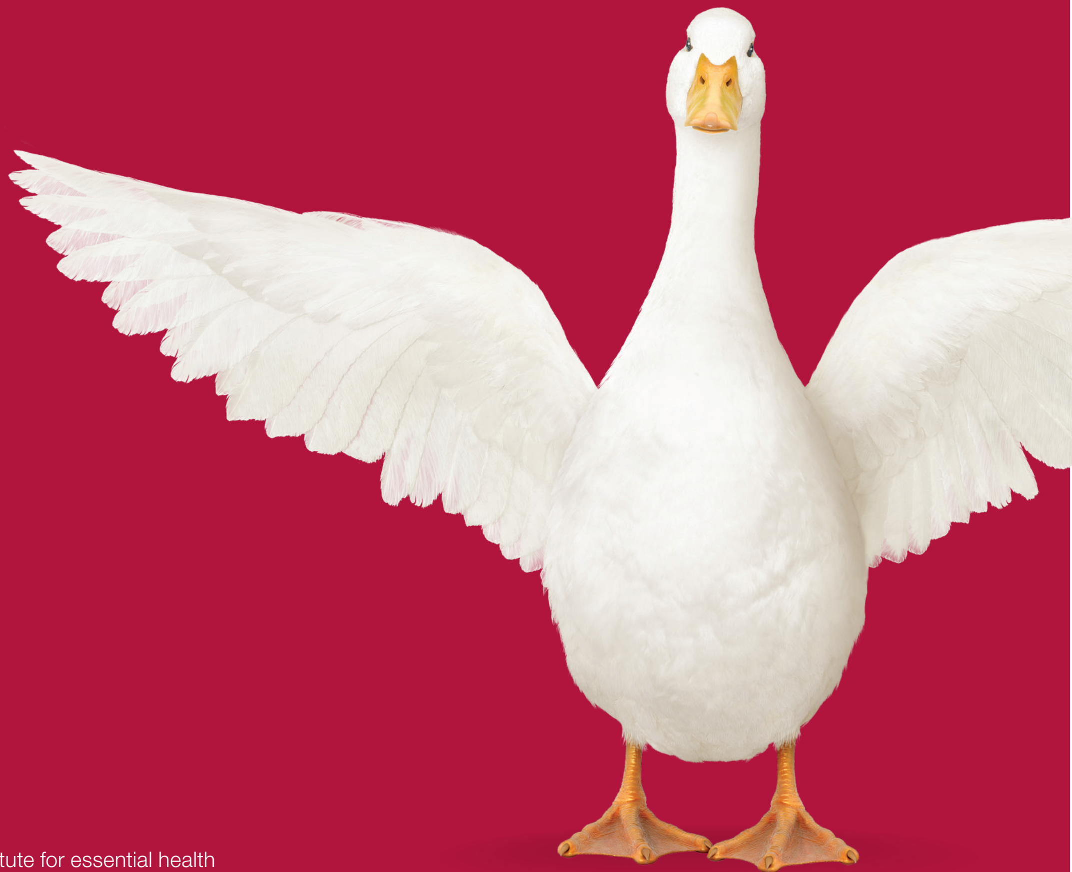
Aflac

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.



This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law.

THIS IS NOT A MEDICARE SUPPLEMENT PLAN. PLEASE READ CAREFULLY.

In California, coverage is underwritten by Continental American Life Insurance Company.

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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 notice the difference in 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 may not be 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 a heart attack or stroke.

More importantly, the plan helps you focus on recuperation instead of the distraction of 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.

What you need, when you need it.

Group critical illness insurance pays cash benefits that you can use any way you see fit.

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.

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.

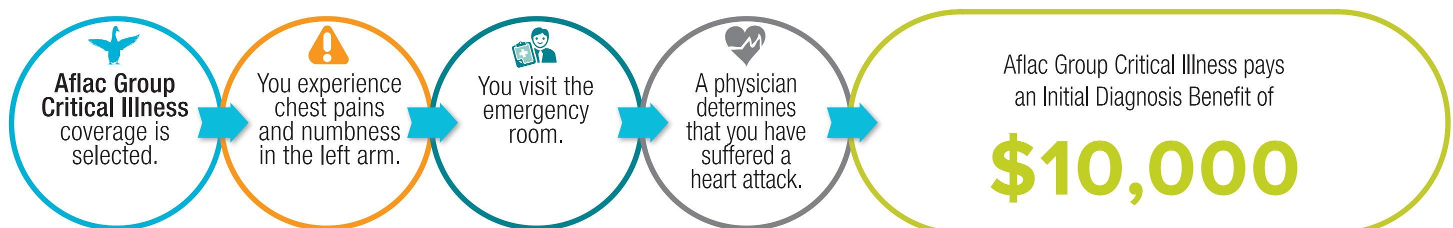
The Aflac Group Critical Illness plan benefits include:

- Critical Illness Benefit payable for:
  - Cancer
  - Heart Attack (Myocardial Infarction)
  - Stroke
  - Kidney Failure (End-Stage Renal Failure)
  - Limited Benefit Major Organ Transplant
  - Bone Marrow Transplant (Stem Cell Transplant)
  - Sudden Cardiac Arrest
  - Coronary Artery Bypass Surgery
  - Non-Invasive Cancer
  - Skin Cancer
- Health Screening Benefit
- Mammography

Features:

- Benefits are paid directly to you, unless otherwise assigned.
- Coverage is available for you, your spouse, and dependent children.
- Coverage may be continued (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 Initial Diagnosis Benefit.

For more information, ask your insurance agent/producer, call 1.800.433.3036, or visit aflacgroupinsurance.com.

Benefits Overview

COVERED CRITICAL ILLNESSES:

Illness	Benefit
CANCER (Internal or Invasive)	100%
HEART ATTACK (Myocardial Infarction)	100%
STROKE (Ischemic or Hemorrhagic)	100%
LIMITED BENEFIT MAJOR ORGAN TRANSPLANT (25% of this benefit is payable for insureds placed on a transplant list for a limited benefit major organ transplant)	100%
KIDNEY FAILURE (End-Stage Renal Failure)	100%
BONE MARROW TRANSPLANT (Stem Cell Transplant)	100%
SUDDEN CARDIAC ARREST	100%
NON-INVASIVE CANCER	25%
CORONARY ARTERY BYPASS SURGERY	25%

INITIAL DIAGNOSIS
We will pay a lump sum benefit upon initial diagnosis of a covered critical illness when such diagnoses is caused by or solely attributed to an underlying disease. Cancer diagnoses are subject to the cancer diagnosis limitation. Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

ADDITIONAL DIAGNOSIS
We will pay benefits for each different critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months. Cancer diagnoses are subject to the cancer diagnosis limitation.

REOCCURRENCE
We will pay benefits for the same critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months. Cancer diagnoses are subject to the cancer diagnosis limitation.

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. Children-only coverage is not available.

SKIN CANCER BENEFIT
We will pay $250 for the diagnosis of skin cancer. We will pay this benefit once per calendar year.

MAMMOGRAPHY BENEFIT
We will pay $200 for mammography tests performed while an insured's coverage is in force. This benefit is payable as follows:

a) A baseline mammogram for women age 35 to 39, inclusive.

b) A mammogram for women age 40 to 49, inclusive, every two years or more frequently based on the women's physicians' recommendations.

c) A mammogram every year for women age 50 and over.

Payment of this benefit will not reduce the face amount of the certificate. This benefit is payable once per calendar year.

WAIVER OF PREMIUM

If you become totally disabled due to a covered critical illness prior to age 65, after 90 continuous days of total disability, we will waive premiums for you and any of your covered dependents. As long as you remain totally disabled, premiums will be waived up to 24 months, subject to the terms of the plan.

SUCCESSOR INSURED BENEFIT

If spouse coverage is in force at the time of the primary insured's death, the surviving spouse may elect to continue coverage. Coverage would continue at the existing spouse face amount and would also include any dependent child coverage in force at the time.

HEALTH SCREENING BENEFIT (Employee and Spouse 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 employee and spouse. **This benefit is not paid for dependent children.**

HEART EVENT RIDER (This benefit is paid based on your selected benefit amount.)

100% FOR OPEN HEART SURGERIES Coronary Artery Bypass Surgery (CABS)*, Mitral Valve Replacement or Repair, Aortic Valve Replacement or Repair, Surgical Treatment of Abdominal Aortic Aneurysm.

10% FOR INVASIVE HEART PROCEDURE AngioJet Clot Busting, Balloon Angioplasty, Laser Angioplasty, Atherectomy, Stent Implantation, Cardiac Catheterization, Automatic Implantable (or Internal) Cardioverter Defibrillator Pacemakers

*Benefits from the Heart Event Rider and certificate will not exceed 100% of the maximum applicable benefit. When you purchase the Heart Event Rider, the 25% CABS partial benefit in your certificate is increased to 100%. That means the CABS benefit in the Heart Event Rider, combined with the benefit in your certificate, equal 100% of the maximum benefit—not 125%.

