Aflac

# Group Critical Illness

**INSURANCE – PLAN INCLUDES BENEFITS FOR CANCER AND HEALTH SCREENING**

We help take care of your expenses while you take care of yourself.

NM STATE UNIVERSITY

Aflac | CAIC CONTINENTAL AMERICAN INSURANCE COMPANY

# AFLAC GROUP CRITICAL ILLNESS INSURANCE

Policy Series CAI2800

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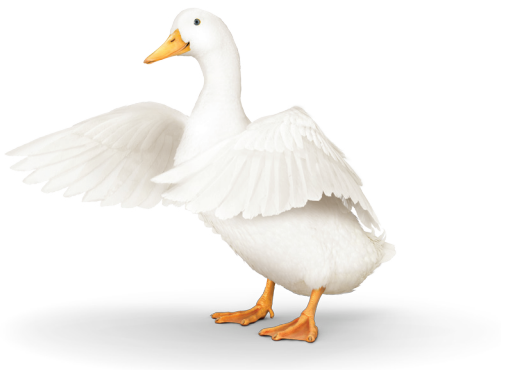
## Aflac can help ease the financial stress of surviving a critical illness.

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.

### Understanding the facts can help you decide if the Aflac group Critical Illness plan makes sense for you.

**FACT NO. 1**

ABOUT **1 in 6**

HEALTHCARE DOLLARS IS SPENT ON CARDIOVASCULAR DISEASE.[1]

**FACT NO. 2**

**$108.9** BILLION

THE AMOUNT OF MONEY CORONARY HEART DISEASE COST THE UNITED STATES. THIS TOTAL INCLUDES THE COST OF HEALTH CARE SERVICES, MEDICATIONS AND LOST PRODUCTIVITY.[2]

[1] Business Pulse, Heart Health Infographic, 2016 CDC Foundation.
[2] Centers for Disease Control and Prevention Heart Disease Fact Sheet 2015

Coverage underwritten by Continental American Insurance Company (CAIC)
A proud member of the Aflac family of insurers

**Here's why the Aflac group Critical Illness plan may be right for you.**

For more than 60 years, Aflac has been dedicated to helping provide individuals and families peace of mind and financial security when they've needed it most. The Aflac group Critical Illness plan is just another innovative way to help make sure you're well protected under our wing.

But it doesn't stop there. Having group Critical Illness insurance from Aflac means that you may have added financial resources to help with medical costs or ongoing living expenses.

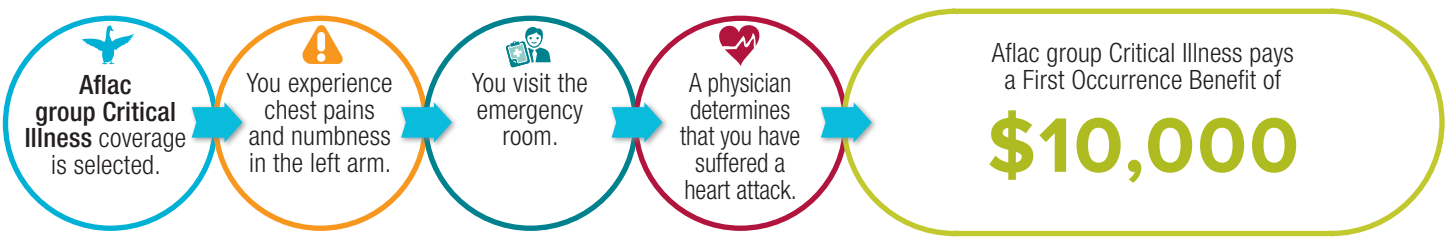
### The Aflac group Critical Illness plan benefits include:

- Critical Illness Benefit payable for:
  - Cancer
  - Heart Attack (Myocardial Infarction)
  - Sudden Cardiac Arrest
  - Stroke
  - Major Organ Transplant
  - End-Stage Renal Failure
  - Coronary Artery Bypass Surgery
  - Carcinoma In Situ
- Health Screening Benefit

### Features:

- Benefits are paid directly to you unless otherwise assigned.
- Coverage is available for you, your spouse or domestic partner, and dependent children.
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire.

