Aflac

Group Accident

INSURANCE – HIGH 24-HOUR PLAN

When you least expect them — accidents can happen.

We're here to help.

Warning: Any person who knowingly, and with intent to injure, defraud, or deceive and Insurer, makes any claim for proceeds of an insurance Policy containing false, incomplete, or misleading information is guilty of a felony.

Underwritten by Continental American Life Insurance Company

City of SACRAMENTO

Aflac®

We've got you under our wing.®

AFLAC GROUP ACCIDENT

Group Accidental Injury Insurance – High 24-Hour Plan

Policy Series CAI7700-MP (CA)

AC[G]

Introducing added protection for life's unexpected moments.

If you're like most people, you don't budget for accidents. But at some point, you may make an unexpected trip to your local emergency room. And that could add a set of unexpected bills into the mix—even if you already have a major medical plan.

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

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

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

What you need, when you need it.

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

Here's why the Aflac group Accident 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. Our group Accident plan is just another innovative way to help make sure you're well protected under our wing.

But it doesn't stop there. Having the group Accident plan from Aflac means that your family may have added financial resources to help with the costs of follow-up care as well.

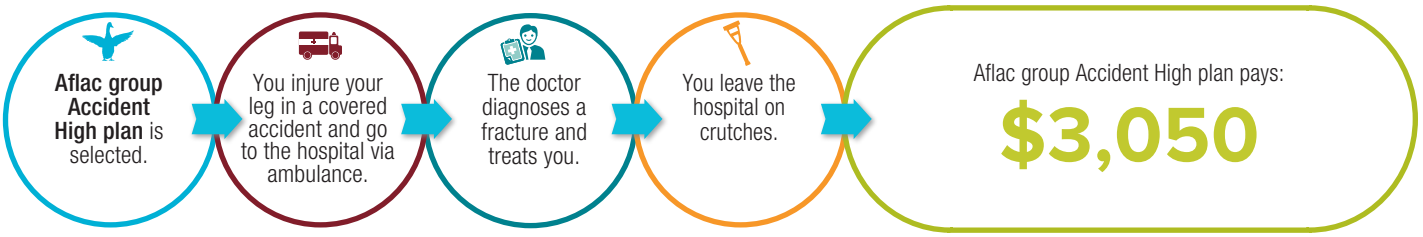
The Aflac group Accident plan benefits:

- Transportation and Lodging Benefits
- Fractures and Dislocations Benefits
- Medical Fees Benefit
- Hospital Admission Benefit
- Accidental-Death and -Dismemberment Benefits
- Coverage for certain serious conditions, such as coma and paralysis

Features:

- Coverage is guaranteed-issue (which means you may qualify for coverage without having to answer health questions).
- Benefits are paid directly to you, unless otherwise assigned.
- Coverage is available for you, your spouse, and dependent children.
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire.
- Fast claims payment. Most claims are processed in about four business days.

How it works



Amount payable was generated based on benefit amounts for:
Ambulance ($100), Complete Leg Fracture ($2,700), Medical Fees ($125), Crutches-($100), Accident Follow-Up (one visit, $25)

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 or call 1.800.433.3036. aflacgroupinsurance.com

Benefits Overview

HOSPITAL BENEFITS	EMPLOYEE	SPOUSE	CHILD
HOSPITAL ADMISSION We will pay this benefit when you are admitted to a hospital and confined as a resident bed patient because of injuries received in a covered accident within six months of the date of the accident. We will pay this benefit once per calendar year. We will not pay this benefit for confinement to an observation unit, or for emergency room treatment or outpatient treatment.	$1,000	$1,000	$1,000
HOSPITAL CONFINEMENT (per day) We will provide this benefit on the first day of hospital confinement for up to 365 days when you are confined to a hospital due to a covered accident. Hospital confinement must begin within 90 days from the date of the accident.	$200	$200	$200
HOSPITAL INTENSIVE CARE (per day) We will pay this benefit for up to 30 days if you are injured in a covered accident and the injury causes you to be confined to a hospital intensive care unit. This benefit is payable in addition to the Hospital Confinement Benefit.	$400	$400	$400
MEDICAL FEES (for each accident) If you are injured in a covered accident and receive treatment within one year after the accident, we will pay up to the maximum benefit amount for physician charges, emergency room services, supplies, and X-rays. Initial treatment must be received within 60 days after the accident.	$125	$125	$75
PARALYSIS (lasting 90 days or more and diagnosed by a physician within 90 days)			
Quadriplegia	$10,000	$10,000	$10,000
Paraplegia	$5,000	$5,000	$5,000
Paralysis means the permanent loss of movement of two or more limbs. If you are injured in a covered accident and the injury causes paralysis which lasts more than 90 days and is diagnosed by a physician within 90 days after the accident, we will pay the appropriate amount shown. The amount paid will be based on the number of limbs paralyzed. If this benefit is paid and you later die as a result of the same covered accident, we will pay the appropriate Death Benefit, less any amounts paid under the Paralysis Benefit.			

ACCIDENTAL-DEATH AND -DISMEMBERMENT (within 90 days)*	EMPLOYEE	SPOUSE	CHILD
ACCIDENTAL-DEATH	$50,000	$10,000	$5,000
ACCIDENTAL COMMON-CARRIER DEATH (plane, train, boat, or ship)	$100,000	$50,000	$15,000
SINGLE DISMEMBERMENT	$6,250	$2,500	$1,250
DOUBLE DISMEMBERMENT	$25,000	$10,000	$5,000
LOSS OF ONE OR MORE FINGERS OR TOES	$1,250	$500	$250
PARTIAL AMPUTATION OF FINGERS OR TOES (including at least one joint)	$100	$100	$100

Dismemberment - If you are injured in a covered accident and the injury causes loss of a hand, foot or sight within 90 days after the accident, we will pay the amount shown.

