Aflac
Group Critical Illness Advantage

INSURANCE – PLAN INCLUDES BENEFITS FOR CANCER AND HEALTH SCREENING

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

The plan does not contain comprehensive adult wellness benefits as defined by law.
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.

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

**FACT NO. 1**

**ESTIMATED 83.6 MILLION**

American adults—greater than 1 in 3—have one or more types of cardiovascular disease (CVD).1

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**FACT NO. 2**

**CORONARY HEART DISEASE COST THE UNITED STATES $108.9 BILLION**

This total includes the cost of health care services, medications and lost productivity.2

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1 American Heart Association/American Stroke Association 2013 Statistical Fact Sheet
2 Centers for Disease Control and Prevention Heart Disease Fact Sheet 2015

Coverage underwritten by Continental American Insurance Company (CAIC)
A proud member of the Aflac family of insurers
For more than 60 years, Aflac has been dedicated to helping provide individuals and families peace of mind and financial security when they’ve needed it most. The Aflac Group Critical Illness plan is just another innovative way to help make sure you’re well protected under our wing.

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

**The Aflac Group Critical Illness plan benefits include:**

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

**Features:**

- Benefits are paid directly to you, unless you choose otherwise.
- 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.
- Fast claims payment. Most claims are processed in about four days.

**How it works**

1. **Aflac Group Critical Illness Advantage coverage is selected.**
2. You experience chest pains and numbness in the left arm.
3. You visit the emergency room.
4. A physician determines that you have had suffered a heart attack.
5. Aflac Group Critical Illness Advantage pays a First Occurrence Benefit of $10,000.

Amount payable based on $10,000 First Occurrence Benefit.

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

COVERED CRITICAL ILLNESSES:

<table>
<thead>
<tr>
<th>Illness</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>CANCER (Internal or Invasive)</td>
<td>100%</td>
</tr>
<tr>
<td>HEART ATTACK (Myocardial Infarction)</td>
<td>100%</td>
</tr>
<tr>
<td>STROKE (Ischemic or Hemorrhagic)</td>
<td>100%</td>
</tr>
<tr>
<td>MAJOR ORGAN TRANSPLANT</td>
<td>100%</td>
</tr>
<tr>
<td>KIDNEY FAILURE (End-Stage Renal Failure)</td>
<td>100%</td>
</tr>
<tr>
<td>BONE MARROW TRANSPLANT (Stem Cell Transplant)</td>
<td>100%</td>
</tr>
<tr>
<td>SUDDEN CARDiac ARREST</td>
<td>100%</td>
</tr>
<tr>
<td>NON-INVASIVE CANCER</td>
<td>25%</td>
</tr>
<tr>
<td>CORONARY ARTERY BYPASS SURGERY</td>
<td>25%</td>
</tr>
</tbody>
</table>

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.

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.
COVERED HEALTH SCREENING TESTS INCLUDE:

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

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CRITICAL ILLNESS ADVANTAGE INSURANCE

LIMITATIONS AND EXCLUSIONS,
TERMS YOU NEED TO KNOW, AND NOTICES
LIMITATIONS AND EXCLUSIONS

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;
  – In Alaska: injuring or attempting to injure oneself intentionally
• Suicide – committing or attempting to commit suicide, while sane or insane;
  – In Missouri: committing or attempting to commit suicide, while sane
  – In Illinois and Minnesota: this exclusion does not apply
• Illegal Acts – participating or attempting to participate in an illegal activity, or working at an illegal job:
  – In Arizona: participating in or attempting to commit a felony, or being engaged in an illegal occupation;
  – In Florida: participating or attempting to participate in an illegal activity, or working at an illegal occupation;
  – In Illinois and Pennsylvania: Illegal Occupation - committing or attempting to commit a felony or being engaged in an illegal occupation;
  – In Michigan: Illegal Occupation – the commission of or attempt to commit a felony, or being engaged in an illegal occupation;
  – In Nebraska: being engaged in an illegal occupation, or commission of or attempting to commit a felony;
  – In Ohio: committing or attempting to commit a felony, or working at an illegal job
• Participation in Aggressive Conflict:
  – War (declared or undeclared) or military conflicts;
    – In Florida: War does not include acts of terrorism
    – In Oklahoma: War, or act of war, declared or undeclared when serving in the military service or an auxiliary unit thereto
  – Insurrection or riot
  – Civil commotion or civil state of belligerence
• Illegal Substance Abuse:
  – Abuse of legally-obtained prescription medication
  – Illegal use of non-prescription drugs
  – In Arizona: Being intoxicated or under the influence of any narcotic unless administered on the advice of a physician
  – In Michigan, Nevada, and South Dakota: this exclusion does not apply
Diagnosis, treatment, testing, and confinement must be in the United States or its territories.
All benefits under the plan, including benefits for diagnoses, treatment, confinement and covered tests, are payable only while coverage is in force.

