctor determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.
- Occupational HIV: The date a doctor determines you are HIV positive as supported by the ELISA test, Western Blot test, or another test approved by the FDA.
- Coma: The first day of the period for which a Doctor confirms a Coma due to one of the underlying diseases has lasted for 7 consecutive days.
- Coronary Artery Bypass: The date the surgery occurs.
- Kidney Failure: The date a Doctor recommends that an Insured begin renal dialysis.
- Loss of Sight, Speech, or Hearing: The date the loss due to one of the underlying diseases is objectively determined by a doctor to be total and

irreversible.
- Paralysis: The date a Doctor Diagnosis you with Paralysis due to one of the underlying diseases as specified in this Plan, where such Diagnosis is based on clinical and/or laboratory findings as supported by your medical records.
- Major Organ Transplant: The date the surgery occurs.

Specified Disease is one of the illnesses defined below and shown in the Rider Schedule:
- Advanced Alzheimer's Disease
- Advanced Parkinson's Disease
- Benign Brain Tumor
- Coma
- Coronary Artery Bypass
- Kidney Failure (Renal Failure)
- Loss of Sight, Speech, or Hearing
- Major Organ Transplant
- Occupational HIV
- Paralysis

Advanced Alzheimer's Disease means Alzheimer's Disease that causes the insured to be incapacitated. Alzheimer's Disease is a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's Disease. To be incapacitated due to Alzheimer's Disease, the insured must:
- Exhibit the loss of intellectual capacity involving impairment of memory and judgment, resulting in a significant reduction in mental and social functioning, and
- Require substantial physical assistance from another adult to perform at least three ADLs.

Advanced Parkinson's Disease means Parkinson's Disease that causes the insured to be incapacitated. Parkinson's Disease is a brain disorder that is diagnosed by a psychiatrist or neurologist as Parkinson's Disease. To be incapacitated due to Parkinson's Disease, the insured must:
- Exhibit at least two of the following clinical manifestations:
  i. Muscle rigidity
  ii. Tremor
  iii. Bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses), and
- Require substantial physical assistance from another adult to perform at least three ADLs.

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

Multiple Endocrine Neoplasia is a genetic disease in which one or more of the endocrine glands are overactive or form a tumor.

Neurofibromatosis is a genetic disease in which the nerve tissue grows tumors that may be benign and may cause serious damage by compressing nerves and other tissue.

Von Hippel-Lindau Syndrome is a genetic disease that predisposes a person to have benign or malignant tumors.

Coma means a state of continuous state of profound unconsciousness, lasting for a period of seven or more consecutive days and characterized by the absence of:
- Spontaneous eye movements;
- Response to painful stimuli; and
- Vocalization.

Coma must be caused by one of the following diseases:
- Brain Aneurysm
- Diabetes, which is a metabolic disease characterized by the inadequate secretion or utilization of insulin, by excessive urine production, by excessive amounts of sugar in the blood and urine, and by thirst, hunger, and loss of weight.
- Encephalitis, which is a disease characterized by inflammation of the brain, usually caused by a direct viral infection or a hyper-sensitivity reaction to a virus or foreign protein.
- Epilepsy, which is a neurological disease characterized by sudden, recurring attacks of motor, sensory, or psychic malfunction with or without loss of consciousness or convulsive seizures.
- Hyperglycemia, which is a disease where an excessive amount of glucose circulates in the blood plasma
- Hypoglycemia, which is a disease where blood glucose concentrations fall below a level necessary to properly support the body's need for energy and stability throughout its cells.
- Meningitis
- Stroke
- Sudden Cardiac Arrest which is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction[, due to cardiac rhythm abnormalities or acute coronary syndrome.] For the purposes of this Plan, a death is a Sudden Cardiac Arrest when the sole cause of death (as shown on the death certificate) is one of the following, that is the result of cardiac rhythm abnormalities or acute coronary syndrome:
  – Cardiovascular collapse
  – Sudden Cardiac Arrest
  – Cardiac arrest
  – Sudden cardiac death

Sudden Cardiac Arrest is not a Heart Attack.

HIV means the disease called Human Immunodeficiency Virus.

