JAMES MADISON UNIVERSITY.

October 26, 2020

ADDENDUM NO.: One

TO ALL OFFERORS:

REFERENCE:	Request for Proposal No:	**RFP# LBS-1090**
	Dated:	October 7, 2020
	Commodity:	Employee Voluntary Benefits/Services
	RFP Closing On:	~~November 4, 2020 at 2:00 pm EST~~ **November 10, 2020 at 2:00 pm EST**

Please note the clarifications and/or changes made on this proposal program:

1. Question: Please provide either A) a census in Excel format of eligible participants with their Age or Date of Birth, gender (male/female), and Hire Date, or B) a summary census broken down by age bands and gender (male/female).

   Answer: A Summary Census (Excel file) with eligible employees YOB and gender titled "YOB GENDER all active employees ft pt" is attached.

2. Question Can you provide a census on all part time and full time eligible employees? The census data should consist of:

   1. Gender
   2. Date of Birth

   Answer: A Summary Census (Excel file) with eligible employees YOB and gender titled "YOB GENDER all active employees ft pt" is attached.

3. Question: Please describe any enrollment issues or billing problems that JMU experiences now with the voluntary benefit program.

   Answer: JMU has in the past experienced issues with seamless enrollment changes as it relates to payroll accounting. These are currently resolved.

4. Question: Who is JMU's current broker/advisor for the AFLAC program?

   Answer: JMU contracts directly with AFLAC.

5. Question: How are voluntary benefits enrolled now, online or through worksite meetings?

MSC 5720
752 Ott Street, Room 1042
Wine Price Building
Harrisonburg, VA 22807
Office of 540.568.3145 Phone
PROCUREMENT SERVICES 540.568.7935 Fax

Answer: **Enrollment is currently done online *and* through worksite meetings. JMU's preference is for Contractors to provide both types of enrollment with on-campus meetings offered monthly.**

6. Question: Can you please provide any more details on the AFLAC plans, such as a benefits booklet or certificate of coverage document?

   Answer: **The AFLAC benefit brochures are attached.**

7. Question: Will JMU allow advisors/TPAs to quote AFLAC's newer voluntary benefit programs, which have several advantages over their older programs?

   Answer: **JMU invites all offerors to submit a proposal that can provide voluntary benefit services as described in RFP# LBS-1090. Offerors should clearly outline all associated administrative fees as well as benefit/service cost.**

8. Question: To help quote competitive short-term disability, legal and home & auto, can you please provide us with an employee census (Gender, Date of Birth, Salary, occupation, and zip-code) in excel format?

   Answer: **A Summary Census (Excel file) with eligible employees YOB and gender titled "YOB GENDER all active employees ft pt" is attached.**

9. Question: How many of the 793 part-time employees are eligible for coverage and/or payroll deduction access?

   Answer: **All part-time employees would be eligible for these coverages, if they meet the requirements established by the plan. All voluntary benefits are currently payroll deducted.**

10. Question: Can you provide a claims report for AFLAC disability that includes the open, closed, and incurred claims for the previous three years?

    Answer: **This is not being shared publicly by AFLAC due to HIPAA concerns.**

11. Question: For the in-force carriers in place, could you provide us a copy of the Summary plan description (SPDs)/certificate of coverage and benefit booklets for each of the plans?

    Answer: **Benefits booklets are attached. Home, Pet, and Auto Insurance are individually written policies.**

12. Question: What is the accumulated sick leave policy for JMU?

    Answer: **Classified employees participate in either the Virginia Sickness & Disability Plan or the Traditional Sick Leave Plan through the Commonwealth of Virginia, based on date of hire. Administrative & Professional Faculty and Instructional faculty have the choice of either the Virginia Sickness & Disability Plan or the JMU Faculty & Sickness Disability Plan.**

13. Question: Can you provide us the number of participants enrolled in each plan, and the total annual premium for each line of coverage?

Answer:

AFLAC: Refer to RFP# LBS-1090, Attachment E for all AFLAC current policy rates. Current enrollment counts are as follow:

Accident- 186
Cancer- 181
Hospital- 92
Short-Term Disability- 8
Critical Care- 34

MetLife:

	Current Enrollment	Earned Premiums (Oct 2019-Sept 2020)		
Home Owners	7	$4,220		
Pet Insurance	14	$5,504.20		
Auto	11	$11,018		
Renters	0	0		

LegalShield:

	Current Enrollment	Total Annual Premium/Each
Individual Legal	1	$179.28
Family Legal	5	$191.40
Individual IDShield	8	$101.28
Family IDShield	26	$191.28
Individual Legal & IDShield Combo	1	280.80
Family Legal & IDShield Combo	10	$346.80

Financial Integrity Resources Management (FIRM)

	Current Enrollment	Estimated Annual Program

		Contribution
Virginia 529 College	**30**	**$80,500**
ABLE Tax-advantage Savings Plan for individuals with disabilities	**0**	**0**

14. Question: What is the effective start date of the new contract?

    Answer: The specific contract start date is unknown at this time but anticipated to be prior to April 2021.

15. Question: When do you anticipate implementation and marketing (open enrollment) of the selected voluntary programs?

    Answer: JMU anticipates open enrollment in May 2021 along with health insurance and FSAs.

16. Question: To help us understand appropriate voluntary benefit plan design, can you please provide us a summary plan description including deductibles on your core major medical insurance?

    Answer: Various core major medical health insurance plans are offered through the Commonwealth of Virginia. More information can be found at https://www.dhrm.virginia.gov/employeebenefits/health-benefits/active-employees

17. Question: Who is the current administrator for the Section 125 pre-tax benefits?

    Answer: There are four (4) pre-tax plans offered by the University and all are through AFLAC. Refer to RFP LBS 1090, Attachment E for this information in regards to AFLAC plans.

18. Question: Is the Section 125 administrator for pretax voluntary provided and/or paid by AFLAC? a. If yes, would you expect selected vendor to provide same Section 125 plan document and administrative service at no cost to JMU?

    Answer: Yes, AFLAC provides pretax administration. Offerors should outline any applicable administrative cost within their proposals.

19. Question: What is the Section 125 Plan year?

    Answer: July 1 – June 30 (fiscal year)

20. Question: What are the Section 125 open enrollment dates?

Answer: **May 1-15 each year**

21. Question: How many benefit fairs and locations do you expect carrier participation?

Answer: **JMU typically has an annual benefits fair at one central location. Our carriers are on campus monthly to provide one-on-one meetings.**

22. Question: Will employees at these sites be permitted to attend group and/or individual meetings? Will there be rooms available to conduct these meetings?

Answer: **Employees are allowed time away from work to attend HR-sponsored events such as the benefits fair. Additionally, employees are allowed time away from work to attend individual benefit-related meetings. For those monthly visits by vendors, we do have one central meeting room available in the Human Resource Office.**

23. Question: Are there any specific goals/ improvement opportunities that JMU recognizes as important?

Answer: **The university is committed to offering a variety of robust voluntary benefits. The preference is to make all voluntary benefits offered available to all employees, whether full or part-time.**

24. Question: Are any of the current plans offered pre-tax? If so, which plans?

Answer: **There are four (4) pre-tax plans offered by the University and all are through AFLAC. Refer to RFP LBS 1090, Attachment E for this information in regards to AFLAC plans.**

25. Question: Would JMU consider an offer that includes FSA administration?

Answer: **JMU employees have the option to participate in an FSA through the Commonwealth of Virginia. More information can be found at https://www.dhrm.virginia.gov/employeebenefits/flexible-spending-accounts**

26. Question: Would JMU consider offering all plans, including core, through one full services benefits administration platform?

Answer: **No. Core medical insurance is offered to employees by the Commonwealth of Virginia. More information can be found at https://www.dhrm.virginia.gov/employeebenefits/health-benefits/active-employees**

27. Question: Can you provide a copy of your current medical plan?

Answer: **Various major medical plans are offered through the Commonwealth of Virginia. More information can be found at https://www.dhrm.virginia.gov/employeebenefits/health-benefits/active-employees**

28. Question: Who is your payroll vendor?

Answer: **JMU's Payroll Department handles all university payroll.**

29. Question: Assuming you offer an HSA, are your current plans HSA compatible?

Answer: **JMU does not offer employees an HSA.**

30. Question: Will the current policies remain on payroll deduction or will employees be encouraged to keep plans individually if they do not want to update their coverage?

Answer: **Current policies will not continue to remain on payroll deduction. Employees that elect to keep their current plans would manage them individually.**

31. Question: What other disability coverage is offered to JMU employees in addition to the AFLAC plan? Can you provide details?

Answer: **Classified employees participate in either the Virginia Sickness & Disability Plan or the Traditional Sick Leave Plan through the Commonwealth of Virginia, based on date of hire. Administrative & Professional Faculty and Instructional faculty have the choice of either the Virginia Sickness & Disability Plan or the JMU Faculty & Sickness Disability Plan**

32. Question: What are your expectations regarding benefit plan year and open enrollment dates?

Answer: **The benefit plan year will be based on the fiscal year (July – June). Open enrollment for state health benefits, FSAs, and supplemental health insurance is May 1-15.**

33. Question: To ensure a competitive offer for Short-term Disability, the following census information is requested:
    - DOB/Age
    - Gender
    - Salary
    - Occupation
    - Class
    - An identifier (name or EE ID)

Answer: **A Summary Census (Excel file) with eligible employees YOB and gender titled "YOB GENDER all active employees ft pt" is attached.**

34. Question: Please provide a copy of booklet or certificate for the current Short-Term Disability plan.

Answer: **The AFLAC benefit brochures are attached.**

35. Question: Is the group looking for group voluntary products or individually owned voluntary products?

Answer: **Individually owned voluntary products.**

36. Question: Will you accept bids from multiple requesters or one per company?

Answer: **Offerors should include all proposed voluntary benefits/services in one (1) response to RFP# LBS-1090. JMU reserves the right to select from amongst the offered benefits/services and to make multiple awards for RFP# LBS-1090.**

37. Question: Can you provide the full benefit plans of the current voluntary coverages?

Answer: **Benefits booklets are attached. Home, Pet, and Auto Insurance are individually written policies.**

38. Question: Do plans need to be HSA compliant?

Answer: **No.**

39. Question: Please provide a census that includes DOB, gender, salary, and job title.

Answer: **A Summary Census (Excel file) with eligible employees YOB and gender titled "YOB GENDER all active employees ft pt" is attached.**

40. Question: When is open enrollment?

Answer: **May 1-15**

41. Question: When is the effective date for the Supplemental Health Insurance?

Answer: **July 1**

42. Question: Will Supplemental Health Insurance enrollment be aligned with Core enrollment?

Answer: **Yes.**

43. Question: Will the incumbent voluntary benefits continue to be payroll deducted or will they be removed from payroll?

Answer: **Current policies will not continue to remain on payroll deduction. Employees that elect to keep their current plans would manage them individually.**

44. Question: Can you describe the current method used for open enrollment?

Answer: **Employees are sent email communication, as well as mailed communications. Employees enrolled in text messaging also receive a text reminder. Human Resources creates an open enrollment website. Group meetings and face-to-face meetings are scheduled.**

45. Question: Will the selected vendor be allowed to conduct group meetings and meet with each employee face-to-face (in-person or virtually)?

Answer: **Employees may voluntarily schedule one-on-one meetings. COVID guidelines will dictate whether the meetings are in-person or virtual.**

46. Question: What HR/payroll system is currently being used?

Answer: **PeopleSoft Release 9.2.**

47. Question: What enrollment technology platform is used? Please describe how that vendor/administrator would work with us to enroll and administer our products efficiently?

Answer: **Email communication as well as mailed communications would be used, as well as the HR benefits website. Employees enrolled in text messaging would also receive a text reminder. Voluntary group meetings and face-to-face meetings would be scheduled for interested employees.**

48. Question: What effective date is JMU targeting for roll-out/enrollments?

Answer: **JMU anticipates open enrollment May 1-15, 2021**

49. Question: Is JMU interested in Long Term Care policies?

Answer: **JMU is interested in seeing additional voluntary benefits services in addition to the ones that we already offer.**

50. Question: Does the University have a requirement or preference as to how supporting documentation (e.g. organizational chart or plan details) should be included in responses?

Answer: **It is preferred that responses appear directly beneath the questions, if possible. Plan documents, organizational charts, or other multi-page items can be included as an attachment.**

51. Question: Does the University have a preference as to how our responses to the questions for "Other Voluntary Benefits Services" on page 3 are formatted? Will you accept a pdf of the questions and our responses?

Answer: **It is preferred that responses appear directly beneath the questions, if possible.**

The University requires hardcopy, sealed proposals be mailed, express mailed, or hand delivered directly to the University as specified on the signature page of RFP# LBS-1090. Refer to Section V. Proposal Preparation and Submission for instructions regarding including electronic proposal versions with the hardcopy proposal.

52. Question: Will an electronic version of our proposal suffice? Or are printed/mailed copies mandated?

Answer: **The University requires hardcopy, sealed proposals be mailed, express mailed, or hand delivered directly to the University as specified on the signature page of RFP# LBS-1090. Refer to Section V. Proposal Preparation and Submission for instructions regarding including electronic proposal versions with the hardcopy proposal.**

53. Question: Our firm provides Long Term Disability to several universities in the state for employees who participate in the optional Retirement programs often managed by TIAA. Typically these are the faculty members. Does JMU provide a long term disability option to your optional retirement plan participants or is everyone including the Faculty covered by VRS?

    Answer: **JMU offers a voluntary long-term disability plan to faculty members who are not enrolled in the Virginia Sickness & Disability Plan, as well as to classified employees in the Traditional Sick Leave Plan. Offeror should provide details on any voluntary long-term disability plans they are offering.**

54. Question: The RFP states that the University will consider payroll deduction as the method of payment for voluntary benefits/services. Are you able to confirm if the Supplemental Health plans will be payroll deducted?

    Answer: It is JMU's preference that the Contractor provide payroll deduction combined with direct billing for supplemental health insurance premiums. This is the current practice at JMU so that when an employee experiences a lapse in paychecks (e.g. long holidays or leave of absence), the current provider will direct bill the employee. The direct bill option also allows for plans to be portable if the employee terminates employment with the University. Offerors should provide detail on their plan and options for managing employee premium payments and any responsibilities that JMU Payroll would have in the process.

