

# Aflac Cancer Protection Assurance

## CANCER INDEMNITY INSURANCE – OPTION 2

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We've been dedicated to helping provide peace of mind and financial security for more than 60 years.



THE POLICY IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE OR OTHER MINIMUM ESSENTIAL COVERAGE.

# AFLAC CANCER PROTECTION ASSURANCE

## CANCER INDEMNITY INSURANCE – OPTION 2

Policy Series B70000



### **Aflac Cancer Protection Assurance: real coverage when you need it most.**

Cancer treatment is changing—and Aflac is proud to be changing with it. Aflac Cancer Protection Assurance helps cover innovative treatments with benefits that really care for you as a whole person.

From prevention to recovery, Aflac is with you every step of the way. Our benefits are built to see you all the way through cancer treatment and they'll stay with you for life after cancer.\*

Of course, you hope you'll never get it. But for many—and for certain types of cancer—advances in science and treatment have transformed cancer into an illness that can be managed over a lifetime.



\*Coverage remains in force as long as premiums are paid.

Aflac herein means American Family Life Assurance Company of Columbus.

Understand the difference Aflac makes in your financial security.

Aflac pays cash benefits directly to you, unless otherwise assigned. This means that you can have added financial resources to help with expenses incurred due to medical treatment, ongoing living expenses or any purpose you choose.

## We're with you: Aflac Cancer Protection Assurance stays with you for life.

Aflac Cancer Protection Assurance pays cash benefits directly to you, unless assigned, when you need them most. If you're ever diagnosed with a covered cancer, these benefits are more important than ever. Why? Because cancer treatment can be expensive.

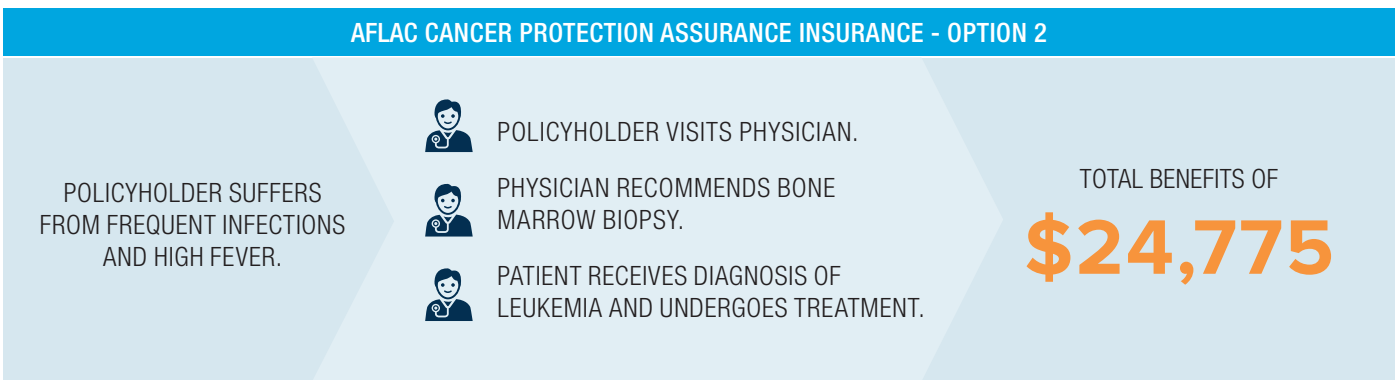
Major medical may not cover the cost of things like deductibles, co-pays, lost work time, or even travel. Aflac Cancer Protection Assurance can help with cancer-associated costs like these. It helps support you through the physical, emotional, and financial costs of cancer—and stays with you for life. Here's how it works:

**We're with you, even when you're well.** We pay a benefit for early detection and preventative care, like mammograms, PSA blood tests, and many other kinds of cancer screenings, too.

**We'll see you all the way through treatment.** If you're diagnosed with cancer, we offer benefits that you can count on. You'll receive a benefit upon initial diagnosis of a covered cancer and our support doesn't end there.

**We give you the freedom to choose the best care for you.** You and your doctor decide on a treatment plan together; we help provide you with financial support for every month that you're undergoing that treatment. Want a second opinion? We provide a benefit for that, too.

### How it works



The above example is based on a scenario for Aflac Cancer Protection Assurance – Option 2 that includes the following benefit conditions: Bone Marrow Biopsy (Cancer Screening Benefit) of \$75, Initial Diagnosis Benefit of \$5,200, IV Chemotherapy for 3 months (Physician-Administered Radiation Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy Benefit) of \$3,600, Immunotherapy (Physician-Administered Radiation Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy Benefit) for 6 months of \$7,200, Antinausea Benefit (9 months) of \$900, Stem Cell Transplant Benefit of \$7,000, Hospital Confinement Benefit (4 days) of \$800.

Benefits and/or premiums may vary based on state and benefit option selected. Riders are available for an additional premium. The policy has limitations, exclusions, and pre-existing condition limitations that may affect benefits payable. The policy may contain a waiting period. This brochure is for illustrative purposes only. Refer to the policy for complete benefit details, definitions, limitations and exclusions.

For more information, ask your insurance agent/producer, call 1.800.992.3522, or visit [aflac.com](http://aflac.com).

## Benefits overview Choose the Policy and Riders that Fit Your Needs

| BENEFIT:  | DESCRIPTION:   |
|---|--|
| CANCER SCREENING  | One \$75 benefit per calendar year, per covered person<br>Benefit increases to three screenings per calendar year after the diagnosis for internal cancer or an associated cancerous condition   |
| PROPHYLACTIC SURGERY (DUE TO A POSITIVE GENETIC TEST RESULT)                | \$250 per covered person, per lifetime   |
| INITIAL DIAGNOSIS   | Named Insured or Spouse: \$5,200<br>Dependent Child: \$10,400<br>Payable once per covered person, per lifetime   |
| ADDITIONAL OPINION  | \$300 per covered person, per lifetime   |
| RADIATION THERAPY, CHEMOTHERAPY, IMMUNOTHERAPY OR EXPERIMENTAL CHEMOTHERAPY | Self-Administered: \$250 per calendar month<br>Physician Administered: \$1,200 per calendar month<br>This benefit is limited to one self-administered treatment and one physician-administered treatment per calendar month  |
| HORMONAL THERAPY  | \$25 once per calendar month   |
| TOPICAL CHEMOTHERAPY  | \$150 once per calendar month  |
| ANTINAUSEA  | \$100 once per calendar month  |
| STEM CELL AND BONE MARROW TRANSPLANTATION                                   | \$7,000; lifetime maximum of \$7,000 per covered person<br>Donor Benefit:<br>\$100 for stem cell donation, or<br>\$750 for bone marrow donation<br>Payable one time per covered person   |
| BLOOD AND PLASMA  | Inpatient: \$50 times the number of days paid under the Hospital Confinement Benefit, per covered person<br>Outpatient: \$175 per day, per covered person  |
| SURGICAL/ANESTHESIA   | \$100-\$3,400<br>Anesthesia: additional 25% of the Surgery Benefit<br>Maximum daily benefit will not exceed \$4,250; no lifetime maximum on the number of operations   |
| SKIN CANCER SURGERY   | Laser or Cryosurgery: \$35<br>Excision of lesion of skin without flap or graft: \$170<br>Flap or graft without excision: \$250<br>Excision of lesion of skin with flap or graft: \$400<br>Maximum daily benefit will not exceed \$400. No lifetime maximum on the number of operations |
| PROPHYLACTIC SURGERY (WITH CORRELATING INTERNAL CANCER DIAGNOSIS)           | \$250 per covered person, per lifetime   |
| HOSPITALIZATION CONFINEMENT FOR 30 DAYS OR LESS                             | Named Insured or Spouse: \$200<br>Dependent Child: \$250   |
| HOSPITALIZATION CONFINEMENT FOR 31 DAYS OR MORE                             | Named Insured or Spouse: \$400<br>Dependent Child: \$500   |
| OUTPATIENT HOSPITAL SURGICAL ROOM CHARGE                                    | \$200 per day, per covered person  |