We will pay the indicated percentages of your maximum benefit if you are treated with one of the specified surgical procedures (Category I) or interventional procedures (Category II) shown if the date of treatment is after the waiting period; treatment is incurred while coverage is in force; treatment is recommended by a doctor/qualifed medical professional; and is not excluded by name or specific description. This benefit is paid based on your selected benefit amount.

OPTIONAL BENEFITS RIDER

Benefit	Percentage
LIMITED BENEFIT BENIGN BRAIN TUMOR	100%
ADVANCED ALZHEIMER'S DISEASE	25%
ADVANCED PARKINSON'S DISEASE	25%

These benefits will be paid based on the face amount in effect on the critical illness date of diagnosis. We will pay the optional benefit if the insured is diagnosed with one of the conditions listed in the rider schedule if the date of diagnosis is while the rider is in force.

PROGRESSIVE DISEASES RIDER

Benefit	Percentage
AMYOTROPHIC LATERAL SCLEROSIS (ALS or Lou Gehrig's Disease)	100%
SUSTAINED MULTIPLE SCLEROSIS	100%

This benefit is paid based on your selected Progressive Disease Benefit amount. We will pay the benefit shown upon diagnosis of one of the covered diseases if the date of diagnosis is while the rider is in force.

LIMITATIONS AND EXCLUSIONS

All limitations and exclusions that apply to the plan also apply to the riders unless amended by the riders.

Cancer Diagnosis Limitation Benefits are payable for cancer and/or non-invasive cancer as long as the insured:

- Is treatment-free from cancer for at least 12 months before the diagnosis date; and
- Is in complete remission prior to the date of a subsequent diagnosis, as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the cancer.

EXCLUSIONS

We will not pay for loss due to:

- **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 Occupation** – committing or attempting to commit a felony, or being engaged in an illegal occupation;
- **Participation in Aggressive Conflict of any kind, including:**
  - War (declared or undeclared) or military conflicts;
  - Insurrection or riot
- **Intoxicants and controlled substances:** loss sustained or contracted in consequence of the Insured's being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician

Diagnosis, treatment, testing, and confinement must be in the United States or its territories.

All benefits under the plan, including benefits for diagnoses, treatment, confinement and covered tests, are payable only while coverage is in force.

TERMS YOU NEED TO KNOW

Bone Marrow Transplant (Stem Cell Transplant) means a procedure to replace damaged or destroyed bone marrow with healthy bone marrow stem cells. For a benefit to be payable, a Bone Marrow Transplant (Stem Cell Transplant) must be caused by at least one of the following diseases:

- Aplastic anemia
- Congenital neutropenia
- Severe immunodeficiency syndromes
- Sickle cell anemia
- Thalassemia
- Fanconi anemia
- Leukemia
- Lymphoma
- Multiple myeloma

The Bone Marrow Transplant (Stem Cell Transplant) benefit is not payable if the transplant results from a covered critical illness for which a benefit has been paid under this plan.

Cancer (internal or invasive) is a disease that meets either of the following definitions:

- A malignant tumor characterized by the uncontrolled growth and spread of malignant cells, and the invasion of distant tissue (that is, cancer that has metastasized), or
- A disease meeting the diagnostic criteria of malignancy.

A qualified medical professional must have examined and provided a report on the histocytologic architecture or pattern of the tumor, tissue, or specimen.

Leukemia, lymphoma, and Hodgkin's disease are included in the definition of cancer (internal or invasive). Also included are: (internal or invasive) also includes:

- Melanoma that is Clark's Level III or higher or Breslow depth equal to or greater than 0.77mm,
- Myelodysplastic syndrome – RCMD (refractory cytopenia with multilineage dysplasia),
- Myelodysplastic syndrome – RAEB (refractory anemia with excess blasts),
- Myelodysplastic syndrome – RAEB-T (refractory anemia with excess blasts in transformation), or
- Myelodysplastic syndrome – CMML (chronic myelomonocytic leukemia).