55. Question: Can you provide Census data for everyone currently on any voluntarily insurance policy?

    Answer: A Summary Census (Excel file) with eligible employees YOB and gender titled "YOB GENDER all active employees ft pt" is attached.

56. Question: Can you provide claims data for the last 24-36 months?

    Answer: This is not being shared publicly by AFLAC due to HIPAA concerns.

57. Question: Can you provide any High Cost Claimants for the last 24-36 Months?

    Answer: This is not being shared publicly by AFLAC due to HIPAA concerns.

Signify receipt of this addendum by initialing "Addendum #1_____" on the signature page of your proposal.

Sincerely,

LeeAnne Beatty Smith
Buyer Senior
Phone: 540-568-7523

AFLAC HOSPITAL ADVANTAGE

HOSPITAL CONFINEMENT INDEMNITY INSURANCE

POLICY SERIES A49000

PREFERRED

This brochure is for a hospital confinement indemnity policy. Options 1, 2, and 3 provide limited benefits. The policy is not a substitute for major medical coverage. It is designed to supplement a major medical program. It does not constitute comprehensive health insurance coverage and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act and does NOT satisfy the federal individual mandate that requires that YOU have health insurance coverage.

Aflac Hospital Advantage

HOSPITAL CONFINEMENT INDEMNITY INSURANCE

Policy Series A49000

OPTION 1 BENEFITS	

OPTION 2 BENEFITS *ALL BENEFITS OF OPTION 1 PLUS THE FOLLOWING*	

OPTION 3 BENEFITS *ALL BENEFITS OF OPTIONS 1 & 2 PLUS THE FOLLOWING*	

OPTION 4 BENEFITS *ALL BENEFITS OF OPTIONS 1, 2, & 3 PLUS THE FOLLOWING*	

The policy has limitations and exclusions that may affect benefits payable. This schedule is for illustrative purposes only. Refer to the policy for benefit details, definitions, limitations, and exclusions. Policy Forms A49100VAR, A49200VAR, A49300VAR, and A49400VAR; and Application Forms A49001cVAR, A49001VAR, A49001GcVAR, A49001GVAR.

Aflac will pay the following benefits, as applicable, for a covered sickness or injury 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.

BENEFIT	BENEFIT AMOUNT	ADDITIONAL BENEFIT INFORMATION
OPTION 1 **HOSPITAL CONFINEMENT**	$1,000	
REHABILITATION FACILITY	$100 per day	
HOSPITAL EMERGENCY ROOM	$100 per day	
HOSPITAL SHORT-STAY	$100	
WAIVER OF PREMIUM		
CONTINUATION OF COVERAGE		
OPTION 2 *All benefits of Option 1 plus the following* **PHYSICIAN VISIT**	$25 per day	

BENEFIT	BENEFIT AMOUNT	ADDITIONAL BENEFIT INFORMATION
MEDICAL DIAGNOSTIC AND IMAGING	$150	
AMBULANCE	$100 per day – ground ambulance $1,000 per day – air ambulance	
OPTION 3 *All benefits of Options 1 & 2 plus the following* **SURGICAL**	$50–$1,000 (based on the Schedule of Operations listed in the policy)	
INVASIVE DIAGNOSTIC EXAMS	$100 per day	
OPTION 4 *All benefits of Options 1, 2, & 3 plus the following* **DAILY HOSPITAL CONFINEMENT**	$100 per day	
DAILY HOSPITAL INTENSIVE CARE UNIT CONFINEMENT	$100 per day	

WHAT IS NOT COVERED

LIMITATIONS AND EXCLUSIONS

Aflac will not pay benefits for care or treatment that is: (1) caused by a pre-existing condition, unless it begins more than 12 months after the effective date of coverage, or (2) received prior to the effective date of coverage.

Aflac will not pay benefits for any illness, disease, infection, or disorder that is medically evaluated, diagnosed, or treated by a physician before coverage has been in force 30 days. Benefits for treatment of any illness, disease, infection, or disorder will apply only to treatment occurring 30 days or more after the effective date of the policy.

Benefits for a covered sickness for all persons added to the policy (including newborns) are subject to a 30-day waiting period. Aflac will waive the waiting period for newborns added after the policy has been in force for ten full months.

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.

The policy does not cover losses caused by or resulting from:

- Being pregnant or giving birth within the first ten months of the effective date of coverage (complications of pregnancy will be covered to the same extent as a sickness and pregnancy due to an act of rape or incest will be covered to the same extent as an injury);
- Receiving routine nursing or routine well-baby care for a newborn child (other than provided by the Physician Visit Benefit);
- Participating in, or attempting to participate in, an illegal activity that is defined as a felony, (*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, while sane or insane;
- Having dental treatment except as a result of injury or 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 elective surgery that is not medically necessary within the first 12 months of the effective date of coverage;
- Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve (Aflac will upon receipt of written notice of military service, refund all premiums as is applicable to such persons on a pro rata basis);
- Donating an organ within the first 12 months of the effective date of coverage;
- Having mental or emotional disorders, including but not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, or post-partum depression. The policy will pay, however, for covered losses resulting from Alzheimer's disease, or similar forms of senility or senile dementia, that manifests itself while coverage is in force.

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

Complications of pregnancy do not include any of the following: premature delivery, multiple gestation pregnancy, false labor, occasional spotting, prescribed rest during pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy not constituting a classifiably distinct pregnancy complication. Cesarean deliveries are not considered complications of pregnancy.

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

The term *hospital emergency room* does not include urgent care centers.

Benefits are not payable for confinement in a hospital intensive care unit under the Daily Hospital Intensive Care Unit Confinement Benefit for confinement in units such as telemetry or surgical recovery rooms, postanesthesia care units, progressive care units, intermediate care units, private monitored rooms, observation units located in emergency rooms or outpatient surgery units, step-down intensive care units, or other facilities that do not meet the standards for a hospital intensive care unit.

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

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

INTOXICANTS AND NARCOTICS: Aflac will not be liable for any loss resulting from the insured being drunk, or under the influence of any narcotic unless taken on the advice of a physician.

PRE-EXISTING CONDITION LIMITATIONS: A *pre-existing condition* is an illness, disease, infection, disorder, or injury for which, within the 12-month period before the effective date of coverage, prescription medication was taken or medical testing, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. No claim for loss incurred that starts after one year from the date of issue of the policy will be reduced or denied because a sickness or physical condition, not excluded by name or specific description before the date of loss, had existed before the effective date of coverage.

TERMS YOU NEED TO KNOW

COVERED PERSON: any person insured under the coverage type that you applied for on the application: individual (named insured listed in the Policy Schedule), named insured/spouse only (named insured and spouse), one-parent family (named insured and dependent children), or two-parent family (named insured, spouse, and dependent children). *Spouse* is defined as the person to whom you are legally married and who is listed on your application. Newborn children are automatically insured 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 child's birth, and Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due. Coverage will include any other dependent child, regardless of age, who is incapable of self-sustaining employment by reason of intellectual disability 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(s) coverage begins as shown in the Policy Schedule or on any attached endorsements or riders. 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 upon any renewal date.

HOSPITAL CONFINEMENT: a stay of a covered person confined to a bed in a hospital for 23 or more hours for which a room charge is made. The hospital confinement must be on the advice of a physician, medically necessary, and the result of a covered sickness or injury. The term *hospital confinement* does not include emergency rooms.

INJURY: a bodily injury caused directly by an accident, independent of sickness, 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.

PERIOD OF HOSPITAL CONFINEMENT: the number of days a covered person is assigned to and incurs a charge for a bed in a hospital. Confinements must begin while coverage under the policy is in force. Covered confinements not separated by 90 days or more from a previously covered confinement are considered a continuation of the previous period of hospital confinement. Hospitalization that begins prior to the end of one calendar year and continues into the next calendar year will be considered one confinement.

PERIOD OF HOSPITAL INTENSIVE CARE UNIT CONFINEMENT: the number of days a covered person is assigned to and incurs a charge for a bed in a hospital intensive care unit. Confinements must begin while coverage under the policy is in force. Covered confinements not separated by 90 days or more from a previously covered confinement are considered a continuation of the previous period of hospital intensive care unit confinement. Hospitalization that begins prior to the end of one calendar year and continues into the next calendar year will be considered one confinement.

SICKNESS: an illness, disease, infection, or disorder, independent of injury, medically evaluated, diagnosed, or treated by a physician 30 days or more after the effective date of coverage and while coverage is in force.

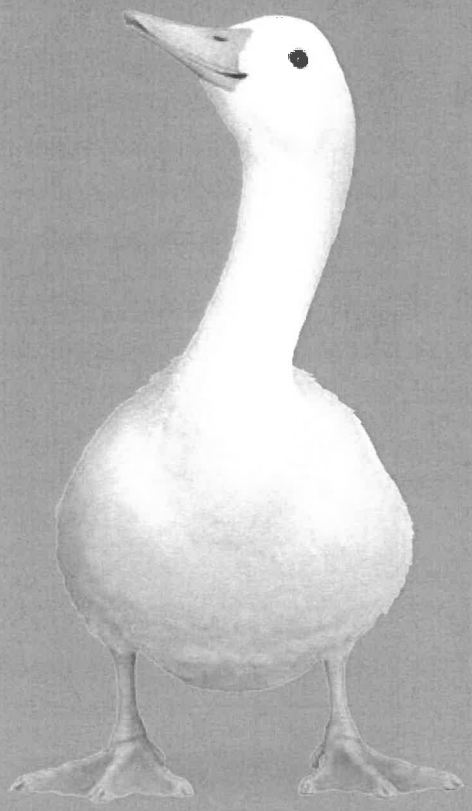
Underwritten by:
American Family Life Assurance Company of Columbus
Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999

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

Aflac Accident Advantage

ACCIDENT-ONLY INSURANCE – OPTION 3

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



Aflac SmartClaim®
One Day Pay℠

AFLAC ACCIDENT ADVANTAGE

ACCIDENT-ONLY INSURANCE – OPTION 3

Policy Series A36000

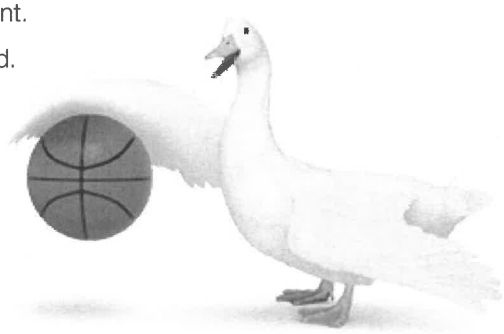
AA[3]

Be Prepared for Life's Unexpected Mishaps

Accidents can happen at any time. You could suffer an accidental injury while you are working around the house or walking into work. Or your child may get injured at basketball practice. When an accident happens, it can be costly. Even with major medical insurance, there may be out-of-pocket expenses that you'll have to pay.

In the event of an unexpected injury, Aflac can help protect your personal finances. We provide individuals and families affordable insurance that helps with expenses that may not be covered by major medical insurance. Aflac pays cash benefits directly to you (unless you specify otherwise), so you can use the cash for anything you want. Which means uncovered medical expenses won't break the bank if you are injured.

And since we can process your claim quickly, Aflac helps give you the peace of mind knowing you can spend more time recovering and less time worrying about bills.



The facts say you need the protection of the Aflac Accident Advantage insurance policy:

FACT NO. 1

ABOUT **1** OUT OF **8**

PEOPLE SEEK MEDICAL ATTENTION FOR AN INJURY.[1]

FACT NO. 2

$5,500

THE AVERAGE MEDICAL EXPENSES FOR AN ACCIDENTAL INJURY.[1]

[1]*Injury Facts*, 2014 Edition, National Safety Council.

Aflac herein means American Family Life Assurance Company of Columbus.

Understand the difference Aflac can make in your financial security.

Aflac pays cash benefits for covered accidental injuries directly to you, unless assigned. Your own peace of mind and the assurance that your family will have help financially are powerful reasons to consider Aflac.

The financial impact of an accident is often surprising. Most people have expenses after an accident they never thought of before. From out-of-pocket medical costs to a temporary loss of income, your finances may be strained. If you or a family member suffered an accidental injury, can your finances handle it?

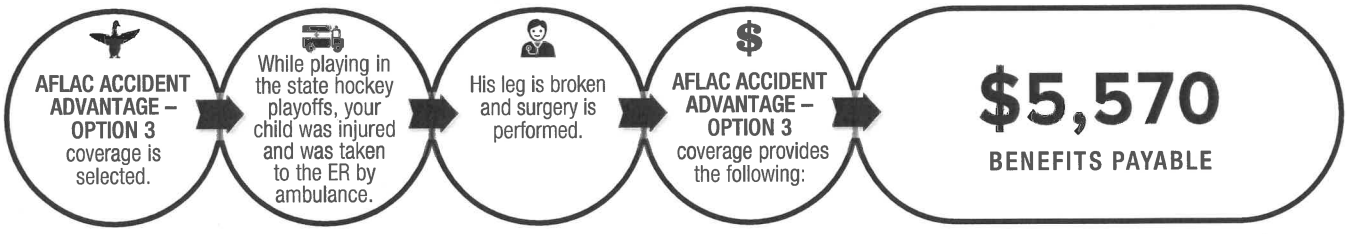
What does the Aflac Accident Advantage policy include?

- A wellness benefit payable for routine medical exams to encourage early detection and prevention.
- Benefits payable for fractures, dislocations, lacerations, concussions, burns, emergency dental work, eye injuries, and surgical procedures.
- Benefits payable for initial treatment, X-rays, major diagnostic exams, and follow-up treatments.
- Benefits payable for physical, speech, and occupational therapy.
- Daily hospitalization benefits payable for hospital stays, and additional daily benefits paid for stays in a hospital intensive care unit.