If a covered accident causes you to lose one hand, foot or the sight of one eye, we will pay the single loss dismemberment benefit shown. If you lose **both** hands, feet, the sight of both eyes, or a combination of any two, we will pay the Double Dismemberment Benefit shown.

If you lose one or more fingers or toes in a covered accident, we will pay the finger/toe benefit shown.

Dismemberment means **loss of a hand:** the hand is cut off at or above the wrist joint; or **loss of a foot**: the foot is cut off at or above the ankle; or **loss of sight**: at least 80% of the vision in one eye is lost. Such loss of sight must be permanent and irrecoverable or **loss of a finger/toe:** the finger or toe is cut off at or above the joint where it is attached to the hand or foot.

If you do not qualify for the Dismemberment Benefit but lose at least one joint of a finger or toe, we will pay the Partial Dismemberment Benefit.

If this benefit is paid and you later die as a result of the same covered accident, we will pay the appropriate Accidental-Death Benefit less any amounts paid under this benefit.

*If you are injured in a covered accident and the injury causes death within 90 days after the accident, we will pay the Accidental-Death Benefit shown. If the Accidental-Death Benefit is paid, we will not pay the Accidental Common Carrier Death Benefit.

If you are injured in a covered accident as a result of traveling as a fare-paying passenger on a common carrier and the injury causes death days after the accident, we will pay the Accidental Common Carrier Death Benefit in the amount shown.

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

If the Accidental Common Carrier Death Benefit is paid, we will **not** pay the Accidental-Death Benefit.

Accidental injury means bodily injury caused solely by or as the result of a covered accident.

Covered accident means an accident that occurs on or after the effective date, while the certificate is in force, and that is not specifically excluded.

Benefits Overview

MAJOR INJURIES (diagnosis and treatment within 90 days)	EMPLOYEE	SPOUSE/CHILD
FRACTURES (closed reduction)		
Hip/Thigh	$4,500	$4,000
Vertebrae (except processes)	$4,050	$3,600
Pelvis	$3,600	$3,200
Skull (depressed)	$3,375	$3,000
Leg	$2,700	$2,400
Forearm/Hand/Wrist	$2,250	$2,000
Foot/Ankle/Knee Cap	$2,250	$2,000
Shoulder Blade/Collar Bone	$1,800	$1,600
Lower Jaw (mandible)	$1,800	$1,600
Skull (simple)	$1,575	$1,400
Upper Arm/Upper Jaw	$1,575	$1,400
Facial Bones (except teeth)	$1,350	$1,200
Vertebral Processes	$900	$800
Coccyx/Rib/Finger/Toe	$360	$320
DISLOCATIONS (closed reduction)		
Hip	$3,600	$2,700
Knee (not knee cap)	$2,600	$1,950
Shoulder	$2,000	$1,500
Foot/Ankle	$1,600	$1,200
Hand	$1,400	$1,050
Lower Jaw	$1,200	$900
Wrist	$1,000	$750
Elbow	$800	$600
Finger/Toe	$320	$240

- A **fracture** is a break in the bone which can be seen by X-ray. If you fracture a bone in a covered accident, and it is diagnosed and treated by a doctor, we will pay the appropriate amount shown.
- **Dislocation** means a completely separated joint. If you dislocate a joint in a covered accident, and it is diagnosed and treated by a doctor within 90 days after the accident, we will pay the amount shown.
- We will pay no more than 150% of the benefit amount for the bone fracture or dislocated joint which has the higher dollar value. If you fracture a bone **and** dislocate a joint, we will pay for both, but no more than 150% of the benefit amount for the bone fractured or joint dislocated that has the higher dollar value.
- Open reduction is paid at 150% of closed reduction.
- A **chip facture** is a piece of bone which is completely broken off near a joint. Chip fractures are paid at 10% of the benefit shown.
- Partial dislocations are paid at 25% of the dislocation benefit.

SPECIFIC INJURIES	ALL*
RUPTURED DISC (treatment within 60 days; surgical repair within one year)	
Injury occurring during first certificate year	$100
Injury occurring after first certificate year	$400
TENDONS/LIGAMENTS (within 60 days; surgical repair within 90 days)	
If you tear, sever, or rupture a tendon or ligament in a covered accident, receive treatment from a doctor within 60 days, and have surgical repair within 90 days after the accident, we will pay the appropriate amount shown. The amount paid will be based on the number (single or multiple) of tendons or ligaments repaired. If you fracture a bone or dislocate a joint in addition to tearing, severing, or rupturing a tendon or ligament, we will only pay one benefit. We will pay the largest of the fracture, dislocation, tendon, or ligament benefits.	$600 (Multiple) $400 (Single)
TORN KNEE CARTILAGE (treatment within 60 days; surgical repair within one year)	
Injury occurring during first certificate year	$100
Injury occurring after first certificate year	$400
EYE INJURIES	
Treatment and surgical repair within 90 days	$250
Removal of foreign body, with or without anesthesia	$50
CONCUSSION (a head injury resulting in electroencephalogram abnormality)	$200
COMA (a state of profound unconsciousness lasting more than 30 days)	$10,000
EMERGENCY DENTAL (injury to sound natural teeth)	
Repaired with crown	$150
Resulting in extraction	$50
BURNS (treatment within 72 hours and based on percent of body surface burned)	
Second-Degree Burns	
Less than 10%	$100
At least 10%, but less than 25%	$200
At least 25%, but less than 35%	$500
35% or more	$1,000
Third-Degree Burns	
Less than 10%	$500
At least 10%, but less than 25%	$3,000
At least 25%, but less than 35%	$7,000
35% or more	$10,000
First-degree burns are not covered.	
LACERATIONS (treatment and repair within 72 hours)	
Under 2" long	$50
2" to 6" long	$200
Over 6" long	$400
Lacerations not requiring stitches	$25