|   |  |                                |                                |
|---|--|--------------------------------|--------------------------------|
| EXTENDED-CARE FACILITY                                      | \$100 per day; limited to 30 days in each calendar year, per covered person  |                                |                                |
| SKILLED NURSING HOME  | \$100 per day; lifetime maximum of 100 days for this benefit   |                                |                                |
| HOME HEALTH CARE  | \$100 per day; lifetime maximum of 100 days for this benefit   |                                |                                |
| HOSPICE CARE  | \$1,000 for first day; \$50 per day thereafter; \$12,000 lifetime maximum per covered person   |                                |                                |
| NURSING SERVICES  | \$100 per day; payable for only the number of days the Hospital Confinement Benefit is payable   |                                |                                |
| SURGICAL PROSTHESIS   | \$2,000; lifetime maximum of \$4,000 per covered person  |                                |                                |
| NONSURGICAL PROSTHESIS                                      | \$175 per occurrence, per covered person; lifetime maximum of \$350 per covered person   |                                |                                |
| BREAST RECONSTRUCTION                                       | Breast Tissue/Muscle Reconstruction Flap Procedures: \$2,000<br>Breast Reconstruction (occurring within 5 years of breast cancer diagnosis): \$500<br>Breast Symmetry (on the nondiseased breast occurring within 5 years of breast reconstruction): \$220<br>Permanent Areola Repigmentation (on the diseased breast): \$100<br>Maximum daily benefit will not exceed \$2,000 |                                |                                |
| OTHER RECONSTRUCTIVE SURGERY                                | Facial Reconstruction: \$500<br>Anesthesia: additional 25% of the Other Reconstructive Surgery Benefit<br>Maximum daily benefit will not exceed \$500  |                                |                                |
| EGG HARVESTING, STORAGE (CRYOPRESERVATION) AND IMPLANTATION | \$1,000 for a covered person to have oocytes extracted and harvested<br>\$200 for the storage of a covered person's oocyte(s) or sperm<br>\$200 for embryo transfer<br>Lifetime maximum of \$1,400 per covered person  |                                |                                |
| ANNUAL CARE   | \$200 on the anniversary date of diagnosis; lifetime maximum of five annual \$200 payments per covered person  |                                |                                |
| AMBULANCE   | \$250 ground<br>\$2,000 air ambulance  |                                |                                |
| TRANSPORTATION  | \$.40 cents per mile for transportation; payable up to a combined maximum of \$1,200, per round trip   |                                |                                |
| LODGING   | \$65 per day; limited to 90 days per calendar year   |                                |                                |
| CONTINUATION OF COVERAGE                                    | Yes  |                                |                                |
| OPTIONAL RIDERS:  | DESCRIPTION:   |                                |                                |
| INITIAL DIAGNOSIS BUILDING BENEFIT RIDER                    | This benefit will increase the amount of your Initial Diagnosis Benefit, as shown in the policy, by \$100 for each unit purchased, up to five units, for each covered person on the anniversary date of coverage, while coverage remains in force.   |                                |                                |
| SPECIFIED-DISEASE BENEFIT RIDER                             | When a covered person is diagnosed with any of the diseases listed in the Specified-Disease Rider:   |                                |                                |
|   | Initial diagnosis  | Hospitalization                |                                |
|   | \$2,000  | 30 days or less; \$400 per day | 31 days or more; \$800 per day |
| DEPENDENT CHILD RIDER                                       | \$10,000 when a covered dependent child is diagnosed as having internal cancer or an associated cancerous condition; payable only once for each covered dependent child  |                                |                                |

REFER TO THE FOLLOWING PAGES FOR BENEFIT DETAILS, DEFINITIONS, LIMITATIONS AND EXCLUSIONS.



American Family Life Assurance Company of Columbus  
(herein referred to as Aflac)  
Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999  
Toll-Free 1.800.99.AFLAC (1.800.992.3522)

The policy described in this Outline of Coverage provides supplemental coverage  
and will be issued only to supplement insurance already in force.

**LIMITED BENEFIT, SPECIFIED DISEASE INSURANCE**  
**Outline of Coverage for Policy Form B70200MA**  
**THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.**

If you are eligible for Medicare, review the “Guide to Health Insurance for People with Medicare” furnished by Aflac.

- (1) The coverage outlined here is that of an **individual, limited benefit**, policy of insurance. **Cancer Insurance Coverage** is designed to supplement a Covered Person’s existing accident and sickness coverage only when certain losses occur as a result of the disease of Cancer or an Associated Cancerous Condition. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

**Caution:** The specified disease insurance policy is issued on the basis that the information shown on the application is correct and complete. Statements made in the application are deemed representations and not warranties. A copy of your application is attached to your policy. Carefully check the application. Write to us within 30 days of the date you receive the policy if any information on the application is not correct or complete. Incorrect or incomplete information may result in the denial of claims or voiding of the policy (subject to the terms in the Time Limit on Certain Defenses section). You may contact us at 1932 Wynnton Road, Columbus, Georgia 31999.

**(2) SUMMARY OF POLICY FEATURES:**

**The policy:**

1. is not a Medicare Supplement policy.
2. is guaranteed-renewable for your lifetime.
3. is not subject to automatic premium increases as you get older.
4. may be subject to across the board premium increases for all policyholders in your class.
5. does not offer an option to purchase inflation protection.
6. does not offer an option to purchase nonforfeiture protection.
7. does contain special age limitations for purchase.
8. does not have a pre-existing conditions provision.
9. has a waiting period of 30 days before benefits are payable by policy.
10. does not offer a waiver of premium.

