Aflac University℠

Personal Cancer Indemnity Plan

Field Sales Guide

For Training Purposes Only

American Family Life Assurance Company of Columbus (Aflac)

M1071B

09/05

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Preface

This manual is a reference guide for associates to use with Aflac's new Personal Cancer Indemnity (PCI) product. Many of the forms, benefits, policy provisions, etc., vary from state to state. For each state in which an associate is licensed to sell Aflac products, it is the associate's responsibility to review the state introduction packet for state variations. Keep this in mind when marketing multi-state accounts.

Good luck and good selling!

Section 1

Introduction

The Personal Cancer Protector Plan (PCPP) was first introduced in Georgia in December 1997, and introductions continued throughout 1998. Each year, the percentage of Level 3 sales has increased. In 2002, Level 3 accounted for half of all PCPP sales. This increasing trend toward the highest level of coverage indicated that there may be an increased demand for either a Level 4 or for increased benefits that further distinguish Levels 2 and 3.

Many changes have also taken place in the fight against cancer since the PCPP was developed in 1997. Several drugs have emerged from clinical trials to become FDA-approved treatments. New drugs and therapies now offer more treatment options than surgery, radiation, or chemotherapy alone. More screening and detection procedures are available—whether used as diagnostic tools or to check for recurrences of cancer.

We needed a new plan to address these advances in cancer treatment, as well as our sales patterns, while maintaining the strength of our number two product line. Based on suggestions from our field force, internal departments at worldwide headquarters, and policyholders, we have developed the Personal Cancer Indemnity Plan.

What Is Cancer?

Cancer is a group of diseases characterized by uncontrolled growth and spread of abnormal cells. If the spread is not controlled, it can result in death.

(Source: American Cancer Society, *Cancer Facts & Figures 2003)*

Aflac must be more specific in our definition of cancer. The Personal Cancer Indemnity Policy defines *cancer* as follows:

> A disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. *Cancer* also includes leukemia and Hodgkin's disease.
>
> Benefits are payable for carcinomas in situ (in the natural or normal place, confined to the site of origin without having invaded neighboring tissue). Benefits are not payable for such conditions diagnosed prior to the effective date of this policy. **Premalignant conditions or conditions with malignant potential, including myelodysplastic and myeloproliferative disorders, will not be considered cancer.**
>
> Cancer must be positively diagnosed by a physician who is certified by the American Board of Pathology to practice pathologic anatomy or by a certified osteopathic pathologist. Pathologic interpretation of the histology of skin lesions will be accepted from dermatologists certified by the American Board of Dermatopathology. The diagnosis must be based on a microscopic examination of fixed tissue or preparations from the hemic system (either during life or postmortem). The pathologist making the diagnosis will base judgment solely on the criteria of *malignancy* as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen.
>
> A clinical diagnosis of cancer will be accepted as evidence that cancer exists when a pathological diagnosis cannot be made, provided medical evidence substantially documents the diagnosis of cancer and the covered person receives treatment for cancer. The pathological report or, if applicable, the clinical diagnosis, must be submitted to Aflac for benefits to be payable.

What Causes Cancer?

Cancer is caused by both external factors (tobacco, chemicals, radiation, and infectious organisms) and internal factors (inherited mutations, hormones, immune conditions, and mutations that occur from metabolism).

(Source: American Cancer Society, *Cancer Facts & Figures 2003)*

Who Is at Risk of Developing Cancer?

Anyone. Since the occurrence of cancer increases as individuals age, most cases affect adults beginning in middle age. About 77 percent of all cancers are diagnosed at age 55 and older.

- In the United States, men have slightly less than a 1-in-2 lifetime risk of developing cancer; for women, the risk is a little more than 1 in 3.
- Male smokers have a 20-fold relative risk of developing lung cancer compared with nonsmokers. This means they are about 20 times more likely to develop lung cancer than nonsmokers.
- Women who have a first-degree (mother, sister, or daughter) family history of breast cancer have about a two-fold increased risk of developing breast cancer compared with women who do not have a family history. This means that women with a first-degree family history are about two times more likely to develop breast cancer than women who do not have a family history of the disease.

(Source: American Cancer Society, *Cancer Facts & Figures 2003)*

Can Cancer Be Prevented?

All cancers caused by cigarette smoking and heavy use of alcohol could be prevented completely. The American Cancer Society estimates that in 2003 more than 180,000 cancer deaths were expected to be caused by tobacco use. Scientific evidence suggests that about one-third of the 556,500 cancer deaths expected to occur in 2003 were to be related to nutrition, physical inactivity, obesity, and other lifestyle factors and could also be prevented.

Regular screening examinations by a health care professional can result in the detection of cancers of the breast, colon, rectum, cervix, prostate, testis, oral cavity, and skin at earlier stages, when treatment is more likely to be successful. Self-examinations for cancers of the breast and skin may also result in detection of tumors at earlier stages. Cancers that can be detected by screening account for about half of all new cancer cases. The five-year relative survival rate for these cancers is about 82 percent. If all of these cancers were diagnosed at a localized stage through regular cancer screenings, five-year survival would increase to about 95 percent.

(Source: American Cancer Society, *Cancer Facts & Figures 2003)*

What Are the Costs of Cancer?

The National Institutes of Health estimate overall costs for cancer in the year 2002 at $171.6 billion. Lack of health insurance and other barriers to health care prevent many Americans from receiving optimal health care.

(Source: American Cancer Society, *Cancer Facts & Figures 2003)*

How Can Aflac Help?

Aflac's Personal Cancer Indemnity Plan is designed to help with the expenses of cancer treatment that may not be covered by major medical insurance. Even the best insurance plans typically have deductibles and copayments that must be paid out-of-pocket. Also, cancer treatment often creates other costs not covered by traditional insurance, such as travel and lodging expenses to receive treatment in another city, lost wages because of time away from work, child-care expenses, or the expense of hiring household help. By offering a First-Occurrence Benefit immediately upon the diagnosis of cancer, Aflac provides our policyholders with a one-time payment to be used however they wish. Thereafter, benefits that assist with continuing costs are offered for specific inpatient or outpatient cancer treatments.

