NEW YORK MEDICAL COLLEGE

- Aflac pays cash directly to the insured to offset any out-of-pocket expenses incurred during a sickness or injury (co-payments, deductibles, loss of wages, mortgage/rent, car payments, transportation, etc.)
- Aflac’s benefits are supplemental, and independent of any health insurance benefits
- Aflac pays most claims within four business days
- Aflac’s policies are voluntary, guaranteed renewable and fully portable at discounted group rates
- With payroll deduction, these plans are paid for using pre-tax dollars

Benefit Offering Includes:

**Classic Cancer Care Indemnity Plan** – Pays cash directly to the insured or a family member to help cope with out-of-pocket expenses related to the diagnosis and treatment of Cancer. Benefits include: First Occurrence, Hospitalization, Experimental Treatments, Radiation & Chemotherapy, Blood & Plasma, Transportation & Lodging, Bone Marrow Transplantation for you and the donor, Stem Cell Transplantation, and much more! Sign up is now through age 75 and guaranteed renewable for life. Includes Wellness Benefit. Initial Diagnosis Benefit Rider - Increases by $500 per year the Initial Diagnosis Benefit shown in the policy.

**Specified Health Event Rider** - Only available as a rider to the Personal Cancer Indemnity Plan. Covers Stroke, Heart Attack, and End-Stage Renal Failure.

**Personal Accident Indemnity Plan** - Pays cash directly to the insured or family member for treatment of accidental injury on or off the job, 24/7 anywhere you are. Benefits are paid for Emergency Treatment, Follow-Up Visits, Physical Therapy, Hospitalization, Transportation & Lodging, Major Diagnostic Exams like MRI, CT, AD&D rider, and much more! Sign up is through age 70 and guaranteed renewable for life. Includes annual Health Screening Benefit after 12 months.

**Personal Sickness Indemnity Plan** – Pays cash directly to the insured or a family member for treatment of a sickness 24/7 anywhere you are. Benefits are paid for Physician’s visits, Hospitalization, Major Diagnostic Exams like MRI, CT Scan, EEG. Surgical Benefit, Ambulance, and much more. Sign up is through age 70 and guaranteed renewable for life.

CONTACT MARC HEINBERG FOR THE AFLACTS:
CELL: 917-406-9996
EMAIL: MARC_HEINBERG@US.AFLAC.COM

This announcement is for illustrative purposes only. Refer to the policy for complete details, limitations and exclusions.
NEW YORK MEDICAL COLLEGE
BI-WEEKLY RATES

Personal Accident Expense Plan (Pre-tax)

Ages 18-70         Individual                $11.76
                   Husband & Wife          $15.84
                   1 Parent Family        $17.22
                   2 Parent Family        $21.90

Personal Sickness Plan I (Pre-tax)

Ages 18-39  40-49  50-59  60-70
Individual  $7.71  $8.26  $10.66  $15.78
Husband & Wife  $14.49  $15.00  $18.14  $26.26
1 Parent Family  $11.77  $11.82  $14.22  $19.34
2 Parent Family  $18.51  $18.55  $21.69  $29.82

Above Pre-Tax rates do not illustrate Pre-Tax Savings
All products are Fully Portable and Guaranteed Renewable for Life at the same group discounted rates*
Rates are based on age of employee, and do not increase as you get older
Since 1955, AFLAC has never raised rates on existing policies

* as long as you have been enrolled for at least 30 days

Your AFLAC representative: MARC HEINBERG (917)406-9996  EMAIL: marc_heinberg@us.aflac.com
**NEW YORK MEDICAL COLLEGE**

**BI-WEEKLY RATES**

**Classic Cancer Plan Only* (Pre-tax)**

<table>
<thead>
<tr>
<th>Ages</th>
<th>Individual</th>
<th>Husband &amp; Wife</th>
<th>1 Parent Family**</th>
<th>2 Parent Family**</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-75</td>
<td>$15.18</td>
<td>$25.98</td>
<td>$15.18</td>
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</tr>
</tbody>
</table>

**DEPENDENT CARE RIDER** – Additional 42 cents per pay period

**Initial Diagnosis Rider (Pre-Tax)**
(May only be purchased with Cancer Plan)

<table>
<thead>
<tr>
<th>Ages 18-75</th>
<th>Individual</th>
<th>Husband &amp; Wife</th>
<th>1 Parent Family</th>
<th>2 Parent Family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$2.70</td>
<td>$6.00</td>
<td>$2.70</td>
<td>$6.00</td>
</tr>
</tbody>
</table>

**Specified Health Event Rider w/ Recovery (Pre-Tax)**
(May only be purchased with Cancer Plan)

<table>
<thead>
<tr>
<th>Ages</th>
<th>Individual</th>
<th>Husband &amp; Wife</th>
<th>1 Parent Family</th>
<th>2 Parent Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-35</td>
<td>$4.38</td>
<td>$7.44</td>
<td>$4.68</td>
<td>$7.44</td>
</tr>
<tr>
<td>36-45</td>
<td>$7.20</td>
<td>$12.36</td>
<td>$7.26</td>
<td>$12.36</td>
</tr>
<tr>
<td>56-75</td>
<td>$12.36</td>
<td>$25.02</td>
<td>$12.72</td>
<td>$25.02</td>
</tr>
</tbody>
</table>

Above Pre-Tax rates do not illustrate Pre-Tax Savings
All products are Fully Portable and Guaranteed Renewable for Life at the same group discounted rates*
Rates are based on age of employee, and do not increase as you get older
Since 1955, AFLAC has never raised rates on existing policies

* as long as you have been enrolled for at least 30 days

Your AFLAC representative: **MARC HEINBERG** (917)406-9996  EMAIL: marc_heinberg@us.aflac.com
AFLAC
CANCER CARE
SPECIFIED-DISEASE INSURANCE
CLASSIC
We’ve been dedicated to helping provide
peace of mind and financial security for
nearly 60 years.
Added Protection for You and Your Family

Chances are you know someone who’s been affected, directly or indirectly, by cancer. You also know the toll it’s taken on them—physically, emotionally, and financially. That’s why we’ve developed the Aflac Cancer Care insurance policy. The plan pays a cash benefit upon initial diagnosis of a covered cancer, with a variety of other benefits payable throughout cancer treatment. You can use these cash benefits to help pay out-of-pocket medical expenses, the rent or mortgage, groceries, or utility bills—the choice is yours.

And while you can’t always predict the future, here at Aflac we believe it’s good to be prepared. The Aflac Cancer Care plan is here to help you and your family better cope financially—and emotionally—if a positive diagnosis of cancer ever occurs. That way you can worry less about what may be ahead.

HOW IT WORKS

The above example is based on a scenario for Aflac Cancer Care – Classic that includes the following benefit conditions: Physician visit (Cancer Wellness Benefit) of $75, bone marrow biopsy (Surgical/Anesthesia Benefit) of $125, National Cancer Institute Evaluation/Consultation Benefit of $500, Initial Diagnosis Benefit of $4,000, venous port (Surgical/Anesthesia Benefit) of $125, Injected Chemotherapy Benefit (10 weeks) of $6,000, Immunotherapy Benefit (3 months) of $1,050, Antinausea Benefit (3 months) of $300, Hospital Confinement Benefit (10-week hospitalization) of $14,000, Blood/Plasma Benefit (10 transfusions) of $1,000.

THE FACTS SAY YOU NEED THE PROTECTION OF AFLAC’S CANCER CARE PLAN:

FACT NO. 01

IN THE UNITED STATES, MEN HAVE SLIGHTLY LESS THAN A 1-in-2 LIFETIME RISK OF DEVELOPING CANCER.¹

FACT NO. 02

IN THE UNITED STATES, WOMEN HAVE SLIGHTLY MORE THAN A 1-in-3 LIFETIME RISK OF DEVELOPING CANCER.¹

¹Cancer Facts & Figures 2012, American Cancer Society.

The policy has limitations and exclusions that may affect benefits payable. For costs and complete details of the coverage, contact your Aflac insurance agent/producer. This brochure is for illustrative purposes only. Refer to the policy for benefit details, definitions, limitations, and exclusions.

Aflac herein means American Family Life Assurance Company of New York.
# Classic Cancer Care Benefit Overview