The following are not considered internal or invasive cancers:

- Superficial cervical cancer, superficial bladder tumors, or pre-malignant tumors or polyps
- Early breast cancer requiring lumpectomy without radiation or chemotherapy
- Early prostate (Stage A) cancer
- Non-Invasive Cancer (as defined below)
- Melanoma that is diagnosed as
  - Clark's Level I or II,
  - Breslow depth less than 0.77mm, or
  - Stage 1A melanomas under TNM Staging

Non-Invasive Cancer is a cancer that is confined in its site of origin (in situ) without having invaded neighboring tissue.

For the purposes of the plan, Non-Invasive Cancer includes:

Cancer in one organ, such as prostate or indolent cancer (this does not include cancer that has spread throughout the organ, such as breast cancer , which would be considered an invasive cancer)

- Myelodysplastic Syndrome – RA (refractory anemia)
- Myelodysplastic Syndrome – RARS (refractory anemia with ring sideroblasts)

Skin Cancer, as defined in this plan, is not payable under the Non-Invasive Cancer Benefit.

Skin Cancer is a cancer that forms in the tissues of the skin. The following are considered skin cancers:

- Basal cell carcinoma
- Squamous cell carcinoma of the skin
- Melanoma in Situ – that is, melanoma cells that occur only on the outer layer of the skin (the epidermis), where there is no invasion of the deeper layer (the dermis)
- Melanoma that is diagnosed as
  - Clark's Level I or II,

- – Breslow depth less than 0.77mm, or
- – Stage 1A melanomas under TNM Staging

These conditions are not payable under the Cancer (internal or invasive) Benefit.

Cancer, non-invasive cancer, or skin cancer 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 qualified medical professional.
2. Clinical Diagnosis is based only on the study of symptoms. A clinical diagnosis will be accepted only if:
   - – Diagnosis is consistent with professional medical standards,
   - – Medical evidence exists to support the diagnosis, and
   - – A doctor/qualified medical professional is treating you for cancer or non-invasive cancer

Complete Remission is evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the cancer.

Coronary Artery Bypass Surgery 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 attributed 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.

Critical Illness is a disease or a sickness as defined in the plan that first manifests while your coverage is in force.

Date of Diagnosis is defined as follows:

- Bone Marrow Transplant (Stem Cell Transplant): The date the surgery occurs.
- Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or non-invasive cancer is based on such specimens).
- Coronary Artery Bypass Surgery: The date the surgery occurs.
- Heart Attack (Myocardial Infarction): The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the heart attack (myocardial Infarction) definition.
- Kidney Failure (End-Stage Renal Failure): The date a doctor/qualified medical professional recommends that an insured begin renal dialysis.
- Limited Benefit Major Organ Transplant: The date the surgery occurs.
- Non-Invasive Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or non-invasive cancer is based on such specimens).
- Skin Cancer: The date the skin biopsy samples are taken for microscopic examination.
- Stroke: The date the stroke occurs (based on documented neurological deficits and neuroimaging studies).
- Sudden Cardiac Arrest: The date the pumping action of the heart fails (based on the sudden cardiac arrest definition).

Dependent means your spouse or your dependent child. Spouse is your legal wife, husband, or partner in a legally recognized union. Dependent children are your or your spouse's natural children, step-children, foster children, children subject to legal guardianship, legally adopted children, or children placed for adoption, who are younger than age 26. Newborn children are automatically covered from the moment of birth. Refer to your certificate for details.

Diagnosis (Diagnosed) refers to the definitive and certain identification of an illness or disease that:

- Is made by a doctor/qualified medical professional and
- Is based on clinical or laboratory investigations, as supported by your medical records.

Doctor/Qualified Medial Professional is a person who is duly qualified as a practitioner of the healing arts acting within the scope of his license, and:

Is licensed to practice medicine; prescribe and administer drugs; or to perform surgery, or

- Is a duly qualified medical practitioner according to the laws and regulations in the state in which treatment is made.

A doctor/qualified medical professional does not include you or any of your family members.

For the purposes of this definition, family member includes your spouse as well as the following members of your immediate family:

- Son
- Daughter
- Mother
- Father
- Sister
- Brother

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

Employee is a person who meets eligibility requirements and who is covered under the plan. The employee is the primary insured under the plan.

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 (Myocardial Infarction) does not include:

- Any other disease or injury involving the cardiovascular system.
- Sudden cardiac arrest not caused by a heart attack (myocardial infarction).

Diagnosis of a Heart Attack (Myocardial Infarction) must include the following:

- New and serial electrocardiographic (ECG) findings consistent with heart attack (myocardial infarction), and
- 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.)

Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms may also be used.