In addition to providing valuable benefits for the treatment of cancer, Aflac's Personal Cancer Indemnity Plan offers a Wellness Benefit for many common cancer screenings, whether or not cancer is detected. In many cases, this cash benefit provides the exact incentive a person needs to undergo a cancer screening when he or she may not otherwise do so. As the statistics on the previous page indicate, early detection provides the best opportunity for cancer treatment. By promoting cancer screenings, our coverage may increase the possibility of early detection for our policyholders with cancer.

Section 2

Policy Provisions

Important Policy Provisions

30-Day Waiting Period

The Personal Cancer Indemnity policy contains a 30-day waiting period. If a covered person is diagnosed with cancer before the policy has been in force for 30 days:

- Benefits for treatment of that cancer will apply only to treatment occurring two years from the effective date, or
- The policyholder may choose to void the policy from its beginning and receive a full refund of premium.

Diagnosis Date

The diagnosis date is the day the tissue specimen, culture, and/or titer is taken upon which the diagnosis of cancer is based. The diagnosis date is not the date the diagnosis is communicated.

Effective Date

The effective date is the date shown in the Policy Schedule, **not** the date the application was signed.

Sample Personal Cancer Indemnity Policy

(Series A-75000, Level 3)

Three levels of the Personal Cancer Indemnity Plans are available: (Form A-75100 Level 1), (Form A-75200 Level 2), and (Form A-75300 Level 3). We will use Form A-75300 for illustrative purposes in this manual.

This is a sample base policy to be used for training purposes only. **Benefits, limitations, and exclusions may vary by state; please refer to your specific state introduction packet for complete details.**

CANCER INDEMNITY INSURANCE

IMPORTANT: This is a limited benefit, specified-disease policy. It pays benefits for Cancer treatment only. Read it carefully with the Outline of Coverage, if applicable.

The Named Insured as shown in the Policy Schedule will be referred to as "you," "your," or "yours." **American Family Life Assurance Company of Columbus (AFLAC),** a stock company, will be referred to as "we," "our," "us," or "AFLAC."

CONSIDERATION

This policy is issued in consideration of statements made in your application and the payment of the premium shown in the Policy Schedule. A copy of your application is attached and is a part of this policy. We agree to indemnify covered persons for the treatment of Cancer. The following paragraphs set forth: the insurance benefits, limitations and exclusions, definitions of terms, and other provisions.

YOUR RIGHT TO EXAMINE THIS POLICY

It is important to us that you are satisfied with this policy and that it meets your insurance needs. If you are not satisfied, you may return it within 30 days after you receive it. Send it to our associate (duly licensed agent) or to AFLAC Worldwide Headquarters, 1932 Wynnton Road, Columbus, Georgia 31999. You will receive a full refund of all premiums paid, and your policy will be void from its Effective Date. If you return the policy, please note in writing: "This policy is returned for cancellation and refund of premium."

IMPORTANT NOTICE

Please read your application attached to this policy. This policy is issued on the basis that the information shown on the application is correct and complete. Carefully check the application. Write to us within 30 days of the date you receive this policy if any information shown on it is not correct or complete. Incorrect information can result in the denial of a claim or termination of the policy. No associate (duly licensed agent) may change this policy or waive any of its provisions.

THIS POLICY IS GUARANTEED-RENEWABLE FOR YOUR LIFETIME, SUBJECT TO OUR RIGHT TO CHANGE PREMIUMS BY CLASS UPON ANY RENEWAL DATE.

We agree that this policy will never be restricted by the addition of any rider without your consent, nor will renewal be refused because of any change in any covered person's health or physical condition. You are guaranteed the right to renew this policy for your lifetime by the timely payment of premiums at the rate in effect at the beginning of each term.

We may change the established premium rate, but only if the rate is changed for all policies of this class. While this policy is in force, no change will be made in your class because of the age, sex, or physical condition of any covered person. "Class" means all policies of this form number and premium classification in your state that are then in force. If the established premium rate changes, we will notify you in writing at your last known address at least 30 days before the change becomes effective.

American Family Life Assurance Company of Columbus (AFLAC)
Worldwide Headquarters: 1932 Wynnton Road, Columbus, Georgia 31999
For assistance or information about this policy, call 1-800-99-AFLAC (1-800-992-3522).

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Policy Schedule

NAMED INSURED: John A. Doe

POLICY NUMBER: 111-2222

TYPE OF COVERAGE: Individual

COVERAGE: XXXXXX
AAABBB

MODE OF PAYMENT: Monthly

PREMIUMS:		**EFFECTIVE DATES:**	
Cancer Policy:	$XX.xx	Cancer Policy:	XX/XX/XX
Building Benefit Rider: (___) Units	$XX.xx	Building Benefit Rider: (___) Units	XX/XX/XX
Specified-Disease Rider:	$XX.xx	Specified-Disease Rider:	XX/XX/XX
Return of Premium Rider:	$XX.xx	Return of Premium Rider:	XX/XX/XX

In witness whereof, AFLAC's president and secretary signed this policy in Columbus, Georgia, as of the policy Effective Date shown in the Policy Schedule.

ABC

Daniel P. Amos, President

ABCD

Joey M. Loudermilk, Secretary

This is a legal contract between you and AFLAC.
READ YOUR POLICY CAREFULLY.

Part 1
DEFINITIONS

A. ACTIVITIES OF DAILY LIVING (ADLs): activities used in measuring your levels of personal functioning capacity. Normally, these activities are performed without assistance, allowing you personal independence in everyday living.

The ADLs are:

1. Maintaining continence: controlling urination and bowel movements, including your ability to use ostomy supplies or other devices such as catheters;
2. Transferring: moving between a bed and a chair, or a bed and a wheelchair;
3. Dressing: putting on and taking off all necessary items of clothing;
4. Toileting: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene; and
5. Eating: performing all major tasks of getting food into your body.

B. AMBULATORY SURGICAL CENTER: a facility, licensed as such, that provides outpatient surgical services. It does not include a Physician's or dentist's office, a clinic, or any other such location.

