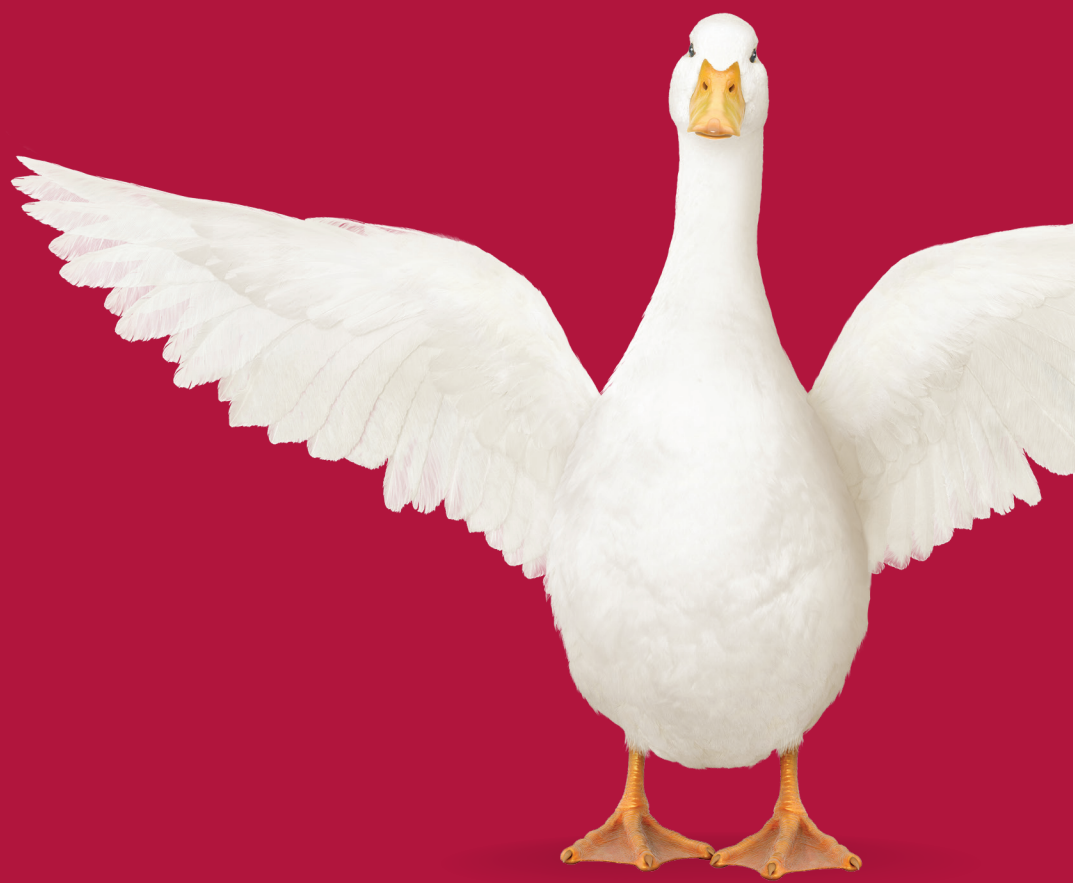
Aflac

Group Specified Disease

INSURANCE – PLAN INCLUDES BENEFITS FOR CANCER AND HEALTH SCREENING

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



This plan provides limited benefits health insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.

This is a limited plan. It pays benefits for Cancer, End Stage Kidney Disease, Major Organ Failure, Stroke, Heart Attack (Myocardial Infarction), Coronary Atherosclerotic Heart Disease diagnosis only.

Aflac®

AFLAC GROUP SPECIFIED DISEASE

SD[G]

Aflac can help ease the financial stress of surviving a specified disease.

Chances are you may know someone who's been diagnosed with a specified disease. You can't help notice the difference in the person's life—both physically and emotionally. What's not so obvious is the impact a specified disease may have on someone's personal finances.

That's because while a major medical plan may pay for a good portion of the costs associated with a specified disease, there are a lot of expenses that may not be covered. And, during recovery, having to worry about out-of-pocket expenses is the last thing anyone needs.

That's the benefit of an Aflac Group Specified Disease plan.