<table>
<thead>
<tr>
<th>BENEFIT NAME</th>
<th>BENEFIT AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancer Wellness Benefit</strong></td>
<td>$75 per year, per Covered Person</td>
</tr>
<tr>
<td><strong>Cancer Diagnosis Benefits:</strong></td>
<td></td>
</tr>
<tr>
<td>Initial Diagnosis Benefit</td>
<td>Insured/Spouse: $4,000; Dependent Child: $8,000; payable once per Covered Person</td>
</tr>
<tr>
<td>Medical Imaging With Diagnosis Benefit</td>
<td>$135; two payments per year, per Covered Person; no lifetime max</td>
</tr>
<tr>
<td>NCI Evaluation/Consultation Benefit</td>
<td>$500 payable only once per Covered Person</td>
</tr>
<tr>
<td><strong>Cancer Treatment Benefits:</strong></td>
<td></td>
</tr>
<tr>
<td>Injected Chemotherapy Benefit</td>
<td>$600 per day; limited to one payment per week; no lifetime max</td>
</tr>
<tr>
<td>Oral Chemotherapy Benefit</td>
<td>$250 per day up to $750 max per month for Oral/Topical Benefit†</td>
</tr>
<tr>
<td>Topical Chemotherapy Benefit</td>
<td>$150 per prescription, per month up to $750 max per month for Oral/Topical Benefit†</td>
</tr>
<tr>
<td>Radiation Therapy Benefit</td>
<td>$350 per day; limited to one payment per week; no lifetime max</td>
</tr>
<tr>
<td>Experimental Treatment Benefit</td>
<td>$350 per week outside of a clinical trial; $100 per week as part of a clinical trial; no lifetime max</td>
</tr>
<tr>
<td>Immunotherapy Benefit</td>
<td>$350 once per month; $1,750 lifetime max per Covered Person</td>
</tr>
<tr>
<td>Antinausea Benefit</td>
<td>$100 per month; no lifetime max</td>
</tr>
<tr>
<td>Stem Cell Transplantation Benefit</td>
<td>$7,000; lifetime max $7,000 per Covered Person</td>
</tr>
<tr>
<td>Bone Marrow Transplantation Benefit</td>
<td>$7,000; $7,000 lifetime max per Covered Person; $750 to donor</td>
</tr>
<tr>
<td>Blood and Plasma Benefit</td>
<td></td>
</tr>
<tr>
<td>Surgical/Anesthesia Benefit</td>
<td>$100–$3,400 (Anesthesia: additional 25% of Surgical Benefit); maximum daily benefit not to exceed $4,250; no lifetime max on number of operations</td>
</tr>
<tr>
<td>Skin Cancer Surgery Benefit</td>
<td>$35–$400; no lifetime max on number of operations</td>
</tr>
<tr>
<td>Additional Surgical Opinion Benefit</td>
<td>$200 per day; no lifetime max</td>
</tr>
<tr>
<td><strong>Hospitalization Benefits:</strong></td>
<td></td>
</tr>
<tr>
<td>Hospital Confinement Benefit</td>
<td>$200 per day; no lifetime max</td>
</tr>
<tr>
<td>Outpatient Hospital Surgical Room Benefit</td>
<td>$200 (payable in addition to Surgical/Anesthesia Benefit); no lifetime max on number of operations</td>
</tr>
<tr>
<td><strong>Continuing Care Benefits:</strong></td>
<td></td>
</tr>
<tr>
<td>Extended-Care Facility Benefit</td>
<td>$100 a day, limited to 30 days per year, per Covered Person</td>
</tr>
<tr>
<td>Home Health Care Benefit</td>
<td>$50 per day; lifetime max of 100 days per Covered Person</td>
</tr>
<tr>
<td>Hospice Care Benefit</td>
<td>$1,000 for the 1st day; $50 per day thereafter; $12,000 lifetime max per Covered Person</td>
</tr>
<tr>
<td>Nursing Services Benefit</td>
<td>$100 per day; no lifetime max</td>
</tr>
<tr>
<td>Surgical Prosthesis Benefit</td>
<td>$2,000; lifetime max $4,000 per Covered Person</td>
</tr>
<tr>
<td>Nonsurgical Prosthesis Benefit</td>
<td>$175 per occurrence; lifetime max $350 per Covered Person</td>
</tr>
<tr>
<td>Reconstructive Surgery Benefit</td>
<td>$220–$2,000 (Anesthesia: 25% of Reconstructive Surgery Benefit); no lifetime max on number of operations</td>
</tr>
<tr>
<td>Egg Harvesting and Storage (Cryopreservation) Benefit</td>
<td>$1,000 to have oocytes extracted; $350 for storage; $1,350 lifetime max per Covered Person</td>
</tr>
<tr>
<td><strong>Ambulance, Transportation, Lodging, and Other Benefits:</strong></td>
<td></td>
</tr>
<tr>
<td>Ambulance Benefit</td>
<td>$250 ground or $2,000 air; no lifetime max</td>
</tr>
<tr>
<td>Transportation Benefit</td>
<td>$.40 per mile; max $1,200 per round trip; no lifetime max</td>
</tr>
<tr>
<td>Lodging Benefit</td>
<td>$65 per day; limited to 90 days per year</td>
</tr>
<tr>
<td>Bone Marrow Donor Screening Benefit</td>
<td>$40; limited to one benefit per Covered Person, per lifetime</td>
</tr>
</tbody>
</table>

†Up to three different oral/topical chemotherapy medicines per calendar month.

REFER TO THE FOLLOWING DISCLOSURE STATEMENT FOR BENEFIT DETAILS, DEFINITIONS, LIMITATIONS, AND EXCLUSIONS.
SPECIFIED-DISEASE COVERAGE ONLY

REQUIRED DISCLOSURE STATEMENT FOR POLICY FORM NY78300

The policy described in this Disclosure Statement provides supplemental coverage and will be issued only to supplement insurance already in force.

If you are eligible for Medicare, review the Medicare Supplement Buyer’s Guide furnished by Aflac.

This is an individual policy of insurance. This policy provides specified disease coverage ONLY. This policy does NOT provide basic hospital, basic medical, or major medical insurance, as defined by the New York State Insurance Department.
1. Read Your Policy Carefully: This Disclosure Statement provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Aflac. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

2. All treatments listed below must be National Cancer Institute or Food and Drug Administration approved for the treatment of Cancer or an Associated Cancerous Condition, as applicable.

**A. CANCER WELLNESS BENEFITS:**

1. CANCER WELLNESS: Aflac will pay $75 per Calendar Year when a Covered Person receives one of the following:

   - mammogram
   - breast ultrasound
   - breast MRI
   - CA15-3 (blood test for breast Cancer tumor)
   - Pap smear
   - ThinPrep
   - biopsy
   - flexible sigmoidoscopy
   - hemoccult stool specimen (lab confirmed)
   - chest X-ray
   - CEA (blood test for colon Cancer)
   - CA 125 (blood test for ovarian Cancer)
   - PSA (blood test for prostate Cancer)
   - testicular ultrasound
   - thermography
   - colonoscopy
   - virtual colonoscopy

   This benefit is limited to one payment per Calendar Year, per Covered Person. These tests must be performed to determine whether Cancer or an Associated Cancerous Condition exists in a Covered Person and must be administered by licensed medical personnel. No lifetime maximum.

2. BONE MARROW DONOR SCREENING: Aflac will pay $40 when a Covered Person provides documentation of participation in a screening test as a potential bone marrow donor. This benefit is limited to one benefit per Covered Person per lifetime.

**B. CANCER DIAGNOSIS BENEFITS:**

1. INITIAL DIAGNOSIS BENEFIT: Aflac will pay the amount listed below when a Covered Person is diagnosed as having Internal Cancer or an Associated Cancerous Condition while this policy is in force, subject to Part 2, Limitations and Exclusions, Section C, of the policy.

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Named Insured or Spouse</td>
<td>$4,000</td>
</tr>
<tr>
<td>Dependent Child</td>
<td>$8,000</td>
</tr>
</tbody>
</table>

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

2. MEDICAL IMAGING WITH DIAGNOSIS BENEFIT: Aflac will pay $135 when a Covered Person receives an initial diagnosis or follow-up evaluation of Internal Cancer or an Associated Cancerous Condition, using one of the following medical imaging exams: CT scans, MRIs, bone scans, thyroid scans, multiple gated acquisition (MUGA) scans, positron emission tomography (PET) scans, transrectal ultrasounds, or abdominal ultrasounds. This benefit is limited to two payments per Calendar Year, per Covered Person. No lifetime maximum.

**C. CANCER TREATMENT BENEFITS:**

1. DIRECT NONSURGICAL TREATMENT BENEFITS: All benefits listed below are not payable based on the number, duration, or frequency of the medication(s), therapy, or treatment received by the Covered Person (except as provided in Benefit C1b). Benefits will not be paid under the Experimental Treatment Benefit or Immunotherapy Benefit for any medications or treatment paid under the Injected Chemotherapy Benefit, the Oral/Topical Chemotherapy Benefits, or the Radiation Therapy Benefit.

   a. INJECTED CHEMOTHERAPY BENEFIT: Aflac will pay $600 per day during which a Covered Person receives Physician-prescribed Injected Chemotherapy. The Surgical/Anesthesia Benefit provides amounts payable for insertion and removal of a pump. Benefits will not be paid for each week of continuous infusion of medications dispensed by a pump, implant, or patch. This benefit is limited to one payment per Calendar Week in which the medication(s) or treatment is received. No lifetime maximum.

   b. ORAL/TOPICAL CHEMOTHERAPY BENEFITS:

      (1) ORAL CHEMOTHERAPY BENEFIT: Aflac will pay $250 per day during which a Covered Person is prescribed and receives Oral Chemotherapy for the treatment of Cancer or an Associated Cancerous Condition.

      (2) TOPICAL CHEMOTHERAPY BENEFIT: Aflac will pay $150 per Calendar Month during which a Covered Person is prescribed and receives Topical Chemotherapy for the treatment of Cancer or an Associated Cancerous Condition.

Oral/Topical Chemotherapy benefits are limited to the Calendar Month in which the medication(s) or treatment is received. If the prescription is for more than one month,
the benefit is limited to the Calendar Month in which the prescription is received. Total benefits are payable for up to three different Oral/Topical Chemotherapy medicines per Calendar Month, up to a maximum of $750 per Calendar Month. Refills of the same prescription within the same Calendar Month are not considered a different Chemotherapy medicine. No lifetime maximum.

c. RADIATION THERAPY BENEFIT: Aflac will pay $350 per day during which a Covered Person receives Radiation Therapy for the treatment of Cancer or an Associated Cancerous Condition. This benefit will not be paid for each week a radium implant or radioisotope remains in the body. This benefit is limited to one payment per Calendar Week in which the therapy is received. No lifetime maximum.

d. EXPERIMENTAL TREATMENT BENEFIT: Aflac will pay $350 once per Calendar Week during which a Covered Person receives Physician-prescribed experimental Cancer chemotherapy medications outside of a clinical trial. Aflac will pay $100 once per Calendar Week during which a Covered Person receives Physician-prescribed experimental Cancer chemotherapy medications as part of a clinical trial. Chemotherapy medications must be approved by the National Cancer Institute as a viable experimental treatment for Cancer. This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, Immunotherapy, colony-stimulating factors, and therapeutic devices or other procedures related to these experimental treatments. Benefits will not be paid for each week of continuous infusion of medications dispensed by a pump, implant, or patch. This benefit is limited to the Calendar Week in which the chemotherapy medications are received. No lifetime maximum.

Benefits will not be paid under the Experimental Treatment Benefit for any medications paid under the Immunotherapy Benefit.

3. SURGICAL TREATMENT BENEFITS:

a. SURGICAL/ANESTHESIA BENEFIT: When a surgical operation is performed on a Covered Person for a diagnosed Internal Cancer or Associated Cancerous Condition, Aflac will pay the indemnity listed in the Schedule of Operations for the specific procedure received. If any operation for the treatment of Internal Cancer or an Associated Cancerous Condition is performed other than those listed, Aflac will pay an amount comparable to the amount shown in the Schedule of Operations for the operation most nearly similar in severity and gravity.

EXCEPTIONS: Surgery for Skin Cancer will be payable under Benefit C3b. Reconstructive Surgery will be payable under Benefit E7.

Two or more surgical procedures performed through the same incision will be considered one operation, and benefits will be paid based upon the highest eligible benefit. Aflac 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. No lifetime maximum on the number of operations.

b. 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, Aflac will pay the indemnity listed below for the specific procedure received. The indemnity amount listed below includes anesthesia services. The maximum daily benefit will not exceed $400. No lifetime maximum on the number of operations.

   Laser or Cryosurgery $ 35

Surgeries OTHER THAN Laser or Cryosurgery:
   Biopsy 70
   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

c. ADDITIONAL SURGICAL OPINION BENEFIT: Aflac will pay $200 per day for an additional surgical opinion, by a Physician, concerning surgery for a diagnosed Cancer or an Associated Cancerous Condition. This benefit is not payable on the same day the National Cancer Institute Evaluation/Consultation Benefit is payable. No lifetime maximum.