HIV Positive means the presence of HIV antibodies in the blood. This must be evidenced by:
- A positive screening test enzyme-linked immunosorbent assay (ELISA) and
- A positive supplement test, such as the Western Blot.

All such tests must be approved by the Food and Drug Administration (FDA), and the interpretation of positive results must be in keeping with the manufacturer's specifications.

Occupational HIV refers to your testing positive for HIV as a direct result of an HIV-Specific Covered Injury, subject to all three of the following provisions:
- You must file an incident report (notice of exposure) with your employer within 48 hours of the positive test result. This report must:
  – Be on a form acceptable to the company,
  – Describe the nature of the exposure to HIV, and
  – Be sent to the company as soon as reasonably possible after the covered injury.
- You must not have previously tested positive for HIV. If you had previously tested positive for HIV, you must have subsequently tested negative for HIV before the date of the Covered Injury.
- You must have a preliminary HIV screening test—such as an ELISA or other appropriate Food and Drug Administration (FDA) approved test (other than saliva or urine testing)— within 14 days of the Covered Injury at an authorized laboratory other than the laboratory of your employer. We must receive notification of the negative results as soon as reasonably possible.

Thereafter, you must test HIV positive within 26 weeks of the date of that covered injury.

HIV-Specific Covered Injury means an accidental:
- Cutaneous exposure through abraded skin,
- Percutaneous exposure, or

- Mucocutaneous exposure.

An HIV-Specific covered injury must occur while you are covered by this rider.

Loss of Sight, Speech, or Hearing

- Loss of Sight means the total and irreversible loss of all sight in both eyes. Loss of Sight must be caused by one of the following diseases:
  - Retinal Disease, which is a disease that affects the retina of the eye
  - Optic Nerve Disease, which is a disease that affects the optic nerve of the eye
  - Hypoxia, which is a disease characterized by a deficiency in the amount of oxygen reaching the tissues of the eyes.
- Loss of Speech means the total and permanent loss of the ability to speak. Loss of Speech must be caused by one of the following diseases:
  - Arteriovenous Malformation
- Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of Hearing does not include hearing loss that can be corrected by the use of a hearing aid or device. Loss of Hearing must be caused by one of the following diseases:
  - Alport Syndrome, which is an inherited disease of the kidney caused by a genetic mutation and can be characterized by hearing loss
  - Autoimmune Inner Ear Disease, which is an inflammatory condition of the inner ear occurring when the body's immune system attacks cells in the inner ear that are mistaken for bacteria or a virus
  - Chicken Pox, which is an acute contagious disease that is caused by the varicella-zoster virus and is characterized by skin eruptions, slight fever, and malaise.
  - Diabetes, which is a metabolic disease characterized by the inadequate secretion or utilization of insulin, by excessive urine production, by excessive amounts of sugar in the blood and urine, and by thirst, hunger, and loss of weight.
  - Goldenhar Syndrome, which is rare congenital disease that causes abnormalities in the face and head and can cause hearing loss.
  - Meniere's Disease, which is a disorder of the inner ear that causes spontaneous episodes of vertigo, hearing loss, ear ringing, and a feeling of fullness or pressure in the ear.
  - Meningitis
  - Mumps, which is an infectious disease characterized by inflammatory swelling of the parotid and usually other salivary glands, and is caused by paramyxovirus.

Paralysis or Paralyzed means the permanent, total, and irreversible loss of muscle function to the whole of at least two limbs as a result of one or more of the following diseases. The Diagnosis of Paralysis must be supported by neurological evidence.

- Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease), which is a chronic, progressive motor neuron disease occurring when nerve cells in the brain and spinal cord that control voluntary movement to degenerate, causing muscle weakness and atrophy, eventually leading to paralysis.
- Cerebral Palsy, which is a disorder of movement, muscle tone, or posture that is caused by injury or abnormal development in the immature brain. Cerebral Palsy can be characterized by stiffness and movement difficulties, or by involuntary and uncontrolled movements.
- Poliomyelitis (Polio) which is an acute infectious disease caused by the poliovirus and characterized by fever, motor paralysis, and atrophy of skeletal muscles, often resulting in permanent disability and deformity, and marked by inflammation of nerve cells in the anterior gray matter in each lateral half of the spinal cord.
- Stroke