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

More importantly, the plan helps you focus on recuperation instead of the distraction of out-of-pocket costs. With the Specified Disease plan, you receive cash benefits directly (unless otherwise assigned)—giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses.

What you need, when you need it.

Group specified disease insurance pays cash benefits that you can use any way you see fit.

Here's why the Aflac Group Specified Disease plan may be right for you.

For more than 60 years, Aflac has been dedicated to helping provide individuals and families peace of mind and financial security when they've needed it most. The Aflac Group Specified Disease plan is just another innovative way to help make sure you're well protected.

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

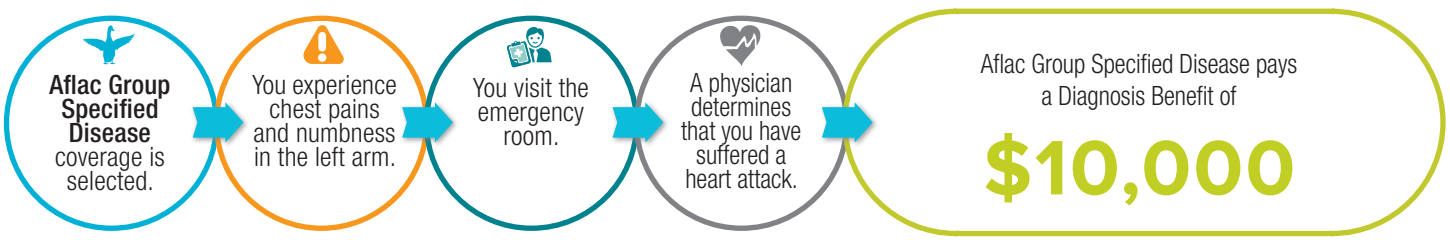
The Aflac Group Specified Disease plan benefits include:

- Specified Disease Benefit payable for:
  - Cancer
  - Heart Attack (Myocardial Infarction)
  - Stroke
  - End Stage Kidney Disease
  - Major Organ Failure
  - Coronary Atherosclerotic Heart Disease
  - Non-Invasive Cancer
  - Skin Cancer
- Health Screening Benefit

Features:

- Benefits are paid directly to you, unless otherwise assigned.
- Coverage is available for you, your spouse, and dependent children.

How it works



Amount payable based on $10,000 Diagnosis Benefit.

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

Benefits Overview

COVERED SPECIFIED DISEASES:

CANCER (Internal or Invasive)	100%
HEART ATTACK (Myocardial Infarction)	100%
STROKE	100%
MAJOR ORGAN FAILURE	100%
END STAGE KIDNEY DISEASE	100%
NON-INVASIVE CANCER	25%
CORONARY ATHEROSCLEROTIC HEART DISEASE	25%

DIAGNOSIS
An insured may receive up to 100% of their face amount upon the diagnosis of a covered specified disease. Benefits will be based on the face amount in effect on the specified disease date of diagnosis.

Once benefits have been paid for a covered specified disease, diagnosis of an additional specified disease or the diagnosis of the same disease will be paid up to the Lifetime Maximum Benefit of 300% per insured.

Once the lifetime maximum amount has been paid for any one insured, coverage on that insured ceases. Payments for partial and additional benefits do not count toward the lifetime benefit amount.

CHILD COVERAGE AT NO ADDITIONAL COST
Each dependent child is covered at 50 percent of the primary insured's benefit amount at no additional charge. Children-only coverage is not available.

SKIN CANCER BENEFIT
We will pay $250 for the diagnosis of skin cancer. We will pay this benefit once per calendar year.

TRANSIENT ISCHEMIC ATTACK (TIA)
We will pay $250 for the diagnosis of a transient ischemic attack (TIA). We will pay this benefit once per calendar year. This benefit is payable in addition to all other applicable benefits

HEALTH SCREENING BENEFIT (Employee and Spouse only)
We will pay $50 for health screening tests performed while an insured's coverage is in force. We will pay this benefit once per calendar year.