Why Aflac Accident Advantage may be the right choice for you:

- No underwriting questions to answer[2]
- No coordination of benefits—we pay regardless of any other insurance you may have
- No network restrictions—you choose your own health care provider
- Portable—take the plan with you if you change jobs or retire
- 24-hour accident insurance

How it works



The above example is based on a scenario for the Aflac Accident Advantage – Option 3 that includes the following benefit conditions: Ambulance Benefit of $200 (ground ambulance transportation); Accident Treatment Benefit of $200 (hospital emergency room treatment with X-rays); Accident Specific-Sum Injuries Benefit of $1,750 (fractured leg {femur}–open reduction under anesthesia); Initial Accident Hospitalization Benefit of $1,000; Accident Hospital Confinement Benefit of $250 (hospitalized for 1 day); Major Diagnostic and Imaging Exams Benefit of $200 (CT scan); Appliances Benefit of $300 (wheelchair); Therapy Benefit of $315 (9 physical therapy treatments); Accident Follow-Up Treatment Benefit of $210 (6 follow-up treatments); Family Support Benefit of $20 (hospitalized for 1 day); Family Lodging Benefit of $125 (hospital and motel/hotel more than 50 miles from residence); and Organized Sporting Activity Benefit of $1,000.

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 outline of coverage and policy for complete benefit details, definitions, limitations, and exclusions.

[2]Association and associate-only accounts have one underwriting question.

AFLAC ACCIDENT ADVANTAGE – OPTION 3 BENEFIT OVERVIEW

BENEFIT NAME	BENEFIT AMOUNT

REFER TO THE OUTLINE OF COVERAGE AND POLICY FOR COMPLETE BENEFIT DETAILS, DEFINITIONS, LIMITATIONS, AND EXCLUSIONS.

ACCIDENT-ONLY COVERAGE

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

ACCIDENT-ONLY COVERAGE

THE POLICY PROVIDES LIMITED BENEFITS.

BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

OUTLINE OF COVERAGE

This IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the *Guide to Health Insurance for People With Medicare* available from Aflac.

(1) **Read Your Policy Carefully.** This outline of coverage provides a very brief description of the important features of the coverage. 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) Accident-Only coverage is designed to provide, to persons insured, coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the policy. **Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.**

(3) **Benefits.** 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.

HOSPITAL BENEFITS:

INITIAL ACCIDENT HOSPITALIZATION BENEFIT: Aflac will pay $1,000 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 Aflac will pay $2,000 if a Covered Person is admitted directly to an Intensive Care Unit of a Hospital for treatment for Injuries sustained in a covered accident. This benefit is payable only once per Period of Hospital Confinement (including Intensive Care Unit confinement) and only once per Calendar Year, per Covered Person. Hospital Confinements must start within 30 days of the accident.

ACCIDENT HOSPITAL CONFINEMENT BENEFIT: Aflac will pay $250 per day when a Covered Person is admitted for a Hospital Confinement of at least 18 hours for treatment of Injuries sustained in a covered accident. Aflac will pay this benefit up to 365 days per covered accident, per Covered Person. Hospital Confinements must start within 30 days of the accident. **The Accident Hospital Confinement Benefit and the Rehabilitation Facility Benefit will not be paid on the same day. The highest eligible benefit will be paid.**

INTENSIVE CARE UNIT CONFINEMENT BENEFIT: Aflac will pay an additional $400 for each day a Covered Person receives the Accident Hospital Confinement Benefit and is confined and charged for a room in an Intensive Care Unit for treatment of Injuries sustained in a covered accident. This Intensive Care Unit Confinement Benefit is payable for up to 15 days per covered accident, per Covered Person. Hospital Confinements must start within 30 days of the accident.

SERVICE BENEFITS:

ACCIDENT TREATMENT BENEFIT: Aflac will pay the applicable amount shown below when a Covered Person receives treatment for Injuries sustained in a covered accident. This benefit is payable for treatment received under the care of a Physician at a(n):

Hospital Emergency Room with X-Ray	$200
Hospital Emergency Room without X-Ray	$170
Office or facility (other than a Hospital Emergency Room) with X-Ray	$150
Office or facility (other than a Hospital Emergency Room) without X-Ray	$120

Treatment must be received within 72 hours of the accident for benefits to be payable. This benefit is payable once per 24-hour period and only once per covered accident, per Covered Person.

AMBULANCE BENEFIT: Aflac will pay $200 when a Covered Person requires ambulance transportation to a Hospital for Injuries sustained in a covered accident. Ambulance transportation must be within 72 hours of the covered accident. Aflac will pay $1,500 when a Covered Person requires transportation provided by an air ambulance for

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Injuries sustained in a covered accident. A licensed professional ambulance company must provide the ambulance service.

BLOOD/PLASMA/PLATELETS BENEFIT: Aflac will pay $200 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 and is payable only one time per covered accident, per Covered Person.

MAJOR DIAGNOSTIC AND IMAGING EXAMS BENEFIT: Aflac will pay $200 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, Medical Diagnostic Imaging Center, a Physician's office, or an Ambulatory Surgical Center. This benefit is limited to one payment per Calendar Year, per Covered Person. No lifetime maximum.

AFTER CARE SERVICES:

ACCIDENT FOLLOW-UP TREATMENT BENEFIT: Aflac will pay $35 per day when a Covered Person receives treatment for Injuries sustained in a covered accident and later requires additional treatment over and above treatment administered in the first 72 hours following the accident. Aflac will pay for one treatment per day for up to a maximum of six treatments per covered accident, per Covered Person. The treatment must begin within 30 days of the covered accident or discharge from the Hospital. Treatments must be received under the care of a Physician. This benefit is payable for acupuncture when furnished by a licensed certified acupuncturist. **The Accident Follow-Up Benefit is not payable for the same days that the Therapy Benefit is paid.**

THERAPY BENEFIT: Aflac will pay $35 per therapy treatment when a Covered Person receives treatment for Injuries sustained in a covered accident and later a Physician advises the Covered Person to seek treatment from a licensed Occupational, Physical, or Speech Therapist. Occupational, physical, or speech 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. Aflac will pay for one treatment per day for up to a maximum of ten treatments per covered accident, per Covered Person. The treatment must take place within six months after the accident. **The Therapy Benefit is not payable for the same days that the Accident Follow-Up Treatment Benefit is paid.**

APPLIANCES BENEFIT: Aflac will pay the applicable amount shown below 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:

Back brace	$300
Body jacket	$300
Knee scooter	$300
Wheelchair	$300
Leg brace	$125
Crutches	$100
Walker	$100
Walking boot	$100
Cane	$25

This benefit is payable once per covered accident, per Covered Person.

PROSTHESIS BENEFIT: Aflac will pay $800 when a Covered Person receives a Prosthetic Device, prescribed by a Physician, 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. This benefit is payable once per covered accident, per Covered Person.

PROSTHESIS REPAIR OR REPLACEMENT BENEFIT: Aflac will pay $800 when:

1. a Covered Person requires replacement of an existing Prosthetic Device for which benefits were previously paid under the Prosthesis Benefit. The replacement must occur 36 months or more after any previously paid Prosthesis Benefit, or
2. a Covered Person sustains damages, as a result of Injuries sustained in a covered accident, which require repair or replacement of an existing Prosthetic Device.

This benefit is not payable for hearing aids, wigs, or dental aids to include false teeth. This benefit is payable once per Covered Person, per lifetime.

REHABILITATION FACILITY BENEFIT: Aflac will pay $150 per day when a Covered Person is admitted for a Hospital Confinement and is transferred to a bed in a Rehabilitation Facility for treatment of Injuries sustained in a covered accident and a charge is incurred. This benefit is limited to 30 days for each Covered Person per Period of Hospital Confinement and is limited to a Calendar Year maximum of 60 days. No lifetime maximum. **The Rehabilitation Facility Benefit will not be payable for the same days that the Accident Hospital Confinement Benefit is paid. The highest eligible benefit will be paid.**

HOME MODIFICATION BENEFIT: Aflac will pay $3,000 for a home modification aid when a Covered Person suffers a Catastrophic Loss in a covered accident. This benefit is payable once per covered accident, per Covered Person.

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ACCIDENT SPECIFIC-SUM INJURIES BENEFITS: When a Covered Person receives treatment under the care of a Physician for Injuries sustained in a covered accident, Aflac will pay specified benefits ranging from $35–$12,500 for dislocations, burns, skin grafts, eye injuries, lacerations, fractures, concussion, emergency dental work, coma, paralysis, surgical procedures, miscellaneous surgical procedures and pain management. See policy for specific amounts payable.

ACCIDENTAL-DEATH & DISMEMBERMENT BENEFITS:

ACCIDENTAL-DEATH BENEFIT: Aflac will pay the applicable lump-sum benefit indicated below for an Accidental-Death. Accidental-Death must occur as a result of an Injury sustained in a covered accident and must occur within 90 days of such accident.

Named Insured or Spouse-	
Common-Carrier Accident	$150,000
Other Accident	$40,000
Hazardous Activity Accident	$10,000
Child-	
Common-Carrier Accident	$25,000
Other Accident	$10,000
Hazardous Activity Accident	$5,000

Aflac will pay an additional 25 percent of the Accidental-Death Benefit when two or more Accidental-Deaths occur in the same covered accident. Accidental-Death must occur as a result of an Injury sustained in a covered accident and must occur within 90 days of such accident.

In the event of the Accidental-Death of a covered Spouse or Dependent Child, Aflac will pay you the applicable lump-sum benefit indicated above. If you are disqualified from receiving the benefit by operation of law, then the benefit will be paid to the deceased Covered Person's estate unless Aflac has paid the benefit before receiving notice of your disqualification.

In the event of your Accidental-Death, Aflac will pay the applicable lump-sum benefit indicated above for your Accidental-Death to the beneficiary named in the application for the policy unless you subsequently changed your beneficiary. If you changed your beneficiary, then Aflac will pay this benefit to the beneficiary named in your last change of beneficiary request of record. If any beneficiary is a minor child, then any benefits payable to such minor beneficiary will not be paid 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 applicable state law. If any beneficiary is disqualified from receiving the benefit by operation of law, then the benefit will be paid as though that beneficiary died before you unless Aflac has paid the benefit before receiving notice of the beneficiary's disqualification. If a beneficiary dies before you do, the interest of that beneficiary terminates. If a beneficiary does not survive you by 15 days, then the benefit will be paid as though the beneficiary died before you unless Aflac has paid the benefit before receiving notice of the beneficiary's death. If no beneficiary survives you, Aflac will pay the benefit to your estate.

ACCIDENTAL-DISMEMBERMENT BENEFIT: Aflac will pay the applicable lump-sum benefit indicated below for Dismemberment. Dismemberment must occur as a result of an Injury sustained in a covered accident and must occur within 90 days of such accident. If a Covered Person does not qualify for the Accidental-Dismemberment Benefit but loses (with or without reattachment) at least one joint of a finger or toe, other than the first interphalangeal joint, we will pay the Partial Dismemberment Benefit.

Named Insured or Spouse-	
Dismemberment or complete loss of, with or without reattachment:	
Both arms and both legs	$40,000
Two eyes, feet, hands, arms or legs	$40,000
One eye, foot, hand, arm, or leg	$10,000
One or more fingers and/or one or more toes	$2,000
Partial Dismemberment of finger or toe	$625
Child-	
Dismemberment or complete loss of, with or without reattachment:	
Both arms and both legs	$12,500
Two eyes, feet, hands, arms or legs	$12,500
One eye, foot, hand, arm, or leg	$3,750
One or more fingers and/or one or more toes	$625
Partial Dismemberment of finger or toe	$300

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.

ADDITIONAL BENEFITS:

WELLNESS BENEFIT (a preventive benefit; the Accidental-Death, Dismemberment, or Injury of a Covered Person is not required for this benefit to be payable): Aflac will pay $60 if you or any one Covered Person undergoes routine examinations or other preventive testing during the Calendar Year. Services covered are annual physical examinations,

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dental examinations, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, ultrasounds, prostate-specific antigen tests (PSAs), and blood screenings. This benefit is payable only once per policy, per Calendar Year. Service must be under the supervision of or recommended by a Physician, received while your policy is in force, and a charge must be incurred.

FAMILY SUPPORT BENEFIT: Aflac will pay $20 for each day a Covered Person qualifies for benefits under the Accident Hospital Confinement Benefit. Aflac will pay this benefit up to 30 days per covered accident.

ORGANIZED SPORTING ACTIVITY BENEFIT: Aflac will pay an additional 25 percent of the benefits payable when a Covered Person receives treatment for Injuries sustained in a covered accident while participating in an Organized Sporting Activity. This benefit is not payable for Injuries that are caused by or occur as a result of a Covered Person's participating in any sport or sporting activity for wage, compensation, or profit, including officiating or coaching; or racing any type vehicle in an organized event. This benefit is limited to $1,000 per policy, per Calendar Year.

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

1. Your policy has been in force for at least six months;
2. We have received premiums for at least six consecutive months;
3. Your premiums have been paid through payroll deduction and you leave your employer for any reason;
4. You or your employer notifies us in writing within 30 days of the date your premium payments cease because of 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.

WAIVER OF PREMIUM BENEFIT:

Employed: If you, due to Injuries sustained in a covered accident, are completely unable to do all of the usual and customary duties of your occupation or any occupation whatsoever, for more than 180 consecutive days while the policy is in force, 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 (or proof of your inability to perform three or more ADLs) and a Physician's statement certifying 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 Injuries sustained in a covered accident, are completely unable to perform three or more of the Activities of Daily Living (ADLs) without Direct Personal Assistance for more than 180 consecutive days while the policy is in force, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require a Physician's statement certifying your inability to perform said activities, and may each month thereafter require a Physician's statement that total inability continues.

This Waiver of Premium Benefit is limited to a total maximum of 36 months per eligibility of the Waiver of Premium Benefit regardless of whether you are employed or not employed.

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.

You must pay all premiums to keep the policy and any applicable rider(s) in force until Aflac approves your claim for this Waiver of Premium Benefit. You must also resume premium payment to keep the policy and any applicable rider(s) in force, beginning with the first premium due after you no longer qualify for Waiver of Premium Benefits.

TRANSPORTATION BENEFIT: Aflac will pay $600 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.