## How it works




Amount payable based on $10,000 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, ask your insurance agent/producer, call 1.800.433.3036, or visit aflacgroupinsurance.com.**

## Benefits Overview

**COVERED CRITICAL ILLNESSES:**

| | |
|---|---|
| **CANCER** (Internal or Invasive) | 100% |
| **HEART ATTACK** (due to coronary artery disease or acute coronary syndrome) | 100% |
| **SUDDEN CARDIAC ARREST** (due to rhythm abnormalities or acute coronary syndrome) | 100% |
| **STROKE** (Ischemic Stroke due to advanced arteriosclerosis or arteriosclerosis of the arteries of the neck or brain; Hemorrhagic Stroke due to uncontrolled high blood pressure, malignant hypertension, brain aneurysm, or arteriovenous malformation) | 100% |
| **MAJOR ORGAN TRANSPLANT** | 100% |
| **END-STAGE RENAL FAILURE** | 100% |
| **CARCINOMA IN SITU** (Payment of this benefit will reduce your benefit for cancer by 25%.) | 25% |

**HEART EVENT BENEFIT**

| | |
|---|---|
| **CATEGORY I – SPECIFIED SURGERIES OF THE HEART** | |
| Coronary Artery Bypass Surgery | 100% |
| Mitral valve replacement or repair | 100% |
| Aortic valve replacement or repair | 100% |
| Surgical Treatment of Abdominal aortic aneurysm | 100% |
| **CATEGORY II – INVASIVE PROCEDURES AND TECHNIQUES OF THE HEART** | |
| AngioJet Clot Busting | 10% |
| Balloon Angioplasty (or Balloon valvuloplasty) | 10% |
| Laser Angioplasty | 10% |
| Atherectomy | 10% |
| Stent implantation | 10% |
| Cardiac catheterization | 10% |
| Automatic Implantable (or Internal) Cardioverter Defibrillator (AICD) | 10% |
| Pacemakers | 10% |

### FIRST OCCURRENCE BENEFIT
After the waiting period, a lump sum benefit is payable upon initial diagnosis of a covered critical illness. Employee benefit amounts available are $10,000 or $20,000. Spouse or domestic partner coverage is also available in benefit amounts of $5,000 or $10,000, not to exceed one half of the employee's amount. Recurrence of a previously diagnosed cancer is payable provided the diagnosis is made when the certificate is in-force, and provided the insured is free of any signs or symptoms of that cancer for 12 consecutive months, and has been treatment-free for that cancer for 12 consecutive months.

### ADDITIONAL OCCURRENCE BENEFIT
Benefits will be paid for each different Critical Illness after the first when the following two conditions are met: 1. The Date of Diagnosis for the new Critical Illness is separated from the prior, different Critical Illness by at least 6 months, or you are Treatment-Free From Cancer for at least 12 months, and 2. The new Critical Illness is not caused by or affected 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—for cancer—you have been Treatment-Free From Cancer for at least 12 months. Cancer that has spread (metastasized), even though there is a new tumor, will not be considered an additional occurrence unless you have been treatment-free for 12 months.

### 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
After the waiting period, you may receive a maximum of $50 for any one covered health screening test per calendar year. We will pay this benefit regardless of the results of the test. Payment of this benefit will not reduce the critical illness benefit payable under the plan. There is no limit to the number of years you can receive the Health Screening Benefit; it will be payable as long as coverage remains in force. 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. Benefits are paid for Covered Dependent Children at 100% of the Employee benefit amount.

**COVERED HEALTH SCREENING TESTS INCLUDE:**

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

**ADDITIONAL BENEFITS RIDER** (This benefit is paid based on your selected benefit amount.)

| | |
|---|---|
| **PARALYSIS** | 100% |
| **SEVERE BURNS** | 100% |
| **COMA** | 100% |
| **LOSS OF SPEECH / SIGHT / HEARING** | 100% |

## LIMITATIONS AND EXCLUSIONS

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

### IF DIAGNOSIS OCCURS AFTER THE AGE OF 70, HALF OF THE BENEFIT IS PAYABLE.

The Plan contains a 30-day Waiting Period. This means that we will not pay benefits to you if you were Diagnosed before your coverage was in force 30 days from the Effective Date. If a Critical Illness is first Diagnosed during the Waiting Period, we will only pay benefits for loss beginning after coverage has been in force for 6 months. Or, you may elect to void the Certificate from the beginning and receive a full premium refund.

The applicable benefit amount will be paid if: the date of diagnosis is after the waiting period; the date of diagnosis occurs while the certificate is in force; and the cause of the illness is not excluded by name or specific description.