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

Kidney Failure (End-Stage Renal Failure) is covered only under the following conditions:

- A doctor/qualified medical professional advises that regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) is necessary to treat the kidney failure (end-stage renal failure); or
- The kidney failure (end-stage renal failure) results in kidney transplantation.

Maintenance Drug Therapy is a course of systemic medication given to a patient after a cancer goes into complete 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 a cancer that is still present.

Limited Benefit 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
- Cardiomyopathy
- Cirrhosis
- Chronic obstructive pulmonary disease
- Congenital Heart Disease
- Coronary Artery Disease
- Cystic fibrosis
- Hepatitis
- Interstitial lung disease
- Lymphangioleiomyomatosis.
- Polycystic liver disease
- Pulmonary fibrosis
- Pulmonary hypertension
- Sarcoidosis
- Valvular heart disease

A Limited Benefit Major Organ Transplant benefit is not payable if the major organ transplant results from a covered critical illness for which a benefit has been paid.

Stroke means apoplexy due to rupture or acute occlusion of a cerebral artery. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. Stroke must be either:

- Ischemic: Due to advanced arteriosclerosis or arteriosclerosis of the arteries of the neck or brain, or vascular embolism, or
- Hemorrhagic: Due to uncontrolled hypertension, malignant hypertension, brain aneurysm, or arteriovenous malformation.

The stroke must be positively diagnosed by a doctor/qualified medical professional based upon documented neurological deficits and confirmatory neuroimaging studies.

Stroke does not include:

- Non-permanent, brief episodes of neurological dysfunction – such as transient ischemic attack (TIA) – caused by focal brain or retinal ischemia and including symptoms typically lasting less than one hour, and without evidence of acute infarction
- Head injury
- Chronic cerebrovascular insufficiency
- Reversible ischemic neurological deficits unless brain tissue damage is confirmed by neurological imaging

Stroke will be covered only if the Insured submits evidence of the neurological damage by providing:

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

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 coronary artery disease, cardiomyopathy, or hypertension.

Sudden Cardiac Arrest is not a heart attack (myocardial infarction). A sudden cardiac arrest benefit is not payable if the sudden cardiac arrest is caused by or contributed to by a heart attack (myocardial infarction).

Total Disability or Totally Disabled means you are:

- Not working at any job for pay or benefits,
- Under the care of a doctor/qualified medical professional for the treatment of a covered critical illness, and
- Unable to Work, which means either:
  - During the first 365 days of total disability, you are unable to work at the occupation you were performing when your total disability began; or
  - After the first 365 days of total disability, you are unable to work at any gainful occupation for which you are suited by education, training, or experience.

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

Treatment-Free from Cancer refers to the period of time in which you are not taking prescribed drugs and medicines for the treatment of cancer, or undergoing definitive therapy for cancer. “Treatment” does not include maintenance drug therapy or routine follow-up visits to verify whether cancer or carcinoma in situ has returned.

HEART EVENT RIDER

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) refers to open chest surgery, where the heart is exposed and/or manipulated for open cardiothoracic situations. We will pay benefits for the following open heart surgery procedures when they are performed as a direct result of one of the following: acute coronary syndrome, atherosclerosis, coronary artery disease, cardiomyopathy, or valvular heart disease.

Coronary Artery Bypass Surgery (also Coronary Artery Bypass Graft Surgery or Bypass Surgery) is a surgical procedure performed to relieve angina and reduce the risk of death from coronary artery disease.

- 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. A blood vessel 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 the rider.

Mitral Valve Replacement or Repair is a surgical procedure in which a patient's mitral valve is repaired or replaced by a different valve.

Aortic Valve Replacement or Repair is a surgical procedure in which a patient's aortic valve is repaired or replaced by a different valve.

Surgical Treatment of Abdominal Aortic Aneurysm involves opening the abdomen and repairing or removing an abdominal aortic aneurysm.

Category II – Invasive Procedures and Techniques of the Heart

We will pay Category II benefits for the following invasive procedures and techniques of the heart when they are performed as a result of one of the following: acute coronary syndrome, atherosclerosis, coronary artery disease, cardiomyopathy, or valvular heart disease.

AngioJet Clot Busting clears blood clots from coronary arteries before angioplasty and stenting. The device delivers a high-pressure saline solution through the artery to the clot, breaking it up and simultaneously drawing it out.

Balloon Angioplasty (or Balloon Valvuloplasty) opens 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 uses a laser tip to burn/break down plaque in the clogged blood vessel.