Aflac will also pay $600 per round trip 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 of the site of the accident or residence of the Covered Person. The local attending Physician must prescribe the treatment requiring Hospital Confinement, and the treatment must not be available locally. This benefit is payable for up to three round trips per Calendar Year, per Covered Person. This benefit is not payable for transportation by ambulance or air ambulance to the Hospital.

FAMILY LODGING BENEFIT: Aflac will pay $125 per night for one motel/hotel room for a member(s) of the Immediate Family

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that 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. This benefit is limited to one motel/hotel room per night and is payable up to 30 days per covered accident.

(4) Optional Benefit

Additional Accidental-Death Benefit Rider: (Series A36050) Applied For: ☐Yes ☐No

EXCEPTIONS, REDUCTIONS AND LIMITATIONS OF THE RIDER: Aflac will not pay benefits under the rider for an Accidental-Death that is caused by or occurs as a result of a Hazardous Activity Accident. Refer to your policy for additional Limitations and Exclusions.

ACCIDENTAL-DEATH BENEFIT: Aflac will pay the applicable lump-sum benefit indicated below for an Accidental-Death. Accidental-Death must occur as a result of an Injury sustained in a covered accident and must occur within 90 days of such accident.

	Named Insured	Spouse	Child
Common-Carrier Accident	$35,000	$35,000	$7,000
Other Accident	35,000	35,000	7,000

Aflac will pay an additional 25 percent of the Accidental-Death Benefit when two or more Accidental-Deaths occur in the same covered accident. Accidental-Death must occur as a result of an Injury sustained in a covered accident and must occur within 90 days of such accident.

In the event of the Accidental-Death of a covered Spouse or Dependent Child, Aflac will pay you the applicable lump-sum benefit indicated above. If you are disqualified from receiving the benefit by operation of law, then the benefit will be paid to the deceased Covered Person's estate unless Aflac has paid the benefit before receiving notice of your disqualification.

In the event of your Accidental-Death, Aflac will pay the applicable lump-sum benefit indicated above for your Accidental-Death to the beneficiary named in the application for the policy unless you subsequently changed your beneficiary. If you changed your beneficiary, then Aflac will pay this benefit to the beneficiary named in your last change of beneficiary request of record. If any beneficiary is a minor child, then any benefits payable to such minor beneficiary will not be paid 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 applicable state law. If any beneficiary is disqualified from receiving the benefit by operation of law, then the benefit will be paid as though that beneficiary died before you unless Aflac has paid the benefit before receiving notice of the beneficiary's disqualification. If a beneficiary dies before you do, the interest of that beneficiary terminates. If a beneficiary does not survive you by 15 days, then the benefit will be paid as though the beneficiary died before you unless Aflac has paid the benefit before receiving notice of the beneficiary's death. If no beneficiary survives you, Aflac will pay the benefit to your estate.

The rider will terminate upon the earlier of the termination of the policy to which it is attached, your failure to pay premiums for the rider, or your death.

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(5) Exceptions, Reductions and Limitations of the Policy:

Aflac will not pay benefits for services rendered by you or a member of the Immediate Family of a Covered Person.

For any benefit to be payable, the Injury, treatment, or loss must occur on or after the Effective Date of coverage and while coverage is in force.

Aflac will not pay benefits for treatment or loss due to Sickness including (1) any bacterial, viral, or microorganism 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.

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 the coverage or any prior claim under any other Aflac coverage for which benefits were received that were not lawfully due and that fraudulently induced payment.

Aflac will not pay benefits for an Injury, treatment, or loss that is caused by or occurs as a result of a Covered Person's:

- Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve;
- 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 cause of the loss occurred);
- Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions) or voluntarily

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taking any kind of poison or inhaling any kind of gas or fumes;

- Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any detention facility or penal institution;
- Intentionally self-inflicting a bodily injury, or committing or attempting suicide, while sane or insane;
- Having cosmetic surgery or other elective procedures that are not Medically Necessary; or
- Having dental treatment except as a result of Injury.

(6) Renewability. The policy is guaranteed-renewable for your lifetime by the timely payment of premiums at the rate in effect at the beginning of each term, except that we may discontinue or terminate the policy if you have performed an act or practice that constitutes fraud, or have made an intentional misrepresentation of material fact, relating in any way to the policy, including claims for benefits under the policy. Premium rates may be changed only if changed on all policies of the same form number and class in force in your state.

RETAIN THIS OUTLINE OF COVERAGE FOR YOUR RECORDS.
THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF YOUR POLICY.
THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

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TERMS YOU NEED TO KNOW

ACCIDENTAL-DEATH: Death of a covered person caused by a covered injury. See the limitations and exclusions for injuries not covered by the policy.

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

The ADLs are:

- 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; and
- Eating: Performing all major tasks of getting food into your body.

CATASTROPHIC LOSS: An injury that results in total and permanent or irrevocable loss of: the sight of one eye; the use of one hand/arm; or the use of one foot/leg.

COMMON-CARRIER ACCIDENT: An accident 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 on the application: individual (named insured listed in the Policy Schedule), named insured/spouse only (named insured and spouse), one-parent family (named insured and dependent children), or two-parent family (named insured, spouse, and dependent children). Spouse is defined as the person to whom you are legally married and who is listed on your application. Newborn children are automatically covered under the terms of the policy from the moment of birth. If individual or named insured/spouse only coverage is in force and you desire uninterrupted coverage for a newborn child, you must notify Aflac in writing within 31 days of the child's birth. Upon notification, Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due, if any. Coverage provided under any one-parent family or two-parent family policy will continue to include any other 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 prior to age 26 and while covered under the policy. Dependent children are your natural children, stepchildren, or legally adopted children who are under age 26. Children born to your dependent children or children born to the dependent children of your spouse are not covered under the policy. A dependent child (including persons incapable of self-sustaining employment by reason of mental retardation or physical handicap) must be under age 26 at the time of application to be eligible for coverage.

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

HAZARDOUS ACTIVITY ACCIDENT: An accident 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 pilot, officer, or member of the crew of an aircraft, having any duties aboard an aircraft, or 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 for which a room charge is made. The hospital confinement must be on the advice of a physician, medically necessary, and the result of a covered injury. 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. See the limitations and exclusions for injuries not covered by the policy.

ORGANIZED SPORTING ACTIVITY: A competition or supervised organized practice for a competition. The competition must be governed by a set of written rules, be officiated by someone certified to act in that capacity, and overseen by a legal entity such as a public school system or sports conference. The legal entity must have a set of bylaws and competition must be on a regulation playing surface. Participation must be on an amateur basis. The organized sporting activity benefit is not payable for injuries that are caused by or occur as a result of a covered person's participating in any sport or sporting activity for wage, compensation, or profit, including officiating or coaching; or racing any type vehicle in an organized event.

OTHER ACCIDENT: An accident 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.

SICKNESS: An illness, disease, infection, disorder, or condition not caused by an injury, occurring on or after the effective date of coverage and while coverage is in force.

Refer to the outline of coverage and policy for complete benefit details, definitions, limitations, and exclusions.

ADDITIONAL INFORMATION

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

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

The term hospital emergency room does not include urgent care centers.

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

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

Burns must be treated by a physician within 72 hours after a covered accident. If a covered person receives one or more skin grafts for a covered burn, we will pay a total of 50 percent of the burns benefit amount that we paid for the burn involved.

Dislocations must be diagnosed by a physician within 72 hours after the date of the injury and require correction by a physician. It can be corrected by open or closed reduction. We will pay for no more than two dislocations per covered accident, per covered person. Benefits are payable for only the first dislocation of a joint. If a dislocation is reduced with local or no anesthesia by a physician, we will pay 25 percent of the amount shown for the closed reduction dislocation.

Coma must have a duration of at least seven days. The condition must require intubation for respiratory assistance. Coma does not include any medically induced coma.

Emergency dental work does not include false teeth such as dentures, bridges, veneers, partials, crowns, or implants. We will pay for no more than one emergency dental work benefit per covered accident, per covered person.

Fractures must be diagnosed by a physician within 14 days after the date of the injury and require correction by a physician. It can be corrected by open or closed reduction. We will pay for no more than two fractures per covered accident, per covered person. For the closed reduction for chip fractures and other fractures not reduced by open or closed reduction, we will pay 25 percent of the benefit amount shown in the policy.

Lacerations must be repaired within 72 hours after the accident and repaired under the attendance of a physician. A laceration resulting from an open fracture will not be payable under the laceration benefit.

Paralysis must be confirmed by the attending physician. The duration of the paralysis must be a minimum of 30 days. This benefit will be payable once per covered person.

Surgical procedures must be performed within one year of a covered accident. Two or more surgical procedures performed through the same incision will be considered one operation, and benefits will be paid based upon the most expensive procedure.

A miscellaneous surgical procedures benefit is only payable for one miscellaneous surgical procedure, per 24-hour period, even though more than one surgical procedure may be performed.

When a covered person is prescribed, receives, and incurs a charge for an epidural administered into the spine for pain management in a hospital or a physician's office for injuries sustained in a covered accident, we will pay a pain management benefit amount. This benefit is not payable for an epidural administered during a surgical procedure. This benefit is payable no more than twice per covered accident, per covered person.

Aflac®

Refer to the outline of coverage and policy for complete benefit details, definitions, limitations, and exclusions.

Aflac SmartClaim®

One Day Pay℠

aflac.com | 1.800.99.AFLAC (1.800.992.3522)

One Day Pay℠ available for most properly-documented, individual Accident claims submitted online through Aflac SmartClaim® by 3 p.m. ET. Aflac SmartClaim® not available on the following: Aflac Plus Rider. Processing time is based on business days after all required documentation needed to render a decision is received and no further validation and/or research is required. Individual Company Statistic, 2015.

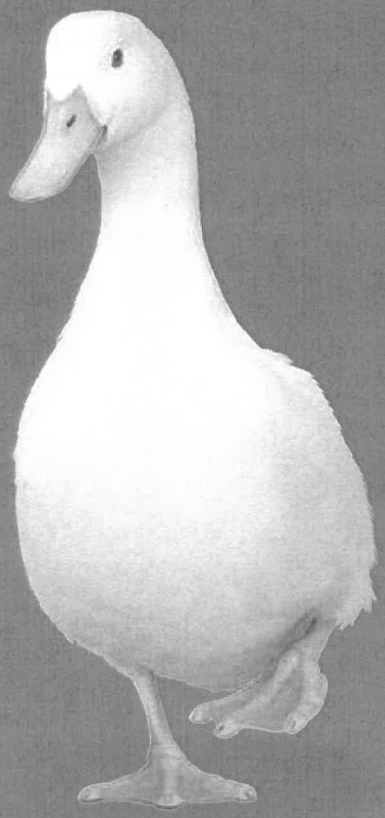
Underwritten by:
American Family Life Assurance Company of Columbus
Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999

FSC MIX Paper FSC® C007639

Aflac Critical Care Protection

SPECIFIED HEALTH EVENT INSURANCE – OPTION 1

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



Aflac®

AFLAC CRITICAL CARE PROTECTION

SPECIFIED HEALTH EVENT INSURANCE – OPTION 1

Policy A74100VA; Riders A74050VA and A74051VA

CCP[1]

Critical care for you. Added financial protection for your family.

Aflac's Critical Care Protection policy helps provide financial peace of mind if you experience a serious health event, such as a heart attack or stroke. You will receive a lump sum benefit upon diagnosis of a covered event with additional benefits to be paid for things such as a hospital confinement, ambulance, transportation, lodging, and therapy.

All benefits are paid directly to you, unless otherwise assigned, and can be used for any out-of-pocket expenses you have such as car payments, mortgage or rent payments, or utility bills. Aflac Critical Care Protection allows you to help protect the things you love the most from the things you expect the least.

Get the facts:

FACT NO. 1

ABOUT EVERY **34** SECONDS

AN AMERICAN SUFFERS A HEART ATTACK.[1]

FACT NO. 2

ABOUT EVERY **40** SECONDS

SOMEONE IN THE UNITED STATES HAS A STROKE.[1]

[1]*Heart Disease and Stroke Statistics,* 2014 Update, American Heart Association.

Aflac herein means American Family Life Assurance Company of Columbus.

Understand the difference Aflac can make in your financial security.

Aflac pays cash benefits directly to you, unless you choose otherwise. Aflac Critical Care Protection is designed to provide you with cash benefits if you experience a specified health event, such as sudden cardiac arrest or end-stage renal failure. This means that you will have added financial resources to help with expenses incurred due to a serious health event, to help with ongoing living expenses, or to help with any purpose you choose.

An illness or injury can happen to anyone, anytime–and when it does, everyday expenses may suddenly seem overwhelming. Fortunately, Aflac's Critical Care Protection can help with those everyday expenses, so all you have to focus on is getting well.

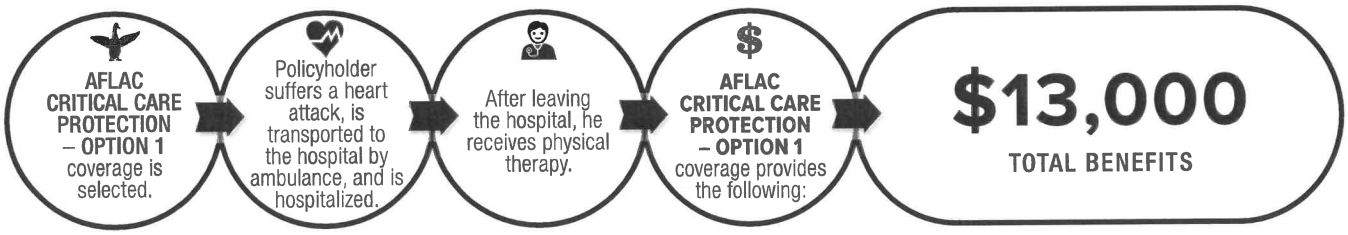
Aflac Critical Care Protection offers more types of benefits compared to other critical illness coverage on the market:

- Pays $7,500 upon diagnosis of having had a specified health event, which increases to $10,000 for dependent children
- Pays $300 per day for covered hospital stays
- Pays benefits for physical therapy, speech therapy, rehabilitation therapy, home health care, and many more
- Transportation and lodging benefits payable for travel to receive treatment
- Guaranteed-renewable–as long as premiums are paid, the policy cannot be canceled

Specified health events covered by the Critical Care Protection policy include:

- Heart Attack
- Stroke
- Coronary Artery Bypass Graft Surgery (CABG)
- Sudden Cardiac Arrest
- Third-Degree Burns
- Coma
- Paralysis
- Major Human Organ Transplant
- End-Stage Renal Failure
- Persistent Vegetative State

How it works



The above example is based on a scenario for Aflac Critical Care Protection – Option 1 that includes the following benefit conditions: First-Occurrence Benefit (heart attack) of $7,500, Ambulance Benefit (ground ambulance transportation) of $250, Hospital Confinement Benefit (5 days) of $1,500, and Continuing Care Benefit (30 days) of $3,750.