D. HOSPITALIZATION BENEFITS:

1. HOSPITAL CONFINEMENT BENEFIT: (includes confinement in a U.S. government Hospital): When a Covered Person is confined to a Hospital for treatment of Cancer or an Associated Cancerous Condition, Aflac will pay $200 per day for each day a Covered Person is confined. No lifetime maximum.

   If a Covered Person is hospitalized and receives benefits under Benefit D1 and is later confined to the Extended-Care Facility within 30 days of that confinement. For each day this benefit is payable, benefits under Benefit D1 are NOT payable. Benefits are limited to 30 days in each Calendar Year per Covered Person.

2. OUTPATIENT HOSPITAL SURGICAL ROOM BENEFIT: When a surgical operation is performed on a Covered Person for treatment of a diagnosed Internal Cancer or Associated Cancerous Condition, Aflac will pay $200 per day for each day a Covered Person is confined. No lifetime maximum.

   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 benefits under Benefit D1 and is confined to the Extended-Care Facility within 30 days of that confinement.

3. HOSPICE CARE BENEFIT: When a Covered Person is diagnosed with Internal Cancer or an Associated Cancerous Condition and receives benefits under Part 6 and later requires home health care within 30 days of Hospital Confinement, Aflac will pay $50 per day if a Covered Person receives Home Health Care as a direct result of Cancer or an Associated Cancerous Condition. Lifetime maximum of 100 days per Covered Person.

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

4. NURSING SERVICES BENEFIT: While confined in a Hospital for the treatment of Cancer or an Associated Cancerous Condition, if a Covered Person requires private nurses and their services other than those regularly furnished by the Hospital, Aflac 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. No lifetime maximum.

5. SURGICAL PROSTHESIS BENEFIT: Aflac will pay $2,000 for surgically implanted prosthetic devices that are prescribed as a direct result of surgery for Internal Cancer or Associated Cancerous Condition treatment. 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.

6. NONSURGICAL PROSTHESIS BENEFIT: Aflac will pay $175 per occurrence, per Covered Person 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. Lifetime maximum of $350 per Covered Person.

7. RECONSTRUCTIVE SURGERY BENEFIT: Aflac will pay the specified indemnity listed below for a reconstructive surgical operation that is performed on a Covered Person as a result of treatment of Cancer or treatment of an Associated Cancerous Condition. The maximum daily benefit will not exceed $2,000. No lifetime maximum on number of operations.

- 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
- Facial Reconstruction: 500

Aflac 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, Aflac will pay an amount comparable to the amount shown above for the operation most nearly similar in severity and gravity.

8. EGG HARVESTING AND STORAGE (CRYOPRESERVATION) BENEFIT: Aflac will pay $1,000 for a Covered Person to have oocytes extracted and harvested. In addition, Aflac will pay, one time per Covered Person, $350 for the storage of a Covered Person’s oocyte(s) or sperm 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. Lifetime maximum of $1,350 per Covered Person.

2. TRANSPORTATION BENEFIT: Aflac 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:

a. 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.

b. 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. No lifetime maximum.

**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.**

3. LODGING BENEFIT: Aflac will pay $65 per day 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.

G. WAIVER OF PREMIUM BENEFIT:
If you, due to having Cancer or an Associated Cancerous Condition, are completely unable to perform all of the usual and customary duties of your occupation [if you are not employed: are completely unable to perform two or more Activities of Daily Living (ADLs) without the assistance of another person] for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require an employer’s statement (if applicable) and a Physician’s statement of your inability to perform said duties or activities, and may each month thereafter require a Physician’s statement that total inability continues.

If you die and your Spouse becomes the new Named Insured, premiums will resume and be payable on the first premium due date after the change. The new Named Insured will then be eligible for this benefit if the need arises.
Aflac may ask for and use an independent consultant to determine whether you can perform an ADL when this benefit is in force. Aflac will also waive, from month to month, any premiums falling due while you are receiving Hospice Benefits.

3. Optional Benefits:

INITIAL DIAGNOSIS BUILDING BENEFIT RIDER: (NY78050)
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. All amounts cited in this rider are for one unit of coverage. If more than one unit has been purchased, the amounts listed must be multiplied by the number of units in force. The number of units you purchased is shown in both the Policy Schedule and the attached application.

The INITIAL DIAGNOSIS BENEFIT, as shown in the policy, will be increased by $100 for each unit purchased on each rider anniversary date while this rider 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 this rider is attached. This benefit will cease to build for each Covered Person on the anniversary date of this 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 this rider, 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 NY78050:

This rider contains a 30-day waiting period. If a Covered Person has Internal Cancer or an Associated Cancerous Condition diagnosed before coverage has been in force 30 days from the Effective Date, you may, at your option, elect to void the rider from its beginning and receive a full refund of premium.

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 this 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 this 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 this rider for a recurrence, extension, or metastatic spread of that same Internal Cancer or Associated Cancerous Condition.

SPECIFIED HEALTH EVENT WITH FIRST OCCURRENCE BUILDING BENEFIT RIDER: (NY78055)
Applied for:  Yes  No

While this coverage is in force, we will pay the following benefits to a Covered Person, as applicable, subject to the Pre-Existing Conditions provision, Limitations and Exclusions, and all other policy and rider provisions:

A. FIRST-OCCURRENCE BENEFIT: Aflac will pay the following benefit amount for each Covered Person when he or she is first diagnosed as having had a Specified Health Event:

Named Insured/Spouse
$5,000 (Lifetime maximum $5,000 per Covered Person)

Dependent Children
$7,500 (Lifetime maximum $7,500 per Covered Person)

This benefit is payable only once for each Covered Person and will be paid in addition to any other benefit in this rider.

B. FIRST-OCCURRENCE BUILDING BENEFIT: The First-Occurrence Benefit above will be increased by $500 on each rider anniversary date while this rider 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 First-Occurrence Benefit. This benefit will cease to build for each Covered Person on the anniversary date of this rider following the Covered Person’s 65th birthday or at the time of a Specified Health Event, subject to the

DEPENDENT CHILD RIDER: (NY78051)
Applied for:  Yes  No
Limitations and Exclusions of the rider, for that Covered Person, whichever occurs first. However, regardless of the age of the Covered Person on the Effective Date of this rider, this benefit will accrue for a period of at least five years unless a Specified Health Event is diagnosed prior to the fifth year of coverage.

C. REOCCURRENCE BENEFIT: If benefits have been paid to a Covered Person under the First-Occurrence Benefit above, Aflac will pay $2,500 if such Covered Person is later diagnosed as having had a subsequent Specified Health Event.

For the Reoccurrence Benefit to be payable, the Specified Health Event must occur more than 180 days after the date the First-Occurrence Benefit or Reoccurrence Benefit became payable. No lifetime maximum.

D. HOSPITAL CONFINEMENT BENEFIT: (includes confinement in a U.S. government Hospital) When a Covered Person requires Hospital Confinement for the treatment of a covered Specified Health Event, Aflac will pay $240 per day for each day a Covered Person is confined. This benefit is limited to confinements for the treatment of a covered Specified Health Event that occur within 500 days following the occurrence of the most recent covered Specified Health Event. No lifetime maximum.

Hospital Confinement Benefits are payable for only one covered Specified Health Event at a time per Covered Person.

Benefits are not payable on the same day as the Continuing Care Benefit. If the Hospital Confinement Benefit and the Continuing Care Benefit are payable on the same day, only the highest eligible benefit will be paid.

E. CONTINUING CARE BENEFIT: If, as the result of a covered Specified Health Event, a Covered Person receives any of the following treatments from a licensed Physician, Aflac will pay $125 (one hundred twenty-five dollars) each day a Covered Person receives one or more of the following treatments:

1. rehabilitation therapy
2. physical therapy
3. speech therapy
4. occupational therapy
5. respiratory therapy
6. dietary therapy/consultation
7. home health care
8. dialysis
9. hospice care
10. extended care
11. Physician visits
12. nursing home care

Treatment is limited to 75 days for continuing care received within 180 days following the occurrence of the most recent covered Specified Health Event. Daily maximum for this benefit is $125 (one hundred twenty-five dollars) regardless of the number of treatments received.

Benefits are not payable on the same day as the Hospital Confinement Benefit (D). If the Hospital Confinement Benefit (D) and the Continuing Care Benefit (E) are payable on the same day, only the highest eligible benefit will be paid. No lifetime maximum.

The Ambulance Benefit, Transportation Benefit, and Lodging Benefit will be paid for care received within 180 days following the occurrence of a covered Specified Health Event. Benefits are payable for only one covered Specified Health Event at a time per Covered Person. If a Covered Person is eligible to receive benefits for more than one covered Specified Health Event, we will pay benefits only for care received within the 180 days following the occurrence of the most recent event.

F. AMBULANCE BENEFIT: If, due to a covered Specified Health Event, a Covered Person requires ground ambulance transportation to or from a Hospital, Aflac will pay $250. If air ambulance transportation is required due to a covered Specified Health Event, we will pay $2,000. A licensed professional or licensed volunteer ambulance company must provide the ambulance service. This benefit will not be paid for more than two times per occurrence of a Specified Health Event. Ambulance Benefits are not payable beyond the 180th day following the occurrence of a covered Specified Health Event. No lifetime maximum.

G. TRANSPORTATION BENEFIT: If a Covered Person requires special medical treatment that has been prescribed by the local attending Physician for a covered Specified Health Event, Aflac will pay 50 cents per mile for transportation of a Covered Person for the round-trip distance between the Hospital or medical facility and the residence of the Covered Person. This benefit is not payable for transportation by ambulance or air ambulance to the Hospital. This benefit will be paid only for the Covered Person for whom the special treatment is prescribed. If the special treatment is for a covered Dependent Child and commercial travel is necessary, we will pay this benefit for up to two adults to accompany the covered Dependent Child. The benefit amount payable is limited to $1,500 per occurrence of a covered Specified Health Event. Transportation Benefits are not payable beyond the 180th day following the occurrence of a covered Specified Health Event. THIS BENEFIT IS NOT PAYABLE FOR TRANSPORTATION TO ANY HOSPITAL LOCATED WITHIN A 50-MILE RADIUS OF THE RESIDENCE OF THE COVERED PERSON. No lifetime maximum.

H. LODGING BENEFIT: Aflac will pay $60 per day for lodging for you or any one adult family member when a Covered Person receives special medical treatment for a covered Specified Health Event at a Hospital or medical facility. The Hospital, medical facility, and lodging must be 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 15 days per occurrence of a covered Specified Health Event. Lodging Benefits are not payable beyond the 180th day following the occurrence of a covered Specified Health Event. No lifetime maximum.
I. WAIVER OF PREMIUM BENEFIT:

Employed: If you, due to a Specified Health Event, are completely unable to do all of the usual and customary duties of your occupation for a period of 90 continuous days, Aflac will waive, from month to month, any premiums for this rider falling due during your continued inability. For premiums to be waived, Aflac will require an employer’s statement and a Physician’s statement of your inability to perform said duties, and may each month thereafter require a Physician’s statement that total inability continues.