TERMS YOU NEED TO KNOW
Bone Marrow Transplant (Stem Cell Transplant) means a procedure to replace damaged or destroyed bone marrow with healthy bone marrow stem cells. For a benefit to be payable, a Bone Marrow Transplant (Stem Cell Transplant) must be caused by at least one of the following diseases:
• Aplastic anemia
• Congenital neutropenia
• Severe immunodeficiency syndromes
• Sickle cell anemia
The Bone Marrow Transplant (Stem Cell Transplant) benefit is not payable if the transplant results from a covered critical illness for which a benefit has been paid under this plan.

Cancer (internal or invasive) is a disease that meets either of the following definitions:
A malignant tumor characterized by:
• The uncontrolled growth and spread of malignant cells, and
• The invasion of distant tissue.

A disease meeting the diagnostic criteria of malignancy, as established by the American Board of Pathology. A pathologist must have examined and provided a report on the histocytologic architecture or pattern of the tumor, tissue, or specimen.
Cancer (internal or invasive) also includes:
• Melanoma that is Clark’s Level III or higher or Breslow depth equal to or greater than 0.77mm,
• Myelodysplastic syndrome – RAEB-T (refractory anemia with excess blasts in transformation), or
• Myelodysplastic syndrome – CMML (chronic myelomonocytic leukemia).
The following are not considered internal or invasive cancers:
• Pre-malignant tumors or polyps
• Carcinomas in Situ
• Any superficial, non-invasive skin cancers including basal cell and squamous cell carcinoma of the skin
• Melanoma in Situ
• Melanoma that is diagnosed as
Coronary Artery Bypass Surgery means open heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts and where such narrowing or blockage is attributed to coronary artery disease or acute coronary syndrome. This excludes any non-surgical procedure, such as, but not limited to, balloon angioplasty, laser relief, or stents.

Critical Illness is a disease or a sickness as defined in the plan that first manifests while your coverage is in force. In Illinois, critical illness is a sickness or disease that began while the insured’s coverage is in force. In South Dakota, critical illness is a disease or a sickness that 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 carcinoma in situ 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 recommends that an insured begin renal dialysis.
- 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 carcinoma in situ is based on such specimens).
- Skin Cancer: The date the skin biopsy samples are taken for microscopic examination.
- Stroke: The date the stroke occurs (based on documented neurological deficits and neuroimaging studies).
- Sudden Cardiac Arrest: The date the pumping action of the heart fails (based on the sudden cardiac arrest definition).

Dependent means your spouse or your dependent child. Spouse is your legal wife or husband. (In Delaware, Illinois, Nevada, Oregon, or Washington DC - or a person who is in a legally recognized domestic partnership, civil union, or similar relationship with you), who is listed on your application. Dependent children are your or your spouse’s natural children, step-children, legally adopted children, or children placed for adoption, who are younger than age 26 (in Indiana, this includes children subject to legal guardianship). Newborn children are automatically covered from the moment of birth.

There is an exception to the age-26 limit listed above. This limit will not apply to any dependent child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent (in Arkansas, chiefly dependent) on a parent for support. The employee or the employee’s spouse must furnish proof of this incapacity and dependency to the company within 31 days (in Indiana, 120 days) following the dependent child’s 26th birthday.

- In South Dakota, this limit will not apply to any child who is incapable of self-sustaining employment and is chiefly dependent upon the insured for support and maintenance.
- In Texas, this limit will not apply to any dependent child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support and maintenance. Dependent Children may also include grandchildren, who are unmarried, under age 26, and if they are your dependents for federal
In Washington DC, Domestic Partner is an unmarried same or opposite
sex adult who resides with you and has registered in a state or local
domestic partner registry with you.

In Nevada, Domestic Partner is defined as a person who is party
to a valid domestic partnership, has not terminated that domestic
partnership, and meets the requisites for a valid domestic partnership.

In order to enter into a valid domestic partnership, it is necessary
that the two persons register with the state of Nevada when it is
established, by having previously furnished proof to the state of Nevada,
that both persons have a common residence, neither person is married
or a member of another domestic partnership, the two persons are not
related by blood in a way that would prevent them from being married
to each other in the state of Nevada, both persons are at least 18 years
of age, and both persons are competent to consent to the domestic
partnership.

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

Heart Attack (Myocardial Infarction) is the death of a portion of the heart
muscle (myocardium) caused by a blockage of one or more coronary
arteries due to coronary artery disease or acute coronary syndrome.

Heart Attack (Myocardial Infarction) does not include:
- Any other disease or injury
  involving the cardiovascular
  system.

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
phosphokinase (CPK) a CPK-MB
measurement must be used.)

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

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

Kidney Failure (End-Stage Renal Failure) is covered only under the
following conditions:
- A doctor advises that regular
  renal dialysis, hemo-dialysis,
or peritoneal dialysis (at least
  weekly) is necessary to treat the
  kidney failure (end-stage renal
  failure); or
- The kidney failure (end-stage
  renal failure) results in kidney
  transplantation.

Maintenance Drug Therapy is a course of systemic medication given to a
patient after a cancer goes into complete remission because of primary
treatment. Maintenance Drug Therapy includes ongoing hormonal therapy,
immunotherapy, or chemo-prevention therapy. Maintenance Drug Therapy
is meant to decrease the risk of cancer recurrence; it is not meant to treat
a cancer that is still present.