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. Policy Form A74100VA; Rider Forms A74050VA and A74051VA; and Application Forms A74001cVA, A74001VA, A74001GcVA, and A74001GVA.

Aflac Critical Care Protection – Option 1 Benefit Overview

BENEFIT NAME	BENEFIT AMOUNT
[redacted]	[redacted]

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

LIMITED BENEFIT

AFLAC CRITICAL CARE PROTECTION

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

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

SPECIFIED HEALTH EVENT INSURANCE
Supplemental Health Insurance Coverage
Policy Form Series A74100

1. **Read Your Policy Carefully:** This document provides a very brief description of some of the important features of the 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. **Specified Health Event Insurance Coverage** is designed to supplement your existing accident and sickness coverage only when certain losses occur as a result of Specified Health Events or other conditions as specified. Specified Health Events are: Heart Attack, Stroke, End-Stage Renal Failure, Major Human Organ Transplant, Third-Degree Burns, Persistent Vegetative State, Coma, Paralysis, Coronary Artery Bypass Graft Surgery (CABG), or Sudden Cardiac Arrest. Coverage is provided for the benefits outlined in **(3) Benefits.** The benefits described in **(3) Benefits** may be limited by **(5) Exceptions, Reductions, and Limitations of the Policy.**

3. **Benefits:** While coverage is in force, Aflac will pay the following benefits, as applicable, subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions. The term "Hospital Confinement" does not include emergency rooms. Treatment or confinement in a U.S. government Hospital does not require a charge for benefits to be payable.

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

   Dependent Children
   $10,000 (Lifetime maximum $10,000 per Covered Person)

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

   B. **SUBSEQUENT SPECIFIED HEALTH EVENT BENEFIT:** If benefits have been paid to a Covered Person under the First-Occurrence Benefit above, Aflac will pay $3,500 if such Covered Person is later diagnosed as having had a subsequent Specified Health Event.

   For the Subsequent Specified Health Event Benefit to be payable, the subsequent Specified Health Event must occur 180 days or more after the occurrence of any previously paid Specified Health Event for such Covered Person. No lifetime maximum.

   C. **CORONARY ANGIOPLASTY BENEFIT:** Aflac will pay $1,000 when a Covered Person has a Coronary Angioplasty, with or without stents.

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

   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 Loss, Aflac will pay $300 per day for each day a Covered Person is charged as an inpatient. **This benefit is limited to confinements for the treatment of a covered Loss that occur within 500 days following the occurrence of the most recent covered Loss. No lifetime maximum.**

   Hospital Confinement Benefits are payable for only one covered Loss at a time per Covered Person. Confinement in a U.S. government Hospital does not require a charge for benefits to be payable.

   This benefit is not payable on the same day as the Continuing Care Benefit. The highest eligible benefit will be paid.

   E. **AMBULANCE BENEFIT:** If, due to a covered Loss, 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 Loss, we will pay $2,000. A licensed professional ambulance company must provide the ambulance service. This benefit will not be paid for more than two times per occurrence of a Loss.
   This benefit is not payable beyond the 180th day following the occurrence of a covered Loss. No lifetime maximum.

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

   F. **CONTINUING CARE BENEFIT:** If, as the result of a covered Loss, a Covered Person receives any of the following treatments from a licensed Physician, Aflac will pay $125 each day a Covered Person is charged:

   1. rehabilitation therapy
   2. physical therapy
   3. speech therapy
   7. home health care
   8. dialysis
   9. hospice care

4. occupational therapy
5. respiratory therapy
6. dietary therapy/consultation
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 Loss. Daily maximum for this benefit is $125 regardless of the number of treatments received.

This benefit is not payable on the same day as the Hospital Confinement Benefit. The highest eligible benefit will be paid. 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 Loss, Aflac will pay 50 cents per mile for noncommercial travel or the costs incurred for commercial travel (coach class plane, train, or bus fare) 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. Reimbursement will be made only for the method of transportation actually taken. This benefit will be paid only for the Covered Person for whom the special treatment is prescribed. If the special treatment is for a Dependent Child and commercial travel is necessary, we will pay this benefit for up to two adults to accompany the Dependent Child. The benefit amount payable is limited to $1,500 per occurrence of a covered Loss. **Transportation Benefits are not payable beyond the 180th day following the occurrence of a covered Loss. 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 the charges incurred up to $75 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 special medical treatment for a covered Loss 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 Loss.

This benefit is not payable beyond the 180th day following the occurrence of a covered Loss. No lifetime maximum.

I. **WAIVER OF PREMIUM BENEFIT:**

Employed: If you, due to a covered Specified Health Event, are completely unable to do all of the Usual and Customary Duties of your occupation for a period of 180 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued total inability. For premiums to be waived, Aflac will require an employer's statement and a Physician's statement of your total 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 covered Specified Health Event, are completely unable to perform three or more of the Activities of Daily Living (ADLs) without Direct Personal Assistance for a period of 180 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued total inability. For premiums to be waived, Aflac will require a Physician's statement of your total 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.

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

1. Your policy has been in force for at least six months;
2. We have received premiums for at least six consecutive months;
3. Your premiums have been paid through payroll deduction, and you leave your employer for any reason;
4. You or your employer 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 or any other method agreed to by Aflac and the employer.

4. **Optional Benefits:**

FIRST-OCCURRENCE BUILDING BENEFIT RIDER: (Series A74050) Applied for ❑ Yes ❑ No

The First-Occurrence Benefit, as defined in the policy, 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 policy, 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. (If the rider is Individual coverage, no further premium will be billed for the rider after the payment of benefits.)

SPECIFIED HEALTH EVENT RECOVERY BENEFIT RIDER: (Series A74051) Applied for ❑ Yes ❑ No

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 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, Major Human Organ Transplant, Third-Degree Burns, Persistent Vegetative State, Coma, Paralysis, Coronary Artery Bypass Graft Surgery (CABG), or Sudden Cardiac Arrest occurring on or after the Effective Date of coverage under the rider. (If the rider is Individual coverage, no further premium will be billed for the rider after the payment of lifetime maximum benefits.)

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.

Lifetime maximum of six months per Covered Person.

5. **Exceptions, Reductions, and Limitations of the Policy (not a daily hospital expense plan):**

   A. Aflac will not pay benefits for any claims incurred during the first twelve months for Pre-existing Conditions.

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

   C. 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.

   D. For any benefit to be payable, the Loss must occur on or after the Effective Date of coverage and while coverage is in force. If more than one Specified Health Event per Covered Person occurs on the same day, only the highest eligible benefit will be paid.

   E. Aflac will not pay benefits whenever fraud is committed in making a claim under the coverage.

   F. **The policy does not cover Losses or confinements caused by or resulting from:**

      1. Participating in, or attempting to participate in, an illegal activity that is defined as a felony ("felony" is as defined by the law of the jurisdiction in which the activity takes place);
      2. Intentionally self-inflicting a bodily Injury or committing or attempting suicide, while sane or insane;
      3. Having elective surgery that is not Medically Necessary within the first 12 months of the Effective Date of coverage; or
      4. Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve. (Aflac will upon receipt of written notice of military service, refund all premiums as is applicable to such persons on a pro rata basis.)

   PRE-EXISTING CONDITION LIMITATIONS: A "Pre-existing Condition" is an illness, disease, infection, disorder, or Injury for which, within the 12-month period before the Effective Date of coverage, prescription medication was taken or medical testing, medical advice, consultation, or treatment was recommended by or received from a Physician, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Claims incurred during the first twelve months after the Effective Date of coverage will not be covered for pre-existing conditions.

6. **Renewability:** The policy is guaranteed-renewable for your lifetime by the timely payment of premiums at the rate in effect at the beginning of each term. 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 IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.
REFER TO THE POLICY FOR COMPLETE DEFINITIONS, DETAILS, LIMITATIONS AND EXCLUSIONS.

TERMS YOU NEED TO KNOW

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

The ADLs are:

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

COMA: a continuous state of profound unconsciousness lasting for a period of seven or more consecutive days and characterized by the absence of: (1) spontaneous eye movements, (2) response to painful stimuli, and (3) vocalization. The condition must require intubation for respiratory assistance. The term coma does not include any medically induced coma. The coma must begin on or after the effective date of coverage and while coverage is in force for benefits to be payable.

CORONARY ANGIOPLASTY: a medical procedure in which a balloon is used to open narrowed or blocked blood vessels of the heart (coronary arteries). This procedure may be performed with or without stents.

CORONARY ARTERY BYPASS GRAFT SURGERY (CABG): open-heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as but not limited to coronary angioplasty, valve replacement surgery, stent placement, laser relief, or other surgical or nonsurgical procedures.

COVERED PERSON: any person insured under the coverage type that you applied for on the application: individual (named insured listed in the Policy Schedule), named insured/spouse only (named insured and spouse), one-parent family (named insured and dependent children), or two-parent family (named insured, spouse, and dependent children). Spouse is defined as the person to whom you are legally married and who is listed on your application. Newborn children are automatically covered under the terms of the policy from the moment of birth. If individual or named insured/spouse only coverage is in force and you desire uninterrupted coverage for a newborn child, you must notify Aflac in writing within 31 days of the child's birth. Upon notification, Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due, if any. One-parent family or two-parent family coverage will continue to include any other dependent child, regardless of age, who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap, and who became so incapacitated prior to age 26. 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 intellectual disability or physical handicap) must be under age 26 at the time of application to be eligible for coverage.

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

END-STAGE RENAL FAILURE: permanent and irreversible kidney failure, not of an acute nature.

HEART ATTACK: a myocardial infarction. 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, cardiac arrest, or any other dysfunction of the cardiovascular system. The heart attack must occur on or after the effective date of coverage and while coverage is in force for benefits to be payable. Sudden cardiac arrest is not a heart attack.

HOSPITAL: a legally operated institution licensed by the state in which it is located that maintains and uses a laboratory, X-ray equipment, and an operating room on its premises or in facilities available to it on a prearranged, written, contractual basis. 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 professional nurse, and maintain the patients' written histories and medical records on the premises. The term hospital also includes ambulatory surgical centers. The term hospital does not include any institution or part thereof used as an emergency room; a rehabilitation unit; a hospice unit, including any bed designated as a hospice bed or a swing bed; a transitional care unit; a convalescent home; a rest or nursing facility; a psychiatric unit; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

HOSPITAL CONFINEMENT: a stay of a covered person confined to a bed in a hospital for a period of 23 hours or more for which a room charge is made. The hospital confinement must be on the advice of a physician and medically necessary. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable.

INTOXICANTS AND NARCOTICS: Aflac will not be liable for any loss resulting from the insured's being drunk, or under the influence of any narcotic, unless taken on the advice of a physician.

LOSS: a specified health event or coronary angioplasty occurring on or after the effective date of coverage and while coverage is in force.

MAJOR HUMAN ORGAN TRANSPLANT: a surgery in which a covered person receives, as a result of a surgical transplant, one or more of the following human organs: kidney, liver, heart, lung, or pancreas. **This does not include transplants involving mechanical or nonhuman organs.**

PARALYSIS: complete and total loss of use of two or more limbs (paraplegia, quadriplegia, or hemiplegia) for a continuous period of at least 30 days as the result of a spinal cord injury. The paralysis must be confirmed by the attending physician. The spinal cord injury causing the paralysis must occur on or after the effective date of coverage and while coverage is in force for benefits to be payable.

PERSISTENT VEGETATIVE STATE: a state of severe mental impairment in which only involuntary bodily functions are present for a continuous period of at least 30 days and for which there exists no reasonable expectation of regaining significant cognitive function. The procedure for establishing a persistent vegetative state is as follows: two physicians, one of whom must be the attending physician, who, after personally examining the covered person, shall certify in writing, based upon conditions found during the course of their examination, that:

1. The covered person's cognitive function has been substantially impaired; and
2. There exists no reasonable expectation that the covered person will regain significant cognitive function.

PHYSICIAN: a person legally qualified to practice medicine, other than you or a member of your immediate family, who is licensed as a physician by the state where treatment is received to treat the type of condition for which a claim is made.

SPECIFIED HEALTH EVENT: heart attack, stroke, end-stage renal failure, major human organ transplant, third-degree burns, persistent vegetative state, coma, paralysis, coronary artery bypass graft surgery (CABG), or sudden cardiac arrest.

STROKE: apoplexy due to rupture or acute occlusion of a cerebral artery. 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), cerebrovascular insufficiency, or lacunar infarction (LACI).

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 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.

THIRD-DEGREE BURNS: an area of tissue damage in which there is destruction of the entire epidermis and underlying dermis and that covers more than 10 percent of total body surface. The damage must be caused by heat, electricity, radiation, or chemicals. This does not include skin abrasions caused by falling on and scraping skin on asphalt, concrete, or any other surface.

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

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Aflac Short-Term Disability Insurance

DISABILITY INCOME PROTECTION

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

Aflac®

AFLAC SHORT-TERM DISABILITY INSURANCE

DISABILITY INCOME PROTECTION

Policy A57600VA and Riders A57650VA, A57651VA, and A57653VA

SD

Helping Pay Your Bills, While You Pay Attention to You

What if one day, not very far in the future, you become disabled and you can't go to work. How would you pay for the expenses of daily life such as monthly mortgage or rent, groceries and your utilities? The bills keep on coming even if you're unable to work. That's where Aflac's short-term disability insurance policy can help make the difference. It's a source of monthly income you may need to help take care of your bills while you take care of yourself.