Multiple Lacerations: We will pay for the largest single laceration requiring stitches**.**

*EMPLOYEE/ SPOUSE/ CHILD

Benefits Overview

ADDITIONAL BENEFITS	ALL*
AMBULANCE **AIR AMBULANCE** If you require transportation to a hospital by a professional ambulance or air ambulance service within 90 days after a covered accident, we will pay the amount shown.	$100 $500
BLOOD/PLASMA If you receive blood or plasma within 90 days following a covered accident, we will pay the amount shown.	$100
APPLIANCES We will pay this benefit when you are advised by a physician to use a medical appliance due to injuries received in a covered accident. Benefits are payable for crutches, wheelchairs, leg braces, back braces, and walkers.	$100
INTERNAL INJURIES We will pay this benefit if you have internal injuries as the result of a covered accident which results in open abdominal or thoracic surgery.	$1,000
ACCIDENT FOLLOW-UP TREATMENT We will pay this benefit for up to six treatments per covered accident, per insured for follow-up treatment. The insured must have received initial treatment within 72 hours of the accident, and the follow-up treatment must begin within 30 days of the covered accident or discharge from the hospital. This benefit is not payable for the same visit that the Physical Therapy Benefit is paid.	$25
EXPLORATORY SURGERY without repair (e.g., arthroscopy)	$250
PROSTHESIS If you require the use of a prosthetic device due to injuries received in a covered accident, we will pay this benefit. Hearing aids, wigs, or dental aids, including but not limited to false teeth, are not covered.	$500
PHYSICAL THERAPY We will pay this benefit for up to six treatments per covered accident, per insured for treatment from a physical therapist. The insured must have received initial treatment within 72 hours of the accident, and physical therapy must begin within 30 days of the covered accident or discharge from the hospital. Treatment must take place within six months after the accident. This benefit is not payable for the same visit that the Accident Follow-Up Treatment Benefit is paid.	$25
TRANSPORTATION If hospital treatment or diagnostic study is recommended by your physician and is not available in your city of residence, we will pay the amount shown. Transportation must begin within 90 days from the date of the covered accident. The distance to the hospital must be greater than 50 miles from your residence.	$300 (train/ plane) $150 (bus)
FAMILY LODGING BENEFIT (per night) If you are required to travel more than 100 miles from your home for inpatient treatment of injuries received in a covered accident, we will pay this benefit for an immediate adult family member's lodging. Benefits are payable up to 30 days per accident and only while you are confined to the hospital. The treatment must be prescribed by your local physician.	$100
WELLNESS BENEFIT (per 12-month period) After 12 months of paid premium and while coverage is in force, we will pay this benefit for preventive testing once each 12-month period. Benefits include and are payable for annual physical exams, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, PSA tests, ultrasounds, and blood screenings.	$60

*EMPLOYEE/ SPOUSE/ CHILD

ACCIDENT INSURANCE

LIMITATIONS AND EXCLUSIONS
WHAT IS NOT COVERED, AND TERMS YOU NEED TO KNOW

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.

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

- Participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. We will return the prorated premium for any period not covered when you are in such service.
- Operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those that are not motor-driven.
- Participating or attempting to participate in an illegal activity or working at an illegal job.
- Committing or attempting to commit suicide, while sane or insane.
- Injuring or attempting to injure yourself intentionally.
- Having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness.
- Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, the Virgin Islands, Bermuda, and Jamaica, except under the Accidental Common-Carrier Death Benefit.
- Riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.
- Participating in any professional or semiprofessional organized sport.
- Being legally intoxicated or under the influence of any narcotic, unless taken under the direction of a physician.
- Driving any taxi, or intrastate or interstate long-distance vehicle for wage, compensation, or profit.
- Mountaineering using ropes and/or other equipment, parachuting, or hang gliding.
- Having cosmetic surgery or other elective procedures that are not medically necessary, or having dental treatment, except as a result of a covered accident.

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

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

PRE-EXISTING CONDITION LIMITATION

We will not pay benefits for a loss that is caused by, that is contributed to, or that results from a pre-existing condition for 12 months after the effective date of coverage.

Pre-Existing Condition means within the 12-months period prior to the effective date of a certificate and attached riders, as applicable: those conditions for which medical advice or treatment was received or recommended.

A claim for benefits for loss starting after 12-months from the effective date of a certificate and attached riders will not be reduced or denied on the grounds that it is caused by a pre-existing condition.

A certificate may have been issued as a replacement for a certificate previously issued under the plan. If so, then the pre-existing condition limitation provision of the certificate applies only to any increase in benefits over the prior certificate. Any remaining period of the pre-existing condition limitation of the prior certificate will continue to apply to the prior level of benefits.