This benefit is only payable for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for the covered employee and spouse. **This benefit is not paid for dependent children.**

LIMITATIONS AND EXCLUSIONS

EXCLUSIONS

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

- Self-Inflicted Injuries - injuring oneself intentionally
- Suicide - committing or attempting to commit suicide
- Illegal Acts - commission of or attempt to commit a felony
- War or act of war (whether declared or undeclared), participation in a riot or insurrection
- The insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a doctor.

Diagnosis must be made and treatment must be received in the United States, its possessions, or the countries of Canada or Mexico. All benefits under the plan, including benefits for diagnoses, treatment, confinement and covered tests, are payable only while coverage is in force.

TERMS YOU NEED TO KNOW

CANCER refers to Internal or Invasive cancer, Non-invasive cancer, and skin cancer, as defined below:

Cancer (Internal or invasive) is a disease that meets either of the following definitions:

- A malignant tumor characterized by:
- The uncontrolled growth and spread of malignant cells, and
- The invasion of distant tissue, or
- A disease meeting the diagnostic criteria of malignancy, as established by the American Board of Pathology. A Pathologist must have examined and provided a report on the histocytologic architecture or pattern of the tumor, tissue, or specimen.

Internal or Invasive Cancer also includes:

- Melanoma that is Clark's Level III or higher or Breslow depth equal to or greater than 0.77mm,
- Myelodysplastic syndrome – RCMD (refractory cytopenia with multilineage dysplasia),
- Myelodysplastic syndrome – RAEB (refractory anemia with excess blasts),
- Myelodysplastic syndrome – RAEB-T (refractory anemia with excess blasts in transformation), or
- Myelodysplastic syndrome – CMML (chronic myelomonocytic leukemia).

Non-Invasive Cancer is a Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue. For the purposes of this Plan, a Non-Invasive Cancer is:

- Internal Carcinoma in Situ
- Myelodysplastic Syndrome – RA (refractory anemia)
- Myelodysplastic Syndrome – RARS (refractory anemia with ring sideroblasts)

Skin Cancer, as defined in this Plan, is not payable under the Non-Invasive Cancer benefit.

Skin Cancer is a Cancer that forms in the tissues of the skin. The following are considered Skin Cancers:

- Basal cell carcinoma
- Squamous cell carcinoma of the skin
- Melanoma in Situ (Melanoma in Situ means melanoma cells that occur only on the outer layer of the skin (the epidermis), where there is no invasion of the deeper layer (the dermis)
- Melanoma that is Diagnosed as:
- Clark's Level I or II,
- Breslow depth less than 0.77mm, or
- Stage 1A melanomas under TNM Staging

These Skin Cancer conditions are not payable under the Cancer (internal or invasive) benefit.

CANCER must be Diagnosed in one of two ways:

Pathological Diagnosis is a Diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This Diagnosis must be made by a certified Pathologist and conform to the American Board of Pathology standards.

Clinical Diagnosis is based only on the study of symptoms. The Company will accept a Clinical Diagnosis if:

A Doctor cannot make a Pathological Diagnosis because it is medically inappropriate or life-threatening,

Medical evidence exists to support the Diagnosis, and

A Doctor is treating the Insured for Cancer or Carcinoma in Situ.

Any medically appropriate Diagnosis will be accepted.

CORONARY ATHEROSCLEROTIC HEART DISEASE means the diagnosis of at least 75% cross-sectional occlusion of one or more major coronary arteries (Left Main, Left Anterior Descending, Circumflex or Right Coronary Artery) as a result of Coronary Atherosclerotic Heart Disease. The diagnosis must be confirmed by coronary arteriography or other recognized diagnostic techniques capable of assessing precisely the degree of arterial stenosis.

HEART ATTACK (MYOCARDIAL INFARCTION) is the death of a portion of the heart muscle (myocardium) caused by a blockage of one or more coronary arteries. Diagnosis of a Heart Attack (Myocardial Infarction) must include the following:

New and serial electrocardiographic (ECG) findings consistent with Heart Attack (Myocardial Infarction), and

Elevation of cardiac enzymes above generally accepted laboratory levels of normal. (In the case of creatine physphokinase (CPK) a CPK-MB measurement must be used.)

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

END STAGE KIDNEY DISEASE means the chronic, irreversible failure of both kidneys to work at a level needed for day-to-day life. For a specified disease benefit to be payable for a Diagnosis of End Stage Kidney Disease, a Doctor must have recommended that the Insured begin renal dialysis.