ACCIDENT

WE WILL NOT PAY BENEFITS FOR INJURY, TOTAL DISABILITY, OR DEATH CONTRIBUTED TO, CAUSED BY, OR RESULTING FROM:

- War – participating in war or any act of war, declared or not; participating in the armed forces of, or contracting with, any country or international authority. We will return the prorated premium for any period not covered by this certificate when you are in such service.
- Suicide – committing or attempting to commit suicide, while sane or insane.
- Sickness – having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness.
- Self-Inflicted Injuries – injuring or attempting to injure yourself intentionally.
- Racing – riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.
- Intoxication – being legally intoxicated, or being under the influence of any narcotic, unless taken under the direction of a doctor. *Legally intoxicated* means that condition as defined by the law of the jurisdiction in which the accident occurred.
- Illegal Acts – participating or attempting to participate in an illegal activity, or working at an illegal job.
- Sports – participating in any organized sport—professional or semi-professional.
- Cosmetic Surgery – having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of a covered accident.
- An injury arising from any employment.
- An injury or sickness covered by Worker's Compensation.

TERMS YOU NEED TO KNOW

Accidental injury or injuries means bodily injury or injuries resulting from an unforeseen and unexpected traumatic event that meets the definition of *covered accident*.

Common carrier means an airline carrier that is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports; a railroad train that is licensed and operated for passenger service only; or a boat or ship that is licensed for passenger service and operated on a regular schedule between established ports.

Covered accident means an unforeseen and unexpected traumatic event resulting in bodily injury. An event meets the qualifications of covered accident if it occurs on or after the plan's effective date, occurs while coverage is in force, and is not specifically excluded.

Dependent children are your or your Spouse/Domestic Partner's natural children, step-children, legally adopted children, or children placed for adoption who are younger than age 26.

However, there is an exception to the age-26 limit listed above. This limit will not apply to any child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. You or your Spouse/Domestic Partner must furnish proof of this incapacity and dependency to the company within 31 days following the child's 26th birthday.

Dismemberment means: loss of a hand – The hand is removed at or above the wrist joint; loss of a foot – The foot is removed at or above the ankle; or loss of sight – At least 80% of the vision in one eye is lost (such loss of sight must be permanent and irrecoverable); or loss of a finger/toe – The finger or toe is removed at or above the joint where it is attached to the hand or foot.

Doctor is defined as a person who is a legally qualified to practice

medicine, licensed as a physician by the state where treatment is received, and licensed to treat the type of condition for which a claim is made. A doctor does not include you or your family member.

Team Member means a person who is actively at work with the master policyholder, engaged in full-time work, and is included in the class of Team Members eligible for coverage.

Family member includes your Spouse (who is defined as your legal wife or husband) or Domestic Partner as well as the following members of your immediate family: son, daughter, mother, father, sister, or brother.

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

Hospital refers to a place that is legally licensed and operated as a hospital; provides overnight care of injured and sick people; is supervised by a doctor; has full-time nurses supervised by a registered nurse; has on-site or pre-arranged use of X-ray equipment, laboratory, and surgical facilities; and maintains permanent medical history records.

A hospital is not a nursing home; an extended-care facility; a convalescent home; a rest home or a home for the aged; a place for alcoholics or drug addicts; or a mental institution.

Hospital Intensive Care Unit refers to a specifically designed hospital facility that provides the highest level of medical care and is restricted to patients who are critically ill or injured. Hospital Intensive Care Units must be separate and apart from the surgical recovery room; separate and apart from rooms, beds, and wards customarily used for patient confinement; permanently equipped with special life-saving equipment to care for the critically ill or injured; and under constant and continuous observation by nursing staffs assigned to the Intensive Care Unit on an exclusive, full-time basis.

Rehabilitation Unit is a unit of a hospital providing coordinated multidisciplinary physical restorative services. These services must be provided to inpatients under a doctor's direction. The doctor must be knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit specifically designated for this service.

You and **Your** refer to an Team Member as defined in the plan.

We refers to Continental American Insurance Company.