- (3) **THE PURPOSE OF AN OUTLINE OF COVERAGE.** An outline of coverage provides a very brief description of the important features of the coverage. You should compare this outline of coverage to the outlines of coverage for other policies that are available to you. This is not a contract of insurance, but only a summary of the coverage. Only the individual policy contains

the actual contractual provisions. This means that your policy sets forth in detail the rights and the obligations of both you and Aflac. That is why if you purchase this or any other coverage, it is important for you to READ YOUR POLICY CAREFULLY!

**(4) THE TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED.**

- a) **RENEWABILITY: THE POLICY IS GUARANTEED-RENEWABLE.** This means that you have the right to continue the coverage as long as you pay your premiums on time. This is subject to the terms of your policy. We can not change any of the terms of your policy on our own. This is except that, in the future, WE MAY INCREASE THE PREMIUM YOU PAY.
- b) We may discontinue or terminate the policy if you have performed an act or practice that constitutes fraud, or have made an intentional misrepresentation of material fact, relating in any way to the policy, including claims for benefits under the policy.
- c) The policy does not provide a conversion privilege without proof of insurability, other than in the case of dissolution of marriage, death or termination of dependency. Please see the Right of Conversion section of the policy for details.
- d) We may change the established premium rate only if it is first approved by the Massachusetts Commissioner of Insurance. Premium changes will not be specific to any one person, but will be made for all policies of this form number and premium classification in the state where the policy was issued that are then in force.

**(5) THE TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED.**

- a) It is important to us that you are satisfied with the policy. If you are not satisfied, you may return it within 30 days after you receive it. Send it to Aflac Worldwide Headquarters, 1932 Wynnton Road, Columbus, Georgia 31999. You will receive a full refund of all premiums paid (less any benefits paid), and your policy will be void from its Effective Date. If you return the policy, please note in writing: “This policy is returned for cancellation and refund of premium.”

- b) The policy does not contain a provision providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy.

**(6) THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.** If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide that is available from Aflac. Neither Aflac nor its associates (duly licensed agents) represent Medicare, the federal government, or any state government.

**(7) BENEFITS PROVIDED BY THE POLICY:** We will pay the following benefits, as applicable, while coverage is in force, subject to all other limitations and exclusions, conditions, and provisions of the policy, unless indicated otherwise. All treatments listed below must be National Cancer Institute (NCI) or Food and Drug Administration (FDA) approved for the treatment of Cancer or an Associated Cancerous Condition, as applicable.

**CANCER SCREENING BENEFIT:** We will pay \$75 per Calendar Year when a Covered Person receives one of the following:

mammogram • breast ultrasound • breast MRI • thermography • CA15-3 (blood test for breast cancer) • CA 125 (blood test for ovarian cancer) • Pap smear/ThinPrep • PSA (blood test for prostate cancer) • CEA (blood test for colon cancer) • P32 uptake serum protein electrophoresis (blood test for multiple myeloma) • testicular ultrasound • transrectal ultrasound • abdominal ultrasound • flexible sigmoidoscopy • colonoscopy • virtual colonoscopy • cystoscopy • colposcopy • bronchoscopy • mediastinoscopy • esophagoscopy • sigmoidoscopy • proctosigmoidoscopy • gastroscopy • laryngoscopy • chest X-ray • computerized tomography (CT or CAT scan) • magnetic resonance imaging (MRI) • bone scan • thyroid scan • multiple gated acquisition (MUGA) scan • positron emission tomography (PET) scan • biopsy • hemocult stool specimen (lab confirmed) • Genetic Testing • bone marrow donor screening • cancer vaccine

This benefit is limited to one \$75 payment per Calendar Year, per Covered Person, with no Positive Medical Diagnosis. If a Covered Person receives a Positive Medical Diagnosis for Internal Cancer or an Associated Cancerous Condition, this benefit will pay up to a total of three \$75 payments per Calendar Year for screenings performed on such Covered Person. Screenings must be administered by licensed medical personnel. Except for Genetic Testing, bone marrow donor screening, and cancer vaccine, the screening must be performed for the purpose of determining whether Cancer or an Associated Cancerous Condition exists in a Covered Person. There is no lifetime maximum for this benefit.

**PROPHYLACTIC SURGERY BENEFIT (DUE TO A POSITIVE GENETIC TEST RESULT):** We will pay \$250 when a Covered Person has surgery due to a positive test result received for a genetic alteration or mutation associated with a hereditary Cancer syndrome and such surgery is recommended by a

Physician. The Genetic Testing must be performed while coverage is in force.

**This benefit is payable once per Covered Person, per lifetime.**

#### **CANCER DIAGNOSIS BENEFITS:**

**INITIAL DIAGNOSIS BENEFIT:** We will pay the amount listed below when a Covered Person is diagnosed as having Internal Cancer or an Associated Cancerous Condition while the policy is in force, subject to the Limitations and Exclusions.

|                         |          |
|-------------------------|----------|
| Named Insured or Spouse | \$ 5,200 |
| Dependent Child         | \$10,400 |

**This benefit is payable once per Covered Person, per lifetime.** In addition to the Positive Medical Diagnosis, we may require additional information from the attending Physician and Hospital.

**ADDITIONAL OPINION BENEFIT:** We will pay \$300 when a charge is incurred for an additional surgical opinion from a Physician or an evaluation or consultation with a Physician for the purpose of determining the appropriate course of treatment for a covered Internal Cancer or Associated Cancerous Condition. **This benefit is payable once per Covered Person, per lifetime.**

#### **CANCER TREATMENT BENEFITS:**

##### **NONSURGICAL TREATMENT BENEFITS:**

##### **RADIATION THERAPY, CHEMOTHERAPY, IMMUNOTHERAPY, OR EXPERIMENTAL CHEMOTHERAPY BENEFIT:**

**SELF-ADMINISTERED:** We will pay \$250 once per Calendar Month for which a Covered Person receives and incurs a charge for self-administered Physician-prescribed Chemotherapy, Immunotherapy, or Experimental Chemotherapy as part of a treatment regimen for Cancer or an Associated Cancerous Condition.

**PHYSICIAN-ADMINISTERED:** We will pay \$1,200 once per Calendar Month for which a Covered Person is prescribed, receives, and incurs a charge for Radiation Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy administered by a member of the medical profession in a Medical Facility as part of a treatment regimen for Cancer or an Associated Cancerous Condition.

This benefit is limited to one self-administered treatment and one physician-administered treatment per Calendar Month. After this benefit has been paid for 12 Calendar Months, we will require annual documentation from the attending Physician certifying that the Cancer or Associated Cancerous Condition is still detectable and active in the body and is not in remission in order for this benefit to continue to be payable.