C. BONE MARROW TRANSPLANTATION: the harvesting, storage, and subsequent reinfusion of bone marrow from the recipient or a matched donor in which chemotherapy and/or total body radiotherapy to destroy the patient's residual bone marrow is administered. **It does not include the harvesting of peripheral blood cells or stem cells and subsequent reinfusion.**

D. CANCER: a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. "Cancer" also includes leukemia and Hodgkin's disease.

Benefits are payable for carcinomas in situ (in the natural or normal place, confined to the site of origin without having invaded neighboring tissue). Benefits are not payable for such conditions diagnosed prior to the Effective Date of this policy. **Premalignant conditions or conditions with malignant potential, including myelodysplastic and myeloproliferative disorders, will not be considered Cancer.**

Such Cancer must be positively diagnosed by a Physician who is certified by the American Board of Pathology to practice pathologic anatomy or by a certified osteopathic pathologist. Pathologic interpretation of the histology of skin lesions will be accepted from dermatologists certified by the American Board of Dermatopathology. The diagnosis must be based on a microscopic examination of fixed tissue or preparations from the hemic system (either during life or postmortem). The pathologist making the diagnosis will base judgment solely on the criteria of "malignancy" as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen.

A clinical diagnosis of Cancer will be accepted as evidence that Cancer exists when a pathological diagnosis cannot be made, provided medical evidence substantially documents the diagnosis of Cancer and the covered person receives treatment for Cancer. Such pathological report or, if applicable, clinical diagnosis must be submitted to AFLAC for benefits to be payable.

E. EFFECTIVE DATE: the date(s) shown in the Policy Schedule. The Effective Date of the policy **is not** the date you signed the application for coverage, but the date recorded by AFLAC in the Policy Schedule.

F. HOSPICE: a licensed agency, organization, or unit, that provides a centrally administered and autonomous continuum of palliative and supportive care to terminally ill persons and their families. The care must be directed and coordinated by the Hospice organization and received primarily in the patient's home, or on an outpatient or short-term inpatient basis in a Hospice unit.

G. HOSPITAL: an institution legally licensed as such that maintains and uses on its premises or in facilities available to it on a prearranged, written, contractual basis: a laboratory, X-ray equipment and an operating room. The institution must also have permanent and full-time facilities for the care of overnight resident bed patients under the supervision of one or more licensed Physicians, provide 24-hour-a-day nursing service by or under the supervision of a registered nurse, and maintain the patients' written histories and medical records on the premises. "Hospital" also includes Ambulatory Surgical Centers. "Hospital" does not include any institution, or part thereof, used as: a Hospice unit, including any bed designated as a Hospice bed; a swing bed; a convalescent home; a rest or nursing facility; a psychiatric unit; a rehabilitation unit or facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental diseases or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

H. IMMEDIATE FAMILY: anyone related to you in the following manner: spouse; brother or sister (includes stepbrother and stepsister); children (includes stepchildren); parent(s) (includes stepparents); grandchildren; father- or mother-in-law; and spouses, as applicable, of any of these.

I. IMMUNOTHERAPY: immunoglobulins or colony-stimulating factors given as a part of a treatment regimen for internal Cancer to stimulate or restore the ability of the immune system to fight infection and disease.

J. NCI-DESIGNATED CANCER CENTER: a Cancer treatment or research facility that currently holds a National Cancer Institute (NCI) designation.

K. PHYSICIAN: a legally qualified person, other than a member of your Immediate Family, who is licensed as a Physician by the state to treat the type of condition for which a claim is made.

L. STEM CELL TRANSPLANTATION: the harvesting, storage, and subsequent reinfusion of peripheral blood cells or stem cells from the recipient or from a matched donor in which chemotherapy and/or total body radiotherapy to destroy the patient's residual bone marrow is administered. **It does not include the harvesting, storage, and subsequent reinfusion of bone marrow from the recipient or a matched donor under general anesthesia.**

M. TYPE OF COVERAGE: see your Policy Schedule to determine the Type of Coverage issued: Individual, One-Parent Family, or Two-Parent Family.

1. **Individual:** coverage for only you (the Named Insured listed in the Policy Schedule).
2. **One-Parent Family:** coverage for you (the Named Insured) and all of your dependent children. "Dependent children" are your natural children, stepchildren, or legally adopted children who are unmarried and under 25 years of age, and who qualify as legal dependents for tax exemption purposes under the United States Internal Revenue Service Tax Code.
3. **Two-Parent Family:** coverage for you (the Named Insured), your spouse, and all of your dependent children (or those of your spouse). "Dependent children" are your natural children, stepchildren or legally adopted children who are unmarried and under 25 years of age, and who qualify as legal dependents for tax exemption purposes under the United States Internal Revenue Service Tax Code.

Persons covered under Individual, One-Parent Family, or Two-Parent Family are referred to as "covered persons." Any One-Parent Family or Two-Parent Family member specifically excluded by name from coverage is not included in the One-Parent Family or Two-Parent Family definition. Any person who becomes a family member after the Effective Date of this policy, except a newborn, who is automatically covered from the moment of birth, or an adopted child, who is covered from the date the petition is filed, must be added by endorsement. Persons added as family members by endorsement will be covered for only that Cancer diagnosed on or after the 30th day following the Effective Date of their endorsement. If this is an Individual policy, newborn children are automatically covered from the moment of birth, and adopted children are covered from the date the petition is filed; however, if you desire uninterrupted coverage, you must notify AFLAC in writing within 31 days of the birth of your child or the date the petition is filed for an adopted child. Upon notification, AFLAC will convert this policy to One-Parent Family or Two-Parent Family coverage and advise you of the additional premium due. If this is a One-Parent Family or a Two-Parent Family policy, it is not necessary to notify AFLAC of the birth or adoption of a child, and no additional premium will be required for coverage of newborns or adopted children. If you wish any other person to be covered after the Effective Date of the policy, you must apply for such coverage, and that person must be added by endorsement. If Two-Parent Family coverage is already in force, an additional premium will not be required. Insurance for persons added by endorsement becomes effective on the date specified on the endorsement.

