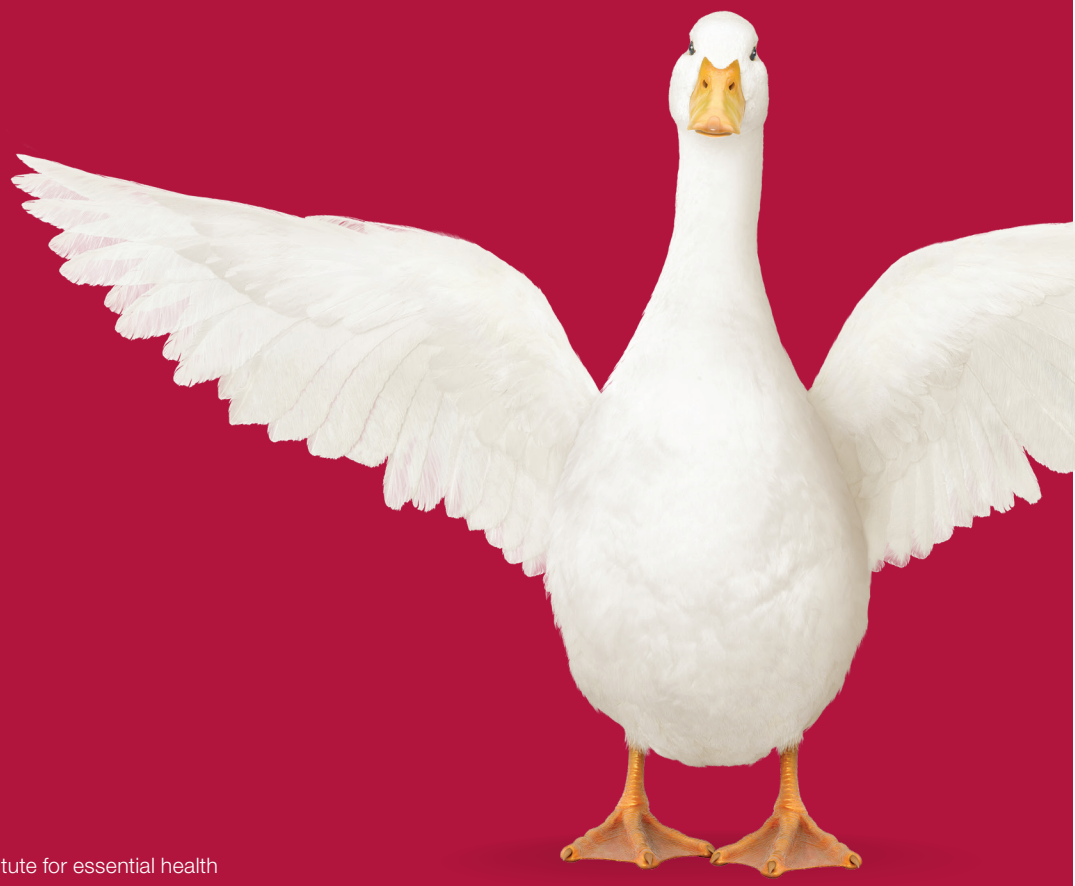
Aflac

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.

Aflac®

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.

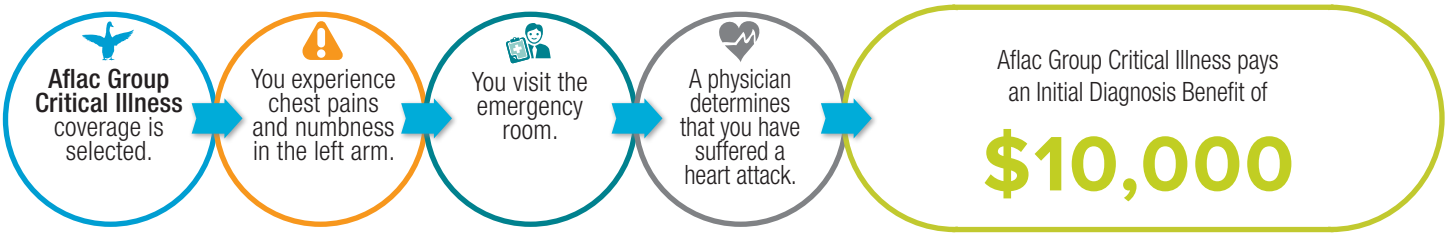
The Aflac Group Critical Illness plan benefits include:

- 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
  - Severe Burn
  - Limited Benefit Coma
  - Limited Benefit Paralysis
  - Limited Benefit Loss of Sight / Hearing / Speech
- 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:

CANCER (Internal or Invasive)	100%
HEART ATTACK (Myocardial Infarction)	100%
STROKE (Ischemic or Hemorrhagic)	100%
KIDNEY FAILURE (End-Stage Renal Failure)	100%
BONE MARROW TRANSPLANT (Stem Cell Transplant)	100%
SUDDEN CARDIAC ARREST	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%
SEVERE BURN*	100%
LIMITED BENEFIT PARALYSIS**	100%
LIMITED BENEFIT COMA**	100%
LIMITED BENEFIT LOSS OF SPEECH / SIGHT / HEARING**	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.

