Aflac
Critical Care and Recovery

SPECIFIED HEALTH EVENT INSURANCE – PLAN 1

We've been dedicated to helping provide peace of mind and financial security for more than 65 years.

THE POLICY IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

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AFLAC CRITICAL CARE AND RECOVERY

SPECIFIED HEALTH EVENT INSURANCE – PLAN 1

Policy Series A71000

CCR[1]

Critical Care for you. Added financial protection for your family

Serious health events are often unexpected — and when they happen, everyday expenses may suddenly seem overwhelming. Aflac Critical Care and Recovery insurance helps provide financial protection should you experience a serious health event, such as a heart attack or stroke. You will receive a lump sum benefit upon diagnosis of a covered event with additional benefits to be paid for things such as a hospital confinement, ambulance, transportation, lodging, and therapy.

Aflac herein means American Family Life Assurance Company of Columbus.

Understand the difference Aflac can make in your financial security.

Aflac pays cash benefits directly to you, unless otherwise assigned. Aflac Critical Care and Recovery is designed to provide you with cash benefits if you experience a specified health event, such as sudden cardiac arrest or stroke. This means you can focus on recovery and not be so concerned about finances.

Health care costs continue to rise, and major medical insurance was not designed to cover everything. From out-of-pocket medical costs to a temporary loss of income, your finances may be strained. Aflac can help cover those costs. Best of all, you get paid directly (unless otherwise assigned) — not the doctor or hospital.

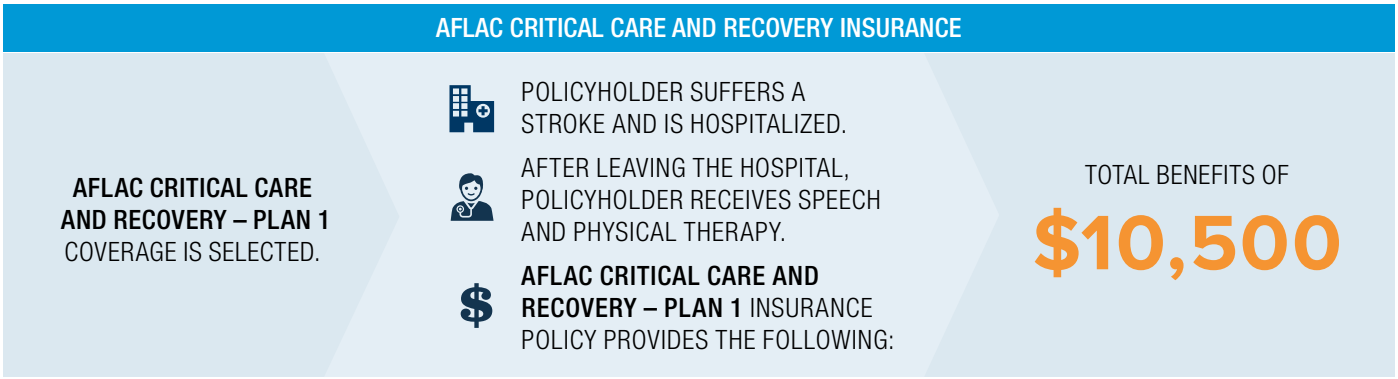
The Critical Care and Recovery insurance policy:

- Pays a lump-sum benefit upon diagnosis of having had a primary specified health event, which increases for dependent children.
- Pays benefits for hospital confinement, continuing care, transportation, lodging, and therapy.
- Is guaranteed-renewable—as long as premiums are paid, the policy cannot be canceled.
- Has no deductibles, copayments, or network restrictions–you choose your own medical treatment provider.

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

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

How it works



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

Benefits and/or premiums may vary based on state and plan option selected. Riders are available for an additional cost. The policy/riders have limitations, exclusions, and pre-existing condition limitations that may affect benefits payable. The policy may contain a waiting period. This brochure is for illustrative purposes only. Refer to the policy/riders for complete benefit details, definitions, limitations and exclusions.

For more information, contact your insurance agent/producer, call 1.800.992.3522, or visit aflac.com.