Not Employed: If you, due to a Specified Health Event, are completely unable to perform two or more of the Activities of Daily Living (ADLs) without the assistance of another person for a period of 90 continuous days, Aflac will waive, from month to month, any premiums for this rider falling due during your continued inability. For premiums to be waived, Aflac will require a Physician’s statement of your inability to perform said activities, and may each month thereafter require a Physician’s statement that total inability continues.

If you die and your spouse becomes the new Named Insured, premiums will start again and be due on the first premium due date after the change. The new Named Insured will then be eligible for this benefit if the need arises.

While this benefit is being paid, Aflac may ask for and use an independent consultant to determine whether you can perform an ADL.

SPECIFIED HEALTH EVENT WITH FIRST OCCURRENCE BUILDING BENEFIT AND RECOVERY BENEFIT RIDER: (NY78056)

Applied for: □ Yes □ No

While this coverage is in force, we will pay the following benefits to a Covered Person, as applicable, subject to the Pre-Existing Conditions provision, Limitations and Exclusions, and all other policy and rider provisions:

A. FIRST-OCCURRENCE BENEFIT: Aflac will pay the following benefit amount for each Covered Person when he or she is first diagnosed as having had a Specified Health Event:

Named Insured/Spouse
$5,000 (Lifetime maximum $5,000 per Covered Person)

Dependent Children
$7,500 (Lifetime maximum $7,500 per Covered Person)

This benefit is payable only once for each Covered Person and will be paid in addition to any other benefit in this rider.

B. FIRST-OCCURRENCE BUILDING BENEFIT: The First-Occurrence Benefit above will be increased by $500 on each rider anniversary date while this rider 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 First-Occurrence Benefit. This benefit will cease to build for each Covered Person on the anniversary date of this rider following the Covered Person’s 65th birthday or at the time of a Specified Health Event, subject to the Limitations and Exclusions of the rider, for that Covered Person, whichever occurs first. However, regardless of the age of the covered person on the Effective Date of this rider, this benefit will accrue for a period of at least five years unless a Specified Health Event is diagnosed prior to the fifth year of coverage.

C. REOCURRENCE BENEFIT: If benefits have been paid to a Covered Person under the First-Occurrence Benefit above, Aflac will pay $2,500 if such Covered Person is later diagnosed as having had a subsequent Specified Health Event.

For the Reoccurrence Benefit to be payable, the Specified Health Event must occur more than 180 days after the date the First-Occurrence Benefit or Reoccurrence Benefit became payable. No lifetime maximum.

D. HOSPITAL CONFINEMENT BENEFIT: (includes confinement in a U.S. government Hospital) When a Covered Person requires Hospital Confinement for the treatment of a covered Specified Health Event, Aflac will pay $240 per day for each day a Covered Person is confined. This benefit is limited to confinements for the treatment of a covered Specified Health Event that occur within 500 days following the occurrence of the most recent covered Specified Health Event. No lifetime maximum.

Hospital Confinement Benefits are payable for only one covered Specified Health Event at a time per Covered Person.

Benefits are not payable on the same day as the Continuing Care Benefit. If the Hospital Confinement Benefit and the Continuing Care Benefit are payable on the same day, only the highest eligible benefit will be paid.

E. CONTINUING CARE BENEFIT: If, as the result of a covered Specified Health Event, a Covered Person receives any of the following treatments from a licensed Physician, Aflac will pay $125 each day a Covered Person receives one or more of the following treatments:

1. rehabilitation therapy
2. physical therapy
3. speech therapy
4. occupational therapy
5. respiratory therapy
6. dietary therapy/consultation
7. home health care
8. dialysis
9. hospice care
10. extended care
11. Physician visits
12. nursing home care

Treatment is limited to 75 days for continuing care received within 180 days following the occurrence of the most recent covered Specified Health Event. Daily maximum for this benefit is $125 regardless of the number of treatments received.

Benefits are not payable on the same day as the Hospital Confinement Benefit. If the Hospital Confinement Benefit and the Continuing Care Benefit are payable on the same day, only the highest eligible benefit will be paid. No lifetime maximum.
The Ambulance Benefit, Transportation Benefit, and Lodging Benefit will be paid for care received within 180 days following the occurrence of a covered Specified Health Event. Benefits are payable for only one covered Specified Health Event at a time per Covered Person. If a Covered Person is eligible to receive benefits for more than one covered Specified Health Event, we will pay benefits only for care received within the 180 days following the occurrence of the most recent event.

F. AMBULANCE BENEFIT: If, due to a covered Specified Health Event, a Covered Person requires ground ambulance transportation to or from a Hospital, Aflac will pay $250. If air ambulance transportation is required due to a covered Specified Health Event, we will pay $2,000. A licensed professional or licensed volunteer ambulance company must provide the ambulance service. This benefit will not be paid for more than two times per occurrence of a Specified Health Event. Ambulance Benefits are not payable beyond the 180th day following the occurrence of a covered Specified Health Event. No lifetime maximum.

G. TRANSPORTATION BENEFIT: If a Covered Person requires special medical treatment that has been prescribed by the local attending Physician for a covered Specified Health Event, Aflac will pay 50 cents per mile for transportation of a Covered Person for the round-trip distance between the Hospital or medical facility and the residence of the Covered Person. This benefit is not payable for transportation by ambulance or air ambulance to the Hospital. This benefit will be paid only for the Covered Person for whom the special treatment is prescribed. If the special treatment is for a covered Dependent Child and commercial travel is necessary, we will pay this benefit for up to two adults to accompany the covered Dependent Child. The benefit amount payable is limited to $1,500 per occurrence of a covered Specified Health Event. Transportation Benefits are not payable beyond the 180th day following the occurrence of a covered Specified Health Event. This benefit is not payable for transportation to any hospital located within a 50-mile radius of the residence of the Covered Person. No lifetime maximum.

H. LODGING BENEFIT: Aflac will pay $60 per day for lodging for you or any one adult family member when a Covered Person receives special medical treatment for a covered Specified Health Event at a Hospital or medical facility. The Hospital, medical facility, and lodging must be 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 15 days per occurrence of a covered Specified Health Event. Lodging Benefits are not payable beyond the 180th day following the occurrence of a covered Specified Health Event. No lifetime maximum.

I. SPECIFIED HEALTH EVENT RECOVERY BENEFIT: Aflac will pay $500 per month while a Covered Person remains in Specified Health Event Recovery upon receipt of written proof of loss from that person’s Physician.

For Periods of Specified Health Event Recovery less than one month, we will pay a pro rata benefit. Lifetime maximum of six months per Covered Person.

J. WAIVER OF PREMIUM BENEFIT:

Employed: If you, due to a Specified Health Event (as defined in Part 3, Item D), are completely unable to do all of the usual and customary duties of your occupation for a period of 90 continuous days, Aflac will waive, from month to month, any premiums for this rider falling due during your continued inability. For premiums to be waived, Aflac will require an employer’s statement and a Physician’s statement of your inability to perform said duties, and may each month thereafter require a Physician’s statement that total inability continues.

Not Employed: If you, due to a Specified Health Event (as defined in Part 3, Item D), are completely unable to perform two or more of the Activities of Daily Living (ADLs) without the assistance of another person for a period of 90 continuous days, Aflac will waive, from month to month, any premiums for this rider falling due during your continued inability. For premiums to be waived, Aflac will require a Physician’s statement of your inability to perform said activities, and may each month thereafter require a Physician’s statement that total inability continues.

If you die and your spouse becomes the new Named Insured, premiums will start again and be due on the first premium due date after the change. The new Named Insured will then be eligible for this benefit if the need arises.

While this benefit is being paid, Aflac may ask for and use an independent consultant to determine whether you can perform an ADL.

THE LIMITATIONS AND EXCLUSIONS LISTED IN THE POLICY DO NOT APPLY TO THE SPECIFIED HEALTH EVENT RIDERS NY78055 AND NY78056. ONLY THE LIMITATIONS AND EXCLUSIONS LISTED BELOW APPLY TO THESE RIDERS.

A. Aflac will not pay benefits for a Specified Health Event that is caused by a Pre-Existing Condition unless the Specified Health Event occurs more than 30 days after the Effective Date. Benefits are payable for only one covered Specified Health Event at a time per Covered Person.

B. Aflac will not pay benefits whenever coverage provided by this 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.

C. Aflac will not pay benefits whenever fraud is committed in making a claim under this coverage or any prior claim under any other Aflac coverage for which you received benefits that were not lawfully due and that fraudulently induced payment.
D. This rider does not cover losses or confinements caused by or resulting from:

1. Any loss sustained or contracted, directly or indirectly, due to a Covered Person’s being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician.
2. Intentionally self-inflicting bodily Injury or attempting suicide.
3. Being exposed to war or any act of war, declared or undeclared, or serving in any of the armed forces or units auxiliary thereto (If you are a member of a reserve component of the armed forces of the United States, including the National Guard, you may continue or suspend this rider during a period of active duty that does not exceed more than five years. When you notify us to suspend this rider, we will refund any premium paid for coverage after the date we receive the notice. We will reinstate this rider, if the policy to which it is attached is currently in force, when your active duty ends without evidence of insurability when we receive (1) your written request to reinstate this rider, and (2) the premium for the period from the date your active service ends to the next premium due date. The reinstated rider will contain no new exclusions or waiting periods and will be effective as of the date your active duty ends. If we do not receive both your written request and the required premium within 60 days after your active duty ends, you may still apply for reinstatement.) (In this case, you must comply with the Reinstatement provision).

PRE-EXISTING CONDITIONS FOR THE SPECIFIED HEALTH EVENT
Riders NY78055 and NY78056

A “Pre-Existing Condition” is a Sickness for which, within the six-month period before the Effective Date of coverage, medical advice or treatment was recommended or received from a Physician. Benefits for a Specified Health Event that is caused by a Pre-Existing Condition will not be covered unless the Specified Health Event occurs more than 30 days after the Effective Date. Any reoccurrence of a Specified Health Event occurring more than 30 days after the Effective Date will be covered.

4. Exceptions, Reductions, and Limitations of the Policy (This is not a daily hospital expense plan):

A. We pay only for treatment of Cancer and Associated Cancerous Conditions, or other diseases and conditions caused, complicated, or aggravated by or resulting from Cancer or Associated Cancerous Conditions, including direct extension, metastatic spread, or recurrence. Benefits are not provided for premalignant conditions or conditions with malignant potential (unless specifically covered); complications of either Cancer or an Associated Cancerous Condition; or any other disease, sickness, or incapacity that is not directly caused or aggravated by Cancer or an Associated Cancerous Condition or the treatment of Cancer or an Associated Cancerous Condition.