The insurance on any dependent child will terminate on the anniversary date of this policy following the child's 25th birthday, on the date the child marries, or at the time the child no longer qualifies as a legal dependent for tax exemption purposes under the United States Internal Revenue Service Tax Code, whichever occurs first (for continuation of coverage, see Part 3, Right of Conversion). Termination will be without prejudice to any claim originating prior to the date of termination. Our acceptance of premium after such date will be considered as premium for only the remaining persons who qualify as covered persons under this policy. You must notify AFLAC, in writing, of any changes that will affect the Type of Coverage. After such notice, AFLAC will arrange for the payment of the appropriate premium due, including returning any unearned premium. Coverage provided under any One-Parent Family or Two-Parent Family policy will continue to include any other unmarried dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated while he/she was covered and before he/she reached age 25. You must furnish proof of such incapacity and dependency to AFLAC within 31 days of the child's 25th birthday. Proof of continued incapacity and dependency must be furnished at AFLAC's request, but not more often than

annually, after the two-year period following the child's 25th birthday.

Part 2
LIMITATIONS AND EXCLUSIONS

A. We pay only for treatment of Cancer, including direct extension, metastatic spread, or recurrence. Benefits are not provided for premalignant conditions; conditions with malignant potential; complications of Cancer; or any other disease, sickness, or incapacity.

B. This policy contains a 30-day waiting period. If a covered person has Cancer diagnosed before coverage has been in force 30 days from the Effective Date of coverage shown in the Policy Schedule, benefits for treatment of that Cancer will apply only to treatment occurring after two years from the Effective Date of the policy or, at your option, you may elect to void the policy from its beginning and receive a full refund of premium.

C. The First-Occurrence Benefit is not payable for: (1) any internal Cancer diagnosed or treated before the Effective Date of this policy and the subsequent recurrence, extension, or metastatic spread of such internal Cancer that is diagnosed prior to the Effective Date of this policy; (2) Cancer diagnosed during this policy's 30-day waiting period; (3) the diagnosis of skin Cancer or melanomas classified as Clark's Levels I and II, or a Breslow level less than or equal to 1.5 mm. **Any covered person who has had a previous diagnosis of Cancer will NOT be eligible for a First-Occurrence Benefit under this policy for a recurrence, extension, or metastatic spread of that same Cancer.**

Part 3
RIGHT OF CONVERSION

A. DISSOLUTION OF MARRIAGE:
If you and your spouse dissolve your marriage by a valid decree of dissolution of marriage and your spouse was covered under a Two-Parent Family policy, the ex-spouse's coverage will terminate. Your ex-spouse may then apply for and receive, without evidence of insurability, a policy providing coverage not greater than the terminated coverage. To obtain the policy, your ex-spouse must make application to AFLAC within 60 days following the entry of the decree of dissolution of marriage and pay the appropriate premium for the policy. No waiting period is required except to the extent that such period has not been met under this policy. If such dissolution of marriage occurs, the Named Insured under this policy at the time of the dissolution will retain that status. Any covered dependents may be covered under either policy, but not both. **Any spouse applying for another Cancer policy who has had internal Cancer diagnosed under this policy will not be eligible for the First-Occurrence Benefit in the new policy.**

B. DEATH:
In the event of your death, your spouse, if alive and covered hereunder, will become the Named Insured. All benefits accrued prior to your death will be paid to your estate. No waiting period is required except to the extent that such period has not been satisfied by that person under this policy. **Please note: Any covered person who has had internal Cancer diagnosed under this policy will not be eligible for the First-Occurrence Benefit in the new policy.**

C. TERMINATION OF DEPENDENCY:
A covered person whose dependency has terminated and who desires to continue coverage as a Named Insured under a separate policy may do so by notifying AFLAC of the request in writing. The dependent will have the right to apply for a Cancer policy without evidence of insurability and without interruption in coverage, provided AFLAC receives written notification of the request prior to 31 days after the anniversary date of this policy following the date he or she is no longer

considered a dependent. **Any dependent applying for another Cancer policy who has had internal Cancer diagnosed under this policy will not be eligible for the First-Occurrence Benefit in the new policy.**

Part 4
UNIFORM PROVISIONS

A. ENTIRE CONTRACT; CHANGES: This policy, together with the application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance. No change in this policy is valid until approved in writing by the secretary and president of AFLAC at our worldwide headquarters. Any such change must be noted on or attached hereto. No associate (duly licensed agent) has the authority to change this policy or to waive any of its provisions.

B. TIME LIMIT ON CERTAIN DEFENSES: (1) After two years from the Effective Date of this policy, any misstatements, except fraudulent misstatements, made by you in the application shall not be used to void the policy or to deny a claim for care commencing after the expiration of such two-year period. (2) No claim for loss commencing after two years from the Effective Date of this policy will be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description, had existed prior to such Effective Date.

C. TERM: The term of this policy begins at midnight, standard time, at the place where you reside on the Effective Date shown in the Policy Schedule. It ends at midnight, at the same standard time, on the first renewal date. Each renewal term ends at midnight, at the same standard time, on the next following renewal date. Renewal dates are determined by the mode of payment. The mode of payment for the original term of this policy is shown in the Policy Schedule. An annual premium will maintain this policy in force for 12 months, semiannual for six months, quarterly for three months, and monthly for one month. Premium for a term is due on the first day of that term. If you fail to pay your premium by the end of the grace period, coverage under this policy will terminate.

D. GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium falling due after the first premium. During the grace period, this policy shall continue in force.

E. REINSTATEMENT: You may request reinstatement of your policy from our associate (duly licensed agent) or from AFLAC. If your policy has lapsed for nonpayment of premium and we accept a later payment without requiring an application, your policy shall be reinstated. If we require a written application and provide you with a conditional receipt, your policy will be reinstated upon our approval of the application. If we do not notify you of our disapproval in writing within 45 days of the date of your application, your policy shall be deemed reinstated. The reinstated policy will cover loss resulting only from hospitalization for and/or treatment of Cancer that is diagnosed more than ten days after the date of reinstatement. In all other respects, you and AFLAC will have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions added in connection with the reinstatement. Any premium accepted in connection with a reinstatement will be applied to a period for which premium has not been previously paid, but not to any period prior to the date of reinstatement.

F. NOTICE OF CLAIM: Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. The notice can be given to AFLAC at our worldwide headquarters or to our associate (duly licensed agent). Notice of claim should include the name of the covered person and the policy number.