**HORMONAL THERAPY BENEFIT:** We will pay \$25 once per Calendar Month for which a Covered Person is prescribed,

receives, and incurs a charge for Hormonal Therapy as part of a treatment regimen for Cancer or an Associated Cancerous Condition.

**TOPICAL CHEMOTHERAPY BENEFIT:** We will pay \$150 once per Calendar Month for which a Covered Person is prescribed, receives, and incurs a charge for a Topical Chemotherapy for the treatment of Cancer or an Associated Cancerous Condition.

See the Payment of Nonsurgical Treatment Benefits section for additional information.

**INDIRECT/ADDITIONAL THERAPY BENEFITS:**

**ANTINAUSEA BENEFIT:** We will pay \$100 once per Calendar Month for which a Covered Person receives and incurs a charge for anti-nausea drugs that are prescribed in conjunction with Radiation Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy. This benefit is payable only once per Calendar Month and is limited to the Calendar Month in which a person receives Radiation Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy, the Calendar Month prior to such treatment, and the Calendar Month following such treatment. There is no lifetime maximum for this benefit.

**STEM CELL AND BONE MARROW TRANSPLANTATION**

**BENEFIT:** We will pay \$7,000 when a Covered Person receives and incurs a charge for a peripheral Stem Cell Transplantation or a Bone Marrow Transplantation for the treatment of Internal Cancer or an Associated Cancerous Condition. There is a lifetime maximum of \$7,000 per Covered Person. In addition, we will pay the Covered Person's donor an indemnity amount for his or her expenses as a result of the donation procedure as follows: \$100 for stem cell donation, or \$750 for bone marrow donation. This benefit is payable one time per Covered Person.

**BLOOD AND PLASMA BENEFIT:** We will pay \$50 times the number of days paid under the Hospital Confinement Benefit when a Covered Person receives and incurs a charge for blood and/or plasma transfusions for the treatment of Internal Cancer or an Associated Cancerous Condition during a covered Hospital confinement. We will pay \$175 for each day a Covered Person receives and incurs a charge for blood and/or plasma transfusions for the treatment of Internal Cancer or an Associated Cancerous Condition as an outpatient in a Physician's office, clinic, Hospital, or Ambulatory Surgical Center. This benefit does not pay for immunoglobulins, Immunotherapy, antihemophilia factors, or colony-stimulating factors. There is no lifetime maximum for this benefit.

**SURGICAL TREATMENT BENEFITS:**

**SURGERY/ANESTHESIA BENEFIT:** We will pay according to the benefits in the Schedule of Operations in the policy when a Covered Person has a surgical procedure performed for the direct treatment of a covered Internal Cancer or Associated Cancerous Condition and a charge is incurred for such surgical

procedure. If any surgical procedure for the treatment of Internal Cancer or an Associated Cancerous Condition is performed other than those listed, we will pay an amount comparable to the amount shown in the Schedule of Operations for the surgical procedure most nearly similar in severity and gravity.

**EXCEPTIONS: Prophylactic Surgery and procedures payable under the Cancer Screening Benefit, Skin Cancer Surgery Benefit, or Reconstructive Surgery Benefit will not be payable under the Surgery/Anesthesia Benefit.**

**The Surgery/Anesthesia Benefit is only payable one time per 24-hour period, even though more than one surgical procedure may be performed. The highest eligible benefit will be paid.**

We will pay an indemnity benefit equal to 25% of the amount shown in the Schedule of Operations for the administration of anesthesia during a covered surgical operation.

The maximum daily benefit will not exceed \$4,250. There is no lifetime maximum on the number of operations.

**SKIN CANCER SURGERY BENEFIT:** When a surgical operation is performed on a Covered Person for a diagnosed skin Cancer, including melanoma or Nonmelanoma Skin Cancer, we will pay the amount listed below when a charge is incurred for the specific procedure. The amount listed below includes anesthesia services. The maximum daily benefit will not exceed \$400. There is no lifetime maximum on the number of operations.

|                      |       |
|----------------------|-------|
| Laser or Cryosurgery | \$ 35 |
|----------------------|-------|

**Surgeries OTHER THAN Laser or Cryosurgery:**

|  |     |
|--|-----|
| Excision of lesion of skin without flap or graft | 170 |
| Flap or graft without excision                   | 250 |
| Excision of lesion of skin with flap or graft    | 400 |

**PROPHYLACTIC SURGERY BENEFIT (WITH CORRELATING INTERNAL CANCER DIAGNOSIS):** We will pay \$250 when, as recommended by a Physician due to a covered diagnosis of Internal Cancer or an Associated Cancerous Condition, one of the Prophylactic Surgeries shown below is performed on a Covered Person:

1. mastectomy due to a covered diagnosis of Internal Cancer other than breast Cancer;
2. oophorectomy due to a covered diagnosis of Internal Cancer other than ovarian Cancer; or
3. orchiectomy due to a covered diagnosis of Internal Cancer other than testicular Cancer.

**This benefit is payable once per Covered Person, per lifetime.**

## **HOSPITALIZATION BENEFITS:**

### **HOSPITAL CONFINEMENT BENEFITS:**

**HOSPITALIZATION FOR 30 DAYS OR LESS:** When a Covered Person is confined to a Hospital for treatment of Cancer or an Associated Cancerous Condition for 30 days or less, we will pay the amount listed below for each day the Covered Person is charged for a room as an inpatient. There is no lifetime maximum for this benefit.

Named Insured or Spouse                      \$200

Dependent Child                                 \$250

**HOSPITALIZATION FOR 31 DAYS OR MORE:** During any continuous period of Hospital confinement of a Covered Person for treatment of Cancer or an Associated Cancerous Condition for 31 days or more, we will pay benefits as described above for the first 30 days. Beginning with the 31st day of such continuous Hospital confinement, Aflac will pay the amount listed below for each day the Covered Person is charged for a room as an inpatient. There is no lifetime maximum for this benefit.

Named Insured or Spouse                      \$400

Dependent Child                                 \$500

### **OUTPATIENT HOSPITAL SURGICAL ROOM CHARGE**

**BENEFIT:** When a surgical operation is performed on a Covered Person for treatment of a diagnosed Internal Cancer or Associated Cancerous Condition, and a surgical room charge is incurred, we will pay \$200. For this benefit to be paid, surgeries must be performed on an outpatient basis in a Hospital or an Ambulatory Surgical Center. This benefit is payable once per day and is not payable on the same day the Hospital Confinement Benefit is payable. This benefit is payable in addition to the Surgery/Anesthesia Benefit. The maximum daily benefit will not exceed \$200. There is no lifetime maximum on number of operations.