Why Aflac Short-Term Disability may be the best choice for you:

- It's sold on an individual basis. You choose the plan that's right for you based on your financial needs and income.
- We offer the option of guaranteed-issue,[1] short-term disability coverage. That means no medical questionnaire is required.
- We pay you a cash benefit for each day you are disabled.[2]

Here's how we can help

When disabled, you may not only lose the ability to earn a living, but you may also lose savings or retirement funds. The financial obligations can be overwhelming. Disability insurance plays an integral and important role in your financial planning.

Aflac provides benefits for both total and partial disability. Even if you're able to work, partial disability benefits may be available to help compensate for lost income.

Aflac does not coordinate benefits. Regardless of any other disability insurance you may have, including Social Security, we will pay you directly.

The facts say you need the protection of the Aflac Short-Term Disability plan:

FACT NO. 1

BEFORE THEY RETIRE, **1-in-4** AMERICANS ENTERING THE WORKFORCE WILL BECOME DISABLED.[3]

FACT NO. 2

NEARLY **90%** OF DISABILITIES ARE NOT WORK RELATED.[3]

[1]Subject to certain conditions.
[2]Subject to your benefit period and elimination period.
[3]2015 Disability Insurance Awareness Month, Facts from LIMRA.

Aflac herein means American Family Life Assurance Company of Columbus.

Understand the difference Aflac makes in your financial security.

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

Coverage Options

Choose the Policy You Need

BENEFIT	DESCRIPTION

OPTIONAL RIDERS

All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations and other policy terms.

*Subject to certain conditions/maximum.

How it works

The above example is based on a scenario for Aflac Short-Term Disability that includes the following benefit conditions: ages 18–49, employed full-time at the time disability began, $2,000 monthly disability benefit amount, $40,000 annual salary, elimination period 0/7 days, 6 month benefit period, benefits based on policy premiums being paid with after-tax dollars.

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 complete benefit details, definitions, limitations, and exclusions. Policy Form A57600VA; Rider Forms A57650VA, A57651VA, and A57653VA; and Application Forms A57601RcVA, A57601RVA, A57601RGcVA, and A57601RGVA.

SHORT-TERM DISABILITY COVERAGE

DISABILITY INCOME PROTECTION

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

DISABILITY INCOME PROTECTION COVERAGE
Policy Series A57600

1. **Read Your Policy Carefully.** This document provides a very brief description of the important features of the coverage. 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. Short-term Disability coverage is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or Sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

3. **Benefits.** The following benefits are a part of the policy.

   Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

   Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will be payable only after the policy has been in force ten months. The maximum period of Disability allowed for Disability due to childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

   Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to a Physician's statement to determine whether you are qualified to receive Disability benefits or whether you are unable to perform three or more ADLs and require Direct Personal Assistance. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

   A. **TOTAL DISABILITY BENEFITS:**

      1. **Working Full Time:** If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

         If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Total Disability. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

         You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, or (2) working at any job for which the person is or becomes qualified by reason of education, training or experience.

      2. **Not Working Full Time:** If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

         If you are unable to perform three or more ADLs within 90 days of your last treatment that is a result of a covered Sickness or Off-the-Job Injury, as certified by a Physician, and you require Direct Personal Assistance to perform such ADLs, we will pay you the Daily Disability Benefit for each day you cannot perform such ADLs. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

         You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, (2) working at any job for which the person is or becomes qualified by reason of education, training or experience, or (3) Physician no longer being able to certify that you are unable to perform three or more ADLs that require Direct Personal Assistance.

   Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to the same or a related condition, until 180 days or more after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under the policy.

   Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under the policy.

   Periods of Disability meeting either of these separation requirements will begin a new Total Disability Benefit Period, subject to a new Elimination Period.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of three months) and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, or (2) working at any job for which a person is or becomes qualified by reason of education, training or experience earning 80 percent or more of your pre-Disability Annual Income.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum period of three months of Disability under this benefit has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to the same or a related condition, until 180 days or more after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under the policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Partial Disability Benefit Period has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under the policy.

Periods of Disability meeting either of these separation requirements will begin a new Partial Disability Benefit Period (a maximum period of three months), subject to a new Elimination Period.

The Partial Disability Benefit Period is not subject to the Total Disability Benefit Period.

C. WAIVER OF PREMIUM BENEFIT: If your covered Sickness or covered Off-the-Job Injury causes your Total Disability or Partial Disability for more than 90 consecutive days (or after the Elimination Period shown in the Policy Schedule, whichever is greater) while the policy is in force, Aflac will waive, from month to month, the premium for the policy and any applicable rider(s) for as long as you remain disabled, up to the applicable Benefit Period shown in the Policy Schedule.

For premiums to be waived, Aflac will require an employer's statement (or proof of your inability to perform three or more ADLs) and a Physician's statement certifying your inability to perform said duties or activities, and may each month thereafter require a Physician's statement that your inability to perform said duties or activities continues. Aflac may ask for and use an independent consultant to determine your Disability when this benefit is in force.

You must pay all premiums to keep the policy and any applicable rider(s) in force until Aflac approves your claim for this Waiver of Premium Benefit. You must also resume premium payment to keep the policy and any applicable rider(s) in force, beginning with the first premium due after you no longer qualify for Disability benefits.

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

4. OPTIONAL BENEFITS:

Disability Benefit for On-the-Job Injury Rider: (Series A57650) Applied For: ☐ Yes ☐ No

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered On-the-Job Injury and occurs while coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Injury. **We reserve the right to a Physician's statement to determine whether you are qualified to receive Disability benefits or whether you are unable to perform three or more ADLs and require Direct Personal Assistance. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

A. TOTAL DISABILITY BENEFITS:

1. **Working Full Time:** If you have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

   If your covered On-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Total Disability. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

   You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, or (2) working at any job for which the person is or becomes qualified by reason of education, training or experience.

2. **Not Working Full Time:** If you do not have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

   If you are unable to perform three or more ADLs within 90 days of your last treatment that is a result of a covered On-the-Job Injury, as certified by a Physician, and you require Direct Personal Assistance to perform such ADLs, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day you cannot perform such ADLs.

This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, (2) working at any job for which the person is or becomes qualified by reason of education, training or experience, or (3) Physician no longer being able to certify that you are unable to perform three or more ADLs that require Direct Personal Assistance.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to the same or a related condition, until 180 days or more after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under the policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under the policy.

Periods of Disability meeting either of these separation requirements will begin a new Total Disability Benefit Period, subject to a new Elimination Period.

B. **PARTIAL DISABILITY BENEFIT:** If you have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of three months) and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, or (2) working at any job for which the person is or becomes qualified by reason of education, training or experience earning 80 percent or more of your pre-Disability Annual Income.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum period of three months of Disability under this benefit has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to the same or a related condition, until 180 days or more after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under the policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Partial Disability Benefit Period has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under the policy.

Periods of Disability meeting either of these separation requirements will begin a new Partial Disability Benefit Period (a maximum period of three months), subject to a new Elimination Period.

The Partial Disability Benefit Period is not subject to the Total Disability Benefit Period.

C. **WAIVER OF PREMIUM BENEFIT:** If your covered On-the-Job Injury causes your Total Disability or Partial Disability for more than 90 consecutive days (or after the Elimination Period shown in the Policy Schedule, whichever is greater) while the rider is in force, Aflac will waive, from month to month, the premium for the policy and any applicable rider(s) for as long as you remain disabled, up to the applicable Benefit Period shown in the Policy Schedule.

For premiums to be waived, Aflac will require an employer's statement (or proof of your inability to perform three or more ADLs) and a Physician's statement certifying your inability to perform said duties or activities, and may each month thereafter require a Physician's statement that your inability to perform said duties or activities continues. Aflac may ask for and use an independent consultant to determine your Disability when this benefit is in force.

You must pay all premiums to keep the policy and any applicable rider(s) in force until Aflac approves your claim for this Waiver of Premium Benefit. You must also resume premium payment to keep the policy and any applicable rider(s) in force, beginning with the first premium due after you no longer qualify for Disability benefits.

The Waiver of Premium Benefit is not available with a three-month Total Disability Benefit Period.

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

Additional Units of Disability Benefit Rider:
(Series A57651) Applied For: ☐ Yes ☐ No

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will be payable only after the rider has been in force ten months. The maximum period of Disability allowed for Disability due to childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to a Physician's statement to determine whether you are qualified to receive Disability benefits or whether you are unable to perform three or more ADLs and require Direct Personal Assistance. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

This benefit will be paid under the same terms as the applicable Total Disability Benefit or Partial Disability Benefit as described in your policy. The additional units of coverage will only be payable for a Disability that begins after the Effective Date of the rider.

A. TOTAL DISABILITY BENEFITS:

1. **Working Full Time:** If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

   If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Total Disability. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

   You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, or (2) working at any job for which the person is or becomes qualified by reason of education, training or experience.

2. **Not Working Full Time:** If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

   If you are unable to perform three or more ADLs within 90 days of your last treatment that is a result of a covered Sickness or Off-the-Job Injury, as certified by a Physician, and you require Direct Personal Assistance to perform such ADLs, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day you cannot perform such ADLs. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

   You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, (2) working at any job for which the person is or becomes qualified by reason of education, training or experience, or (3) Physician no longer being able to certify that you are unable to perform three or more ADLs that require Direct Personal Assistance.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to the same or a related condition, until 180 days or more after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under the policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under the policy.

Periods of Disability meeting either of these separation requirements will begin a new Total Disability Benefit Period, subject to a new Elimination Period.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of three months) and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, or (2) working at any job for which the person is or becomes qualified by reason of education, training or experience earning 80 percent or more of your pre-Disability Annual Income.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum period of three months of Disability under this benefit has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to the same or a related condition, until 180 days or more after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under the policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job

for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Partial Disability Benefit Period has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under the policy.

Periods of Disability meeting either of these separation requirements will begin a new Partial Disability Benefit Period (a maximum period of three months), subject to a new Elimination Period.

The Partial Disability Benefit Period is not subject to the Total Disability Benefit Period.

Aflac Value Rider:
(Series A57653) Applied For: ☐ Yes ☐ No

Aflac will pay you the greater of:

(i) $1,000 less any claims paid (excluding any Waiver of Premium Benefit paid under the policy; or
(ii) $100

at the end of every consecutive five-year period from the rider Effective Date for which the rider remains in force. Each subsequent consecutive five-year period begins on the day after the previous consecutive five-year period ends. If you receive this Aflac Value Benefit and later file a claim that includes days of Disability occurring during the consecutive five-year period that qualified you to receive this Aflac Value Benefit, then we will reduce the amount payable for those days of Disability by the amount you received under the rider less $100.

Both the policy and the rider must remain in force for five consecutive years for you to be eligible for the Aflac Value Benefit. If the rider is issued after the Effective Date of the policy, the initial consecutive five-year period begins on the rider Effective Date. This benefit is limited to five payments per lifetime.

The rider will terminate on the earlier of: (1) the termination of the policy to which the rider is attached (subject to the Grace Period Provision listed in the policy); (2) your failure to pay the premiums for the rider; (3) your receipt of five payments under the rider; (4) your age at the time of any payment under the rider is 70 or greater and your policy will terminate before any subsequent payment under the rider is due; or (5) your death. When the rider terminates (is no longer in force), no further premium will be charged for it.

IMPORTANT PROVISIONS OF THE POLICY

LIMITATIONS AND EXCLUSIONS

A. Disability caused by a Pre-existing Condition will not be covered unless it begins 12 months after the Effective Date of coverage.

B. Aflac will not pay benefits for an illness, disease, infection, or disorder that is diagnosed or treated by a Physician within the first 30 days after the Effective Date of coverage, unless the resulting Disability begins more than 30 days after the Effective Date of coverage.

C. Aflac will not pay benefits for a Disability that is being treated outside the territorial limits of the United States.

D. 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.

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

F. Aflac will not pay benefits for a Disability that is caused by or occurs as a result of any bacterial, viral, or micro-organism infection or infestation, or any condition resulting from insect, arachnid, or other arthropod bites or stings as a Disability due to an Injury; such disability will be covered to the same extent as a Disability due to Sickness.

G. Aflac will not pay benefits for a disability that is caused by or occurs as a result of your:

1. Pregnancy or childbirth within the first ten months of the Effective Date of coverage (Complications of Pregnancy will be covered to the same extent as a Sickness);
2. Participating in any activity or event, including the operation of a vehicle, while under the influence of any narcotic unless taken on the advice of a Physician or while intoxicated ("intoxicated" means that condition as defined by the law of the jurisdiction in which the accident occurred);
3. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place);
4. Intentionally self-inflicting a bodily injury, or committing or attempting suicide, while sane or insane;
5. Having cosmetic surgery or other elective procedures that are not Medically Necessary (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);
6. Having dental treatment, except as a result of Injury;
7. Being exposed to war or any act of war, declared or undeclared or actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve (Aflac will upon receipt of written notice of military service, refund all premiums as is applicable to such persons on a pro rata basis);
8. Donating an organ within the first 12 months of the Effective Date of the policy;
9. Mental or emotional disorders, including but not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, or post-partum depression. The policy will pay, however, for covered disabilities resulting from Alzheimer's disease, or similar forms of senility or senile dementia, that manifests itself while coverage is in force;
10. Work related Injuries.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury.

PRE-EXISTING CONDITION LIMITATIONS: A "Pre-existing Condition" is an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability caused by a Pre-existing Condition will not be covered unless it begins 12 months after the Effective Date of coverage.

Renewability. The policy is guaranteed-renewable to age 75 by payment of the premium in effect at the beginning of each renewal period. Premium rates may be changed only if changed on all policies of the same form number and class in force in your state.

RETAIN FOR YOUR RECORDS.
THIS IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.
REFER TO THE POLICY AND RIDER(S) FOR COMPLETE DEFINITIONS, DETAILS, LIMITATIONS AND EXCLUSIONS.

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.

DAILY DISABILITY BENEFIT: one-thirtieth of the applicable monthly disability benefit shown in the Policy Schedule.

EFFECTIVE DATE: the date(s) coverage begins as shown in the Policy Schedule. The effective date of the policy is not the date you signed the application for coverage.

FULL-TIME JOB: one job at which you work 19 or more hours per week for one employer for pay or benefits.