Aflac Critical Care and Recovery – Plan 1 Benefit Overview

BENEFIT NAME:	BENEFIT AMOUNT:
FIRST–OCCURRENCE BENEFIT: • NAMED INSURED/SPOUSE • DEPENDENT CHILDREN	 $5,000; lifetime maximum $5,000 per covered person $7,500; lifetime maximum $7,500 per covered person
REOCCURRENCE BENEFIT	$2,500; no lifetime maximum
SECONDARY SPECIFIED HEALTH EVENT BENEFIT	$250; no lifetime maximum
HOSPITAL CONFINEMENT BENEFIT	$300 per day; no lifetime maximum
CONTINUING CARE BENEFIT	$125 each day for up to 75 days; no lifetime maximum
AMBULANCE BENEFIT	$250 ground or $2,000 air; no lifetime maximum
TRANSPORTATION BENEFIT	$.50 per mile; up to $1,500 per occurrence; no lifetime maximum
LODGING BENEFIT	Up to $75 per day; limited to 15 days per occurrence; no lifetime max
WAIVER OF PREMIUM BENEFIT	Yes
CONTINUATION OF COVERAGE BENEFIT	Yes

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

SPECIFIED HEALTH EVENT INSURANCE

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)
Worldwide Headquarters • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999
TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)

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

SPECIFIED HEALTH EVENT INSURANCE POLICY

Supplemental Health Insurance Coverage

Policy Form Series A71100

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

(2) Specified Health Event Insurance Coverage is designed to supplement your existing accident and Sickness coverage only when certain losses occur as a result of Specified Health Events. Primary Specified Health Events are: Heart Attack, Stroke, Coronary Artery Bypass Surgery, End-Stage Renal Failure, Major Human Organ Transplant, Major Third-Degree Burns, Persistent Vegetative State, Coma, Paralysis or Sudden Cardiac Arrest occurring after the Effective Date of coverage. Secondary Specified Health Events are: Coronary Angioplasty, with or without stents, occurring after the Effective Date of coverage. Coverage is provided for the benefits outlined in Part (3). The benefits described in Part (3) may be limited by the provisions in Part (5).

Form A92397

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

A. FIRST-OCCURRENCE BENEFIT: Aflac will pay the following benefit amount for each covered person when he or she is first diagnosed as having had a Primary Specified Health Event:

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

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

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

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

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

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

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

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

Benefits D through G will be paid for care received within 180 days following the occurrence of a covered Primary Specified Health Event. Benefits are payable for only one covered Primary Specified Health Event at a time per covered person. If a covered person is eligible to receive benefits for more than one covered Primary Specified Health Event, we will pay benefits only for care received within the 180 days following the occurrence of the most recent event.

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

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

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

Form A92397

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

E. AMBULANCE BENEFIT: If, due to a covered Primary Specified Health Event, a covered person requires ground ambulance transportation to or from a Hospital, Aflac will pay $250 (two hundred fifty dollars). If air ambulance transportation is required due to a covered Primary Specified Health Event, we will pay $2,000 (two thousand dollars). A licensed professional or licensed volunteer ambulance company must provide the ambulance service. This benefit will not be paid for more than two times per occurrence of a Primary Specified Health Event. **Ambulance Benefits are not payable beyond the 180th day following the occurrence of a covered Primary Specified Health Event.** No lifetime maximum.

F. TRANSPORTATION BENEFIT: If a covered person requires special medical treatment that has been prescribed by the local attending Physician for a covered Primary Specified Health Event, Aflac will pay 50 cents (fifty cents) per mile for noncommercial travel or the costs incurred for commercial travel (coach class plane, train, or bus fare) for transportation of a covered person for the round-trip distance between the Hospital or medical facility and the residence of the covered person. This benefit is not payable for transportation by ambulance or air ambulance to the Hospital. Reimbursement will be made only for the method of transportation actually taken. This benefit will be paid only for the covered person for whom the special treatment is prescribed. If the special treatment is for a Dependent Child and commercial travel is necessary, we will pay this benefit for up to two adults to accompany the

Dependent Child. The benefit amount payable is limited to $1,500 (one thousand five hundred dollars) per occurrence of a covered Primary Specified Health Event. **Transportation Benefits are not payable beyond the 180th day following the occurrence of a covered Primary Specified Health Event. THIS BENEFIT IS NOT PAYABLE FOR TRANSPORTATION TO ANY HOSPITAL LOCATED WITHIN A 50-MILE RADIUS OF THE RESIDENCE OF THE COVERED PERSON.** No lifetime maximum.