B. This 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 will apply only to treatment occurring after 12 months 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.

C. The Initial Diagnosis Benefit is not payable for: (1) any Internal Cancer or Associated Cancerous Condition diagnosed or treated before the Effective Date of this 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 this 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 this policy for a recurrence, extension, or metastatic spread of that same Internal Cancer or Associated Cancerous Condition.

D. Aflac will not pay benefits whenever coverage provided by this 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.

E. Aflac will not pay benefits whenever fraud is committed in making a claim under this coverage or any prior claim under any other Aflac coverage for which you received benefits that were not lawfully due and that fraudulently induced payment.

5. Renewability: The policy is guaranteed-renewable for life by payment of the premium in effect at the beginning of each renewal period. Premium rates may change only if changed on all policies of the same form number and class in force in your state.

RETAIN FOR YOUR RECORDS.

THIS DISCLOSURE STATEMENT 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**

**ACTIVITIES OF DAILY LIVING (ADLs):** BATHING: washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower; MAINTAINING CONTINENCE: controlling urination and bowel movements, including your ability to use ostomy supplies or other devices such as catheters; TRANSFERRING: moving between a bed and a chair, or a bed and a wheelchair; DRESSING: putting on and taking off all necessary items of clothing; TOILETING: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene; EATING: performing all major tasks of getting food into your body.

**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 you applied for: 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 from the moment of birth. If coverage is for individual or named insured/Spouse only and you desire uninterrupted coverage for a newborn child, you must notify Aflac in writing within 31 days of the birth of your child, and Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due. Coverage will include any other Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the mental hygiene law), or physical handicap and who became so incapacitated 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.

**EFFECTIVE DATE:** The date coverage begins, as shown in the Policy Schedule. The Effective Date is not the date you signed the application for coverage.

**END-STAGE RENAL FAILURE:** Permanent and irreversible kidney failure, not of an acute nature, requiring dialysis or a kidney transplant to maintain life.

**HEART ATTACK:** A myocardial infarction, coronary thrombosis, or coronary occlusion that is diagnosed or treated after the Effective Date of the rider. The attack must be positively diagnosed by a Physician and must be evidenced by electrocardiographic findings or clinical findings together with blood enzyme findings. The definition of “Heart Attack” shall not be construed to mean congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease, or any other dysfunction of the cardiovascular system.

**PHYSICIAN:** A person legally qualified to practice the healing arts, other than a member of your immediate family, who is acting within the scope of his or her license.

**SPECIFIED HEALTH EVENT:** Heart Attack, Stroke, End-Stage Renal Failure, or Sudden Cardiac Arrest occurring on or after the Effective Date of coverage.

**SPECIFIED HEALTH EVENT RECOVERY:** A Covered Person will be considered in Specified Health Event Recovery if he or she continues to be under the active care and treatment by a Physician for a covered Specified Health Event OR if he or she is unable to engage in the duties of his or her regular occupation due to a covered Specified Health Event. “Specified Health Event” includes Heart Attack, Stroke, End-Stage Renal Failure, or Sudden Cardiac Arrest occurring after the Effective Date of the rider.

**STROKE:** Apoplexy due to rupture or acute occlusion of a cerebral artery that is diagnosed or treated on or after the Effective Date of the rider. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. The Stroke must be positively diagnosed by a Physician based upon documented neurological deficits and confirmatory neuroimaging studies. “Stroke” does not mean head injury, transient ischemic attack (TIA), or cerebrovascular insufficiency.

**SUDDEN CARDIAC ARREST:** Sudden unexpected loss of heart function in which the heart abruptly and without warning stops working as a result of an internal electrical system malfunction of the heart. Any death where the sole cause of death as shown on the death certificate is cardiovascular collapse, Sudden Cardiac Arrest, cardiac arrest, or sudden cardiac death shall be deemed to be Sudden Cardiac Arrest for purposes of the policy. “Sudden Cardiac Arrest” is not a Heart Attack.

**ADDITIONAL INFORMATION**

An Ambulatory Surgical Center does not include a doctor’s or dentist’s office, clinic, or other such location.

A Hospital is not, other than incidentally, a place of rest; a place primarily for the treatment of tuberculosis; a place for the aged; a place for drug addicts or alcoholics; or a place for convalescent, custodial, educational, or rehabilitative care.

A Bone Marrow Transplantation does not include Stem Cell Transplantations.

A Stem Cell Transplantation does not include Bone Marrow Transplantations.

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, the benefits listed in the policy will not require a charge for them to be payable.
We’ve got you under our wing.

aflac.com  1.800.366.3436
Added protection for you and your family

Like many people, you probably have insurance to cover burglaries, fires, auto accidents, and standard hospital bills. But what would happen to your family’s finances if you experienced a catastrophic event, such as a heart attack or stroke—an event that knocked you off your feet or even changed your life forever?

You may think you’re already protected by major medical insurance. Think again. Major medical coverage pays doctor and hospital bills, not out-of-pocket expenses. Nor does it pay cash benefits that can be used to help with expenses, such as car payments, the mortgage or rent, and utility bills—bills that would be difficult, if not impossible, to pay if your income suddenly stopped due to illness or injury. This optional rider complements your major medical coverage and helps provide the peace of mind that comes from knowing you and your family are protected.

HOW IT WORKS

Specified Health Event rider coverage is selected. Policyholder suffers a stroke and is hospitalized. After leaving the hospital, the policyholder receives speech and physical therapy. Specified Health Event rider coverage provides the following: $10,700 TOTAL BENEFITS

The above example is based on a scenario for Aflac Specified Health Event with First-Occurrence Building Benefit and Recovery Benefit Rider that includes the following benefit conditions: Stroke (First-Occurrence Benefit) of $5,000, Hospital Confinement Benefit (5 days) of $1,200, Continuing Care Benefit (30 days) of $3,750, ground ambulance transportation (Ambulance Benefit) of $250, Specified Health Event Recovery Benefit (one month) of $500.

THE FACTS:

FACT NO. 1
ABOUT EVERY 34 SECONDS
AN AMERICAN Suffers a Heart Attack.¹

FACT NO. 2
ON AVERAGE, EVERY 40 SECONDS
SOMEONE IN THE UNITED STATES HAS A STROKE.¹

¹Heart Disease and Stroke Statistics, 2012 Update, American Heart Association.
The rider becomes part of the policy and is subject to all policy provisions, unless modified herein.

SPECIFIED HEALTH EVENTS COVERED BY THE SPECIFIED HEALTH EVENT WITH FIRST-OCCURRENCE BUILDING BENEFIT AND RECOVERY BENEFIT RIDER INCLUDE:

• End-Stage Renal Failure
• Heart Attack
• Stroke
• Sudden Cardiac Arrest

WHAT WE WILL PAY

FIRST-OCCURRENCE BENEFIT
Aflac will pay $5,000 for the insured, $5,000 for the Spouse, or $7,500 for Dependent Children when a Covered Person is first diagnosed as having had a Specified Health Event. This benefit is payable only once for each Covered Person and will be paid in addition to any other benefit in the rider. Lifetime maximum is $5,000 per Covered Person for the named insured/Spouse. Lifetime maximum is $7,500 per Covered Person for Dependent Children.

FIRST-OCCURRENCE BUILDING BENEFIT
The First-Occurrence Benefit will be increased by $500 on each rider anniversary date while the rider 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 First-Occurrence Benefit. 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 of a Specified Health Event, subject to the limitations and exclusions of the rider, for that Covered Person, whichever occurs first. However, regardless of the age of the Covered Person on the Effective Date of the rider, this benefit will accrue for a period of at least five years unless a Specified Health Event is diagnosed prior to the fifth year of coverage.

REOCCURRENCE BENEFIT
Aflac will pay $2,500 if such Covered Person is later diagnosed as having had a subsequent Specified Health Event. For the Reoccurrence Benefit to be payable, the Specified Health Event must occur more than 180 days after the date the First-Occurrence Benefit or Reoccurrence Benefit became payable. No lifetime maximum.

HOSPITAL CONFINEMENT BENEFIT
Aflac will pay $240 per day for each day a Covered Person is confined and requires hospital confinement for the treatment of a covered Specified Health Event. This benefit is limited to confinements for the treatment of a covered Specified Health Event that occur within 500 days following the occurrence of the most recent covered Specified Health Event. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable. No lifetime maximum.

CONTINUING CARE BENEFIT
Aflac will pay $125 each day a Covered Person receives any of the following treatments from a licensed Physician as the result of a covered Specified Health Event:

• Dialysis
• Dietary Therapy/Consultation
• Extended Care
• Home Health Care
• Hospice Care
• Nursing Home Care
• Occupational Therapy
• Physical Therapy
• Physician Visits
• Rehabilitation Therapy
• Respiratory Therapy
• Speech Therapy

Treatment is limited to 75 days for continuing care received within 180 days following the occurrence of the most recent covered Specified Health Event. Daily maximum for this benefit is $125 regardless of the number of treatments received.

Benefits are not payable on the same day as the Hospital Confinement Benefit. If the Hospital Confinement Benefit and the Continuing Care Benefit are payable on the same day, only the highest eligible benefit will be paid. No lifetime maximum.

The Ambulance Benefit, Transportation Benefit, and Lodging Benefit will be paid for care received within 180 days following the occurrence of a covered Specified Health Event. Benefits are payable for more than one covered Specified Health Event at a time per Covered Person. If a Covered Person is eligible to receive benefits for more than one covered Specified Health Event, we will pay benefits only for care received within the 180 days following the occurrence of the most recent event.

AMBULANCE BENEFIT
Aflac will pay $250 if, due to a covered Specified Health Event a Covered Person requires ground ambulance transportation to or from a hospital. Aflac will pay $2,000 if, due to a covered Specified Health Event, a Covered Person requires air ambulance transportation. A licensed professional or licensed volunteer ambulance company must provide the ambulance service. This benefit will not be paid for more than two times per occurrence of a Specified Health Event. Ambulance benefits are not payable beyond the 180th day following the occurrence of a covered Specified Health Event. No lifetime maximum.
**TRANSPORTATION BENEFIT**

**Aflac will pay 50 cents per mile** for transportation of a Covered Person for the round-trip distance between the hospital or medical facility and the residence of the Covered Person if a Covered Person requires special medical treatment that has been prescribed by the local attending Physician for a covered Specified Health Event. This benefit is not payable for transportation by ambulance or air ambulance to the hospital. This benefit will be paid only for the Covered Person for whom the special treatment is prescribed. If the special treatment is for a covered Dependent Child and commercial travel is necessary, we will pay this benefit for up to two adults to accompany the covered Dependent Child. The benefit amount payable is limited to $1,500 per occurrence of a covered Specified Health Event. Transportation benefits are not payable beyond the 180th day following the occurrence of a covered Specified Health Event. This benefit is not payable for transportation to any hospital located within a 50-mile radius of the residence of the Covered Person. No lifetime maximum.

