Group Critical Illness Insurance

You can count on Aflac to help ease the financial impact of surviving a critical illness.

Underwritten by:
Continental American Insurance Company (CAIC)

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

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 Insurance Policy.

It can help with the treatment costs of covered critical illnesses, such as a heart attack or stroke.

More importantly, the Group Critical Illness Insurance Policy helps you focus on recuperation instead of the distraction of out-of-pocket costs. With the Group Critical Illness Insurance Policy, 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.

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.

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:

Aflac Group Critical Illness coverage is selected.	Aflac Group Critical Illness pays an Initial Diagnosis Benefit of: **$10,000**
You experience chest pains and numbness in the left arm.	
You visit the emergency room.	
A physician determines that you have suffered a heart attack.	

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.

COVERED CRITICAL ILLNESS BENEFITS:

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 major organ transplant)	100%
LIMITED BENEFIT COMA	100%
LIMITED BENEFIT PARALYSIS	100%
LIMITED BENEFIT LOSS OF SIGHT	100%
LIMITED BENEFIT LOSS OF HEARING	100%
LIMITED BENEFIT LOSS OF SPEECH	100%
TYPE I DIABETES	100%
CORONARY ARTERY BYPASS SURGERY	100%
NON-INVASIVE CANCER	25%
METASTATIC CANCER	25%
TYPE II DIABETES	10%

INITIAL DIAGNOSIS BENEFIT
We will pay a lump sum benefit upon initial diagnosis of a covered critical illness when such diagnoses is caused by an underlying disease. Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

ADDITIONAL DIAGNOSIS BENEFIT
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.

REOCCURRENCE BENEFIT
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.

REDUCED BENEFIT SKIN CANCERS BENEFIT
We will pay $1,000 for the diagnosis of Reduced Benefit Skin Cancers. We will pay this benefit 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 Group Critical Illness Insurance Policy.

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. See certificate for details.

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.

HEALTH SCREENING BENEFIT - $50 PER CALENDAR YEAR
Payable for health screening tests performed while an insured's coverage is in force. We will pay this benefit once per calendar year, per insured. 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.

ACCIDENTAL OCCUPATIONAL DISEASE RIDER	Percentage of Face Amount
OCCUPATIONAL HIV	100%
OCCUPATIONAL HEPATITIS	10%

The benefit is payable for the initial positive diagnosis of occupational HIV and/or occupational hepatitis if the diagnosis results from an occupational-specific covered injury. The date of diagnosis must be while the rider is in force. Benefits will be paid based on the face amount in effect on the critical illness date of diagnosis.

The occupational HIV benefit is payable only once. The occupational hepatitis benefit is payable once for hepatitis B and once for hepatitis C. After a benefit is paid for each of the three diseases, rider coverage will terminate.

PROGRESSIVE DISEASES RIDER	Percentage of Face Amount
Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease)	100%
Sustained Multiple Sclerosis	100%
Advanced Alzheimer's Disease	100%
Advanced Parkinson's Disease	100%
Chronic Obstructive Pulmonary Disease (COPD)	25%
Chron's Disease	25%

These benefits will be paid based on the face amount in effect on the critical illness date of diagnosis. We will pay the benefit shown upon diagnosis of one of the covered diseases if the date of diagnosis is while the rider is in force.

The Progressive Disease benefit is payable only once per disease.

For any subsequent Progressive Disease to be covered, the date of diagnosis of the subsequent Progressive Disease must satisfy the Additional Diagnosis separation period outlined in the brochure.

TIER I SPECIFIED DISEASE BENEFIT	Percentage of Face Amount
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	25%

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.

TIER II SPECIFIED DISEASE HOSPITALIZATION BENEFIT

Human Coronavirus / Covid-19 / SARS / MERS	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

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.

If your Group Critical Illness Insurance Policy includes attained age rates, that means your policy is age-banded and your rates may increase on the policy anniversary date.

All limitations and exclusions that apply to the Group Critical Illness Insurance Policy also apply to all riders, if applicable, unless amended by the riders.

EXCLUSIONS

We will not pay for loss due to any of the following:

- 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:
  - 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 doctor/qualified medical professional.
- An error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure.

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

All benefits under the Group Critical Illness Insurance Policy, 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.