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

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

Spouse means the person married to you on the effective date of coverage. Spouse coverage may only be issued to your spouse if your spouse is between ages 18 and 64, inclusive. Coverage on your spouse terminates when your spouse attains age 70.

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

Existing children of a registered domestic partner will be covered the same as stepchildren.

Your natural children born after the effective date of of coverage will be covered from the moment of live birth. No notice or additional premium is required.

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

PORTABLE COVERAGE

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

You will be allowed to continue the coverage until the earlier of the date you fail to pay the required premium or the date the group master policy is terminated. Coverage may not be continued if you fail to pay any required premium, you attain age 70, or the group master policy terminates.

TERMINATION

Your insurance will terminate on the earliest of: (1) the date the master policy is terminated, (2) the 31st day after the premium due date if the required premium has not been paid, (3) the date you cease to meet the definition of an employee as defined in the master policy, (4) the premium due date which falls on or first follows the employee's 70th birthday, or (5) the date you are no longer a member of the class eligible.

Insurance for an insured spouse or dependent child will terminate the earliest of: (1) the date the plan is terminated; (2) the date the spouse or dependent child ceases to be a dependent; (3) the premium due date following the date we receive your written request to terminate coverage for your spouse and/or all dependent children.

EFFECTIVE DATE

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

Notice to Consumer: The coverages provided by Continental American Life Insurance Company (CALIC) 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. CALIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.

We've got you under our wing.®

aflacgroupinsurance.com | **1.800.433.3036**

Please contact the California Department of Insurance if you have an issue that cannot be solved with Continental American Life Insurance Company.

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013

Consumer Hotline
1-800-927-Help (4357)
or
1-213-897-8921
TDD Number
1- 800-482-4TDD (4833)

Aflac

Group Hospital Indemnity

INSURANCE PLAN 5

Even a small trip to the hospital can have a major impact on your finances.

Here's a way to help make your visit a little more affordable.

This plan is not a substitute for major medical coverage; it is designed to supplement a major medical program. This is supplemental to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance.

Underwritten by Continental American Life Insurance Company

City of SACRAMENTO

Aflac®

We've got you under our wing.®

AFLAC GROUP HOSPITAL INDEMNITY

INSURANCE PLAN 5

Policy Series CA8500-MP-CA

HI G

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

Does your major medical insurance cover all of your bills?

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

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

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

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

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

What you need, when you need it.

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

Here's why the Aflac group supplemental Hospital Indemnity 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. Our group supplemental Hospital Indemnity 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 supplemental Hospital Indemnity insurance from Aflac means that you will have added financial resources to help with medical costs or ongoing living expenses.

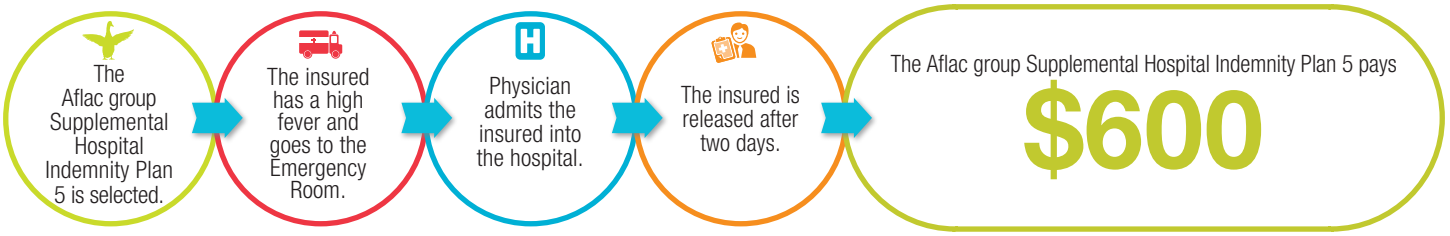
The Aflac group supplemental hospital indemnity plan benefits:

- **Hospital Confinement Benefit**
- **Hospital Admission Benefit**
- **Hospital Intensive Care Benefit**
- **Emergency Room / Physician Benefit**
- **Out-of-Hospital Prescription Drug Benefit**
- **Well Baby Care Benefit**

Features:

- Benefits are paid directly to you unless otherwise assigned.
- Coverage is available for you, your spouse, and dependent children.
- Coverage is portable. That means you can take it with you if you change jobs or retire (with certain stipulations).
- Fast claims payment. Most claims are processed in about four days.

How it works



Amount payable was generated based on benefit amounts for: Hospital Emergency Room Visit ($50), Hospital Admission ($250), and Hospital Confinement ($150 per day).