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**LODGING BENEFIT**

**Aflac will pay $60 per day** for lodging for you or any one adult family member when a Covered Person receives special medical treatment for a covered Specified Health Event at a hospital or medical facility. The hospital, medical facility, and lodging must be 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 15 days per occurrence of a covered Specified Health Event. Lodging benefits are not payable beyond the 180th day following the occurrence of a covered Specified Health Event. No lifetime maximum.

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**SPECIFIED HEALTH EVENT RECOVERY BENEFIT**

**Aflac will pay $500 per month** while a Covered Person remains in specified health event recovery upon receipt of written proof of loss from that person’s Physician. For periods of specified health event recovery less than one month, we will pay a pro rata benefit. Lifetime maximum of six months per Covered Person.

A Covered Person will be considered in specified health event recovery if he or she continues to be under the active care and treatment by a Physician for a covered Specified Health Event or if he or she is unable to engage in the duties of his or her regular occupation due to a covered Specified Health Event. Specified Health Event includes Heart Attack, Stroke, End-Stage Renal Failure, or Sudden Cardiac Arrest occurring after the Effective Date of the rider.

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**WAIVER OF PREMIUM BENEFIT**

**EMPLOYED:** If you, due to a Specified Health Event, are completely unable to do all of the usual and customary duties of your occupation for a period of 90 continuous days, Aflac will waive, from month to month, any premiums for the rider falling due during your continued inability. For premiums to be waived, Aflac will require an employer’s statement and a Physician’s statement of your inability to perform said duties, and may each month thereafter require a Physician’s statement that total inability continues.

**NOT EMPLOYED:** If you, due to a Specified Health Event, are completely unable to perform two or more of the Activities of Daily Living (ADLs) without the assistance of another person for a period of 90 continuous days, Aflac will waive, from month to month, any premiums, for the rider, falling due during your continued inability. For premiums to be waived, Aflac will require a Physician’s statement of your inability to perform said activities, and may each month thereafter require a Physician’s statement that total inability continues.

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**WHAT IS NOT COVERED**

**PRE-EXISTING CONDITIONS**

A pre-existing condition is a sickness for which, within the six-month period before the Effective Date of coverage, medical advice or treatment was recommended or received from a Physician. Benefits for a Specified Health Event that is caused by a Pre-Existing Condition will not be paid unless the Specified Health Event occurs more than 30 days after the Effective Date. Any reoccurrence of a Specified Health Event occurring more than 30 days after the Effective Date will be covered.

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**LIMITATIONS AND EXCLUSIONS**

The limitations and exclusions listed in the policy do not apply to the rider. Only the limitations and exclusions listed below apply to the rider.

Aflac will not pay benefits for a Specified Health Event that is caused by a Pre-Existing Condition unless the Specified Health Event occurs more than 30 days after the Effective Date. Benefits are payable for only one covered Specified Health Event at a time per Covered Person.

Aflac 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.

Aflac will not pay benefits whenever fraud is committed in making a claim under this coverage or any prior claim under any other Aflac coverage for which you received benefits that were not lawfully due and that fraudulently induced payment.

The rider does not cover losses or confinements caused by or resulting from a Covered Person’s:

- Sustaining or contracting any loss, directly or indirectly, due to being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician;
- Intentionally self inflicting bodily injury or attempting suicide;
- Being exposed to war or any act of war, declared or undeclared, or serving in any of the armed forces or units auxiliary thereto. (If you are a member of a reserve component of the armed forces of the United States, including the National Guard, you may continue or suspend the rider during a period...
of active duty that does not exceed more than five years. When you notify us to suspend the rider, we will refund any premium paid for coverage after the date we receive the notice. We will reinstate the rider, if the policy to which it is attached is currently in force, when your active duty ends without evidence of insurability when we receive (1) your written request to reinstate the rider, and (2) the premium for the period from the date your active service ends to the next premium due date. The reinstated rider will contain no new exclusions or waiting periods and will be effective as of the date your active duty ends. If we do not receive both your written request and the required premium within 60 days after your active duty ends, you may still apply for reinstatement.) (In this case, you must comply with the reinstatement provision.)

TERMS YOU NEED TO KNOW

EFFECTIVE DATE: the Effective Date of the rider is as stated in the Policy Schedule.

END-STAGE RENAL FAILURE: permanent and irreversible kidney failure, not of an acute nature, requiring dialysis or a kidney transplant to maintain life.

HEART ATTACK: a myocardial infarction, coronary thrombosis, or coronary occlusion that is diagnosed or treated after the Effective Date of the rider. The attack must be positively diagnosed by a Physician and must be evidenced by electrocardiographic findings or clinical findings together with blood enzyme findings. The definition of Heart Attack shall not be construed to mean congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease, or any other dysfunction of the cardiovascular system.

SPECIFIED HEALTH EVENT: Heart Attack, Stroke, End-Stage Renal Failure, or Sudden Cardiac Arrest occurring on or after the Effective Date of coverage.

STROKE: apoplexy due to rupture or acute occlusion of a cerebral artery that is diagnosed or treated on or after the Effective Date of the rider. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. The Stroke must be positively diagnosed by a Physician based upon documented neurological deficits and confirmatory neuroimaging studies. Stroke does not mean head injury, transient ischemic attack (TIA), or cerebrovascular insufficiency.

SUDDEN CARDIAC ARREST: sudden unexpected loss of heart function in which the heart abruptly and without warning stops working as a result of an internal electrical system malfunction of the heart. Any death where the sole cause of death as shown on the death certificate is cardiovascular collapse, Sudden Cardiac Arrest, cardiac arrest, or sudden cardiac death shall be deemed to be Sudden Cardiac Arrest for purposes of the rider. Sudden Cardiac Arrest is not a Heart Attack.

TERMINATION: the rider will terminate upon the earlier of the termination of the policy to which it is attached, or if the failure to pay premiums for the rider are not paid.
Personal Sickness Indemnity Plan

Hospital Confinement Sickness Indemnity
Limited Benefit Insurance

Plan Benefits
- Physician Visits
- Hospital Confinement
- Major Diagnostic Exams
- Surgical
- Plus ... more
Personal Sickness Indemnity Plan
Policies NY-45100, NY-45200, and NY-45300

- **Policy NY-45100 (Level 1)**
- **Policy NY-45200 (Level 2)**
- **Policy NY-45300 (Level 3)**

**Physician Visits Benefit**

*Aflac New York will pay the amount for the level chosen* when a covered person incurs a charge for a physician visit. Services must be under the supervision of a physician. This is a health maintenance benefit; the sickness of a covered person is not required for this benefit to be payable. No lifetime maximum.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>NY-45100</td>
<td>NY-45200</td>
<td>NY-45300</td>
</tr>
<tr>
<td>Benefit Amount</td>
<td>$15</td>
<td>$20</td>
</tr>
<tr>
<td>Number of Visits per Year:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Family*</td>
<td>6</td>
<td>8</td>
</tr>
</tbody>
</table>

Covered physician visits include, but are not limited to, eye exams, well-baby visits, immunizations, periodic health exams, and routine physicals.

*The following benefits are payable for a covered sickness that occurs while coverage is in force. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable. All of the benefits listed below, except for the Hospital Confinement Benefit, are the same for Levels 1, 2, and 3 (Policies NY-45100, NY-45200, and NY-45300).*

**Hospital Confinement Benefit**

*Aflac New York will pay the amount per day* for the level chosen when a covered person requires hospital confinement as an inpatient for a covered sickness and incurs a charge. Benefits are not payable for days beyond the 180th day in a period of confinement.** No lifetime maximum.

<table>
<thead>
<tr>
<th>Level 1</th>
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<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>NY-45100</td>
<td>NY-45200</td>
<td>NY-45300</td>
</tr>
<tr>
<td>Benefit Amount: Days 1–180</td>
<td>$120</td>
<td>$140</td>
</tr>
</tbody>
</table>

**Major Diagnostic Exams**

*Aflac New York will pay $150* when a covered person requires one of the following exams for a covered sickness:

- CT scan
- MRI (magnetic resonance imaging)
- EEG (electroencephalogram)
- Thallium stress test
- Myelogram
- Angiogram
- Arteriogram

These exams must be performed in a hospital, doctor’s office, or ambulatory surgical center, and a charge must be incurred. This benefit is limited to one payment per calendar year, per covered person. No lifetime maximum.

**Surgical Benefit**

*Aflac New York will pay $100–$2,000* when a covered person has surgery performed for a covered sickness in a hospital or ambulatory surgical center based upon the Schedule of Operations in the policy for the operation most nearly similar in severity and gravity. Only one benefit is payable per 24-hour period for surgery even though more than one surgical procedure may be performed. We will pay the highest eligible benefit. Benefits are not payable for cosmetic or elective surgery that is not due to sickness. Surgical Benefits are not payable for surgery performed in a doctor’s or dentist’s office, clinic, or other such location. Surgery performed but not listed in the schedule will be paid according to the amount shown for the surgery most similar in severity and gravity. No lifetime maximum.

**Ambulance Benefit**

*Aflac New York will pay $100 for ground ambulance and $1,000 for air ambulance* if, because of a covered sickness, a covered person requires transportation to or from a hospital. A licensed professional ambulance company must provide the ambulance service. This benefit is limited to two trips per calendar year, per covered person. No lifetime maximum.

*Family includes two-parent family, one-parent family, and named insured/spouse only.

**A period of confinement is the time period of hospital confinement or hospital intensive care unit confinement that starts while the policy is in force. If the confinement follows a previously covered confinement, it will be deemed a continuation of the first confinement unless the later confinement is the result of an entirely unrelated sickness or the confinements are separated by 30 days or more.
Aflac New York’s Personal Sickness Indemnity Plan pays cash benefits directly to you, unless assigned, regardless of any other insurance you may have.

Guaranteed-Renewable
The policy is guaranteed-renewable for your lifetime, subject to Aflac New York’s right to change the applicable table of premium rates by class.

Effective Date
The effective date is the date shown in the Policy Schedule, not the date the application is signed.

Family Coverage
Family coverage includes the insured; spouse; and dependent, unmarried children under age 19 (or 23 if they are enrolled as full-time students). Newborns are automatically covered under the terms of the policy from the moment of birth. One-parent family coverage includes the insured and all of the insured’s unmarried, dependent children under age 19 (or 23 if they are enrolled as full-time students). A dependent child must be under the age of 19 at the time of application to be eligible for coverage.