G. LODGING BENEFIT: Aflac will pay the charges incurred up to $75 (seventy-five dollars) per day for lodging for you or any one adult family member when a covered person receives special medical treatment for a covered Primary Specified Health Event at a Hospital or medical facility. The Hospital, medical facility, and lodging must be more than 50 miles from the covered person's residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. This benefit is limited to 15 days per occurrence of a covered Primary Specified Health Event. **Lodging Benefits are not payable beyond the 180th day following the occurrence of a covered Primary Specified Health Event.** No lifetime maximum.

H. SECONDARY SPECIFIED HEALTH EVENT BENEFIT: Aflac will pay $250 (two hundred fifty dollars) for each covered person under the policy when he or she has a Coronary Angioplasty, with or without stents. **This benefit is limited to one Coronary Angioplasty per 30-day period.** No lifetime maximum.

I. WAIVER OF PREMIUM BENEFIT:

Employed: If you, due to a Primary Specified Health Event (as defined in Part 1, Item R of the policy), are completely unable to do all of the usual and customary duties of your occupation for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require an employer's statement and a Physician's statement of your inability to perform said duties, and may each month thereafter require a Physician's statement that total inability continues.

Not Employed: If you, due to a Primary Specified Health Event (as defined in Part 1, Item R of the policy), are completely unable to perform three or more of the Activities of Daily Living (ADLs) without the assistance of another person for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require a Physician's statement of your inability to perform said activities, and may each month thereafter require a Physician's statement that total inability continues.

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

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

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

1. Your policy has been in force for at least six months;
2. We have received premiums for at least six consecutive months;
3. Your premiums have been paid through payroll deduction;
4. You or your employer has notified us in writing within 30 days of the date your premium payments ceased due to your leaving employment; and

5. You re-establish premium payments through:
   a. your new employer's payroll deduction process, or
   b. direct payment to Aflac.

You will again become eligible to receive this benefit after:

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

"Payroll deduction" means your premium is remitted to Aflac for you by your employer through a payroll deduction process.

(4) Optional Benefits:

FIRST-OCCURRENCE BUILDING BENEFIT RIDER: (Series A71050) Applied for ❑ Yes ❑ No

The First-Occurrence Building Benefit as defined in the policy, will be increased by $500 (five hundred dollars) on each rider anniversary date while this rider remains in force. (The amount of the monthly increase will be determined on a pro rata basis.) This benefit will be paid under the same terms as the First-Occurrence Benefit. This benefit will cease to build for each covered person on the anniversary date of this rider following the covered person's 65th birthday or at the time of a Primary Specified Health Event, subject to Part 2 of the policy, for that covered person, whichever occurs first. However, regardless of the age of the covered person on the Effective Date of this rider, this benefit will accrue for a period of at least five years unless a Primary Specified Health Event is diagnosed prior to the fifth year of coverage. (If this is Individual coverage, no further premium will be billed for this rider after the payment of benefits.)

PRIMARY SPECIFIED HEALTH EVENT RECOVERY BENEFIT RIDER: (Series A71051)
Applied for ❑ Yes ❑ No

A covered person will be considered in Specified Health Event Recovery if he or she continues to be under the active care and treatment by a Physician for a covered Primary Specified Health Event OR if he or she is unable to engage in the duties of his or her regular occupation due to a covered Primary Specified Health Event. “Primary Specified Health Event” includes Heart Attack, Stroke, Coronary Artery Bypass Surgery, End-Stage Renal Failure, Major Human Organ Transplant, Major Third-Degree Burns, Persistent Vegetative State, Coma, or Paralysis occurring after the Effective Date of this rider.