### EXCLUSIONS

Benefits will not be paid for loss due to:

- Self-Inflicted Injuries — injuring or attempting to injure yourself intentionally or taking action that causes you 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:
  - Abuse of legally-obtained prescription medication
  - Illegal use of non-prescription drugs; or
- Pre-Existing Conditions (except as stated below).

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

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

### PRE-EXISTING CONDITION LIMITATION

**Pre-Existing Condition** is a sickness or physical condition that existed within the 6-month period before your Effective Date. For this Pre-existing Condition, a medical professional must have advised, Diagnosed, or treated you.

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 the 6-month period after your Effective Date.

The Company will not reduce or deny a claim for benefits for any Critical Illness that was Diagnosed more than 6 months after your Effective Date.

A Critical Illness will no longer be considered Pre-existing at the end of 6 consecutive months that start after your Effective Date.

*Benefits are payable for the reoccurrence of a previously Diagnosed Cancer and/or Carcinoma in Situ as long as you: have been free from Signs or Symptoms of that Cancer for a consecutive 12-month period before the Date of Diagnosis (for the reoccurrence), and have been Treatment-Free from that Cancer for the 12 consecutive months before the Date of Diagnosis (for the reoccurrence).

Applicable to Cancer and/or Carcinoma in Situ: If all other plan provisions are met, recurrence of a previously diagnosed cancer will not be reduced or denied provided the diagnosis is made when the certificate is in-force, and provided the insured is free of any signs or symptoms of that cancer for 12 consecutive months, and has been treatment-free for that cancer for 12 consecutive months.

## TERMS YOU NEED TO KNOW

The **Effective Date** of your insurance will be the date shown on the certificate schedule.

**Employee** means the insured as shown on the certificate schedule.

**Spouse** means your legal wife or husband.

**Domestic Partner** is defined as a person who is:

- Party to a valid domestic partnership,
- Has not terminated that domestic partnership, and
- Meets the requisites for a valid domestic partnership.

For two persons to enter into a valid domestic partnership, it is necessary that:

- Both persons have a common residence,
- Neither person is married or a member of another domestic partnership,
- The two persons are not related by blood in a way that would prevent them from being married to each other,
- Both persons are at least 18 years of age, and
- Both persons are competent to consent to the domestic partnership.

**Dependent Children** are your or your Spouse's or Domestic Partner's natural Children, stepchildren, foster Children, legally Adopted Children, or Children Placed for Adoption who are younger than age 26.

Immediate Coverage for Newborn or Adopted Children: The Plan automatically covers Newborn Children from the moment of birth. The Plan automatically covers Adopted Children from the date of filing the petition for adoption.

Children Placed for Adoption are Children for whom you have entered a decree of adoption or for whom you have 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. You 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. You or your Spouse or Domestic Partner must furnish proof of this incapacity and dependency to the Company within 31 days following the Child's 26th birthday.

**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** is the period of time that you have not received consultation, care, or services from a Doctor—including receiving diagnostic measures and taking prescribed medicines. Treatment does not include Maintenance Drug Therapy or routine follow-up visits to verify whether Cancer/Carcinoma in Situ has returned.

**Maintenance Drug Therapy** means ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer due to primary treatment. It is meant to decrease the risk of cancer recurrence rather than the palliative or suppression of 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.

**Myocardial Infarction (Heart Attack)** 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 phosphokinase (CPK), a CPK-MB measurement must be used); and
- Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms.

**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 you submit evidence of the permanent neurological damage by providing:

- Computed Axial Tomography (CAT scan) images, or
- Magnetic Resonance Imaging (MRI).

**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 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 you for Cancer or Carcinoma in Situ..

**Kidney Failure (Renal Failure)** refers to end-stage renal failure, which is 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.

The Company will not cover Kidney Failure caused by a traumatic event, including surgical trauma.

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

**Doctor or Physician** 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 you or your Family Member (as defined below).

**Sudden Cardiac Arrest** 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 is the result of cardiac rhythm abnormalities or acute coronary syndrome (as shown on the death certificate) from one of the following:

- Cardiovascular collapse
- Sudden Cardiac Arrest
- Cardiac arrest
- Sudden cardiac death

Sudden Cardiac Arrest is not a Heart Attack.

**COVERED HEART PROCEDURE** is one of the Category I or Category II procedures defined below:

**CATEGORY I – SPECIFIED SURGERIES OF THE HEART**

**Specified Surgeries of the Heart (Open Heart Surgery)** means open-chest surgery, where the heart is exposed and/or manipulated for open cardiothoracic situations.