**This benefit is also payable for Nonmelanoma Skin Cancer surgery involving a flap or graft. It is not payable for the procedures listed in the Cancer Screening Benefit or any surgery performed in a Physician's office.**

## **CONTINUING CARE BENEFITS:**

**EXTENDED-CARE FACILITY BENEFIT:** When a Covered Person is hospitalized and receives Hospital Confinement Benefits and is later confined, within 30 days of the covered Hospital confinement, to an extended-care facility, a rehabilitation unit or facility, a transitional care unit or any bed designated as a swing bed, or to a section of the Hospital used as such, (collectively referred to as "Extended-Care Facility"), we will pay \$100 per day when a charge is incurred for such continued confinement. For each day this benefit is payable, Hospital Confinement Benefits are NOT payable. Benefits are limited to 30 days in each Calendar Year per Covered Person.

If more than 30 days separates confinements in an Extended-Care Facility, benefits are not payable for the second confinement unless the Covered Person again receives Hospital Confinement Benefits and is confined as an inpatient to the Extended-Care Facility within 30 days of that confinement.

**SKILLED NURSING HOME BENEFIT:** When a Covered Person is hospitalized and receives Hospital Confinement Benefits and is later confined, within 30 days of the covered Hospital confinement, in a Skilled Nursing Home, we will pay \$100 per day when a charge is incurred for such continued confinement. For each day this benefit is payable, Hospital Confinement Benefits are NOT payable.

If more than 30 days separates confinements in a Skilled Nursing Home, benefits are not payable for the second confinement unless the Covered Person again receives Hospital Confinement Benefits and is confined as an inpatient to the Skilled Nursing Home within 30 days of that confinement.

There is a lifetime maximum of 100 days for this benefit.

**HOME HEALTH CARE BENEFIT:** When a Covered Person is hospitalized for the treatment of Internal Cancer or an Associated Cancerous Condition and then has either home health care or health supportive services provided on his or her behalf, we will pay \$100 per day when a charge is incurred for each such visit, subject to the following conditions:

1. The home health care or health supportive services must begin within seven days of release from the Hospital.
2. This benefit will not be payable unless the attending Physician prescribes such services to be performed in the home of the Covered Person and certifies that if these services were not available, the Covered Person would have to be hospitalized to receive the necessary care, treatment, and services.
3. Home health care and health supportive services must be performed by a person, other than a member of your Immediate Family, who is licensed, certified, or otherwise duly qualified to perform such services on the same basis as if the services had been performed in a health care facility.

There is a lifetime maximum of 100 days for this benefit.

**This benefit is not payable the same day the Hospice Care Benefit is payable.**

**HOSPICE CARE BENEFIT:** When a Covered Person is diagnosed with Internal Cancer or an Associated Cancerous Condition and therapeutic intervention directed toward the cure of the disease is medically determined to be no longer appropriate, and if the Covered Person's medical prognosis is one in which there is a life expectancy of six months or less as the direct result of Internal Cancer or an Associated Cancerous

Condition (hereinafter referred to as “Terminally Ill”), we will pay a one-time benefit of \$1,000 for the first day the Covered Person receives Hospice care and \$50 per day thereafter for Hospice care. For this benefit to be payable, we must be furnished: (1) a written statement from the attending Physician that the Covered Person is Terminally Ill, and (2) a written statement from the Hospice certifying the days services were provided. The lifetime maximum for each Covered Person is \$12,000.

**This benefit is not payable the same day the Home Health Care Benefit is payable.**

**NURSING SERVICES BENEFIT:** While confined in a Hospital for the treatment of Cancer or an Associated Cancerous Condition, if a Covered Person requires and is charged for private nurses and their services other than those regularly furnished by the Hospital, we will pay \$100 per day for full-time private care and attendance provided by such nurses (registered graduate nurses, licensed practical nurses, or licensed vocational nurses). These services must be required and authorized by the attending Physician. This benefit is not payable for private nurses who are members of your Immediate Family. This benefit is payable for only the number of days the Hospital Confinement Benefit is payable. There is no lifetime maximum for this benefit.

**SURGICAL PROSTHESIS BENEFIT:** We will pay \$2,000 when a charge is incurred for surgically implanted prosthetic devices that are prescribed as a direct result of surgery for Internal Cancer or an Associated Cancerous Condition treatment. There is a lifetime maximum of \$4,000 per Covered Person.

**The Surgical Prosthesis Benefit does not include coverage for tissue expanders or a Breast Transverse Rectus Abdominis Myocutaneous (TRAM) Flap.**

**NONSURGICAL PROSTHESIS BENEFIT:** We will pay \$175 per occurrence, per Covered Person when a charge is incurred for nonsurgically implanted prosthetic devices that are prescribed as a direct result of treatment for Internal Cancer or an Associated Cancerous Condition. Examples of nonsurgically implanted prosthetic devices include voice boxes, hair pieces, and removable breast prostheses. There is a lifetime maximum of \$350 per Covered Person.

**RECONSTRUCTIVE SURGERY BENEFIT:**

**BREAST RECONSTRUCTION:** We will pay the amount listed below when a charge is incurred for a reconstructive surgical operation that is performed on a Covered Person as a result of treatment of Cancer or an Associated Cancerous Condition. The maximum daily benefit will not exceed \$2,000.

|  |         |
|--|---------|
| Breast Tissue/Muscle Reconstruction  |         |
| Flap Procedures  | \$2,000 |
| Breast Reconstruction (occurring within five years of breast Cancer diagnosis) | 500     |

|  |     |
|--|-----|
| Breast Symmetry (on the nondiseased breast occurring within five years of breast reconstruction) | 220 |
| Permanent Areola Repigmentation  | 100 |

**OTHER RECONSTRUCTIVE SURGERY:** We will pay the amount listed below when a charge is incurred for a reconstructive surgical operation that is performed on a Covered Person as a result of treatment of Cancer or an Associated Cancerous Condition. The maximum daily benefit will not exceed \$500.

|                       |        |
|-----------------------|--------|
| Facial Reconstruction | \$ 500 |
|-----------------------|--------|

We will pay an indemnity benefit equal to 25% of the amount shown above for the administration of anesthesia during a covered reconstructive surgical operation.

If any reconstructive surgery is performed other than those listed, we will pay an amount comparable to the amount shown above for the operation most nearly similar in severity and gravity. There is no lifetime maximum on number of operations.