- The following are not considered internal or invasive cancers:
- Superficial cervical cancer
- Superficial bladder tumors
- Pre-malignant tumors or polyps

- Early breast cancer requiring lumpectomy without radiation or chemotherapy
- Early prostate (Stage A) cancer
- Non-invasive cancer (as defined below)
- Reduced benefit skin cancers (as defined below)
- Melanoma that is diagnosed as
  - Clark's Level I or II,
  - Breslow depth less than 0.77mm, or
  - Stage 1A melanomas under TNM Staging

A Non-Invasive Cancer is:

- Cancer in one organ, such as prostate or indolent cancer (this does not include Cancer that has spread throughout the organ, such as breast cancer, which would be considered an invasive cancer)
- Myelodysplastic Syndrome - RA (refractory anemia)
- Myelodysplastic Syndrome - RARS (refractory anemia with ring sideroblasts)

Premalignant conditions or conditions with malignant potential, other than those specifically named above, are not considered non-invasive cancer

Reduced benefit skin cancers are not payable under the Cancer (internal or invasive) Benefit or the Non-Invasive Cancer Benefit. The following are considered reduced benefit 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

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.

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

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

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

Date of Diagnosis is defined as follows:

- 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).
- 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).
- Reduced Benefit Skin Cancers: The date the skin biopsy samples are taken for microscopic examination.
- Bone Marrow Transplant (Stem Cell Transplant): The date the surgery occurs.
- Limited Benefit Coma: The first day of the period for which a doctor/qualified medical professional confirms a coma that is due to one of the underlying diseases and that has lasted for at least seven consecutive days.
- 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.
- Limited Benefit Loss of 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 Loss of Sight: 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 Loss of Speech: 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 Major Organ Transplant: The date the surgery occurs.
- Metastatic Cancer: The date a doctor/qualified medical professional determines cancer has metastasized to other parts of the body from the original site.
- Limited Benefit Paralysis: The date a doctor/qualified medical professional diagnoses an Insured with pralysis due to one of the underlying diseases as specified in this Group Critical Illness Insurance Policy, where such diagnosis is based on clinical and/or laboratory findings as supported by the isured's medical records.
- 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).
- Type I Diabetes: The date a doctor/qualified medical professional diagnoses an insured as having type I diabetes based on clinical and/or laboratory findings as supported by medical records.
- Type II Diabetes: The date a doctor/qualified medical professional diagnoses an Insured as having Type II Diabetes based on clinical and/or laboratory findings as supported by medical records.

Spouse is your legal wife or husband, including a legally-recognized same-sex spouse, or a person of either gender who is in a legally recognized and registered domestic partnership, (as defined in California Family Code 297), civil union, reciprocal beneficiary relationship, or similar relationship with you, who is listed on your application.

Dependent Children are your or your Spouse's natural children, step-children (including existing children of new domestic partners), grandchildren, 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. Read your certificate carefully 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 Group Critical Illness Insurance Policy. The employee is the primary insured under the Group Critical Illness Insurance Policy.

Heart Attack (Myocardial Infarction) does not include:

- Any other disease or injury involving the cardiovascular system.
- Cardiac Arrest not caused by a Heart Attack (Myocardial Infarction).

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

- New and serial electrocardiographic (ECG) findings consistent with heart attack (myocardial infarction), and
- Elevation of cardiac enzymes above generally accepted laboratory levels of normal. (In the case of creatine physphokinase (CPK) a CPKMB 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 (endstage renal failure); or
- The kidney failure (end-stage renal failure) results in kidney transplantation.

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 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

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

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

- Retinal Disease;
- Optic Nerve Disease; or
- Hypoxia

Limited Benefit Loss of Speech means the total and permanent loss of the ability to speak.

To be considered a Critical Illness, Loss of Speech must be caused by one of the following diseases:

- Alzheimer's Disease
- Arteriovenous Malformation

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.

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 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.

Stroke does not include:

- Transient Ischemic Attacks (TIAs)). TIAs are covered under the Transient Ischemic Attack Critical Illness.
- 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). (In Illinois, contributed to by language does not apply.)

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

Type I Diabetes excludes gestational diabetes and prediabetes.

Type II Diabetes excludes gestational diabetes and prediabetes.