Pre-Existing Conditions
A pre-existing condition is a sickness for which, within the 12-month period before the effective date of coverage, medical advice or treatment was recommended by a physician or received from a physician, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Care or treatment caused by a pre-existing condition will not be covered unless it begins six months or more after the effective date of coverage.

A sickness is an illness, disease, or disorder diagnosed or treated after the effective date of coverage and while coverage is in force.

Limitations and Exclusions
Other than the Physician Visits Benefit, we will not pay benefits for losses incurred as a result of an injury. We will not pay benefits for a covered person’s giving birth within the first ten months of the effective date of the policy as a result of a normal pregnancy, including elective cesarean section (complications of pregnancy* will be covered to the same extent as a sickness).

The policy does not cover losses caused by or resulting from:
• receiving dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident, and except for dental care or treatment necessary due to congenital disease or anomaly;
• intentionally self-inflicting bodily injury or attempting suicide;
• participating in any illegal activity that is classified as a felony (the term felony is as defined by the law of the jurisdiction in which the activity takes place);
• being exposed to war or any act of war, declared or undeclared, or serving in any of the armed forces or units auxiliary thereto (If you are a member of a reserve component of the armed forces of the United States, including the National Guard, you may continue or suspend the policy during a period of active duty that does not exceed more than five years. When you notify us to suspend the policy, we will refund any premium paid for coverage after the date we receive the notice. We will reinstate the policy when your active duty ends without evidence of insurability when we receive (1) your written request to reinstate the policy and (2) the premium for the period from the date your active service ends to the next premium due date. The reinstated policy will contain no new exclusions or waiting periods and will be effective as of the date your active duty ends. If we do not receive both your written request and the required premium within 60 days after your active duty ends, you may still apply for reinstatement. In this case, you must comply with the reinstatement provision.);
• having for various reasons stated in the policy, treatment for a mental or nervous disorder or disease, including depression; alcoholism or drug addiction; sustaining or contracting any loss because of a covered person’s being intoxicated or under the influence of alcohol, drugs or any narcotic unless administered on the advice of a physician and taken according to the physician’s instructions (the term intoxicated refers to that condition as defined by the law of the jurisdiction in which the injury or cause of the loss occurred); • having cosmetic surgery, except that cosmetic surgery will not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect;
• obtaining routine nursing or routine well-baby care for a newborn child (other than provided by the Physician Visits Benefit).

Hospital is not, other than incidentally, a place of rest; a place primarily for the treatment of tuberculosis; a place for the aged; a place for drug addicts or alcoholics; or a place for convalescent, custodial, educational, or rehabilitative care.

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

An ambulatory surgical center does not include a doctor’s office, clinic, or other such location.

*Complications of pregnancy will not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a classifiably distinct complication of pregnancy.

Refer to the policy for complete details, limitations, and exclusions. This brochure is for illustration purposes only.
Aflac New York is ...

- Rated AA in insurer financial strength by Standard & Poor’s (June 2006).
- Rated AA in insurer financial strength by Fitch, Inc. (June 2006).
- Rated A+ (Superior) by the June 2007 A.M. Best Company Report.

Service is a tradition at Aflac New York ... backed by fast, efficient claims service. Providing our best in customer service is the cornerstone of our success. We are as close as your telephone. Our toll-free line puts you in touch with us immediately.

1.800.366.3436
Visit our Web site at aflacny.com.

Your local Aflac New York insurance agent/producer
Peace of Mind and Real Cash Benefits

ACCIDENT INDEMNITY ADVANTAGE®
24-HOUR ACCIDENT-ONLY INSURANCE

Aflac
We've got you under our wing.
The Need

Accidents happen to all kinds of people every day. In 2007, 34.3 million people—about 1 out of 9—sought medical attention for an injury.*

What would the financial impact of an injury mean to your security? Are you prepared for medical debts in addition to everyday household expenditures and lost wages? Out-of-pocket expenses associated with an accident are unexpected and often burdensome; perhaps the accident itself could not have been prevented, but its impact on your finances and your well-being certainly can be reduced.

*Aflac Accident Indemnity Advantage Policy NYR35600

Aflac pays cash benefits directly to you, unless you choose otherwise. This means that you will have added financial resources to help with expenses incurred due to an injury, to help with ongoing living expenses, or to help with any purpose you choose. Aflac Accident Indemnity Advantage is designed to provide you with cash benefits throughout the different stages of care, regardless of the severity of the injury.

Aflac enables you to take charge and to help provide for an unpredictable future by paying cash benefits for accidental injuries. Your own peace of mind and the assurance that your family will have help financially are powerful reasons to consider Aflac.

THE ACCIDENT INDEMNITY ADVANTAGE INSURANCE POLICY HAS:

1. No deductibles and no copayments.
2. No lifetime limit—policy won’t terminate based on number or dollar amount of claims paid.
3. No network restrictions—you choose your own medical treatment provider.
4. No coordination of benefits—we pay regardless of any other insurance.

Aflac herein means American Family Life Assurance Company of New York.
Aflac will pay the following benefits as applicable if a Covered Person’s Accidental Death, dismemberment, or Injury is caused by a covered accident that occurs on or off the job. Accidental Death, dismemberment, or Injury must be independent of Sickness, or the medical or surgical treatment of Sickness, or of any cause other than a covered accident. A covered Accidental Death, dismemberment, or Injury must also occur while coverage is in force and is subject to the limitations and exclusions. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable.

### Health Screening

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Benefit Amount</th>
<th>Additional Benefit Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>$60 once per policy, per 12-month period, payable after the policy has been in force for 12 months</td>
<td>Payable if you or any one family member undergoes routine examinations or other preventive testing during the following policy year. Eligible family members are your Spouse and the Dependent Children of either you or your Spouse. Services covered are annual physical examinations, dental examinations, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, ultrasounds, prostate-specific antigen tests (PSAs), and blood screenings. This benefit will become available following each anniversary of the policy’s Effective Date for service received during the following policy year and is payable only once per policy each 12-month period following your policy anniversary date. Service must be under the supervision of or recommended by a physician, received while the policy is in force, and a charge must be incurred.</td>
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### Accident Emergency Treatment

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<thead>
<tr>
<th>Benefit</th>
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<th>Additional Benefit Information</th>
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</thead>
<tbody>
<tr>
<td>$120 once per 24-hour period and only once per covered accident, per Covered Person</td>
<td>Payable when a Covered Person receives treatment for Injuries sustained in a covered accident. This benefit is payable for treatment by a physician or treatment received in a hospital emergency room. Treatment must be received within 72 hours of the accident for benefits to be payable.</td>
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</table>

### X-Ray

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<thead>
<tr>
<th>Benefit</th>
<th>Benefit Amount</th>
<th>Additional Benefit Information</th>
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</thead>
<tbody>
<tr>
<td>$50 once per covered accident, per Covered Person</td>
<td>Payable when a Covered Person requires an X-ray while receiving emergency treatment in a hospital or a hospital emergency room for Injuries sustained in a covered accident. <strong>This benefit is not payable for X-rays received in a physician’s office.</strong> The X-Ray Benefit is not payable for exams listed in the Major Diagnostic Exams Benefit.</td>
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</table>

### Accident Follow-Up Treatment

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<thead>
<tr>
<th>Benefit</th>
<th>Benefit Amount</th>
<th>Additional Benefit Information</th>
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</thead>
<tbody>
<tr>
<td>$50 for one treatment per day, up to a maximum of six treatments per covered accident, per Covered Person</td>
<td>Payable when a Covered Person receives emergency treatment for Injuries sustained in a covered accident and later requires additional treatment over and above emergency treatment administered in the first 72 hours following the accident. The treatment must begin within 30 days of the covered accident or discharge from the hospital. Treatments must be furnished by a physician in a physician’s office or in a hospital on an outpatient basis. This benefit is payable for acupuncture when furnished by a licensed, certified acupuncturist. The Accident Follow-Up Treatment Benefit is not payable for the same days the Physical Therapy Benefit is paid.</td>
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</table>

### Initial Accident Hospitalization

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Benefit Amount</th>
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</thead>
<tbody>
<tr>
<td>$1,000 once per period of Hospital Confinement or $2,000 once when a Covered Person is admitted directly to an intensive care unit; payable once per calendar year, per Covered Person</td>
<td>Payable when a Covered Person is admitted for a Hospital Confinement of at least 18 hours for treatment of Injuries sustained in a covered accident or if a Covered Person is admitted directly to an intensive care unit of a hospital for treatment of Injuries sustained in a covered accident. Hospital Confinements must start within 90 days of the accident.</td>
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### Accident Hospital Confinement

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Benefit Amount</th>
<th>Additional Benefit Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>$165 per day up to 365 days per covered accident, per Covered Person</td>
<td>Payable when a Covered Person is admitted for a Hospital Confinement of at least 18 hours for treatment of Injuries sustained in a covered accident. Hospital Confinements must start within 90 days of the accident. The Accident Hospital Confinement Benefit and the Rehabilitation Unit Benefit will not be paid on the same day. The highest eligible benefit will be paid.</td>
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</tbody>
</table>

### Intensive Care Unit Confinement

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Benefit Amount</th>
<th>Additional Benefit Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>$640 per day for up to 15 days per covered accident, per Covered Person</td>
<td>Payable for each day a Covered Person is confined and charged for a room in an intensive care unit for treatment of Injuries sustained in a covered accident. Hospital Confinements must start within 90 days of the accident. The Accident Hospital Confinement Benefit and the Intensive Care Unit Confinement Benefit will not be paid on the same day. The highest eligible benefit will be paid.</td>
<td></td>
</tr>
<tr>
<td>BENEFIT</td>
<td>BENEFIT AMOUNT</td>
<td>ADDITIONAL BENEFIT INFORMATION</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>MAJOR DIAGNOSTIC EXAMS</td>
<td>$200 once per calendar year, per Covered Person</td>
<td>Payable when a Covered Person requires one of the following exams for Injuries sustained in a covered accident and a charge is incurred: computerized tomography (CT scan), computerized axial tomography (CAT), magnetic resonance imaging (MRI), or electroencephalography (EEG). These exams must be performed in a hospital or a physician's office. Exams listed in the Major Diagnostic Exams Benefit are not payable under the X-Ray Benefit. No lifetime maximum.</td>
</tr>
<tr>
<td>EPIDURAL PAIN MANAGEMENT</td>
<td>$100 paid no more than twice per covered accident, per Covered Person</td>
<td>Payable when a Covered Person is prescribed, receives, and incurs a charge for an epidural administered for pain management in a hospital or a physician's office for Injuries sustained in a covered accident. This benefit is not payable for an epidural administered during a surgical procedure.</td>
</tr>
<tr>
<td>PHYSICAL THERAPY</td>
<td>$50 per treatment for one treatment per day, up to a maximum of ten treatments per covered accident, per Covered Person</td>
<td>Payable when a Covered Person receives emergency treatment for Injuries sustained in a covered accident and later a physician advises the Covered Person to seek treatment from a licensed physical therapist. Physical therapy must be for Injuries sustained in a covered accident and must start within 30 days of the covered accident or discharge from the hospital. The treatment must take place within six months after the accident. The Physical Therapy Benefit is not payable for the same days that the Accident Follow-Up Treatment Benefit is paid.</td>
</tr>
<tr>
<td>REHABILITATION UNIT</td>
<td>$150 per day, limited to 30 days for each Covered Person per period of Hospital Confinement and limited to a calendar year maximum of 60 days</td>
<td>Payable when a Covered Person is admitted for a Hospital Confinement and is transferred to a bed in a rehabilitation unit of a hospital for treatment of Injuries sustained in a covered accident and a charge is incurred. The Rehabilitation Unit Benefit will not be payable the same days the Accident Hospital Confinement Benefit is paid. The highest eligible benefit will be paid. No lifetime maximum.</td>
</tr>
<tr>
<td>APPLIANCES</td>
<td>$125 once per covered accident, per Covered Person</td>
<td>Payable when a Covered Person receives a medical appliance, prescribed by a physician, as an aid in personal locomotion for Injuries sustained in a covered accident. Benefits are payable for the following types of appliances: a wheelchair, a leg brace, a back brace, a walker, and/or a pair of crutches.</td>
</tr>
</tbody>
</table>