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

	PLAN 5
HOSPITAL ADMISSION (per admission) The benefit is paid when a Covered Person is admitted to a hospital and confined as a resident bed patient because of Injuries received in a Covered Accident or because of a Covered Sickness. In order to receive this benefit for Injuries received in a Covered Accident, the Covered Person must be admitted to a hospital within six months of the date of the Covered Accident. We will not pay benefits for confinement to an observation unit, or for emergency treatment or outpatient treatment. We will pay this benefit once for a period of confinement. We will only pay this benefit once for each Covered Accident or Covered Sickness. If a Covered Person is confined to the hospital because of the same or related Injury or Sickness, we will not pay this benefit again.	**$250** per admission
HOSPITAL CONFINEMENT (up to 180 days per confinement) This benefit is paid when a Covered Person is confined to a hospital as a resident bed patient because of a Covered Sickness or as the result of injuries received in a Covered Accident. To receive this benefit for Injuries received in a Covered Accident, the Covered Person must be confined to a hospital within six months of the date of the Covered Accident. This benefit is payable for only one hospital confinement at a time even if caused by more than one Covered Accident, more than one Covered Sickness, or a Covered Accident and a Covered Sickness.	**$150** per day
HOSPITAL INTENSIVE CARE (30 day maximum for any one period of confinement.) This benefit is paid when a Covered Person is confined in a hospital intensive care unit because of a Covered Sickness or due to an Injury received from a Covered Accident. To receive this benefit for injuries received in a Covered Accident, the Covered Person must be admitted to a hospital intensive care unit within six months of the date of the Covered Accident. We will pay benefits for only one confinement in a hospital intensive care unit at a time, even if it is caused by more than one Covered Accident, more than one Covered Sickness, or a Covered Accident and a Covered Sickness. If we pay benefits for confinement in a hospital intensive care unit and a Covered Person becomes confined to a hospital intensive care unit again within six months because of the same or related condition, we will treat this confinement as the same period of confinement.	**$150** per day
SURGICAL AND ANESTHESIA BENEFIT This benefit is paid when a Covered Person has surgery performed by a physician due to an Injury received in a Covered Accident or because of a Covered Sickness. If two or more surgical procedures are performed at the same time through the same or different incisions, only one benefit, the largest, will be provided. Surgical and anesthesia benefits are available subject to plan definitions and the surgical schedule. (The anesthesia benefit will be 25 percent of the surgical benefit performed.)	Surgery up to **$1,500**; Anesthesia up to **$375**
OUT-OF-HOSPITAL PRESCRIPTION DRUG BENEFIT We will pay an indemnity benefit, based on the plan definitions, for each prescription filled for a Covered Person. Prescription drugs must meet three criteria: (1) be ordered by a doctor; (2) be dispensed by a licensed pharmacist; and (3) be medically necessary for the care and treatment of the patient. This benefit is subject to the Out-of-Hospital Prescription Drug Benefit Maximum. This benefit does not include benefits for: (a) therapeutic devices or appliances; (b) experimental drugs; (c) drugs, medicines or insulin used by or administered to a person while they are confined to a hospital, rest home, extended care facility, convalescent home, nursing home or similar institution; (d) immunization agents, biological sera, blood, or blood plasma; or (e) contraceptive materials, devices, or medications or infertility medication, except where required by law.	**$10** with a 5-prescription maximum per year per covered person
HOSPITAL EMERGENCY ROOM/PHYSICIAN BENEFIT (MEDICAL FEES) If an insured is injured in a Covered Accident or has treatment as the result of a Covered Sickness, he will receive the following: $50 - Physician (per visit) / $25 - Laboratory fees (per visit) / $50 - X-ray (per visit) / $25 - Injections/medications (per visit) Not to exceed a maximum of $50 per visit.	Up to a maximum of **$50** per visit Maximum **$250** per Insured per calendar year Maximum **$1,000** per Family per calendar year
WELL BABY CARE We will pay the Well Baby Care Benefit amount associated with each benefit plan option when an insured baby receives well baby care (four visits per calendar year per insured baby). For this plan, a baby is a Dependent Child 12 months of age or younger. This benefit is payable only if coverage is issued with the Dependent Children Rider.	**$25** per visit
MAMMOGRAPHY AND PAP SMEAR BENEFIT When an insured has one of the above named tests, we will pay for the test up to the maximum benefit amount shown. We will pay this benefit regardless of the results of the tests. Mammography Benefit - We will pay this benefit for mammography tests performed while coverage is in force. We will pay for mammography tests as follows: 1. A baseline mammogram for women age 35 to 39, inclusive; 2. A mammogram for women age 40 to 49, inclusive, every two years or more frequently based on the women's doctor's recommendation; 3. A mammogram every year for women age 50 and over. Pap Smear Benefit - We will pay this benefit for pap smear tests performed the while coverage is in force. This benefit is payable once per calendar year up to the maximum benefit amount per test shown in the Benefit Schedule.	**$50** per visit
WELLNESS We will pay the amount shown when an insured visits a doctor and he is neither injured nor sick. This benefit is payable once per calendar year per insured.	**$50** per visit

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

LIMITATIONS AND EXCLUSIONS

HOSPITAL INSURANCE

WHAT IS NOT COVERED, AND TERMS YOU NEED TO KNOW

LIMITATIONS AND EXCLUSIONS

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.

EXCLUSIONS

We will not pay benefits for loss caused by Pre-Existing Conditions.

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

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

PRE-EXISTING CONDITION LIMITATION

Pre-Existing Condition means within the 12-month period prior to the Effective Date of the certificate those conditions for which medical advice or treatment was received or recommended.

We will not pay benefits for any loss or injury which is caused by, contributed to by, or resulting from a Pre-Existing Condition for 12 months after the Effective Date of the certificate, or for 12 months from the date medical care, treatment, or supplies were received for the Pre-Existing Condition, whichever is less.

A claim for benefits for loss starting after 12 months from the Effective Date of a certificate, as applicable, will not be reduced or denied on the grounds that it is caused by a Pre-Existing Condition.

Pregnancy is a "Pre-Existing Condition" if conception was before the effective date of a certificate.

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

If a certificate is issued as a replacement for a certificate previously issued under the Plan, then the Pre-Existing Condition limitation provision of the new certificate applies only to any increase in benefits over the prior certificate. Any remaining period of Pre-Existing Condition limitation of the prior certificate would continue to apply to the prior level of benefits.