ACCIDENTAL OCCUPATIONAL DISEASE RIDER

All limitations and exclusions that apply to the Group Critical Illness Insurance Policy also apply to the rider unless amended by the rider.

We will not pay an Occupational Disease Benefit if the insured:

- Becomes HIV Positive or Hepatitis Positive as a result of a transmission other than an occupational-specific covered injury,
- Tested HIV Positive or Hepatitis Positive prior to the occupational-specific covered injury, unless the insured previously tested positive on a screening test and subsequently tested negative for that disease prior to the date of the occupational-specific covered injury, or
- Becomes HIV positive or Hepatitis positive as a result of intravenous drug use or sexual transmission.

Hepatitis Positive means the presence of Hepatitis B or Hepatitis C antibodies or antigens in the Insured's blood indicating Hepatitis infection, with the exception of an insured who previously received an immunization for Hepatitis B in the last 10 years. This must be evidenced by: a positive Hepatitis B surface antigen (HSbAg) test for Hepatitis B or a positive HCV RNA test for Hepatitis C; or another test approved by the FDA.

HIV Positive means the presence of HIV antibodies in the insured's blood. This must be evidenced by: a positive screening test, such as enzyme-linked immunosorbent assay (ELISA); or a positive supplement test, such as the Western Blot.

Applicable to both HIV and Hepatitis tests: all such tests must be approved by the Food and Drug Administration (FDA), and the interpretation of positive results must be in keeping with the manufacturer's specifications.

In order to receive an Occupational Disease Benefit for an Occupational-Specific Covered Injury:

You must have two tests which meet the following criteria:

Within 5 days of the Occupational-Specific Covered Injury, you must have a preliminary screening test at an authorized laboratory other than the laboratory of your Employer appropriate for the disease to which you were exposed and the result of such test must show that HIV and/or Hepatitis is not present and that you do not have prior immunity to the Hepatitis virus to which you were exposed. We must receive notification of the negative results as soon as reasonably possible.

You must test HIV Positive and/or Hepatitis Positive within 26 weeks of the date of that Occupational-Specific Covered Injury.

You must file an incident report (notice of exposure) with your Employer within 72 hours of the positive test result. This report must:

Be on a form acceptable to the Company,

Describe the nature of the exposure to HIV and/or Hepatitis, and

Be sent to the Company as soon as reasonably possible after the Occupational-Specific Covered Injury.

Date of Diagnosis is defined as follows:

Occupational HIV: The date a doctor/qualified medical professional determines you are HIV Positive as supported by the ELISA test, Western Blot test, or another test approved by the Food and Drug Administration (FDA).

Occupational Hepatitis: : The date a doctor/qualified medical professional determines you are Hepatitis Positive as supported by a Hepatitis B surface antigen test (HSbAg), a nucleic acid test (NAT) or PCR test for HCV RNA, or another test approved by the FDA.

Occupational-Specific Covered Injury means that while you are actively at work, you are accidentally exposed to another person's blood or other bodily fluids that are contaminated with Human Immunodeficiency Virus (HIV) and/or Hepatitis virus through: cutaneous exposure through abraded skin, percutaneous exposure, or mucocutaneous exposure

PROGRESSIVE DISEASE RIDER

All limitations and exclusions that apply to the Group Critical Illness Insurance Policy also apply to the rider unless amended by the 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.
- Advanced Alzheimer's Disease: The date a doctor/qualified medical professional diagnoses the Insured as having Alzheimer's Disease.
- Advanced Parkinson's Disease: The date a doctor/qualified medical professional diagnoses the Insured as having Parkinson's Disease.
- Chronic Obstructive Pulmonary Disease (COPD): The date a doctor/qualified medical professional diagnoses an insured as having COPD based on clinical and/or laboratory findings as supported by medical records.
- Crohn's Disease: The date a doctor/qualified medical professional diagnoses an insured as having Crohn's Disease based on clinical and/or laboratory findings as supported by medical records.

SPECIFIED DISEASE 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 Group Critical Illness Insurance Policy 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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In California, coverage is underwritten by
Continental American Life Insurance Company.

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Continental American Insurance Company • Columbia, South Carolina

The certificate to which this sales material pertains may be written only in English; the certificate prevails if interpretation of this material varies.

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

This brochure is subject to the terms, conditions, and limitations of Policy Series C22000.