*This benefit is only payable for a burn due to, caused by, and attributed to, a covered accident.
**These benefits are payable for loss due to a covered underlying disease or a covered accident.

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.

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.**

PROGRESSIVE DISEASES RIDER	Percentage of Face Amount
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.

OPTIONAL BENEFITS RIDER	
LIMITED BENEFIT BENIGN BRAIN TUMOR	100%
ADVANCED ALZHEIMER'S DISEASE	100%
ADVANCED PARKINSON'S DISEASE	100%

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.

SPECIFIED DISEASES RIDER

	Percentage of Face Amount
TIER I SPECIFIED DISEASE BENEFIT Adrenal Hypofunction (Addison's Disease), Cerebrospinal Meningitis, Diphtheria, Encephalitis, Huntington's Chorea, Legionnaire's Disease, Lyme Disease, Malaria, Muscular Dystrophy, Myasthenia Gravis, Necrotizing Fasciitis, Osteomyelitis, Poliomyelitis (Polio), Rabies, Sickle Cell Anemia, Systemic Lupus, Systemic Sclerosis (Scleroderma), Tetanus, Tuberculosis We will pay the benefit shown if an insured is diagnosed with one of the Tier I Specified Diseases listed, and if the date of diagnosis is while the rider is in force. For any subsequent Tier I Specified Disease to be covered, the date of diagnosis of the subsequent Tier I Specified Disease must satisfy the Additional Diagnosis separation period outlined in the brochure.	25%
TIER II SPECIFIED DISEASE BENEFIT Covered Diseases: Human Coronavirus / Covid-19 / SARS / MERS We will pay the benefit shown if an insured is diagnosed with human coronavirus, and such diagnosis results in either a period of hospital confinement or hospital intensive care unit confinement as a direct result of human coronavirus. Furthermore, the date of diagnosis must be while the rider is in force. In addition, the insured must be receiving treatment for human coronavirus for the minimum number of days shown. Only the highest eligible benefit amount will be payable under these benefits. In the event a lower benefit amount was previously paid under these benefits for any period of hospital confinement and that confinement is extended or the insured is moved to an intensive care unit triggering a higher payment, the difference between the previous paid benefit amount and the new benefit amount will be provided. Please note that for any subsequent Tier I or Tier II Specified Disease to be covered, the date of diagnosis of the subsequent Tier I or Tier II Specified Disease must satisfy the Additional Diagnosis separation period outlined in the brochure. Please note that any Tier II Specified Disease Benefit requires a diagnosis resulting in either a period of hospital confinement or a period of hospital intensive care unit confinement as a direct result of the Tier II Specified Disease in order for the benefit to be payable..	10% if confined to a hospital for 4-9 days 25% if confined to a hospital for 10 or more days 40% if confined to an intensive care unit

LIMITATIONS AND EXCLUSIONS

All limitations and exclusions that apply to the critical illness plan also apply to all riders, if applicable, 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

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.

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
- Skin Cancer Melanoma that is diagnosed as: Clark's Level I or II, Breslow depth less than 0.77mm, or Stage 1A melanomas under TNM Staging

Skin cancers are are not payable under the Cancer (internal or invasive) Benefit or the Non-Invasive Cancer Benefit. 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

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).
- Limited Benefit Coma: The first day of the period for which a doctor/qualified medical professional confirms a limited benefit coma that is due to one of the underlying diseases and that has lasted for at least seven consecutive days.
- Limited Benefit Loss of Sight, Speech, or Hearing: The date the loss due to one of the underlying diseases is objectively determined by a doctor/qualified medical professional to be total and irreversible.
- Limited Benefit Paralysis: The date a doctor/qualified medical professional diagnoses an insured with paralysis due to one of the underlying diseases as specified in this plan, where such diagnosis is based on clinical and/or laboratory findings as supported by the insured's medical records.
- Severe Burn: The date the burn takes place.

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.

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.

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) 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 meant to decrease the risk of cancer recurrence; it is not meant to treat a cancer that is still present.