Major Organ Transplant means undergoing surgery as a recipient of a
covered transplant of a human heart, lung, liver, kidney, or pancreas. A
transplant must be caused by one or more of the following diseases:
- Bronchiectasis
- Cardiomyopathy
• Cirrhosis
• Chronic obstructive pulmonary disease
• Congenital Heart Disease
• Coronary Artery Disease
• Cystic fibrosis
• Hepatitis

A 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.

Party to a Civil Union: In Illinois, a person who has established a civil union pursuant to the Illinois Religious Freedom Protection and Civil Union Act.

Pathologist is a doctor who is licensed:
• To practice medicine, and
• By the American Board of Pathology to practice pathologic anatomy.

A Pathologist also includes an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Signs and/or symptoms are the evidence of disease or physical disturbance observed by a doctor or other medical professional. The doctor (or other medical professional) must observe these signs while acting within the scope of his license.

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

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

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

Stroke does not include:
• Transient Ischemic Attacks (TIAs)
• Head injury
• Chronic cerebrovascular insufficiency

Stroke will be covered only if the Insured submits evidence of the neurological damage by providing:
• Computed Axial Tomography (CAT scan) images, or
• Magnetic Resonance Imaging (MRI).

Sudden Cardiac Arrest is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to coronary artery disease, cardiomyopathy, or hypertension.

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

Total Disability or Totally Disabled means you are:
• Not working at any job for pay or benefits,
• Under the care of a doctor for the treatment of a covered critical illness, and
• Unable to Work, which means either:
  − During the first 365 days of total disability, you are unable to work at the occupation you were performing when your total disability began; or
  − After the first 365 days of total disability, you are unable to work at any gainful occupation for which you are suited by education, training, or experience.
  − In Ohio, Unable to Work is defined as the inability to perform duties of any gainful occupation for which you are reasonably fitted by training, experience, and accomplishment.

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

Treatment-Free From Cancer refers to the period of time without the consultation, care, or services provided by a doctor. This includes receiving diagnostic measures and taking prescribed drugs and medicines.

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

In Montana, Consultation is not considered treatment or medical treatment.

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.
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.

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

Notice to Consumer: 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.

In Nevada: This limited plan provides supplemental benefits only. It does not constitute comprehensive health insurance coverage (often referred to as “major medical coverage”) and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

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

In Washington DC: NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.
WHAT WE WILL PAY

COVERED CRITICAL ILLNESSES

<table>
<thead>
<tr>
<th>Illnesses Covered Under Plan</th>
<th>Percentage of Maximum Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe Burn*</td>
<td>100%</td>
</tr>
<tr>
<td>Coma**</td>
<td>100%</td>
</tr>
<tr>
<td>Paralysis**</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of Sight**</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of Hearing**</td>
<td>100%</td>
</tr>
<tr>
<td>Loss of Speech**</td>
<td>100%</td>
</tr>
</tbody>
</table>

*This benefit is only payable for burns 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.

These benefits will be paid based on the face amount in effect on the critical illness date of diagnosis.

We will pay the critical illness benefit if the insured is diagnosed with one of the critical illnesses shown if the date of diagnosis occurs while the plan is in force and the critical illness is not excluded by name or specific description in the plan.

Initial Diagnosis
An insured may receive up to 100% of his face amount upon the diagnosis of a covered critical illness.

Additional Diagnosis
Once benefits have been paid for a covered critical illness, we will pay benefits for each different critical illness when the date of diagnosis is separated by at least 6 consecutive months.

Reoccurrence
Once benefits have been paid for a covered critical illness, benefits are payable for that same critical illness when the date of diagnosis is separated by at least 6 consecutive months.

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

All limitations and exclusions that apply to the critical illness plan also apply to these benefits.

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

Date of Diagnosis is defined as follows:

- **Coma**: The first day of the period for which a doctor confirms a coma that is due to one of the underlying diseases and that has lasted for at least seven consecutive days.
- **Loss of Sight, Speech, or Hearing**: The date the loss due to one of the underlying diseases is objectively determined by a doctor to be total and irreversible.
- **Paralysis**: The date a doctor 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.

Critical Illness is one of the illnesses defined below:

**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. 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.
**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.

Coma does not include a medically-induced coma.

To be payable as an Accident benefit, the coma must be caused solely by or be solely attributed to a covered accident.

To be considered a critical illness, the coma must be caused solely by or be solely attributed to one of the following diseases:

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

**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 solely by or be solely attributed to a covered accident. To be considered a critical illness, paralysis must be caused solely by or be solely attributed to 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.

**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 solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of sight must be caused solely by or be solely attributed to one of the following diseases:

- Retinal disease
- Optic nerve disease
- Hypoxia

**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 solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of speech must be caused solely by or be solely attributable to one of the following diseases:

- Alzheimer’s disease
- Arteriovenous malformation

**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 solely by or be solely attributed to a covered accident.

To be considered a critical illness, loss of hearing must be caused solely by or be solely attributed to 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.
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Continental American Insurance Company • Columbia, South Carolina

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This brochure is a brief description of coverage and is not a contract. Read your certificate carefully for exact terms and conditions.

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