Atherectomy opens blocked coronary arteries or clears bypass grafts by using a device on the end of a catheter to cut or shave away atherosclerotic plaque.

Stent Implantation is the implantation of a stainless steel mesh coil 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 refers to the initial placement/implantation of a pacemaker, which sends electrical signals to make the heart beat when a person's natural pacemaker is not working properly. 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.

Valvular Heart Disease is a disease characterized by damage to or a defect in one of the four heart valves.

OPTIONAL BENEFITS RIDER

We will pay the optional benefit if the insured is diagnosed with one of the conditions listed in the rider schedule if the date of diagnosis is while the rider is in force.

Date of Diagnosis is defined as follows:

Advanced Alzheimer's Disease: The date a doctor/qualified medical professional diagnoses the insured as incapacitated due to Alzheimer's disease.

Advanced Parkinson's Disease: The date a doctor/qualified medical professional diagnoses the insured as incapacitated due to Parkinson's disease.

Limited Benefit Benign Brain Tumor: The date a doctor/qualified medical professional determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

Optional Benefit is one of the illnesses defined below and shown in the rider schedule:

Advanced Alzheimer's Disease means Alzheimer's disease, a progressive degenerative disease of the brain, which has been diagnosed by a doctor/qualified medical professional as having progressed to a stage which causes the insured to be incapacitated.

To be incapacitated due to Alzheimer's disease, a doctor/qualified medical professional must determine that the insured exhibits a loss of intellectual capacity resulting in an impairment of memory and judgment, as well as a significant reduction in mental and social functioning, to the extent that the insured requires permanent daily personal supervision. Diagnosis of Advanced Alzheimer's Disease requires proof, made in writing, by a psychiatrist, neurologist, neuropsychologist, or other qualified medical professional of the following:

Formal neuropsychological testing performed by a neuropsychologist confirming dementia;

Completed laboratory tests which rule out causes other than Alzheimer's Disease; and

Magnetic resonance imaging, computerized tomography or other imaging techniques which rule out causes other than Alzheimer's disease.

Advanced Parkinson's Disease means Parkinson's disease which has been diagnosed by a doctor/qualified medical professional as having progressed to classification of Stage 4 or greater and which causes the insured to be incapacitated. Diagnosis of Advanced Parkinson's Disease must be made by a neurologist or other qualified medical professional based upon abnormal results from a neurological examination, cognitive testing, and imaging studies. To be incapacitated due to Parkinson's disease, the insured must exhibit permanent clinical impairment of at least two of the following manifestations:

- Muscle rigidity
- Tremor
- Bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses).

Limited Benefit 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 caused by Multiple Endocrine Neoplasia, Neurofibromatosis, 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.

PROGRESSIVE DISEASE RIDER

We will pay the benefit shown upon diagnosis of one of the covered diseases if the date of diagnosis is while the rider is in force.

Date of Diagnosis is defined for each specified critical illness as follows:

Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease): The date a

doctor/qualified medical professional Diagnoses an Insured as having ALS and where such Diagnosis is supported by medical records.

Sustained Multiple Sclerosis: The date a doctor/qualified medical professional Diagnoses an Insured as having Multiple Sclerosis and where such Diagnosis is supported by medical records.

Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease) means a chronic, progressive motor neuron disease occurring when nerve cells in the brain and spinal cord that control voluntary movement degenerate, causing muscle weakness and atrophy, eventually leading to paralysis.

Sustained Multiple Sclerosis means a chronic degenerative disease of the central nervous system in which gradual destruction of myelin occurs in the brain or spinal cord or both, interfering with the nerve pathways. Sustained Multiple Sclerosis results in one of the following symptoms for at least 90 consecutive days:

- Muscular weakness,
- Loss of coordination,
- Speech disturbances, or
- Visual disturbances.

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.

YOU MAY CONTINUE YOUR COVERAGE
Your coverage may be continued with certain stipulations. See certifcate for details.

TERMINATION OF COVERAGE
Your insurance may terminate when the plan is terminated; the 31st day after the premium due date if the premium has not been paid; or the date you no longer belong to an eligible class. If your coverage terminates, we will provide benefits for valid claims that arose while your coverage was in force. See certificate for details.

NOTICES

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 Life Insurance Company 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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This brochure is a brief description of coverage and is not a contract. Read your certificate carefully for exact terms and conditions. You're welcome to request a full copy of the plan certificate through your employer or by reaching out to our Customer Service Center.

This brochure is subject to the terms, conditions, and limitations of Policy Series C21000.