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 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

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).

Severe Burn or Severely Burned means a burn resulting from fire, heat, caustics, electricity, or radiation. The burn must:

- Be a full-thickness or third-degree burn, as determined by a doctor/ qualified medical professional. A Full-Thickness Burn or Third-Degree Burn is the destruction of the skin through the entire thickness or depth of the dermis (or possibly into underlying tissues). This results in loss of fluid and sometimes shock.
- Cause cosmetic disfigurement to the body's surface area of at least 35 square inches.
- Be caused solely by or be solely attributed to a covered accident.

Limited Benefit Coma means a state of continuous, profound unconsciousness, lasting at least seven consecutive days, and characterized by the absence of:

- Spontaneous eye movements,
- Response to painful stimuli, and
- Vocalization.

Limited Benefit Coma does not include a medically-induced coma.

To be payable as an Accident benefit, the limited benefit coma must be caused by a covered accident.

To be considered a critical illness, the limited benefit coma must be caused by one of the following diseases:

- Brain Aneurysm
- Diabetes
- Encephalitis
- Epilepsy
- Hyperglycemia
- Hypoglycemia
- Meningitis

Limited Benefit Paralysis or Paralyzed means the permanent, total, and irreversible loss of muscle function to the whole of at least two limbs. To be payable as an Accident benefit, the paralysis must be caused by a covered accident. To be considered a critical illness, paralysis must be caused by one or more of the following diseases:

- Amyotrophic lateral sclerosis
- Cerebral palsy
- Parkinson's disease,
- Poliomyelitis

The diagnosis of paralysis must be supported by neurological evidence.

Limited Benefit Loss of Sight means the total and irreversible loss of all sight in both eyes. To be payable as an Accident benefit, loss of sight must be caused by a covered accident. To be considered a critical illness, loss of sight must be caused by one of the following diseases:

- Retinal disease
- Optic nerve disease
- Hypoxia

Limited Benefit Loss of Speech means the total and permanent loss of the ability to speak. To be payable as an Accident benefit, loss of speech must be caused by a covered accident. To be considered a critical illness, loss of speech must be caused by to one of the following diseases:

- Alzheimer's disease
- Arteriovenous malformation

Limited Benefit Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of hearing does not include hearing loss that can be corrected by the use of a hearing aid or device. To be payable as an Accident benefit, loss of hearing must be caused by a covered accident.

To be considered a critical illness, loss of hearing must be caused by one of the following diseases:

- Alport syndrome
- Autoimmune inner ear disease
- Chicken pox
- Diabetes
- Goldenhar syndrome
- Meniere's disease
- Meningitis
- Mumps

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.

Treatment does not include maintenance drug therapy or routine follow-up visits to verify whether cancer or carcinoma in situ has returned.

OPTIONAL BENEFITS RIDER

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 DISEASES RIDER

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.

CHILDHOOD CONDITIONS RIDER

Date of Diagnosis is defined as follows:

- Cystic Fibrosis: The date a doctor/qualified medical professional diagnoses a dependent child as having Cystic Fibrosis and where such diagnosis is supported by medical records.
- Cerebral Palsy: The date a doctor/qualified medical professional diagnoses a dependent child as having Cerebral Palsy and where such diagnosis is supported by medical records.
- Cleft Lip or Cleft Palate: The date a doctor/qualified medical professional diagnoses a dependent child as having Cleft Lip or Cleft Palate and where such diagnosis is supported by medical records.
- Down Syndrome: The date a doctor/qualified medical professional diagnoses a dependent child as having Down Syndrome and where such diagnosis is supported by medical records.
- Phenylalanine Hydroxylase Deficiency Disease (PKU): The date a doctor/qualified medical professional diagnoses a dependent child as having PKU and where such diagnosis is supported by medical records.
- Spina Bifida: The date a doctor/qualified medical professional diagnoses a dependent child as having Spina Bifida and where such diagnosis is supported by medical records.
- Type I Diabetes: The date a doctor/qualified medical professional diagnoses a dependent child as having Type I Diabetes and where such diagnosis isupported by medical records.
- Autism Spectrum Disorder: The date a doctor/qualified medical professional diagnoses a dependent child as having Autism Spectrum Disorder and where such diagnosis is supported by medical records.

If a dependent child has both a Cleft Lip and Cleft Palate or has one on each side of the face, we will pay this benefit only once.

A doctor/qualified medical professional must diagnose Phenylalanine Hydroxylase Deficiency Disease (PKU) based on a PKU test.