G. CLAIM FORMS: When we receive a notice of claim, we will send you forms for filing proof of loss. If the forms are not given to you within ten working days, you will meet the proof-of-loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.

H. PROOF OF LOSS: Written proof of loss must be furnished to AFLAC at our worldwide headquarters within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than 15 months from the time proof is otherwise required.

I. TIME OF PAYMENT OF CLAIMS: All benefits payable under this policy will be paid immediately upon receipt of due written proof of loss.

J. PAYMENT OF CLAIMS: All benefits will be payable to you unless assigned by you or by operation of law. Any accrued benefits unpaid at your death will be paid to your estate.

K. LEGAL ACTIONS: No legal action may be brought to recover on this policy within 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action may be brought after six years from the time written proof of loss is required to be furnished.

L. CONFORMITY WITH STATE AND FEDERAL STATUTES: Any provision of this policy that, on its Effective Date, is in conflict with the statutes of the state in which it was issued or with any federal statute is hereby amended to conform to the minimum requirements of such statutes.

M. OTHER INSURANCE WITH AFLAC: If a person is covered under more than one Cancer policy or rider, only one AFLAC policy chosen by you, your beneficiary, or your estate, as the case may be, will be effective. We will pay benefits under the policies for claims that may have been incurred since their respective Effective Dates. We will also return all premiums paid for the canceled policies from the date of duplication, less any benefits paid under these policies from such date.

Part 5
ELIGIBILITY FOR BENEFITS

A. If you or any covered family member is diagnosed as having Cancer while this policy is in force, we will pay for the diagnosis and treatment of Cancer occurring while this policy remains in force, according to the Benefits section, Part 6, subject to all other limitations and exclusions, conditions, and provisions of this policy, and:

1. If Cancer is diagnosed after the 30-day waiting period (see Part 2B, Limitations and Exclusions), the "diagnosis date" is the day the tissue specimen, culture, and/or titer is taken upon which the diagnosis of Cancer is based. It is not the date the diagnosis was communicated to the covered person.

2. If a covered person has Cancer diagnosed before coverage has been in force 30 days from the Effective Date of coverage shown in the Policy Schedule, benefits for treatment of that Cancer will apply only to treatment occurring after two years from the Effective Date of the policy.

3. The First-Occurrence Benefit is not payable for any Cancer diagnosed before coverage

has been in force 30 days or for any recurrence, extension, or metastatic spread of a Cancer diagnosed prior to the Effective Date of coverage.

B. Outpatient and hospitalization benefits for the treatment of Cancer will accrue as follows:

If Cancer is diagnosed while a covered person is hospitalized or receiving outpatient treatment, benefits will accrue from the day of admission to the Hospital, but will not be retroactive more than 30 days before the date Cancer was diagnosed. EXCEPTION: If skin Cancer is diagnosed during hospitalization, benefits will be limited to the day(s) the covered person actually received treatment for skin Cancer [such as a malignant tumor, ulcer, pimple, or mole that may arise on the surface of the body (skin) including melanomas classified as Clark's Levels I and II, or a Breslow level less than or equal to 1.5 mm]. No benefits will be payable for expenses incurred prior to the 30th day after the Effective Date shown in the Policy Schedule.

Part 6
BENEFITS

Benefit A is a preventive benefit; diagnosis of Cancer is not required for this benefit to be payable.

A. CANCER SCREENING WELLNESS BENEFIT: AFLAC will pay $75 (seventy-five dollars) per calendar year when a charge is incurred for one of the following: mammogram, breast ultrasound, Pap smear, ThinPrep, biopsy, flexible sigmoidoscopy, hemocult stool specimen, chest X-ray, CEA (blood test for colon Cancer), CA 125 (blood test for ovarian Cancer), PSA (blood test for prostate Cancer), thermography, colonoscopy or virtual colonoscopy. These tests must be performed to determine whether Cancer exists in a covered person. This benefit is limited to one payment per calendar year, per covered person. No lifetime maximum.

While this policy is in force, the following benefits will be paid, subject to Part 2, Limitations and Exclusions, and all other policy provisions, if a covered person is diagnosed and treated as having Cancer and is hospitalized for the treatment of Cancer, or receives specified outpatient Cancer treatment.

B. FIRST-OCCURRENCE BENEFIT: AFLAC will pay a First-Occurrence Benefit for each covered person under this policy when he or she is diagnosed as having internal Cancer, subject to Part 2, Limitations and Exclusions, Section C. "Internal Cancer" includes melanomas classified as Clark's Level III and higher or a Breslow level greater than 1.5 mm.

Insured	Spouse	Child
$5,000	$5,000	$7,500

This benefit is payable under this policy only once for each covered person and will be paid in addition to any other benefit in this policy. In addition to the pathological or clinical diagnosis required by the definition of Cancer in Part 1D, we may require additional information from the attending Physician and Hospital.

C. HOSPITAL CONFINEMENT BENEFITS (includes confinement in a U.S. government Hospital):

1. **HOSPITALIZATION FOR 30 DAYS OR LESS:** When a covered person is confined to a Hospital for treatment of Cancer for 30 days or less, AFLAC will pay $300 (three hundred dollars) per day for each day a covered person is charged for a room as an inpatient.

2. **HOSPITALIZATION FOR 31 DAYS OR MORE:** During any continuous period of Hospital confinement of a covered person for treatment of Cancer for 31 days or more, AFLAC will pay benefits as described in Section C1 above for the first 30 days. Beginning with the 31st day of such continuous Hospital confinement, AFLAC will pay $600 (six hundred dollars) per day for each day you are charged for a room as an inpatient.

   No lifetime maximum.

EXCEPTION: a person confined to a U.S. government Hospital does not need to be charged for the Hospital Confinement Benefit to be payable.

When Cancer treatment is received in a U.S. government Hospital, the following benefits are not payable unless the covered person is actually charged and is legally required to pay for such services.

D. **MEDICAL IMAGING BENEFIT:** AFLAC will pay $200 (two hundred dollars) per calendar year when a charge is incurred for each covered person who receives an initial diagnosis or follow-up evaluation of internal Cancer using one of the following medical imaging exams: CT scans, MRI's, bone scans, Multiple Gated Acquisition (MUGA) scans, Positron Emission Tomography (PET) scans or transrectal ultrasounds. These exams must be performed in a Hospital, to include an Ambulatory Surgical Center, or a Physician's office. This benefit is limited to one payment per calendar year, per covered person. No lifetime maximum.