TERMS YOU NEED TO KNOW

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

Spouse – means your legal wife or husband who is between the ages of 18 and 64, or registered domestic partner (As defined in California Family Code Section 297).

Dependent Children – means your natural children, step-children, foster children, legally adopted children or children placed for adoption, who are under age 26. Existing children of a registered domestic partner will be covered the same as stepchildren.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Notice to Consumer: The coverages provided by Continental American Life Insurance Company (CALIC) 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. CALIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.

We've got you under our wing.®

aflacgroupinsurance.com | **1.800.433.3036**

Please contact the California Department of Insurance if you have an issue that cannot be solved with Continental American Life Insurance Company.

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013

Consumer Hotline
1-800-927-Help (4357)
or
1-213-897-8921
TDD Number
1- 800-482-4TDD (4833)

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.

The Aflac group Critical Illness plan is a supplement to health insurance. It is not a substitute for Hospital or Medical Expense Insurance, a Health Maintenance Organization (HMO) Contract, or Major Medical Expense Insurance.

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

City of SACRAMENTO

Aflac®

AFLAC GROUP CRITICAL ILLNESS INSURANCE

Policy Series CAI2800

CI G

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.

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.

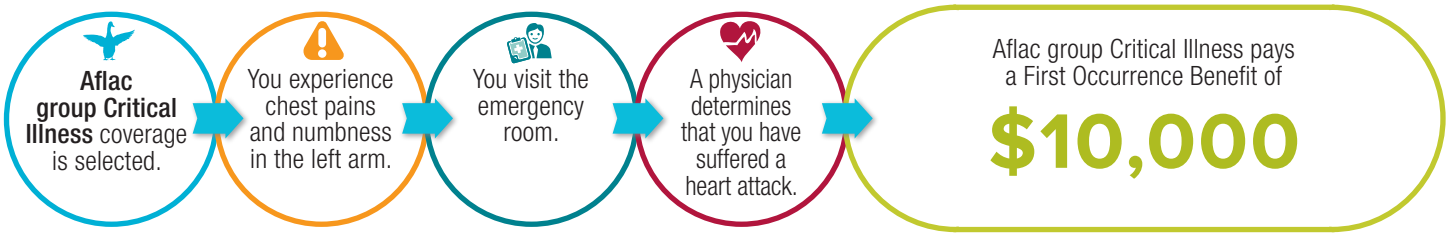
The Aflac group Critical Illness plan benefits include:

- Critical Illness Benefit payable for:
  - Cancer
  - Heart Attack (Myocardial Infarction)
  - Stroke
  - 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, 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 (Myocardial Infarction)	100%
STROKE (Apoplexy or Cerebral Vascular Accident)	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%
CORONARY ARTERY BYPASS SURGERY (Payment of this benefit will reduce your benefit for heart attack by 25%.)	25%
SKIN CANCER	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 are available from $5,000 to $50,000. Spouse coverage is also available in benefit amounts up to $25,000, not to exceed one half of the employee's amount. If you are deemed ineligible due to a previous medical condition, you still retain the ability to purchase spouse coverage.

ADDITIONAL OCCURRENCE BENEFIT

If you collect full benefits for a critical illness under the plan and later are diagnosed with one of the remaining covered critical illnesses, then we will pay the full benefit amount for each additional illness. Occurrences must be separated by at least six months.

REOCCURRENCE BENEFIT

If you collect full benefits for a covered condition and are later diagnosed with the same condition, we will pay the full benefit again. The two dates of diagnosis must be separated by at least 12 months, or for cancer 12 months treatment-free. Cancer that has spread (metastasized), even though there is a new tumor, will not be considered an additional occurrence unless you have gone 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.

MAMMOGRAPHY BENEFIT

After the waiting period, we will pay a $200 mammography benefit once per calendar year for mammography tests. This benefit is payable for a baseline mammogram for women age 35 to 39, inclusive; a mammogram for women age 40 to 49, inclusive, every two years or more frequently based on the women's physician's recommendations; or mammogram every year for women age 50 and over. Payment of this benefit will not reduce the face amount of the certificate.

GENETIC TESTING BENEFIT $250

- Determines your risk of developing a covered illness or condition
- Is available on a guaranteed-issue basis (this means you may qualify for coverage without having to answer health questions)
- Pays a benefit when a genetic screening test is recommended and performed by a physician
- Pays once per calendar year up to the maximum benefit amount shown

After the waiting period, and once per calendar year, you may receive a maximum of $250 for a genetic screening test. The genetic screening test must be recommended and performed by a physician for the purpose of determining the risk of an illness or condition covered under the Critical Illness plan. We will pay this benefit regardless of the results of the test. Payment of this benefit will not reduce the amount payable for the diagnosis of a critical illness. There is no limit to the number of years you can receive the Genetic Screening Test Benefit; it will be payable as long as the certificate remains in force. This benefit is payable for the covered employee and spouse and is payable in addition to the Health Screening Benefit. This benefit is not payable for dependent children.