A doctor/qualified medical professional must diagnose Type I Diabetes based on one of the following diagnostic tests:

- Glycated hemoglobin (A1C) test
- Random blood sugar test
- Fasting blood sugar test

A doctor/qualified medical professional must diagnose Autism Spectrum Disorder based on DSM-V diagnostic criteria.

SPECIFIED DISEASES RIDER

These benefits will be paid based on the face amount in effect on the specified disease date of diagnosis. All limitations and exclusions that apply to the Group Critical Illness Insurance Policy also apply to the rider unless amended by the rider.

No benefits will be paid for loss which occurred prior to the effective date of the Group Critical Illness Insurance Policy.

Date of Diagnosis is defined for each Specified Disease as follows and must be supported by medical records

Adrenal Hypofunction (Addison's Disease): The date a doctor/qualified medical professional diagnoses an insured as having Adrenal Hypofunction.

Cerebrospinal Meningitis: The date a doctor/qualified medical professional diagnoses an Insured as having Cerebrospinal Meningitis.

Diphtheria: The date a doctor/qualified medical professional diagnoses an insured as having Diphtheria based on clinical and/or laboratory findings.

Encephalitis: The date a doctor/qualified medical professional diagnoses an insured as having Encephalitis.

Human Coronavirus: The date a doctor/qualified medical professional diagnoses an insured as having Human Coronavirus based on laboratory findings as supported by viral testing or a blood test.

Huntington's Chorea: The date a doctor/qualified medical professional diagnoses an insured as having Huntington's Chorea based on clinical findings.

Legionnaire's Disease: The date a doctor/qualified medical professional diagnoses an insured as having Legionnaire's Disease by finding Legionella bacteria in a clinical specimen taken from the Insured.

Lyme Disease: The date a doctor/qualified medical professional diagnoses an insured as having Lyme Disease.

Malaria: The date a doctor/qualified medical professional diagnoses an insured as having Malaria.

Muscular Dystrophy: The date a doctor/qualified medical professional diagnoses an insured as having Muscular Dystrophy.

Myasthenia Gravis: The date a doctor/qualified medical professional diagnoses an insured as having Myasthenia Gravis.

Necrotizing Fasciitis: The date a doctor/qualified medical professional diagnoses an insured as having Necrotizing Fasciitis.

Osteomyelitis: The date a doctor/qualified medical professional diagnoses an insured as having Osteomyelitis.

Poliomyelitis: The date a doctor/qualified medical professional diagnoses an insured as having Poliomyelitis.

Rabies: The date a doctor/qualified medical professional diagnoses an insured as having Rabies.

Sickle Cell Anemia: The date a doctor/qualified medical professional diagnoses an insured as having Sickle Cell Anemia.

Systemic Lupus: The date a doctor/qualified medical professional diagnoses an insured as having Systemic Lupus.

Systemic Sclerosis (Scleroderma): The date a doctor/qualified medical professional diagnoses an insured as having Systemic Sclerosis.

Tetanus: The date a doctor/qualified medical professional diagnoses an insured as having Tetanus by finding Clostridium tetani bacteria in a clinical specimen taken from the Insured.

Tuberculosis: The date a doctor/qualified medical professional diagnoses an insured as having Tuberculosis by finding Mycobacterium tuberculosis bacteria in a clinical specimen taken from the Insured.

The term Hospital Intensive Care Unit specifically excludes any type of facility not meeting the definition of Hospital Intensive Care Unit as defined in the Group Critical Illness Insurance Policy, including but not limited to private monitored rooms, surgical recovery rooms, observation units, and the following step-down units:

- A progressive care unit,
- A sub-acute intensive care unit, or
- An intermediate care unit.

The term Hospital specifically excludes any facility not meeting the definition of Hospital as defined in the Group Critical Illness Insurance Policy, including but not limited to:

- A nursing home,
- An extended-care facility,
- A skilled nursing facility,
- A rest home or home for the aged,
- A rehabilitation facility (In Missouri, this is not applicable),
- A facility for the treatment of alcoholism or drug addiction, or
- An assisted living facility.

Human Coronavirus is limited to Coronavirus Disease 19 (COVID-19), Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS). COVID-19 means a viral respiratory disease caused by the SARS-CoV-2 virus. MERS means a viral respiratory illness caused by a coronavirus. SARS means a viral respiratory illness caused by a coronavirus.

Adrenal Hypofunction does not include secondary and tertiary adrenal insufficiency.

YOU MAY CONTINUE YOUR COVERAGE

Your coverage may be continued with certain stipulations. See certificate 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 Insurance Company (CAIC) represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. CAIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.

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