We will only pay benefits under Category I for the following Open-Heart Surgery procedures:

- **Coronary Artery Bypass Surgery** (also **Coronary Artery Bypass Graft Surgery** or **Bypass Surgery)** is a surgical procedure performed to relieve angina and to reduce the risk of death from coronary artery disease. This also includes Coronary Artery Bypass Graft Surgery and Bypass Surgery.
  - **Off-Pump Coronary Artery Bypass (OPCAB)** is a form of bypass surgery that does not stop the heart or use the heart lung machine.
  - **Coronary Artery Bypass Grafting (CABG)** is used to treat a narrowing of the coronary arteries when the blockages are hard to reach or are too long or hard for angioplasty. A blood vessel, usually taken from the leg or chest, is grafted onto the blocked artery, creating a bypass around the blockage. **If more than one artery is blocked, a bypass can be done on each, but only one benefit is payable under this Rider.**
- **Mitral Valve Replacement** or **Repair** refers to a cardiac surgery procedure in which a patient's mitral valve is repaired or replaced by a different valve.
- **Aortic Valve Replacement** or **Repair** is a cardiac surgery procedure in which a patient's aortic valve is repaired or replaced by a different valve.
- **Surgical Treatment of Abdominal Aortic Aneurysm** (to prevent aneurysm rupture) involves opening the abdomen, finding the aorta, and removing (excising) the aneurysm. Abdominal aortic aneurysm is a ballooning or widening of the main artery (the aorta) as it courses down through the abdomen. At the point of the aneurysm, the aneurysm generally measures at least 3 centimeters in diameter.

Category I Benefits exclude all procedures not specifically listed above, including procedures such as, but not limited to, angioplasty, laser relief, stents or other surgical and non-surgical procedures.

**CATEGORY II – INVASIVE PROCEDURES AND TECHNIQUES OF THE HEART**

We will only pay benefits under Category II for the following procedures:

- **AngioJet Clot Busting** s a procedure used to clear blood clots from coronary arteries before angioplasty and stenting. A high-pressure saline solution is delivered through the artery to the clot, breaking the clot apart, and simultaneously drawing it out.
- **Balloon Angioplasty (**or **Balloon Valvuloplasty)** is a procedure used to open a clogged blood vessel. A thin tube is threaded through an artery to the narrowed heart vessel, where a small balloon at its tip is inflated. A balloon opens the narrowing by compressing atherosclerotic plaque against the vessel wall. The balloon is then deflated and removed.
- **Laser Angioplasty** refers to a procedure similar to Balloon Angioplasty. For this procedure, a laser tip is used to burn/break down plaque in the clogged blood vessel.
- **Atherectomy** is a procedure used to open blocked coronary arteries or clear bypass grafts. The procedure requires use of a device on the end of a catheter to cut or shave away atherosclerotic plaque.
- **Stent Implantation** refers to a procedure whereby a stainless steel mesh coil is implanted in a narrowed part of an artery to keep it propped open.
- **Cardiac Catheterization** (also **Heart Catheterization**) is a diagnostic and occasionally therapeutic procedure that allows a comprehensive examination of the heart and surrounding blood vessels.
- **Automatic Implantable** (or **Internal**) **Cardioverter Defibrillator (AICD**) refers to the initial placement of the AICD. AICDs are used for treating irregular heartbeats. The defibrillator is surgically placed inside the patient's chest where it monitors the heart's rhythm. When it identifies a serious arrhythmia, it produces an electrical shock to disrupt the arrhythmia.
- **Pacemaker Placement,** in this context, refers to the initial placement of a pacemaker. Pacemakers are implanted to ensure regular heart beats by sending electrical signals to the heart. This electrical device is placed under the skin. A lead extends from the device to the right side of the heart. Most pacemakers are used to correct a slow heart rate.

Subject to the re-occurrence benefit, only one Category II benefit is payable. Benefits will not be paid for multiple procedures listed under the Category II benefit.

Category II Benefits exclude all procedures not specifically listed above.

We will pay the appropriate Heart Event Benefit if:
- The Date of Treatment is after the Waiting Period,
- Treatment is incurred while this coverage is in force,
- Treatment is recommended by a Doctor, and
- Treatment is not excluded by name or specific description.

We will pay Heart Event Benefits according to the appropriate percentages of the Face Amount shown in the Certificate Schedule. Benefits are not payable for loss if these conditions result from another Specified Critical Illness.