**EGG HARVESTING, STORAGE (CRYOPRESERVATION), AND IMPLANTATION BENEFIT:** We will pay \$1,000 for a Covered Person to have oocytes extracted and harvested due to a positive diagnosis of Internal Cancer or an Associated Cancerous Condition. In addition, we will pay, one time per Covered Person, \$200 for the storage of a Covered Person’s oocyte(s) or sperm when a charge is incurred to store with a licensed reproductive tissue bank or similarly licensed facility. Any such extraction, harvesting, or storage must occur prior to Chemotherapy or radiation treatment that has been prescribed for the Covered Person’s treatment of Cancer or an Associated Cancerous Condition. We will also pay \$200 for embryo transfer resulting from such stored oocyte(s) or sperm of a Covered Person. There is a lifetime maximum of \$1,400 per Covered Person.

**ANNUAL CARE BENEFIT:** We will pay \$200 on the anniversary date of a Covered Person’s diagnosis of a covered Internal Cancer or Associated Cancerous Condition for care other than the direct treatment of Cancer or an Associated Cancerous Condition to meet the Covered Person’s physical, emotional, spiritual, or social needs. There is a lifetime maximum of five annual \$200 payments per Covered Person.

**AMBULANCE, TRANSPORTATION, AND LODGING BENEFITS:**

**AMBULANCE BENEFIT:** We will pay \$250 when a charge is incurred for ambulance transportation of a Covered Person to or from a Hospital where the Covered Person receives treatment for Cancer or an Associated Cancerous Condition. We will pay \$2,000 when a charge is incurred for air ambulance transportation of a Covered Person to or from a Hospital where the Covered Person receives treatment for Cancer or an Associated Cancerous Condition. This benefit is limited to two trips per confinement. The ambulance service

must be performed by a licensed professional ambulance company. There is no lifetime maximum for this benefit.

**TRANSPORTATION BENEFIT:** We will pay 40 cents per mile for transportation, up to a combined maximum of \$1,200, if a Covered Person requires treatment that has been prescribed by the attending Physician for Cancer or an Associated Cancerous Condition.

This benefit includes:

1. Personal vehicle transportation of the Covered Person limited to the distance of miles between the Hospital or Medical Facility and the residence of the Covered Person.
2. Commercial transportation (in a vehicle licensed to carry passengers for a fee) of the Covered Person and no more than one additional adult to travel with the Covered Person. If the treatment is for a covered Dependent Child and commercial transportation is necessary, Aflac will pay for up to two adults to travel with the covered Dependent Child. This benefit is limited to the distance of miles between the Hospital or Medical Facility and the residence of the Covered Person.

This benefit is payable up to a maximum of \$1,200 per round trip for all travelers and modes of transportation combined. There is no lifetime maximum for this benefit.

**THIS BENEFIT IS NOT PAYABLE FOR TRANSPORTATION TO ANY HOSPITAL/FACILITY LOCATED WITHIN A 50-MILE RADIUS OF THE RESIDENCE OF THE COVERED PERSON OR FOR TRANSPORTATION BY AMBULANCE TO OR FROM ANY HOSPITAL.**

**LODGING BENEFIT:** We will pay \$65 per day when a charge is incurred for lodging, in a room in a motel, hotel, or other commercial accommodation, for you or any one adult family member when a Covered Person receives treatment for Cancer or an Associated Cancerous Condition at a Hospital or Medical Facility more than 50 miles from the Covered Person's residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. This benefit is limited to 90 days per Calendar Year.

**CONTINUATION OF COVERAGE BENEFIT:** We will waive all monthly premiums due for the policy and riders for up to two months if you meet all of the following conditions:

1. Your policy has been in force for at least six months;
2. We have received premiums for at least six consecutive months;
3. Your premiums have been paid through payroll deduction, and you leave your employer for any reason;

4. You or your employer notifies us in writing within 30 days of the date your premium payments ceased because of your leaving employment; and
5. You re-establish premium payments through:
  - (1) your new employer's payroll deduction process, or
  - (2) direct payment to Aflac.

You will again become eligible to receive this benefit after:

1. You re-establish your premium payments through payroll deduction for a period of at least six months, and
2. We receive premiums for at least six consecutive months.

**"Payroll deduction" means your premium is remitted to Aflac for you by your employer through a payroll deduction process or any other method agreed to by Aflac and the employer.**

#### **(8) Optional Benefits:**

**INITIAL DIAGNOSIS BUILDING BENEFIT RIDER:**  
**(FORM B70050) Applied for ☐ Yes ☐ No**

**INITIAL DIAGNOSIS BUILDING BENEFIT:** This benefit can be purchased in units of \$100 each, up to a maximum of five units or \$500. **If more than one unit has been purchased, the number of units purchased must be multiplied by \$100.**

The number of units you purchased is shown in both the Policy Schedule and the attached application.

The **INITIAL DIAGNOSIS BUILDING BENEFIT** will increase the amount of your Initial Diagnosis Benefit, as shown in the policy, by \$100 for each unit purchased for each Covered Person on the anniversary date of their coverage, while coverage remains in force. (The amount of the monthly increase will be determined on a pro rata basis.) This benefit will be paid under the same terms as the Initial Diagnosis Benefit in the policy to which the rider is attached. This benefit will cease to build for each Covered Person on the anniversary date of the rider following the Covered Person's 65th birthday or at the time Internal Cancer or an Associated Cancerous Condition is diagnosed for that Covered Person, whichever occurs first. However, regardless of the age of the Covered Person on the Effective Date of coverage, this benefit will accrue for a period of at least five years, unless Internal Cancer or an Associated Cancerous Condition is diagnosed prior to the fifth year of coverage.

#### **Exceptions, Reductions, and Limitations of Rider Form B70050:**

The rider contains a 30-day waiting period. If a Covered Person has Internal Cancer or an Associated Cancerous Condition diagnosed before his or her coverage has been in force 30 days, you may, at your option, elect to void the rider from its

beginning and receive a full refund of premium paid for the rider, less any benefits paid under the rider.

The Initial Diagnosis Building Benefit is not payable for: (1) any Internal Cancer or Associated Cancerous Condition diagnosed or treated before the Effective Date of coverage under the rider and the subsequent recurrence, extension, or metastatic spread of such Internal Cancer or Associated Cancerous Condition; (2) Internal Cancer or Associated Cancerous Conditions diagnosed during the rider's 30-day waiting period; or (3) the diagnosis of Nonmelanoma Skin Cancer. **Any Covered Person who has had a previous diagnosis of Internal Cancer or an Associated Cancerous Condition will NOT be eligible for an Initial Diagnosis Building Benefit under the rider for a recurrence, extension, or metastatic spread of that same Internal Cancer or Associated Cancerous Condition.**

#### **DEPENDENT CHILD RIDER: (FORM B70051)**

Applied for ☐ Yes ☐ No

**DEPENDENT CHILD BENEFIT:** Aflac will pay \$10,000 when a covered Dependent Child is diagnosed as having Internal Cancer or an Associated Cancerous Condition while the rider is in force.