The policy has limitations and exclusions that may affect benefits payable. This brochure is for illustrative purposes only. Refer to the policy for complete details, definitions, limitations, and exclusions.
<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>BENEFIT AMOUNT</th>
<th>ADDITIONAL BENEFIT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROSTHESIS</td>
<td>$750 once per covered accident, per Covered Person</td>
<td>Payable when a Covered Person requires use of a prosthetic device as a result of Injuries sustained in a covered accident. This benefit is not payable for repair or replacement of prosthetic devices, hearing aids, wigs, or dental aids, to include false teeth.</td>
</tr>
<tr>
<td>BLOOD/PLASMA/PLATELETS</td>
<td>$250 once per covered accident, per Covered Person</td>
<td>Payable when a Covered Person receives blood/plasma and/or platelets for the treatment of Injuries sustained in a covered accident. This benefit does not pay for immunoglobulins.</td>
</tr>
<tr>
<td>AMBULANCE</td>
<td>$200 when a Covered Person requires ambulance transportation</td>
<td>Payable when a Covered Person requires ambulance transportation or air ambulance transportation to a hospital for Injuries sustained in a covered accident. Ambulance transportation must be within 72 hours of the covered accident. A licensed professional ambulance company must provide the ambulance service.</td>
</tr>
<tr>
<td></td>
<td>$1,500 when a Covered Person requires air ambulance transportation</td>
<td></td>
</tr>
<tr>
<td>TRANSPORTATION</td>
<td>$600 per round trip, up to three round trips per calendar year, per Covered Person</td>
<td>Payable per round trip to a hospital when a Covered Person requires Hospital Confinement for medical treatment due to an Injury sustained in a covered accident. This benefit is also payable when a covered Dependent Child requires Hospital Confinement for medical treatment due to an Injury sustained in a covered accident if commercial travel (plane, train, or bus) is necessary and such Dependent Child is accompanied by any immediate family member. This benefit is not payable for transportation to any hospital located within a 50-mile radius from the site of the accident or the residence of the Covered Person. The local attending physician must prescribe the treatment requiring Hospital Confinement. This benefit is not payable for transportation by ambulance or air ambulance to the hospital.</td>
</tr>
<tr>
<td>FAMILY LODGING</td>
<td>$125 per night, limited to one motel/hotel room per night, up to 30 days per covered accident</td>
<td>Payable for one motel/hotel room for a member of the immediate family who accompanies a Covered Person who is admitted for a Hospital Confinement for the treatment of Injuries sustained in a covered accident. This benefit is payable only during the same period of time the injured Covered Person is confined to the hospital. The hospital and motel/hotel must be more than 50 miles from the residence of the Covered Person.</td>
</tr>
<tr>
<td>ACCIDENTAL-DEATH</td>
<td></td>
<td>We will pay the applicable lump sum benefit indicated for the Accidental Death of a Covered Person to the beneficiary named in the application. Accidental Death must occur as a result of an Injury sustained in a covered accident and must occur within 90 days of such accident. Note: We do not recommend that you name a minor child as your beneficiary. If you name a minor child as your beneficiary, any benefits due your minor beneficiary will not be payable until a guardian for the financial estate of the minor is appointed by the court or such beneficiary reaches the age of majority as defined by your state. If there is no beneficiary, Aflac will pay any applicable benefit to your estate.</td>
</tr>
</tbody>
</table>

Please see the Terms You Need to Know section of this brochure for more details about Common-Carrier Accidents, Other Accidents, and Hazardous Activity Accidents.
**What is Not Covered**

**Limitations and Exclusions**

We will not pay benefits for services rendered by you or a member of the immediate family of a Covered Person. We will not pay benefits for treatment or loss due to Sickness, including (1) any bacterial, viral, or micro-organism infection or infestation, or any condition resulting from insect, arachnid, or other arthropod bites or stings; or (2) an error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure for any Sickness. 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 an Injury, treatment, disability, or loss that is caused by or occurs as a result of a Covered Person’s:

- Loss sustained or contracted while under the influence of any narcotic, unless administered on the advice of a physician;
- Participating in any illegal activity that is classified as a felony (the term *felony* is as defined by the law of the jurisdiction in which the activity takes place);
- Intentionally self-inflicting a bodily injury, or committing or attempting suicide;
- Having cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent Child which has resulted in a functional defect;
- Having dental treatment except as a result of Injury;
- Being exposed to war or any act of war, declared or undeclared, or serving in any of the armed forces, or units auxiliary thereto [If you are a member of a reserve component of the armed forces of the United States, including the National Guard, you may continue or suspend the policy during a period of active duty. When you notify us to suspend the policy, we will refund any premium paid for coverage after the date we receive the notice. We will reinstate the policy when your active duty ends without evidence of insurability when we receive (1) your written request to reinstate the policy, and (2) the premium for the period from the date your active service ends to the next premium due date. The reinstated policy will contain no new exclusions or waiting periods and will be effective as of the date your active duty ends. If we do not receive both your written request and the required premium within 60 days after your active duty ends, you may still apply for reinstatement. In this case, you must comply with the reinstatement provision].

A hospital is not, other than incidentally, a place of rest; a place primarily for the treatment of tuberculosis; a place for the aged; a place for drug addicts or alcoholics; or a place for convalescent, custodial, educational, or rehabilitative care.

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

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**Table: Benefits and Information**

<table>
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<tr>
<th>Benefit</th>
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<th>Additional Benefit Information</th>
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</thead>
<tbody>
<tr>
<td>Accidental-Dismemberment</td>
<td>$625–$40,000</td>
<td>We will pay the applicable lump sum benefit indicated in the policy for dismemberment. Dismemberment must occur as a result of Injuries sustained in a covered accident and must occur within 90 days of the accident. Only the highest single benefit per Covered Person will be paid for dismemberment. Benefits will be paid only once per Covered Person, per covered accident. If death and dismemberment result from the same accident, only the Accidental-Death Benefit will be paid. Loss of use does not constitute dismemberment, except for eye injuries resulting in loss of the eye or permanent loss of vision such that central visual acuity cannot be corrected to better than 20/200.</td>
</tr>
</tbody>
</table>
**Terms You Need to Know**

**Accidental Death:** death caused by a covered Injury. See the Limitations and Exclusions section for Injuries not covered by the policy.

**Common-Carrier Accident:** an accident, occurring on or after the Effective Date of coverage and while coverage is in force, directly involving a common-carrier vehicle in which a Covered Person is a Passenger at the time of the accident. A common-carrier vehicle is limited to only an airplane, train, bus, trolley, or boat that is duly licensed by a proper authority to transport persons for a fee, holds itself out as a public conveyance, and is operating on a posted regularly scheduled basis between predetermined points or cities at the time of the accident. A Passenger is a person aboard or riding in a common-carrier vehicle other than (1) a pilot, driver, operator, officer, or member of the crew of such vehicle; (2) a person having any duties aboard such vehicle; or (3) a person giving or receiving any kind of training or instruction. A Common-Carrier Accident does not include any Hazardous Activity Accident or any accident directly involving private, on demand, or chartered transportation in which a Covered Person is a Passenger at the time of the accident.

**Covered Person:** any person insured under the coverage type you applied for: 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 covered under the terms of the policy from the moment of birth. If coverage is for individual or named insured/Spouse only, and you desire uninterrupted coverage for a newborn child, you must notify Aflac in writing within 31 days of the birth of your child, and Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due. Coverage will include any other Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the mental hygiene law), or physical handicap, and who became so incapacitated 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. A Dependent Child (including persons incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the mental hygiene law), or physical handicap) must be under age 26 at the time of application to be eligible for coverage.

**Effective Date:** the date(s) that your coverage begins as shown in the Policy Schedule. The Effective Date is not the date you signed the application for coverage.

**Guaranteed-Renewable:** the right to renew the policy by payment of the premium due on or before the renewal date. The policy is Guaranteed-Renewable for your lifetime, subject to Aflac’s right to change premiums by class.

**Hazardous Activity Accident:** an accident that occurs on or after the Effective Date of coverage, while coverage is in force, and while a Covered Person is participating in sky diving, scuba diving, hang gliding, motorized vehicle racing, cave exploration, bungee jumping, parachuting, or mountain or rock climbing, or while a Covered Person is a pilot, an officer, or a member of the crew of an aircraft and has any duties aboard an aircraft, or while giving or receiving any kind of training or instruction aboard an aircraft. A Hazardous Activity Accident does not include any Common-Carrier Accidents.

**Hospital Confinement:** a stay of a Covered Person confined to a bed in a hospital as an inpatient, and for whom a room charge is made. The Hospital Confinement must be on the advice of a physician and the result of a covered Injury. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable.

**Injury:** a bodily injury caused directly by an accident, independent of Sickness, disease, bodily infirmity, or any other cause, occurring on or after the Effective Date of coverage and while coverage is in force. See the Limitations and Exclusions section for Injuries not covered by the policy.

**Other Accident:** an accident occurring on or after the Effective Date of coverage and while coverage is in force that is not classified as either a Common-Carrier Accident or a Hazardous Activity Accident and that is not specifically excluded in the Limitations and Exclusions section.

**Sickness:** an illness, disease, infection, or any other abnormal physical condition, independent of Injury, occurring on or after the Effective Date of coverage and while coverage is in force.
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