HEALTH SCREENING BENEFIT
(Employee and Spouse only)
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. This benefit is payable for the covered employee and spouse. **This benefit is not paid for dependent children.**

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

PARALYSIS	100%
SEVERE BURN	100%
COMA	100%
LOSS OF SPEECH / SIGHT / HEARING	100%

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

OPEN HEART SURGERIES (Category I: Coronary Artery Bypass Surgery (CABS)*, Mitral Valve Replacement or Repair, Aortic Valve Replacement or Repair, Surgical Treatment of Abdominal Aortic Aneurysm). *Payment of this benefit will still reduce the benefit payable for Heart Attack by 25%.	100%
INVASIVE HEART PROCEDURE (Category II: AngioJet Clot Busting, Balloon Angioplasty, Laser Angioplasty, Atherectomy, Stent Implantation, Cardiac Catheterization, Automatic Implantable (or Internal) Cardioverter Defibrillator, Pacemakers)	10%

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%.

CRITICAL ILLNESS LIMITATIONS AND EXCLUSIONS

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

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.

The plan contains a 30-day waiting period. This means that no benefits are payable for anyone who has been diagnosed before your coverage has been in force 30 days from the effective date. If you are first diagnosed during the waiting period, benefits for treatment of that critical illness will apply only to loss starting after 12 months from the effective date or the employee can elect to void the coverage and receive a full refund of premium.

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:

- Intentionally self-inflicted injury or action;
- Suicide or attempted suicide while sane or insane;
- Participation in a felony;
- War, whether declared or undeclared or military conflicts, participation in an insurrection or riot;
- Substance abuse; or
- Pre-Existing Conditions (except as stated below).

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

No benefits will be paid for diagnosis made or treatment received outside of the United States.

PRE-EXISTING CONDITION LIMITATION

Pre-Existing Condition means a sickness or physical condition which, within the 12-month period prior to the effective date, resulted in you receiving medical advice or treatment.

We will not pay benefits for any critical illness starting within 12 months of the effective date which is caused by, contributed to, or resulting from a pre-existing condition. A claim for benefits for loss starting after 12 months from the effective date will not be reduced or denied on the grounds that it is caused by a pre-existing condition. A critical illness will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after the effective date.

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 who is between the ages of 18 and 64, or registered domestic partner (as defined in California Family Code Section 297).

Dependent Children means your natural children, step-children, foster children, legally adopted children or children placed for adoption, who are under age 26. Existing children of a registered domestic partner will be covered the same as stepchildren.

Your natural children born after the effective date of the rider will be covered from the moment of live birth. No notice or additional premium is required.

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

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

Major Organ Transplant means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas.

Myocardial Infarction (Heart Attack) means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart attack does not include any other disease or injury involving the cardiovascular system. Cardiac arrest not caused by a myocardial infarction is not a heart attack. The diagnosis must include all of the following criteria: 1. New and serial eletrocardiographic (EKG) findings consistent with myocardial infarction; 2. Elevation of cardiac enzymes above generally accepted laboratory levels of normal in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used; and 3. Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.

Stroke means apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident which begins on or after the coverage effective date. Stroke does not include transient ischemic attacks and attacks of vertebrobasilar ischemia. We will pay a benefit for stroke that produces permanent clinical neurological sequela following an initial diagnosis made after any applicable waiting period. We must receive evidence of the permanent neurological damage provided from computed axial tomography (CAT scan) or magnetic resonance imaging (MRI). Stroke does not mean head injury, transient ischemic attack, or chronic cerebrovascular insufficiency.

Cancer means a disease manifested by the uncontrolled growth and spread of malignant cells, the invasion of tissue, leukemia or Hodgkin's Disease. Pre-malignant conditions or conditions with malignant potential are not to be construed as cancer for the purposes of the plan. In the plan, we pay benefits according to the type of cancer as defined below:

Skin Cancer is cancer on the surface of the body (skin) that may be a malignant tumor, ulcer, pimple or mole. Malignant melanomas classified as Clark's Level I and II are included in the definition of skin cancer. The diagnosis of skin cancer must be consistent with professional medical standards after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen. **Internal Cancer** is cancer which is not skin cancer or carcinoma in situ, but includes malignant melanomas of Clark's Level III and higher. **Carcinoma in situ** is cancer whose cells are localized or confined to the site of origin and show no tendency to invade or metastasize to other tissues. Example- should an insured person have a tumor removed from an organ (such as a breast or prostate) and that tumor has not spread, the insured person is eligible for only the limited benefit shown on the benefits chedule. However, if that tumor has spread (metastasized) to other tissue (such as lymph nodes), benefits may be payable for internal cancer.

Cancer must be diagnosed in one of two ways; **pathological diagnosis of cancer** is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a certified pathologist whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology; or **clinical diagnosis of cancer or carcinoma in situ** based on the study of symptoms. A clinical diagnosis of cancer will be accepted when such diagnosis is consistent with professional medical standards, and provided medical evidence substantially documents the diagnosis of cancer or the insured person receives care for cancer from a doctor.

Cervical Cancer Screening means conventional Pap test, a human papillomavirus screening test that is approved by the federal Food and Drug Administration, and any cervical cancer screening test approved by the federal Food and Drug Administration.

Clark Level is a measurement of the thickness of a melanoma in relation to the layers of the skin. The Clark Level uses a scale of I to V (1-5) to describe which layers of the skin are involved. Example- Clark Level I would only involve the first layer of skin.

End-Stage Renal Failure means the end-stage renal failure presenting as chronic, irreversible failure of both of your kidneys to function. The kidney failure must necessitate regular renal dialysis, hemodialysis or peritoneal dialysis (at least weekly); or which results in kidney transplantation. Renal failure is covered, provided it is not caused by a traumatic event, including surgical traumas.