This benefit is payable under the rider only once for each covered Dependent Child. In addition to the Positive Medical Diagnosis, we may require additional information from the attending Physician and Hospital.

#### **Exceptions, Reductions, and Limitations of Rider Form B70051:**

The rider contains a 30-day waiting period. If a covered Dependent Child has Internal Cancer or an Associated Cancerous Condition diagnosed before his or her coverage has been in force 30 days, you may, at your option, elect to void the rider from its beginning and receive a full refund of premium paid for the rider, less any benefits paid under the rider.

The Dependent Child Benefit is not payable for: (1) any Internal Cancer or Associated Cancerous Condition diagnosed or treated before the Effective Date of the rider and the subsequent recurrence, extension, or metastatic spread of such Internal Cancer or Associated Cancerous Condition; (2) Internal Cancer or Associated Cancerous Conditions diagnosed during the rider's 30-day waiting period; or (3) the diagnosis of Nonmelanoma Skin Cancer. **Any Dependent Child who has had a previous diagnosis of Internal Cancer or an Associated Cancerous Condition will NOT be eligible for any benefit under the rider for a recurrence, extension, or metastatic spread of that same Internal Cancer or Associated Cancerous Condition.**

#### **SPECIFIED-DISEASE BENEFIT RIDER: (FORM B70052)**

Applied for ☐ Yes ☐ No

**SPECIFIED-DISEASE INITIAL BENEFIT:** While coverage is in force, if a Covered Person is first diagnosed, after the Effective Date of coverage under the rider, with any of the covered Specified Diseases, Aflac will pay a benefit of \$2,000. This benefit is payable only once per Specified Disease per Covered Person. **NO OTHER BENEFITS ARE PAYABLE FOR ANY COVERED SPECIFIED DISEASE NOT PROVIDED FOR IN THE RIDER.**

#### **HOSPITAL CONFINEMENT BENEFITS:**

**HOSPITALIZATION FOR 30 DAYS OR LESS:** When a Covered Person is confined to a Hospital for a covered Specified Disease for 30 days or less, Aflac will pay \$400 for each day the Covered Person is charged for a room as an inpatient.

**HOSPITALIZATION FOR 31 DAYS OR MORE:** During any continuous period of Hospital confinement of 31 days or more for a covered Specified Disease, Aflac will pay benefits as described above for the first 30 days, and beginning with the 31st day of such continuous Hospital confinement, Aflac will pay \$800 for each day the Covered Person is charged for a room as an inpatient.

#### **Exceptions, Reductions, and Limitations of Rider Form B70052:**

Specified diseases must be first diagnosed by a Physician 30 days following the Effective Date of coverage under the rider for benefits to be paid. The diagnosis must be made by and upon a tissue specimen, culture(s), and/or titer(s). If a Covered Person has a Specified Disease diagnosed before his or her coverage has been in force 30 days, benefits for treatment of that Specified Disease will apply only to treatment occurring after two years from the Effective Date of such person's coverage. At your option, you may elect to void the rider from its beginning and receive a full refund of premium paid for the rider, less any benefits paid under the rider.

#### **(9) Payment of Nonsurgical Treatment Benefits:**

If an initial prescription of Hormonal Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy medication instructs a Covered Person to take the medication orally for a period of thirty days or less, then the payment under the applicable Nonsurgical Treatment Benefit is limited to the Calendar Month in which the medication was prescribed, received, and the Covered Person incurred a charge. If a prescription of Hormonal Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy medication which instructs a Covered Person to take the medication orally for a period of thirty days or less is refilled during a Calendar Month in which the stated amount under the applicable Nonsurgical Treatment Benefit has previously been paid, then we will pay the stated amount under the applicable Nonsurgical

Treatment Benefit in advance for one additional Calendar Month for which it has not previously been paid without requiring proof a Covered Person incurred a charge for the medication during that additional Calendar Month. Otherwise, if the prescription is refilled during a Calendar Month in which the stated amount under the applicable Nonsurgical Treatment Benefit has not been previously paid, then the benefit is limited to the Calendar Month in which the medication was prescribed, received, and the Covered Person incurred a charge.

If an initial prescription of Hormonal Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy medication instructs a Covered Person to take the medication orally for a period of more than thirty days but less than 61 days, then we will pay the stated amount under the applicable Nonsurgical Treatment Benefit in advance for one additional, consecutive Calendar Month without requiring proof a Covered Person incurred a charge for the medication during the additional, consecutive Calendar Month.

If an initial prescription of Hormonal Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy medication instructs a Covered Person to take the medication orally for a period of more than sixty days but less than 91 days, then we will pay the stated amount under the applicable Nonsurgical Treatment Benefit in advance for two additional, consecutive Calendar Months without requiring proof a Covered Person incurred a charge for the medication during the additional, consecutive Calendar Months.

If a prescription of Hormonal Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy medication which instructs a Covered Person to take the medication orally for a period of more than thirty days is refilled during a Calendar Month in which the payment under the applicable Nonsurgical Treatment Benefit has previously been paid, then we will pay the stated amount under the applicable Nonsurgical Treatment Benefit in advance for up to three additional, consecutive Calendar Months for which it has not previously been paid without requiring proof a Covered Person incurred a charge for the medication during the three additional, consecutive Calendar Months. Otherwise, if the prescription is refilled during a Calendar Month in which the payment under the applicable Nonsurgical Treatment Benefit has not been previously paid, then, so long as the Covered Person incurred a charge during the first Calendar Month of the prescription, for refills instructing a Covered Person to take the medication orally for a period of more than thirty days but less than 61 days, we will pay the stated amount under the applicable Nonsurgical Treatment Benefit in advance for one additional, consecutive Calendar Month without requiring proof a Covered Person incurred a charge for the medication during the additional, consecutive Calendar Month, and for refills instructing a Covered Person to take the medication orally for a period of more than sixty days but less than 91 days, we will pay the stated amount under the applicable Nonsurgical Treatment Benefit in advance for two additional, consecutive

Calendar Months without requiring proof a Covered Person incurred a charge for the medication during the additional, consecutive Calendar Months.

For injected treatment, the stated amount under the applicable Radiation Therapy, Chemotherapy, Immunotherapy, Or Experimental Chemotherapy Benefit is payable one time per prescribed injection, but not more than one time per Calendar Month. The Surgical/Anesthesia Benefit provides amounts payable for insertion and removal of a pump. Benefits will not be paid for each month of continuous infusion of medications dispensed by a pump, implant, or patch.

If only Experimental Chemotherapy is payable during any Calendar Month, the benefit amount will be reduced 50% for Experimental Chemotherapy for which no charge is incurred. If a Covered Person received the stated amount under the applicable Radiation Therapy, Chemotherapy, Immunotherapy, Or Experimental Chemotherapy Benefit at the reduced 50% amount and, later in the same Calendar Month, receives Radiation Therapy, Chemotherapy, Immunotherapy, or Experimental Chemotherapy where a charge is incurred, we will pay the difference between the 50% previously received and the Radiation Therapy, Chemotherapy, Immunotherapy, or Experimental Therapy Benefit.