Benefits for Category II will reduce the benefit amounts payable for Category I benefits. Benefits will be paid only at the highest benefit level. If procedures from Category I and Category II are performed at the same time, benefits are only eligible at the 100% (higher) event and will not exceed the Face Amount shown on the Certificate Schedule. You are only eligible to receive one payment for each benefit category listed on the schedule page. The dates of loss for covered procedures must be separated by at least 6 months for benefits to be payable for multiple covered procedures.

Payment of initial, re-occurrence, or additional occurrence benefits are subject to the Benefits section of your Certificate.

**ADDITIONAL BENEFITS RIDER LIMITATIONS AND EXCLUSIONS**

If diagnosis occurs after the age of 70, half of the benefit is payable

The rider contains a 30-day Waiting Period. This means that we will not pay benefits to an Insured who has been Diagnosed before his coverage has been in force 30 days from the Effective Date. If a Critical Illness is first Diagnosed during the Waiting Period, we will only pay benefits for loss beginning after coverage has been in force for 6 months. Or, the Insured may elect to void the Certificate from the beginning and receive a full premium refund.

We will not pay for loss if the Specified Critical Illness is 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:
  - Abuse of legally-obtained prescription medication
  - Illegal use of non-prescription drugs

No benefits will be paid for loss which occurred before the effective date of the rider. No benefits will be paid for diagnosis made outside the United States.

**DEFINITIONS**

**Coma**

If you are Diagnosed as being comatose after your Effective Date and after any applicable Waiting Period, we will pay the benefit amount for Coma shown in the Schedule of Benefits. The Diagnosis of Coma must indicate that permanent neurological deficit is present.

**Paralysis**

If you are first Diagnosed as being Paralyzed after your Effective Date and after any applicable Waiting Period, we will pay the benefit amount for Paralysis shown in the Schedule of Benefits. The Diagnosis of Paralysis must include documented evidence of the illness or injury that caused the Paralysis.

**Severe Burn**

If you are first Diagnosed as having suffered a Severe Burn after your Effective Date and after any applicable Waiting Period, we will pay the benefit amount for Severe Burn shown in the Schedule of Benefits.

**Loss of Sight, Speech or Hearing**

If you are first Diagnosed as having suffered Loss of Sight, Speech, or Hearing after your Effective Date and after any applicable Waiting Period, we will pay the benefit amount for Loss of Sight, Speech or Hearing shown in the Schedule of Benefits.

## PORTABLE COVERAGE

When you end employment with the employer and your coverage would otherwise terminate, you may elect to continue your coverage under the plan. You may continue the coverage that you had on the date your employment ended, including any in-force Spouse/Domestic Partner or Dependent Child coverage.

To keep your Certificate in force, you must apply to the Company in writing within 31 days after the date your insurance would otherwise terminate and pay the required premium to us no later than 31 days after the date the certificate would otherwise terminate and on each premium due date thereafter.

Coverage will end 31 days after the date you fail to pay any required premium or the date the group plan is terminated, whichever occurs first.

If you qualify for the Portability Privilege, then we will apply the same benefits, plan provisions, and premium rate as shown in your previously issued certificate.

## TERMINATION

Your insurance will terminate on whichever occurs first (1) The date the Company terminates the Plan; (2) The 31st day after the premium due date, if the premium has not been paid; (3) The date you no longer meet the Plan's definition of an Employee; or (4) The date you no longer belong to an eligible class.

Insurance for a covered Spouse or Domestic Partner or Dependent Child will terminate on the earliest of any of the bullet points listed above, or: (1) The premium due date following the date the covered Spouse or Domestic Partner or Dependent Child no longer qualifies as a Dependent. (2) The premium due date following the date we receive your written request to terminate coverage for your Spouse or Domestic Partner or all Dependent Children.

If your coverage terminates, we will provide coverage for claims arising from critical illnesses that were first diagnosed while your coverage was in force.

**Continental American Insurance Company is not aware of whether you receive benefits from Medicare, Medicaid, or a state variation. If you or a dependent are subject to Medicare, Medicaid, or a state variation, any and all benefits under the plan could be assigned. This means that you may not receive any of the benefits outlined in the plan. Please check the coverage in all health insurance plans you already have or may have before you purchase the insurance outlined in this summary to verify the absence of any assignments or liens.**

**Notice to Consumer: This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a tax penalty. Please consult your tax advisor.**