Spouse means your legal wife or husband. Coverage may only be issued to your Spouse if your Spouse is over 18. We will also recognize Domestic Partners.

PORTABLE COVERAGE

When coverage is effective and would otherwise terminate because you end employment with the employer, coverage may be continued. You may continue the coverage that is in force on the date employment ends, including dependent coverage that is in effect. You must apply to us in writing within 31 days after the date that the insurance would terminate.

You may be allowed to continue the coverage until the earlier of the date you fail to pay the required premium, or the date the group master policy is terminated. Coverage may not be continued if you fail to pay any required premium or the group master policy terminates. Premium for ported coverage is paid directly by you.

TERMINATION

Your insurance will terminate on the date we terminate the plan, the 31st day after the premium due date, if the premium has not been paid, the date you no longer meet the plan's definition of an Team Member, or the date you no longer belong to an eligible class.

If the master policy and/or certificate terminates, we will provide coverage for claims arising from covered accidents that occurred while the plan was in force.

EFFECTIVE DATE

The effective date for you, the Team Member, is as follows: (1) Your insurance will be effective on the date shown on the certificate schedule, provided you are then actively at work. (2) If you are not actively at work on the date coverage would otherwise become effective, the effective date of your coverage will be the date on which you are first thereafter actively at work.

***FRACTURES AND DISLOCATIONS**

Fracture is a break in the bone that can be seen by X-ray. If a bone is fractured in a covered accident, we will pay the appropriate benefit shown. **Multiple fractures** means having more than one fracture requiring open or closed reduction. If these fractures occur in any one covered accident, we will pay the appropriate benefits shown for each fracture, but no more than double the amount for the bone fractured that has the highest benefit amount.

Chip fracture means a piece of bone that is completely broken off near a joint. If a doctor diagnoses a chip fracture, we will pay 25% of the appropriate benefit shown. *If a fracture requires open reduction, we will pay double the amount shown.

Dislocation means a completely separated joint. If a doctor diagnoses and treats the dislocation within 90 days after the covered accident, we will pay the amount shown. If the dislocation requires open reduction, we will pay 200% of the appropriate amount shown. Multiple Dislocations* means having more than one dislocation requiring either open or closed reduction. For each dislocation, we will pay the amounts shown. We will not pay more than 200% of the benefit amount for the dislocated joint that has the highest benefit amount. Partial dislocation* means the joint is not completely separated. If a doctor diagnoses and treats the partial dislocation, we will pay 25% of the amount shown for the affected joint.
* If a dislocation requires open reduction, we will pay double the amount shown.

ACCIDENTAL-DEATH AND -DISMEMBERMENT

Accidental-Death Benefit we will pay the amount shown if, because of a covered accident, you are injured, and the injury causes you to die within 90 days after the accident.
Accidental Common-Carrier Death Benefit we will pay the amount shown if you are a fare-paying passenger on a common carrier, as defined below, are injured in a covered accident, and die within 90 days after the covered accident.
We will pay the Accidental-Death Benefit in addition to the Accidental Common-Carrier Death Benefit..
Single Dismemberment Benefit we will pay the appropriate amount shown if, because of a covered accident, you are injured and lose a hand, a foot, or sight within 90 days after the accident as a result of the injury. If you lose one hand, one foot, or the sight of one eye in a covered accident, we will pay the single dismemberment benefit shown. If you lose both hands, both feet, the sight of both eyes, or a combination of any two, we will pay the double dismemberment benefit shown. If you lose one or more fingers or toes in a covered accident, we will pay the finger/toe benefit shown.
If the Dismemberment Benefit is paid and you later die as a result of the same covered accident, we will pay the appropriate death benefit, less any amounts paid under this benefit.