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.

OFF-THE-JOB INJURY: an injury that occurs while you are not working at any job for which the person is or becomes qualified by reason of education, training or experience for pay or benefits.

ON-THE-JOB INJURY: an injury that occurs while you are working at any job for pay or benefits.

PARTIAL DISABILITY: being under the care and attendance of a physician due to a condition that causes you to be unable to perform one or more but not all of the material and substantial duties of your full-time job, but able to work at any job for which the person is or becomes qualified by reason of education, training or experience earning less than 80 percent of your annual income of your full-time job at the time you became disabled.

SICKNESS: an illness, disease, infection, or any other abnormal physical condition, independent of injury, that is manifested and treated more than 30 days after the effective date of coverage and while coverage is in force.

TOTAL DISABILITY: being under the care and attendance of a physician due to a condition that causes you to be unable to perform the material and substantial duties of your full-time job, and not working at any job for which you are qualified for by reason of education, training or experience.

ADDITIONAL INFORMATION

Complications of pregnancy do not include premature delivery without incidence, multiple gestation pregnancy, false labor, occasional spotting, prescribed rest during pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy not constituting a classifiably distinct pregnancy complication. Cesarean deliveries are not considered complications of pregnancy.

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

Aflac®

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

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American Family Life Assurance Company of Columbus
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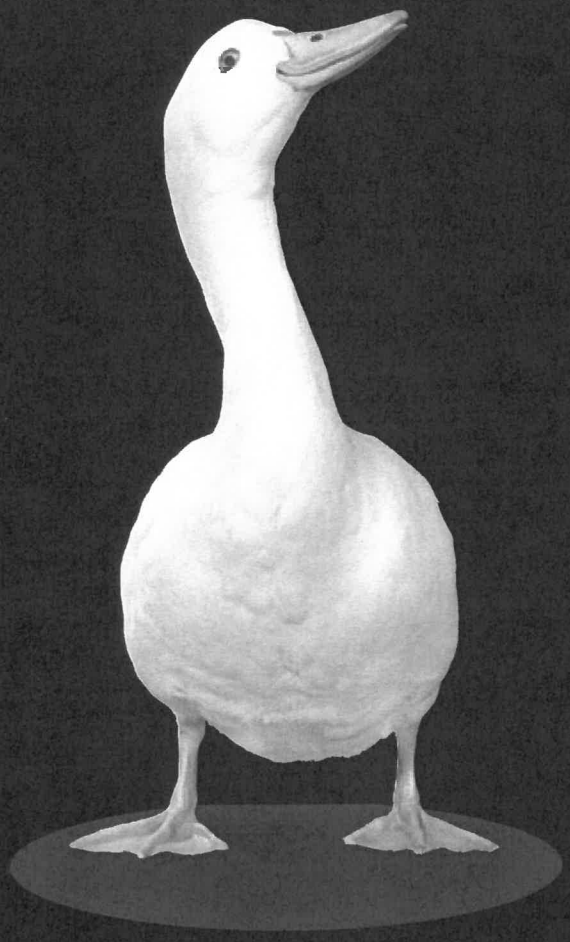
Peace of Mind *and* Cash Benefits



PERSONAL CANCER INDEMNITY
CANCER INDEMNITY INSURANCE

PCI^2

Aflac®

We've got you under our wing.®

PERSONAL CANCER INDEMNITY

CANCER INDEMNITY INSURANCE

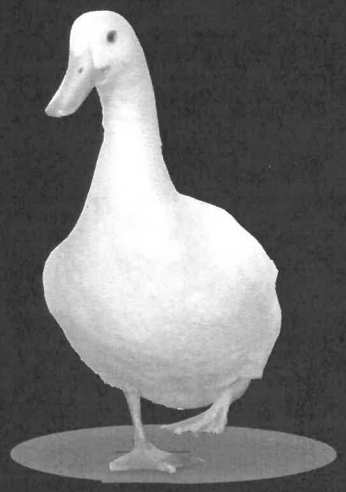
Policy Series A-75200

PCI²

Despite the best efforts of doctors, researchers, and countless organizations, cancer remains a concern for many individuals and families. People from all walks of life are at risk, regardless of age, gender, or ethnic background. Here are a couple of statistics to help you understand the role cancer plays in America's overall health. According to the American Cancer Society:*

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. About 1,596,670 new cancer cases are expected to be diagnosed in 2011.

*Cancer Facts & Figures 2011.



ARE YOU PROTECTED IF SOMETHING UNEXPECTED HAPPENS?

HERE'S HOW WE CAN HELP.

Aflac's Personal Cancer Indemnity insurance policy helps you focus on getting well instead of being distracted by the stress and costs of medical and personal bills. With Aflac, you receive cash benefits directly, unless assigned—giving you the flexibility to help pay bills related to treatment like deductibles, copayments, and travel expenses. Aflac can also help with everyday living expenses, such as car payments, mortgage or rent payments, child care, and utility bills.

1. Your coverage is portable, which means it goes with you if you change jobs.
2. Guaranteed-Renewable – As long as your premiums are paid, your coverage is guaranteed.
3. Our policies have no deductibles, copayments, or network restrictions—you choose your own medical treatment provider.

Aflac herein means American Family Life Assurance Company of Columbus.

PEACE *of* MIND. CASH BENEFITS.

OUR INSURANCE POLICIES HELP PROVIDE BOTH.

FIRST-OCCURRENCE BENEFIT: *Aflac will pay $2,000 for the insured, $2,000 for the spouse, or $3,000 for children* when a covered person is diagnosed with internal cancer. This benefit is payable only once for each covered person and will be paid in addition to any other benefit in the policy. Internal cancer includes melanomas classified as Clark's Level III and higher, or a Breslow level greater than 1.5 mm. In addition to the pathological or clinical diagnosis required by the policy, we may require additional information from the attending physician and hospital. Any covered person who has had a previous diagnosis of cancer will not be eligible for a First-Occurrence Benefit under the policy for a recurrence, extension, or metastatic spread of that same cancer.

HOSPITAL CONFINEMENT BENEFIT: *Aflac will pay $300 per day* when a covered person is confined to a hospital for treatment of cancer and is charged for a room as an inpatient. *Benefits increase to $600 per day* beginning with the 31st day of continuous confinement.

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 remaining benefits do not require a covered person to be charged for such services.

MEDICAL IMAGING BENEFIT: *Aflac will pay $150 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, MRIs, bone scans, multiple gated acquisition (MUGA) scans, positron emission tomography (PET) scans, or transrectal ultrasounds. These exams must be performed in a hospital, an ambulatory surgical center, or a physician's office. This benefit is payable once per calendar year, per covered person.

RADIATION AND CHEMOTHERAPY BENEFIT: *Aflac will pay $300 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 (limited to $300 per daily treatment).
   c. Medications dispensed by a pump or implant (limited to $300 for the initial prescription and $300 for each pump refill).
   d. Oral chemotherapy, regardless of where administered (limited to $300 per prescription).
2. Radiation therapy.
3. The insertion of interstitial or intracavitary application of radium or radioisotopes.

Self-injected medications and oral chemotherapy will be administered based on the receipt of (a) a standard prescription (30-day supply) for oral chemotherapy and (b) the initial prescription for an infusion pump (or a refill thereof), which can be administered by the covered person without the supervision of medical personnel. 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, simulations, dosimetries, treatment plannings, 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. This benefit is not payable the same day the Experimental Treatment Benefit is paid.

THE POLICY HAS LIMITATIONS AND EXCLUSIONS THAT MAY AFFECT THE BENEFITS PAYABLE. THIS BROCHURE IS FOR ILLUSTRATION PURPOSES ONLY. REFER TO THE POLICY AND RIDERS FOR COMPLETE DEFINITIONS, DETAILS, LIMITATIONS, AND EXCLUSIONS.

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*Cancer Facts & Figures 2011, American Cancer Society.

EXPERIMENTAL TREATMENT BENEFIT: *Aflac will pay $300 per day* 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:

- Treatment administered by medical personnel in a physician's office, clinic, or hospital.
- Self-injected medications (limited to $300 per daily treatment, subject to a monthly maximum of $2,400).
- Medications dispensed by a pump (limited to $300 for the initial prescription and $300 for each refill, subject to a monthly maximum of $1,200).
- Oral medications, regardless of where administered (limited to $300 per prescription, subject to a monthly maximum of $1,200 for all prescriptions).

Treatments must be approved by the National Cancer Institute (NCI) as viable experimental treatments for cancer. This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, 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. This benefit is not payable the same day the Radiation and Chemotherapy Benefit is paid.

IMMUNOTHERAPY BENEFIT: *Aflac will pay $400 per calendar month* during which a charge is incurred for a covered person who receives immunoglobulins or colony stimulating factors as prescribed by a physician as part of a treatment regimen for internal cancer. Any medications paid under the Radiation and Chemotherapy Benefit or the Experimental Treatment Benefit will not be paid under the Immunotherapy Benefit. Lifetime maximum of $2,000 per covered person.

NURSING SERVICES BENEFIT: *Aflac will pay $125 per 24-hour day* if, while confined in a hospital, a covered person requires and is charged for private nursing services other than those regularly furnished by the hospital. 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.

ANTINAUSEA BENEFIT: *Aflac will pay $125 per calendar month* during which a charge is incurred for a covered person who receives antinausea drugs that are prescribed while receiving radiation or chemotherapy treatments.

SKIN CANCER SURGERY BENEFIT: *Aflac will pay the indemnity ($100 to $600)* listed when a surgical operation is performed on a covered person for a diagnosed skin cancer and a charge is incurred for the specific procedure. The benefit listed in the policy includes anesthesia services.

SURGICAL/ANESTHESIA BENEFIT: *Aflac will pay the indemnity ($100 to $5,000)* listed in the Schedule of Operations when a surgical operation is performed on a covered person for a diagnosed internal cancer and 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 similar in severity and gravity. (Exceptions: Surgery for skin cancer will be payable under the Skin Cancer Surgery Benefit.

Reconstructive surgery will be paid under the Reconstructive Surgery Benefit.) Two or more surgical procedures performed through the same incision will be considered one operation, and the highest eligible benefit will be paid.

Aflac will pay an indemnity benefit equal to 25 percent 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.

OUTPATIENT HOSPITAL SURGICAL BENEFIT: *Aflac will pay $300* when a surgical operation is performed on a covered person for a diagnosed internal cancer and an operating room charge is incurred. Surgeries must be performed on an outpatient basis in a hospital, to include an ambulatory surgical center. This benefit is not payable for surgery performed in a physician's office or for skin cancer surgery. This benefit is payable in addition to the Surgical/Anesthesia Benefit, is payable once per day, and is not payable the same day as the Hospital Confinement Benefit.

PROSTHESIS BENEFIT: *Aflac will pay $3,000* 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 per covered person.

Aflac will pay $225 when a charge is incurred for nonsurgically implanted prosthetic devices that are prescribed as a direct result of cancer treatment. Lifetime maximum of $450 per covered person.

The Prosthesis Benefit does not include coverage for a breast transverse rectus abdominus myocutaneous (TRAM) flap procedure listed under the Reconstructive Surgery Benefit.

RECONSTRUCTIVE SURGERY BENEFIT: *Aflac will pay the indemnity ($350 to $3,000)* listed when a surgical operation is performed on a covered person for reconstructive surgery for the treatment of cancer and a charge is incurred for the specific procedure. *Aflac will pay an indemnity benefit equal to 25 percent* of the amount shown in the policy 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 in the policy for the operation most similar in severity and gravity.

IN-HOSPITAL BLOOD AND PLASMA BENEFIT: *Aflac will pay $100 times the number of days paid under the Hospital Confinement Benefit* if a covered person receives blood and/or plasma during a covered hospital confinement and a charge is incurred. This benefit does not pay for immunoglobulins, immunotherapy, or colony-stimulating factors.

OUTPATIENT BLOOD AND PLASMA BENEFIT: *Aflac will pay $250 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, and a charge is incurred. This benefit does not pay for immunoglobulins, immunotherapy, or colony-stimulating factors.

SECOND SURGICAL OPINION BENEFIT: *Aflac will pay $250* when a charge is incurred for a second surgical opinion by a licensed physician concerning cancer surgery for a diagnosed cancer. This benefit is not payable the same day the NCI Evaluation/Consultation Benefit is payable.

NATIONAL CANCER INSTITUTE (NCI) EVALUATION/CONSULTATION BENEFIT: *Aflac will pay $500* 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. If the NCI-designated cancer center is more than 50 miles from the covered person's residence, *Aflac will pay $250* for the transportation and lodging of the covered person receiving the evaluation/consultation.

This benefit is also payable at the Aflac Cancer Center and Blood Disorders Service of Children's Healthcare of Atlanta. This benefit is not payable the same day the Second Surgical Opinion Benefit is payable. This benefit is payable only once under the policy per covered person.

AMBULANCE BENEFIT: *Aflac will pay $200 for ground ambulance transportation or $1,000 for air ambulance transportation when a charge is incurred for ambulance transportation* of a covered person to or from a hospital where the covered person receives cancer treatment. This benefit is limited to two trips per confinement. The ambulance service must be performed by a licensed professional ambulance company.

TRANSPORTATION BENEFIT: *Aflac will pay 50 cents per mile* for round-trip transportation between the hospital or medical facility and the residence of the covered person when a covered person requires cancer treatment that has been prescribed by the local attending physician. Benefits are limited to $1,500 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, Aflac 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.

LODGING BENEFIT: *Aflac will pay $60 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.

BONE MARROW TRANSPLANTATION BENEFIT: *Aflac will pay $10,000* when a covered person incurs a charge for a bone marrow transplantation for the treatment of cancer. This does not include the harvesting of peripheral blood cells or stem cells and subsequent reinfusion. *Aflac will pay the covered person's bone marrow donor a benefit of $1,000* for his or her expenses

incurred as a result of the transplantation procedure. Lifetime maximum of $10,000 per covered person.

STEM CELL TRANSPLANTATION BENEFIT: *Aflac will pay $5,000* when a charge is incurred if a covered person receives a peripheral stem cell transplantation for the treatment of cancer. This benefit does not include the harvesting, storage, and subsequent reinfusion of bone marrow from the recipient or a matched donor under general anesthesia. This benefit is payable once per covered person. Lifetime maximum of $5,000 per covered person.