Coronary Artery Bypass Surgery means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to balloon angioplasty, laser relief, stents or other nonsurgical procedures.

Doctor or Physician means any licensed practitioner of the healing arts acting within the scope of his license in treating a critical illness. It doesn't include an insured or their family member.

ADDITIONAL BENEFITS RIDER LIMITATIONS AND EXCLUSIONS

The coverage in this plan summary contains a 30-day waiting period. This means no benefits are payable for any insured who has been diagnosed before his or her coverage has been in force 30 days from the effective date. If an insured is first diagnosed during the waiting period, benefits for treatment of that specified critical illness will apply only to loss commencing after 12 months from the effective date; or, you may elect to void the certificate from the beginning and receive a full refund of premium. The date of diagnosis of a specified critical illness must be separated from the date of diagnosis of a subsequent different critical illness by at least 6 months.

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

Benefits will not be paid for loss due to: (1) Intentionally self-inflicted injury or action; (2) Suicide or attempted suicide while sane or insane; (3) Participation in a felony; (4) War, whether declared or undeclared, or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence; or (5) Substance abuse. No benefits will be paid for diagnosis made outside the United States. No benefits will be paid for loss which occurred prior to the effective date of the rider.

Unless amended the by Additional Benefits Rider, certificate definitions and terms and other provisions apply.

ADDITIONAL BENEFITS RIDER DEFINITIONS

Coma means a state of unconsciousness for 30 consecutive days with:

- No reaction to external stimuli;
- No reaction to internal needs; and
- The use of life support systems.

Paralysis/Paralyzed means the permanent, total, and irreversible loss of muscle function or sensation to the whole of at least two limbs as a result of injury or disease and supported by neurological evidence.

Severe Burn/Severely Burned means cosmetic disfigurement of the surface of a body area not less than 35 square inches due to fire, heat, caustics, electricity, or radiation that is a full-thickness or third-degree burn, as determined by a physician.

A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity, or radiation.

Loss of Speech means the total and permanent loss of the ability to speak as the result of physical injury.

Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of hearing that can be corrected by the use of any hearing aid or device shall not be considered an irrevocable loss.

Loss of Sight means the total and irreversible loss of all sight in both eyes.

HEART EVENT RIDER LIMITATIONS AND EXCLUSIONS
The rider contains a 30-day waiting period. This means no benefits are payable for any insured who has been diagnosed before the coverage has been in force 30 days from the effective date. If an insured is first diagnosed during the waiting period, benefits for treatment of that critical illness will apply only to loss commencing after 12 months from the effective date; or, at your option, you may elect to void the coverage from the beginning and receive a full refund of premium.

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

Unless amended by the Heart Event Rider, certificate definitions, other provisions and terms apply. Benefits provided by the Heart Event Rider amend any benefits shown in the base plan for the same conditions. 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 Category I and Category II procedures are performed at the same time, benefits are only eligible at the 100% (higher) event and will not exceed the initial face amount shown. The insured is only eligible to receive one payment for each benefit category listed. The dates of loss for covered procedures must be separated by at least 12 months for benefits to be payable for multiple covered procedures. Payment of initial, reoccurrence, or additional occurrence benefits are subject to the benefits section of the base certificate.

EXCLUSIONS
No benefits will be paid if the specified critical illness is a result of: (a) Intentionally self-inflicted injury or action; (b) Suicide or attempted suicide while sane or insane; (c) Participation in a felony or an illegal occupation; (d) War, declared or undeclared, or military conflicts, participation in an insurrection or riot, civil commotion, or state of belligerence; or (e) A loss sustained or contracted while intoxicated or under the influence of or any controlled substance unless administered upon the advice of a physician.

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

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

HEART EVENT RIDER DEFINITIONS
Category I – Specified Surgeries of the Heart

Open Heart Surgery means undergoing open chest surgery, where the heart is exposed and/or manipulated for open cardiothoracic situations.

Benefits are paid for the following open heart surgery procedures only:

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.

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 is 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 is a procedure performed to prevent aneurysm rupture. The operation consists of 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 3 cm or more in diameter.

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

Category II Benefits (Invasive, Procedures and Techniques of the Heart) are paid for the following procedures only:

AngioJet Clot Busting is used to clear 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) is 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 is similar to Balloon Angioplasty. A laser tip is used to burn/break down plaque in the clogged blood vessel.

Atherectomy is used to open blocked coronary arteries or clear bypass grafts by using a device on the end of a catheter to cut or shave away atherosclerotic plaque.

Stent Implantation is where 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.

Pacemakers refers to the initial placement of a pacemaker. Pacemakers are implanted to send electrical signals to make the heart beat when a heart'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.

Subject to the Reoccurrence Benefit in the base plan, 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.

GENETIC TESTING RIDER LIMITATIONS AND EXCLUSIONS
The rider contains a 30-day waiting period. This means no benefits are payable for any insured who has a genetic screening test before coverage has been in force 30 days from the insured's effective date of coverage.

Unless amended by the Genetic Screening Test Rider, certificate definitions and terms and other provisions apply.

TERMINATION
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.

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

Notice to Consumer: The coverages provided by Continental American Life Insurance Company (CALIC) 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. CALIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.

Please contact the California Department of Insurance if you have an issue that cannot be solved with Continental American Life Insurance Company.

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013

Consumer Hotline
1-800-927-Help (4357)
or
1-213-897-8921
TDD Number
1- 800-482-4TDD (4833)