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#### **(10) Exceptions, Reductions, and Limitations of the Policy (policy is not a daily hospital expense plan):**

Except as specifically provided in the Benefits section of the policy, we will pay only for treatment of Cancer or Associated Cancerous Conditions, including direct extension, metastatic spread, or recurrence, or other conditions or diseases directly caused or aggravated by Cancer or an Associated Cancerous Condition or the treatment of said Cancer or an Associated Cancerous Condition. Benefits are not provided for premalignant conditions or conditions with malignant potential (unless specifically covered); or any other disease, sickness, or incapacity.

The policy contains a 30-day waiting period. If a Covered Person has Cancer or an Associated Cancerous Condition diagnosed before his or her coverage has been in force 30 days, benefits for treatment of that Cancer or Associated Cancerous Condition, or any recurrence, extension, or metastatic spread of that same Cancer or Associated Cancerous Condition will apply only to treatment occurring after two years from the Effective Date of such person's coverage. At your option, you may elect to void the coverage and receive a full refund of premium.

The Initial Diagnosis Benefit is not payable for: (1) any Internal Cancer or Associated Cancerous Condition diagnosed or treated before the Effective Date of the policy and the subsequent recurrence, extension, or metastatic spread of such Internal Cancer or Associated Cancerous Condition; (2) Internal Cancer or an Associated Cancerous Condition diagnosed during the policy's 30-day waiting period; or (3) the

diagnosis of Nonmelanoma Skin Cancer. **Any Covered Person who has had a previous diagnosis of Internal Cancer or an Associated Cancerous Condition will NOT be eligible for an Initial Diagnosis Benefit under the policy for a recurrence, extension, or metastatic spread of that same Internal Cancer or Associated Cancerous Condition.**

We will not pay benefits whenever coverage provided by the policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

We will not pay benefits for any loss that is diagnosed or treated outside the territorial limits of the United States or its possessions.

We may void the policy and will not pay benefits whenever: (1) material facts or circumstances have been concealed or misrepresented in making a claim under the policy; or (2) fraud is committed or attempted in connection with any matter relating to the policy. If you have received benefits that were not contractually due under the policy, then we reserve the right to offset any benefits payable under the policy up to the amount of benefits you received that were not contractually due.

**(11) THE RELATIONSHIP OF COST OF CARE AND BENEFITS.**

Because the costs of care services are likely to go up over time, you should think about if and how the benefits of this plan may be adjusted.

- a) The benefit level will not increase over time.
- b) There are no automatic benefit adjustment provisions.
- c) You are not guaranteed the option to buy additional benefits.
- d) There are no additional benefits available for purchase.
- e) There will be no additional premium charge imposed as there are no additional benefits available for purchase.

**(12) THE PREMIUM:**

**Total Annual Premium:** \_\_\_\_\_

Annual:

Policy: \$ \_\_\_\_\_

Rider B70050: \$ \_\_\_\_\_

Rider B70051: \$ \_\_\_\_\_

Rider B70052: \$ \_\_\_\_\_

**(13) COMPLAINTS:** If you have a complaint, you may call us at 1-800-992-3522 or your associate (duly licensed agent). If you are not satisfied, you may call the Massachusetts Division of Insurance at (617) 521-7777 or write to them at 1000 Washington Street, Suite 810, Boston, Massachusetts 02118-6200.

**RETAIN FOR YOUR RECORDS.**

**THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.  
THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE  
GOVERNING CONTRACTUAL PROVISIONS.**



## TERMS YOU NEED TO KNOW

**ASSOCIATED CANCEROUS CONDITION:** Myelodysplastic blood disorder, myeloproliferative blood disorder, or internal carcinoma in situ (in the natural or normal place, confined to the site of origin without having invaded neighboring tissue). An associated cancerous condition must receive a positive medical diagnosis. **Premalignant conditions or conditions with malignant potential, other than those specifically named above, are not considered associated cancerous conditions.**

**CANCER:** Disease manifested by the presence of a malignant tumor and characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Cancer also includes but is not limited to leukemia, Hodgkin's disease and melanoma. Cancer must receive a positive medical diagnosis.

**1. INTERNAL CANCER:** all cancers other than nonmelanoma skin cancer (see definition of nonmelanoma skin cancer).

**2. NONMELANOMA SKIN CANCER:** a cancer other than a melanoma that begins in the outer part of the skin (epidermis).

**Associated cancerous conditions, premalignant conditions or conditions with malignant potential will not be considered cancer.**

**COVERED PERSON:** Any person insured under the coverage type that you applied for on the application: individual (named insured listed in the Policy Schedule), named insured/spouse only (named insured and spouse), one-parent family (named insured and dependent children), or two-parent family (named insured, spouse and dependent children). Spouse is defined as the person to whom you are legally married and who is listed on your application. Newborn children are automatically insured for 30 days from the moment of birth. If coverage is for individual or named insured/spouse only and you desire uninterrupted coverage for a newborn child beyond the first 30 days, you must notify Aflac in writing within 31 days of the child's birth and Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due, if any. Coverage will include any other dependent child, regardless of age, who is incapable of self-sustaining employment by reason of intellectual or physical disability and who became so disabled prior to age 26 and while covered under the policy. Dependent children are your natural children, stepchildren or legally adopted children who are under age 26. Children born to your dependent children or children born to the dependent children of your spouse are not covered under the policy.

**EFFECTIVE DATE:** The date(s) coverage begins as shown in the Policy Schedule or any attached endorsements or riders. The effective date is not the date you signed the application for coverage.

## ADDITIONAL INFORMATION

An ambulatory surgical center does not include a physician's or dentist's office, a clinic or other such location.

Experimental chemotherapy does not include laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, therapeutic devices, or other procedures related to these experimental treatments.

The term hospital does not include any institution or part thereof used as an emergency room; an observation unit; a rehabilitation unit; a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a psychiatric unit; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

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

A stem cell transplantation does not include the bone marrow transplantation.

The diagnosis date is not the date the diagnosis is communicated to the covered person.

If nonmelanoma skin cancer is diagnosed during hospitalization, benefits will be limited to the day(s) the covered person actually received treatment for nonmelanoma skin cancer.

If treatment for cancer or an associated cancerous condition is received in a U.S. government hospital, Aflac will not require a covered person to be charged for such services for benefits to be payable.







**aflac.com** || **1.800.99.AFLAC** (1.800.992.3522)

Underwritten by:  
American Family Life Assurance Company of Columbus  
Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999