E. **RADIATION AND CHEMOTHERAPY BENEFIT:** AFLAC will pay $300 (three hundred dollars) per day as follows when a charge is incurred for a covered person who receives one or more of the following Cancer treatments for the purpose of modification or destruction of abnormal tissue:

1. Cytotoxic chemical substances and their administration in the treatment of Cancer:
   a. Injection by medical personnel in a Physician's office, clinic, or Hospital.
   b. Self-injected medications will be limited to $300 (three hundred dollars) per daily treatment, subject to a monthly maximum of $2,400 (two thousand four hundred dollars) for all medications.
   c. Medications dispensed by a pump or implant will be limited to $300 (three hundred dollars) for the initial prescription and $300 (three hundred dollars) for each pump refill, subject to a monthly maximum of $1,200 (one thousand two hundred dollars) for all medications. The Surgical/Anesthesia Benefit provides additional amounts payable for insertion and removal.
   d. Oral chemotherapy, regardless of where administered, will be limited to $300 (three hundred dollars) per prescription, subject to a monthly maximum of $1,200 (one thousand two hundred dollars) for all prescriptions.
2. Radiation therapy or
3. The insertion of interstitial or intracavitary application of radium or radioisotopes. The Surgical/Anesthesia Benefit provides additional amounts payable for insertion and removal.

If delivery of radiation or chemotherapy is other than the ones listed above, benefits will be subject to a monthly maximum of $1,200 (one thousand two hundred dollars).

Treatments must be FDA or NCI approved for the treatment of Cancer. This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, therapeutic devices, simulation, dosimetry, treatment planning or other procedures related to these therapy treatments. Benefits will not be paid for each day the radium or radioisotope remains in the body or for each day of continuous infusion of medications dispensed by a pump or implant. No lifetime maximum.

This benefit is not payable on the same day that the Experimental Treatment Benefit is paid.

F. **EXPERIMENTAL TREATMENT BENEFIT:** AFLAC will pay $300 (three hundred dollars) per day as follows when a charge is incurred for a covered person who receives one or more of the following experimental Cancer treatments, prescribed by a Physician, for the purpose of modification or destruction of abnormal tissue:

1. Treatment administered by medical personnel in a Physician's office, clinic or Hospital.
2. Self-injected medications will be limited to $300 (three hundred dollars) per daily treatment, subject to a monthly maximum of $2,400 (two thousand four hundred dollars).
3. Medications dispensed by a pump will be limited to $300 (three hundred dollars) for the initial prescription and $300 (three hundred dollars) for each refill, subject to a monthly maximum of $1,200 (one thousand two hundred dollars). The Surgical/Anesthesia Benefit provides additional amounts payable for insertion and removal.
4. Oral medications, regardless of where administered, will be limited to $300 (three hundred dollars) per prescription, subject to a monthly maximum of $1,200 (one thousand two hundred dollars) for all prescriptions.

Treatments must be approved by the NCI as 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 therapy treatments. Benefits will not be paid for each day of continuous infusion of medications dispensed by a pump or implant. No lifetime maximum.

This benefit is not payable on the same day that the Radiation and Chemotherapy Benefit is paid.

G. **IMMUNOTHERAPY BENEFIT:** AFLAC will pay $500 (five hundred dollars) per calendar month during which a charge is incurred for a covered person who receives immunoglobulins or colony-stimulating factors as prescribed by his/her Physician as part of a treatment regimen for internal Cancer. Lifetime maximum of $2,500 (two thousand five hundred dollars) per covered person.

Any medications paid under the Radiation and Chemotherapy Benefit or the Experimental Treatment Benefit will not be paid under the Immunotherapy Benefit.

H. **ANTI-NAUSEA BENEFIT:** AFLAC will pay $150 (one hundred fifty dollars) per calendar month during which a charge is incurred for a covered person who receives anti-nausea drugs that are prescribed while receiving radiation or chemotherapy treatments. No lifetime maximum.

I. **NURSING SERVICES BENEFIT:** While confined in a Hospital, if a covered person requires private nurses and their services other than those regularly furnished by the Hospital, AFLAC will pay $150 (one hundred fifty dollars) per 24-hour day for full-time private care and attendance provided by such nurses (registered graduate nurses, licensed practical nurses, or licensed vocational nurses) when a charge is incurred. 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.

J. SURGICAL/ANESTHESIA BENEFIT:

1. When a surgical operation is performed on a covered person for a diagnosed internal Cancer, AFLAC will pay the indemnity listed in the following Schedule of Operations for the specific procedure when a charge is incurred. If any operation for the treatment of Cancer 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 L. Reconstructive surgery will be payable under Benefit N.** 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.

2. 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 combined benefits payable in the Surgical/Anesthesia Benefit for any one operation will not exceed $6,250 (six thousand two hundred fifty dollars). No lifetime maximum on number of operations.

SCHEDULE OF OPERATIONS

ABDOMEN	
Paracentesis	$ 100
Exploratory laparotomy	525
Cholecystectomy	700
BLADDER	
Cystoscopy	140
TUR bladder tumors	525
Cystectomy	
(partial)	900
(complete)	1,800
(with ureteroileal conduit)	3,600
BRAIN	
Burr holes not followed by surgery	700
Ventriculoperitoneal shunt	700
Exploratory craniotomy	1,500
Excision brain tumor	3,500
Hemispherectomy	5,000
BREAST	
Needle biopsy	140
Cutting operation biopsy	280
Lumpectomy	350
Mastectomy	
(partial)	525
(simple)	700
(radical)	1,050
CERVIX	
D & C	175
Colposcopy	175
Vaginal hysterectomy/ uterus only	525
Oophorectomy	525
Abdominal hysterectomy/ uterus only	900
Uterus, tubes & ovaries	1,750
with exenteration	5,000
CHEST	
Thoracentesis	140
Bronchoscopy	300
Mediastinoscopy	300
Thoracostomy	300
Thoracotomy	700
Wedge resection	1,200
Lobectomy	1,500
Pneumonectomy	2,100
ESOPHAGUS	
Esophagoscopy	280
Esophagogastrectomy	1,500
Resection of esophagus	2,000
EYE	
P32 uptake	250
Enucleation	500
INTESTINES	
Sigmoidoscopy	140
Proctosigmoidoscopy	140