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

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

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

LIMITATIONS AND EXCLUSIONS FOR RIDER SERIES A71051 ONLY:

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

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

1. Any loss sustained or contracted due, directly or indirectly, to a covered person's being intoxicated or under the influence of alcohol, drugs, or any narcotic unless administered on the advice of a Physician and taken according to the Physician's instructions (the term "intoxicated" refers to that condition as defined by the law of the jurisdiction in which the Injury or cause of the loss occurred).

2. Participating in any sport or sporting activity for wage, compensation, or profit.

3. Intentionally self-inflicting bodily Injury or attempting suicide.

4. Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve.

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

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

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

1. Any loss sustained or contracted due, directly or indirectly, to a covered person's being intoxicated or under the influence of alcohol, drugs, or any narcotic unless administered on the advice of a Physician and taken according to the Physician's instructions (the term "intoxicated" refers to that condition as defined by the law of the jurisdiction in which the Injury or cause of the loss occurred).

2. Participating in any sport or sporting activity for wage, compensation, or profit.

3. Intentionally self-inflicting bodily Injury or attempting suicide.

4. Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve.

A "Pre-Existing Condition" is an illness, disease, disorder, or Injury for which, within the six-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received from a Physician. Benefits for a Primary or Secondary Specified Health Event that is caused by a Pre-Existing Condition will not be covered unless the Primary or Secondary Specified Health Event occurs more than 30 days after the Effective Date. Any reoccurrence of a Primary or Secondary Specified Health Event occurring more than 30 days after the Effective Date will be covered.

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

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

TERMS YOU NEED TO KNOW

COMA: a continuous state of profound unconsciousness, diagnosed or treated after the effective date of the policy, lasting for a period of seven or more consecutive days, characterized by the absence of (1) spontaneous eye movements, (2) response to painful stimuli, and (3) vocalization. The condition must require intubation for respiratory assistance.

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

CORONARY ARTERY BYPASS SURGERY: open-heart surgery, performed after the effective date of the policy, to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to, coronary angioplasty, laser relief, or other nonsurgical procedures. This does not include valve replacement surgery.

COVERED PERSON: any person insured under the coverage type that you applied for on the application: individual (named insured listed in the Policy Schedule), named insured/spouse only (named insured and spouse), one-parent family (named insured and dependent children), or two-parent family (named insured, spouse, and dependent children). Spouse is defined as the person to whom you are legally married and who is listed on your application. Newborn children are automatically insured from the moment of birth. If coverage is for individual or named insured/spouse only and you desire uninterrupted coverage for a newborn child, you must notify Aflac within 31 days of the birth of your child, and Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due. Coverage will include any other dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and who became so incapacitated prior to age 26 and while covered under the policy. Dependent children are your natural children, stepchildren, or legally adopted children who are under age 26. A dependent child (including persons incapable of self-sustaining employment by reason of mental retardation or physical handicap) must be under age 26 at the time of application to be eligible for coverage.

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

END-STAGE RENAL FAILURE: permanent and irreversible kidney failure, not of an acute nature, requiring dialysis or a kidney transplant to maintain life.

HEART ATTACK: a myocardial infarction, coronary thrombosis, or coronary occlusion that is diagnosed or treated after the effective date of the policy. The attack must be positively diagnosed by a physician and must be evidenced by electrocardiographic findings or clinical findings together with blood enzyme findings. The definition of heart attack shall not be construed to mean congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease, or any other dysfunction of the cardiovascular system.

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

MAJOR THIRD-DEGREE BURNS: an area of tissue damage in which there is destruction of the entire epidermis and underlying dermis, and that covers more than 10 percent of total body surface. The damage must be caused by heat, electricity, radiation, or chemicals.

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

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

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

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

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

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

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

ADDITIONAL INFORMATION

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

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

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Underwritten by:
American Family Life Assurance Company of Columbus
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