EXCLUSIONS

We will not pay benefits for loss contributed to, caused by, or resulting from:

- War – participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. We will return the prorated premium for any period not covered by this certificate when you are in such service.
- Suicide – committing or attempting to commit suicide, while sane or insane.
- Self-Inflicted Injuries – injuring or attempting to injure yourself intentionally.
- Traveling – traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, Bermuda, and Jamaica.
- Racing – Riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.
- Aviation – operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those which are not motor-driven.
- Intoxication – being legally intoxicated, or being under the influence of any narcotic, unless such is taken under the direction of a physician.
- Illegal Acts – participating or attempting to participate in an illegal activity, or working at an illegal job.
- Sports – participating in any organized sport: professional or semiprofessional.
- Custodial Care. This is care meant simply to help people who cannot take care of themselves.
- Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
- Services performed by a relative.
- Services related to sex change, sterilization, in vitro fertilization, or reversal of a vasectomy or tubal ligation.
- A service or a supply furnished by or on behalf of any government agency unless payment of the charge is required in the absence of insurance.
- Elective abortion.
- Treatment, services, or supplies received outside the United States and its possessions or Canada.
- Dental services or treatment.
- Cosmetic surgery, except when due to medically necessary reconstructive plastic surgery.
- Mental or emotional disorders without demonstrable organic disease.
- Alcoholism, drug addiction, or chemical dependency.
- Injury or sickness covered by workers' compensation.
- Routine physical exams and rest cures.

Pregnancy Limitation

Within the first nine months of the effective date of coverage, we will not pay benefits for a loss or injury that is caused by, or occurs as a result of, the Insured's Pregnancy or childbirth. Loss or injury due to complications of pregnancy will be covered to the same extent as a covered sickness.

After this coverage has been in force for nine months from the effective date of coverage, benefits for a loss or injury that is caused by, or occurs as a result of, the Insured's Pregnancy or childbirth will be payable.

Treatment means consultation, care, or services provided by a physician. This includes diagnostic measures and taking prescribed drugs and medicines.

If the certificate is issued as a replacement for a certificate previously issued under this plan, then the pre-existing condition limitation provision of the new certificate applies only to any increase in benefits over the prior certificate. Any remaining pre-existing condition limitation period of the prior certificate continues to apply to the prior level of benefits.

TERMS YOU NEED TO KNOW

You and Your – Refer to an Team Member as defined in the Plan.

Spouse – means your legal Spouse who is 18 years or older. We will also recognize Domestic Partners.

Dependent Children – Means your natural children, stepchildren, foster children, legally adopted children, or children placed for adoption, who are under age 26.

Your natural children will be covered from the moment of live birth. No notice or additional premium is required if the Dependent Children Benefit Rider is already in force. Newborn children are not covered from the time of birth unless Dependent Children Benefit Rider coverage is already in force and effective prior to birth.

Coverage on Dependent Children will terminate on the child's 26th birthday. However, if any child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on his parent(s) for support, the above age of 26 shall not apply. Proof of such incapacity and dependency must be furnished to the company within 31 days following such 26th birthday.

Covered Person – If the certificate is issued as: Individual coverage, the Covered Person means you; Team Member/Spouse/Domestic Partner coverage, Covered Person means you and your legal Spouse/Domestic Partner Single Parent Family coverage, Covered Person means you and your covered dependent children as defined in the applicable rider, that have been accepted for coverage; Family coverage, Covered Person means you and your Spouse/Domestic Partner and covered dependent children, as defined in the applicable rider, that have been accepted for coverage.

Injury or Injuries – An accidental bodily injury or injuries caused solely by or as the result of a Covered Accident.

Covered Accident – An accident, which occurs on or after a Covered Person's Effective Date, while the certificate is in force, and which is not specifically excluded.

Sickness – An illness, infection, disease or any other abnormal condition, which is not caused solely by or the result of an Injury.

Covered Sickness – An illness, infection, disease, or any other abnormal physical condition which is not caused solely by or the result of any Injury which occurs while the certificate is in force; and was not treated or for which a Covered Person did not receive advice within 12 months before the Effective Date of his/her coverage; and is not excluded by name or specific description in the certificate.

Calendar Year – The period beginning on the policy effective date and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

Doctor or Physician – A person, other than yourself, or a member of your immediate family, who is licensed by the state to practice a healing art; performs services which are allowed by his or her license; and performs services for which benefits are provided by the certificate.

Hospital – A place that:

- Is legally licensed and operated as a hospital;
- Provides overnight care of injured and sick people;
- Is supervised by a doctor;
- Has full-time nurses supervised by a registered nurse;

- Has on-site or pre-arranged use of X-ray equipment, laboratory and surgical facilities; and
- Maintains permanent medical history records.