Colonoscopy (does not include virtual)	280
Cutting operation on rectum	
for biopsy	280
Colostomy/or revision of	350
ERCP	350
Ileostomy	350
Colectomy	900
Resection of small intestine	2,100
Abdominal-perineal approach for removal of Cancer of sigmoid colon or rectum	2,500

KIDNEY

Nephrectomy	
(simple)	2,100
(radical	3,600

LIVER

Needle biopsy	140
Wedge biopsy	350
Resection of liver	1,000

LYMPHATIC

Excision of lymph nodes	$ 175
Splenectomy	700
Axillary node dissection	700
Lymphadenectomy	
(unilateral)	700
(bilateral)	900

MANDIBLE

Mandibulectomy	1,400

MISCELLANEOUS

Bone marrow biopsy or aspiration	140
Venous-catheters/venous port for chemotherapy	280
Pathological hip fracture	875

MOUTH

Hemiglossectomy	350
Tonsil/mucous membrane	525
Glossectomy	700
Resection of palate	700

PANCREAS

Jejunostomy	900
Pancreatectomy	2,100
Whipple procedure	3,600

PENIS

Amputation	
(partial)	350
(complete)	700
(radical)	900

PROSTATE

Needle biopsy	140
Cystoscopy	140
TUR prostate	525
Radical prostatectomy	1,400

RADIUM IMPLANTS

Insertion	1,000
Removal	500

SALIVARY GLANDS

Biopsy	$ 350
Parotidectomy	700
Radical neck dissection	1,800

SPINE

Cordotomy	525
Laminectomy	900

STOMACH

Gastroscopy	300
Gastrojejunostomy	900
Gastrectomy	
(partial)	900
(complete)	1,400

TESTIS

Orchiectomy	
(unilateral)	350
(bilateral)	490

THROAT

Laryngoscopy	300
Tracheostomy	300
Laryngectomy	
(without neck dissection)	900
(with neck dissection)	1,800

THYROID

Thyroidectomy	
(partial: one lobe)	525
(total: both lobes)	700

VULVA

Vulvectomy	
(partial)	525
(radical)	1,050

K. OUTPATIENT HOSPITAL SURGICAL BENEFIT: When a surgical operation is performed on a covered person for a diagnosed internal Cancer and an operating room charge is incurred, AFLAC will pay $300 (three hundred dollars). For this benefit to be paid surgeries must be performed on an outpatient basis in a Hospital, to include an Ambulatory Surgical Center. This benefit is payable once per day and is not payable on the same day as the Hospital Confinement Benefit. This benefit is payable in addition to the Surgical/Anesthesia Benefit. No lifetime maximum on number of operations.

This benefit is not payable for surgery performed in a Physician's office or for skin Cancer surgery.

L. SKIN CANCER SURGERY BENEFIT: When a surgical operation is performed on a covered person for a diagnosed skin Cancer, AFLAC will pay the indemnity listed below when a charge is incurred for the specific procedure. The indemnity amount listed below includes anesthesia services. No lifetime maximum on number of operations.

Biopsy	$100
Excision of lesion of skin without flap or graft	250
Flap or graft without excision 375	
Excision of lesion of skin with flap or graft	600

M. PROSTHESIS BENEFIT: (1) AFLAC will pay $3,000 (three thousand dollars) when a charge is incurred for surgically implanted prosthetic devices that are prescribed as a direct result of surgery for Cancer treatment. Lifetime maximum of $6,000 (six thousand dollars) per covered person. (2) AFLAC will pay $250(two hundred fifty dollars) per occurrence, per person for nonsurgically implanted prosthetic devices that are prescribed as a direct result of Cancer treatment when a charge is incurred. Examples of nonsurgically implanted prosthetic devices include voice boxes, hair pieces and removable breast prosthesis. Lifetime maximum of $500 (five hundred dollars) per covered person.
The Prosthesis Benefit does not include coverage for a Breast Transverse Rectus Abdominis Myocutaneous (TRAM) Flap procedure listed under the Reconstructive Surgery Benefit in Part 6, N.

N. RECONSTRUCTIVE SURGERY BENEFIT: When a surgical operation is performed on a covered person for reconstructive surgery for the treatment of Cancer, AFLAC will pay the indemnity listed below when a charge is incurred for the specific procedure. No lifetime maximum on number of operations.

Breast Transverse Rectus Abdominis Myocutaneous (TRAM) Flap	$3,000
Breast Reconstruction	700
Breast Symmetry (on the nondiseased breast occurring within five years of breast reconstruction)	350
Facial Reconstruction	700

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.

O. IN-HOSPITAL BLOOD AND PLASMA BENEFIT: If a covered person receives blood and/or plasma during a covered Hospital confinement, AFLAC will pay $150 (one hundred fifty dollars) times the number of days of covered Hospital confinement paid under C above when

a charge is incurred. This benefit does not pay for immunoglobulins, immunotherapy, or colony-stimulating factors. No lifetime maximum.

P. OUTPATIENT BLOOD AND PLASMA BENEFIT: AFLAC will pay $250 (two hundred fifty dollars) for each day a covered person receives blood and/or plasma transfusions for the treatment of Cancer as an outpatient in a Physician's office, clinic, Hospital, or Ambulatory Surgical Center when a charge is incurred. This benefit does not pay for immunoglobulins, immunotherapy, or colony-stimulating factors. No lifetime maximum.

Q. SECOND SURGICAL OPINION BENEFIT: AFLAC will pay $300 (three hundred dollars) when a charge is incurred for a second surgical opinion concerning Cancer surgery for a diagnosed Cancer by a licensed Physician. This benefit is not payable the same day the NCI Evaluation/Consultation Benefit is payable. No lifetime maximum.