MAJOR ORGAN FAILURE means the failure of the heart, both lungs, the liver, or the pancreas such that homeostasis can only be maintained with external clinical help. The Insured's placement on the United Network for Organ Sharing (UNOS) list, or other similar listing service, for a transplant, will be considered conclusive proof of diagnosis of major organ failure; however any medically appropriate diagnosis of such failure will be accepted.

Only one Major Organ Failure benefit will be paid per Insured.

STROKE
Stroke means apoplexy due to rupture or acute occlusion of a cerebral artery. Stroke is either:

Ischemic Stroke which is Stroke occurring as the result of advanced arteriosclerosis or arteriosclerosis of the arteries of the neck or brain, or vascular embolism, or

Hemorrhagic Stroke which is Stroke occurring as the result of uncontrolled hypertension, malignant hypertension, brain aneurysm, or arteriovenous malformation.

The Stroke must be positively Diagnosed by a Doctor based upon documented neurological deficits and confirmatory neuroimaging studies. Stroke will be covered only if the Insured submits evidence of a stroke by providing Computed Axial Tomography (CAT scan) images, or Magnetic Resonance Imaging (MRI).

- The following are not Stroke for the purposes of this policy:
- Transient Ischemic Attacks (TIAs)
- Head injury
- Chronic cerebrovascular insufficiency
- Reversible ischemic neurological deficits unless brain tissue damage is confirmed by neurological imaging

Transient Ischemic Attack (TIA) occurs when blood flow to part of the brain is temporarily blocked or reduced. The TIA must be positively Diagnosed by a Doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

Specified Disease is a disease or a sickness as defined in the plan that first manifests while your coverage is in force.

Date of Diagnosis is defined as follows:

- Cancer(Internal or invasive)/Non-Invasive Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer / carcinoma in situ is based on such specimens).
- Skin Cancer: The date the skin biopsy samples are taken for microscopic examination.
- Coronary Atherosclerotic Heart Disease: The date a doctor diagnoses an insured with coronary atherosclerotic heart disease.
- Heart Attack (Myocardial Infarction): The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the heart attack (myocardial infarction) definition.
- End Stage Kidney Disease: The date a doctor diagnoses an insured with end stage kidney disease.
- Major Organ Failure: The date a doctor diagnoses an insured with major organ failure.
- Stroke: The date the stroke occurs (based on documented neurological deficits and neuroimaging studies).
- Transient Ischemic Attack (TIA): The date the Transient Ischemic Attack occurs (based on documented diagnostic tests, such as a CT scan or an MRI of the brain, a Doppler ultrasound, or an echocardiogram of the heart).

Dependent means an employee's spouse or dependent child. Dependent children are an employee's or an employee's spouse's natural children, step-children, legally adopted children, or children placed for adoption, who are younger than age 26. Newborn children are automatically covered from the moment of birth. Refer to your certificate for details.

Whenever the terms "spouse," "family member," or any other term that denotes the spousal relationship are used, the same-sex spouse of a New York employee who has entered into a marriage legally performed outside the state of New York shall be included in such use or definition.

A doctor does not include the insured or any of the insured's family members. For the purposes of this definition, family member includes the employee's spouse as well as the following members of the employee's immediate family:

- Son
- Daughter
- Mother
- Father
- Sister
- Brother

This includes step-family members and family-members-in-law.

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

TERMINATION OF COVERAGE

Your insurance may terminate when the plan is terminated; the 31st day after the premium due date if the premium has not been paid; or the date you no longer belong to an eligible class. If your coverage terminates, we will provide benefits for valid claims that arose while your coverage was in force.

NOTICES

If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy.

Notice to Consumer: The coverages provided by American Family Life Assurance Company of New York represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. American Family Life Assurance Company of New York coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to

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For groups situsedin New York, group coverage is underwritten by American Family Life Assurance Company of New York, and customer service is administered by Continental American Insurance Company, 22 Corporate Woods Boulevard Albany, New York 12211.

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

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

This brochure is subject to the terms, conditions, and limitations of Policy Form AF21100NY.