A hospital is not a nursing home; an extended care facility; a convalescent home; a rest home or a home for the aged; a place for alcoholics or drug addicts; or a mental institution.

Hospital Intensive Care Unit – A place that:

1. Is a specifically designated area of the hospital called an intensive care unit that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
2. Is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement;
3. Is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
4. Is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a twenty four hour basis; and
5. Has a doctor assigned to the intensive care unit on a full-time basis.

A hospital intensive care unit is not any of the following step-down units: a progressive care unit; a sub-acute intensive care unit; an intermediate care unit; a private monitored room; a surgical recovery room; an observation unit; or any facility not meeting the definition of a hospital intensive care unit as defined in the certificate.

Effective Date – The date as shown in the Certificate Schedule if you are on that date actively at work for the policyholder. If not, the certificate will become effective on the next date you are actively at work as an eligible Team Member. The certificate will remain in effect for the period for which the premium has been paid. The certificate may be continued for further periods as stated in the plan. The certificate is issued in consideration of the payment in advance of the required premium and of your statements and representations in the application. A copy of your application will be attached and made a part of the certificate. The certificate, on its Effective Date, automatically replaces any certificate or certificates previously issued to you under the plan.

Your Occupation – The occupation in which the insured is regularly engaged at the time the Team Member becomes insured.

Actively at Work – To be considered actively at work, the insured must perform for a full normal workday the regular duties of employment at the regular place of business of the group policyholder or at a location to which the insured may be required to travel to perform the regular duties of employment.

Treatment – Consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

Complications of Pregnancy refers to:

- Conditions requiring Medical Treatment that comes before or comes after the termination of a pregnancy. The diagnoses for this Medical Treatment must be distinct from pregnancy but either adversely affected by pregnancy or caused by pregnancy. For a condition to be a Complication of Pregnancy, it must constitute a classifiably distinct pregnancy complication. Examples of such Complications of Pregnancy are:
  - Acute nephritis,
  - Nephrosis,
  - Cardiac decompensation,
  - Missed abortion,
  - Disease of the vascular, hemopoietic, nervous, or endocrine systems, and Similar medical and surgical conditions of comparable severity.
- Further Complications of Pregnancy include:
  - Hyperemesis gravidarum and pre-eclampsia requiring hospital confinement,
  - Ectopic pregnancy that is terminated, and
  - Spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy do not include the following conditions:

- multiple gestation pregnancy.
- false labor.
- occasional spotting.
- morning sickness.

Other similar conditions associated with a difficult pregnancy are not considered Complications of Pregnancy.

Cesarean deliveries are not considered Complications of Pregnancy.

Individual Termination – Your insurance will terminate on the earliest of the date the plan is terminated; on the 31st day after the premium due date if the required premium has not been paid; on the date you cease to meet the definition of an Team Member as defined in the plan; on the premium due date which falls on or first follows your 70th birthday; or on the date you are no longer a member of an eligible class.

Insurance for an insured Spouse/Domestic Partner or Dependent Child will terminate the earliest of the date the Plan is terminated; the date the Spouse/Domestic Partner or Dependent Child ceases to be a dependent; or the premium due date following the date we receive written request to terminate coverage for an insured's Spouse/Domestic Partner and/or all Dependent Children.

Termination of any Covered Person's insurance under the certificate shall be without prejudice to his or her rights as regarding any claim arising prior thereto.

Portable Coverage – When coverage would otherwise terminate because the Team Member ends employment with the employer, coverage may be continued. The Team Member will continue the coverage that is in force on the date employment ends, including dependent coverage then in effect.

The Team Member will be allowed to continue the coverage until the earlier of the date the Team Member fails to pay the required premium or the date the group master policy is terminated. The insured must apply to us in writing within 31 days after the date that the insurance would terminate. Coverage may not be continued if the Team Member fails to pay any required premium, the insured attains age 70, or the group master policy terminates.

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

Notice to Consumer: The coverages provided by Continental American Insurance Company (CAIC) represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. CAIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.

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The certificate to which this sales material pertains may be written only in English; the certificate prevails if interpretation of this material varies.

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