R. NATIONAL CANCER INSTITUTE EVALUATION/CONSULTATION BENEFIT: AFLAC will pay $500 (five hundred dollars) when a covered person seeks evaluation or consultation at an NCI-Designated Cancer Center as a result of receiving a prior diagnosis of internal Cancer. The purpose of the evaluation/consultation must be to determine the appropriate course of Cancer treatment. AFLAC will pay $250 (two hundred fifty dollars) for the transportation and lodging of the covered person receiving the evaluation/consultation. The NCI-Designated Cancer Center must be more than 50 miles from the covered person's residence for the transportation and lodging portion of this benefit to be payable. This benefit is not payable the same day the Second Surgical Opinion Benefit is payable. (This benefit is also payable at the AFLAC Cancer Center & Blood Disorders Service of Children's Healthcare of Atlanta). This benefit is payable only once under this policy per covered person.

S. AMBULANCE BENEFIT: AFLAC will pay $200 (two hundred dollars) when a charge is incurred for ambulance transportation of a covered person to or from a Hospital where the covered person is confined overnight for Cancer treatment. AFLAC will pay $1,000 (one thousand dollars) when a charge is incurred for air ambulance transportation of a covered person to or from a Hospital where the covered person is confined overnight for Cancer treatment. This benefit is limited to two trips per confinement. The ambulance service must be performed by a licensed professional ambulance company. No lifetime maximum.

T. TRANSPORTATION BENEFIT: If a covered person requires Cancer treatment that has been prescribed by the local attending Physician, AFLAC will pay $.50 (fifty 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. Benefit amounts payable are limited to $1,500 (one thousand five hundred dollars) per round trip. This benefit will be paid only for the covered person for whom the treatment is prescribed.

If the treatment is for a dependent child and commercial travel (coach-class plane, train, or bus fare) is necessary, we will pay this benefit for up to two adults to accompany the dependent child. **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.**

U. LODGING BENEFIT: AFLAC will pay $60 (sixty dollars) per day when a charge is incurred for lodging for you or any one adult family member when a covered person receives Cancer treatment 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.

V. BONE MARROW TRANSPLANTATION BENEFIT: (1) AFLAC will pay $10,000 (ten thousand dollars) when a covered person receives a Bone Marrow Transplantation (see Part 1C) for which a charge is incurred for the treatment of Cancer. (2) AFLAC will pay the covered person's bone marrow donor an indemnity of $1,000 (one thousand dollars) for his or her expenses incurred as a result of the transplantation procedure. Lifetime maximum of $10,000 (ten thousand dollars) per covered person.

W. STEM CELL TRANSPLANTATION BENEFIT: AFLAC will pay $5,000 (five thousand dollars) when a charge is incurred if a covered person receives a peripheral Stem Cell Transplantation (see Part 1L) for the treatment of Cancer. This benefit is payable once per covered person. Lifetime maximum of $5,000 (five thousand dollars) per covered person.

X. EXTENDED-CARE FACILITY BENEFIT: If a covered person is hospitalized and receives benefits under Part 6C and is later confined, within 30 days of hospital confinement, to an extended-care facility, a skilled nursing facility, a rehabilitation unit or facility, a transitional care unit or any bed designated as a swing bed, or to a section of the Hospital used as such, AFLAC will pay $100 (one hundred dollars) per day when a charge is incurred for such continued confinement, limited to the same number of days that the covered person receives benefits under Part 6C. For each day this benefit is payable, benefits under Part 6C, Hospital Confinement Benefits, are NOT payable. Lifetime maximum of 365 days per covered person.

If more than 30 days separates a stay in an extended-care facility, benefits are not payable for the second confinement unless the covered person was again confined to a Hospital prior to the second such confinement.

Y. HOSPICE BENEFIT: When a covered person is diagnosed with Cancer and therapeutic intervention directed toward the cure of the disease is medically determined to be no longer appropriate, and if the covered person's medical prognosis is one in which there is a life expectancy of six months or less as the direct result of Cancer, AFLAC will pay a one-time benefit of $1,000 (one thousand dollars) for the first day the covered person receives Hospice care and $50 (fifty dollars) per day thereafter for Hospice care. For this benefit to be payable, AFLAC must be furnished: (1) a written statement from the attending Physician that the covered person is terminally ill within the terms of this paragraph, and (2) a written statement from the Hospice certifying the days services were provided. This benefit is not payable the same day the Home Health Care Benefit is payable. Lifetime maximum for each covered person is $12,000 (twelve thousand dollars).

Z. HOME HEALTH CARE BENEFIT: When a covered person is hospitalized for the treatment of Cancer and has either home health care or health supportive services provided on his/her behalf, AFLAC will pay $50 (fifty dollars) when a charge is incurred for each such visit, subject to the following conditions:

1. The home health care or health supportive services must begin within seven days of release from the Hospital.
2. This benefit is limited to ten visits per hospitalization.
3. This benefit is limited to 30 visits in any calendar year for each covered person.
4. This benefit will not be payable unless the attending Physician prescribes such services to

be performed in the home of the covered person and certifies that if these services were not available, the covered person would have to be hospitalized to receive the necessary care, treatment, and services.

5. Home health care and health supportive services must be performed by a person who is licensed, certified, or otherwise duly qualified to perform such services on the same basis as if the services had been performed in a health care facility.

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

AA. WAIVER OF PREMIUM BENEFIT: If you, due to having internal Cancer (as defined in Part 1, Definitions, Section D), are completely unable to do all of the usual and customary duties of your occupation [if you are not employed: 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 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 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.

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 under Item Y above (the Hospice Benefit).

BB. CONTINUATION OF COVERAGE BENEFIT: AFLAC will waive all monthly premiums due for the policy and riders for two months if you meet all of the following conditions:

1. Your policy has been in force for at least six months;
2. We have received premiums for at least six consecutive months;
3. Your premiums have been paid through payroll deduction;
4. You or your employer has notified us in writing within 30 days of the date your premium payments ceased due to your leaving employment; and
5. You re-establish premium payments through:
   (a) your new employer's payroll deduction process, or
   (b) direct payment to AFLAC.

You will again become eligible to receive this benefit after:

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

"Payroll deduction" means your premium is remitted to AFLAC for you by your employer through a payroll deduction process.