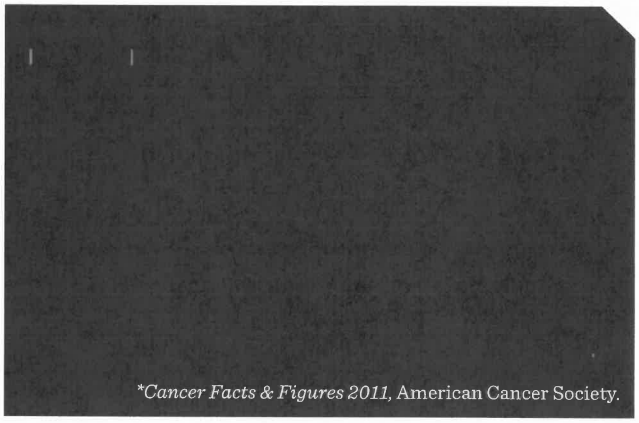
EGG HARVESTING AND STORAGE (CRYOPRESERVATION) BENEFIT: *Aflac will pay $1,500* for a covered person to have oocytes extracted and harvested. In addition, Aflac will pay, one time per covered person, $500 for the storage of a covered person's oocytes or sperm when a charge is incurred to store with a licensed reproductive tissue bank or similarly licensed facility. Any such extraction, harvesting, or storage must occur prior to chemotherapy or radiation treatment that has been prescribed for the covered person's treatment of cancer. Lifetime maximum of $2,000 per covered person.

EXTENDED-CARE FACILITY BENEFIT: *Aflac will pay $75 per day for the first 30 days and $150 per day beginning with the 31st day* when a charge is incurred if a covered person receives Hospital Confinement Benefits and, within 30 days of hospital confinement, is confined 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. For each day this benefit is payable, Hospital Confinement Benefits are not payable. 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. Lifetime maximum of 100 days per covered person.

HOSPICE BENEFIT: *Aflac will pay a one-time benefit of $1,000 for the first day and $50 per day thereafter* for hospice care when a covered person is diagnosed with cancer, therapeutic intervention directed toward the cure of the disease is medically determined no longer appropriate, and the covered person's prognosis is one in which there is a life expectancy of six months or less as the direct result of cancer. This benefit is not payable the same day the Home Health Care Benefit is payable. Lifetime maximum of $12,000 per covered person.

HOME HEALTH CARE BENEFIT: *Aflac will pay $75 per day for the first 30 days and $150 per day beginning the 31st day* when a charge is incurred and the covered person receives home health care within 30 days of hospital confinement as the direct result of cancer. This benefit is not payable the same day the Hospice Benefit is payable. Lifetime maximum of 100 days per covered person.

CANCER SCREENING WELLNESS BENEFIT: *Aflac will pay $75* per calendar year when a covered person receives 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 also payable for an FDA-approved cancer prevention vaccine. The vaccine must be administered by licensed medical personnel. This benefit is limited to one payment per calendar year, per covered person. This benefit is a preventive benefit; a diagnosis of cancer is not required for this benefit to be payable.



**Cancer Facts & Figures 2011,* American Cancer Society.

THE FOLLOWING BENEFITS HAVE NO LIFETIME MAXIMUM: Hospital Confinement, Medical Imaging, Radiation and Chemotherapy, Experimental Treatment, Antinausea, Nursing Services, Surgical/Anesthesia, Outpatient Hospital Surgical, Skin Cancer Surgery, Reconstructive Surgery, In-Hospital Blood and Plasma, Outpatient Blood and Plasma, Second Surgical Opinion, Ambulance, Transportation, Lodging, and Cancer Screening Wellness.

WAIVER OF PREMIUM BENEFIT: If you, due to having internal cancer, are completely unable to do all of the usual and customary duties of your occupation [or, 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. Aflac may ask for and use an independent consultant to determine whether you can perform an ADL without assistance.

Aflac will also waive, from month to month, any premiums falling due while you are receiving hospice benefits under the Hospice Benefit.

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 your new employer's payroll deduction process or direct payment to Aflac. You will again become eligible to receive this benefit after you re-establish your premium payments through payroll deduction for a period of at least six months, and 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.)

TERMS YOU NEED TO KNOW

EFFECTIVE DATE: The Effective Date of the policy 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 children to age 26. Newborn children are automatically insured from the moment of birth. *One-parent family coverage* includes the insured and all dependent children to age 26.

GUARANTEED-RENEWABLE: The policy is Guaranteed-Renewable for your lifetime, subject to Aflac's right to change premiums by class upon any renewal date.

WHAT IS NOT COVERED

LIMITATIONS AND EXCLUSIONS

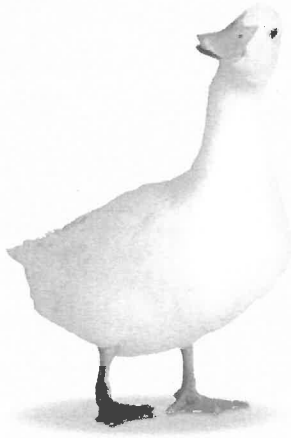
Aflac pays only for treatment of cancer, including direct extension, metastatic spread, or recurrence, or any conditions or diseases directly caused or aggravated by the specified diseases or the treatment of the specified diseases. Benefits are not provided for premalignant conditions; conditions with malignant potential; or any other disease, sickness, or incapacity. Pathological proof of diagnosis must be submitted. Clinical diagnosis will be accepted when a pathological diagnosis is medically inappropriate, provided medical evidence sustains the diagnosis and the covered person receives treatment for cancer.

The First-Occurrence Benefit is not payable for: (1) any internal cancer diagnosed or treated before the Effective Date of the policy and the subsequent recurrence, extension, or metastatic spread of such internal cancer that is diagnosed prior to the Effective Date of the policy; (2) 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 the policy for a recurrence, extension, or metastatic spread of that same cancer.

A 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.

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

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



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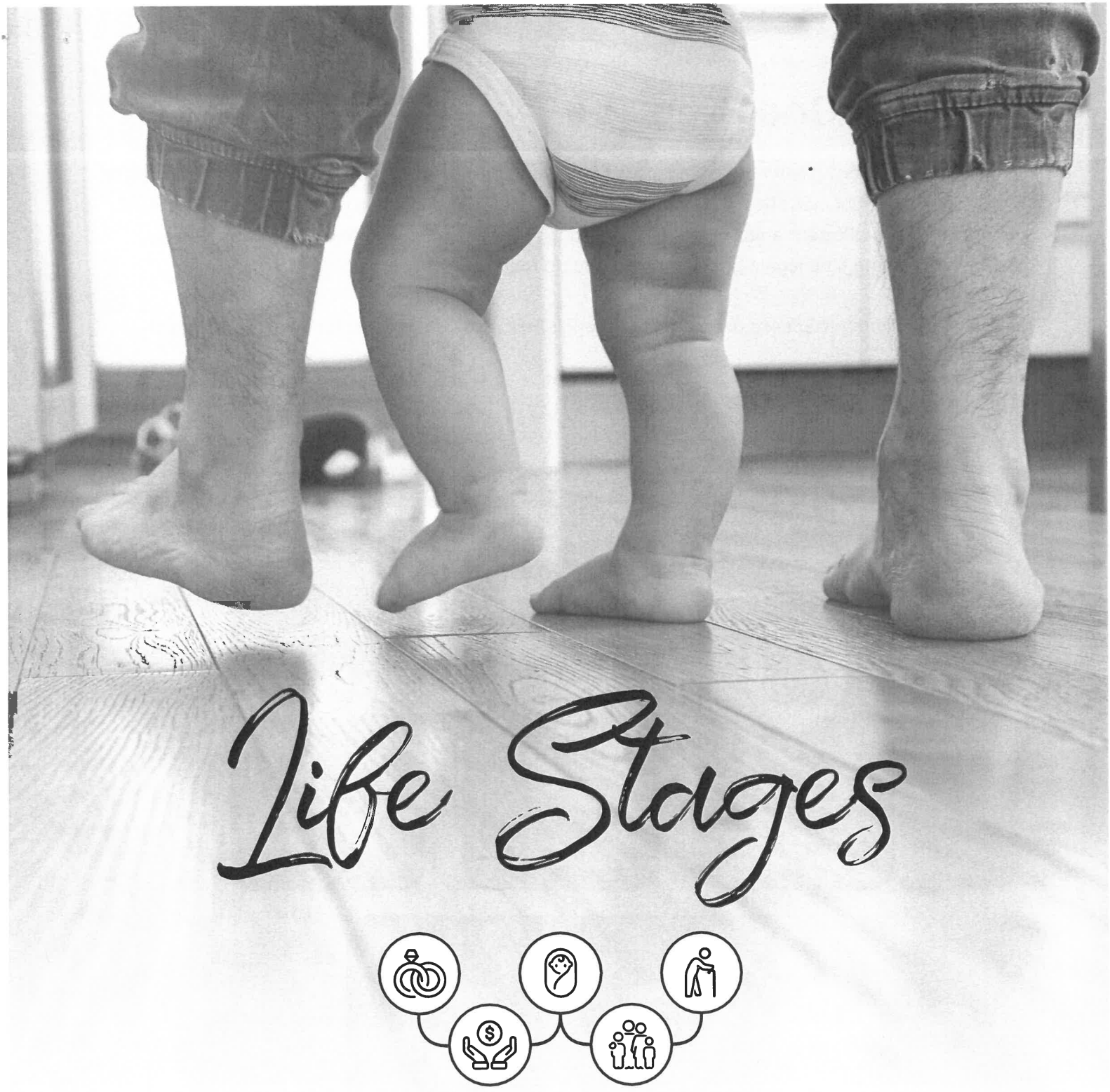


Life Stages

Addressing Your Legal Needs
at Every Stage of Life

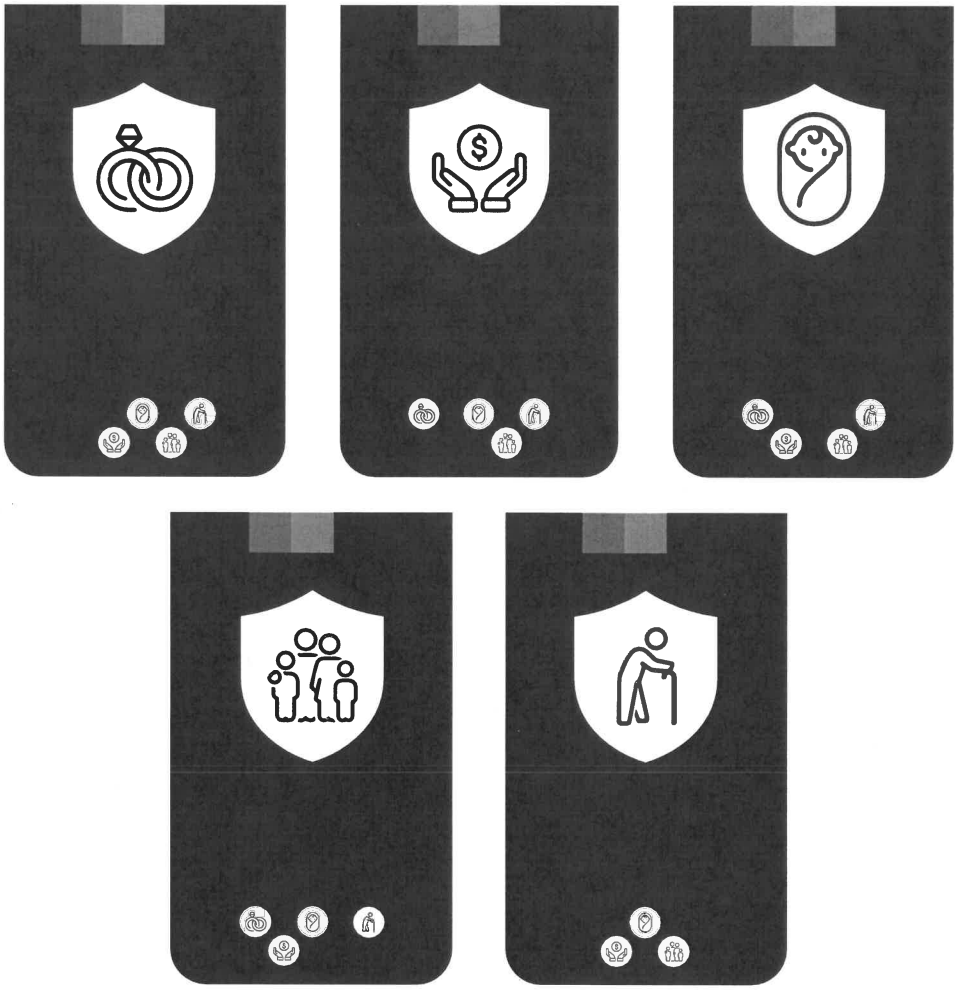
LegalShield®

Take Life One Step at a Time

There are key events in life when having a law firm in your corner isn't just a good idea, it's a necessity. Throughout these specific life stages, we all encounter situations that require an attorney that is knowledgeable in different areas of law. From getting married to end-of-life preparations, you can rest easier knowing your legal rights are protected no matter what stage of life you're in.

By providing affordable access to an attorney, LegalShield has you covered for all of life's biggest occasions.

Legal Stages



Life Stage: Getting Married

Marriage is one of the most beautiful bonds two people can share, but it is important to remember that it is also a legally binding contract. And as is the case with any contract, it is critical that you consult with a lawyer throughout the process. This is an exciting time in your life, and you and your spouse should be free to begin your married life free from distractions. Before you say, "I do," it's best to let a knowledgeable law firm take care of the legal needs so you can simply focus on your wedding.

Our legal plan was created to provide peace of mind and help remove the confusion of legal matters. When planning a wedding, you should not have to work to interpret (or worse yet, enforce) agreements, contracts, purchase orders, etc. Leave that to a LegalShield Provider Law Firm as you embark on this journey of joy and happiness.

Top Legal Needs Associated with Marriage

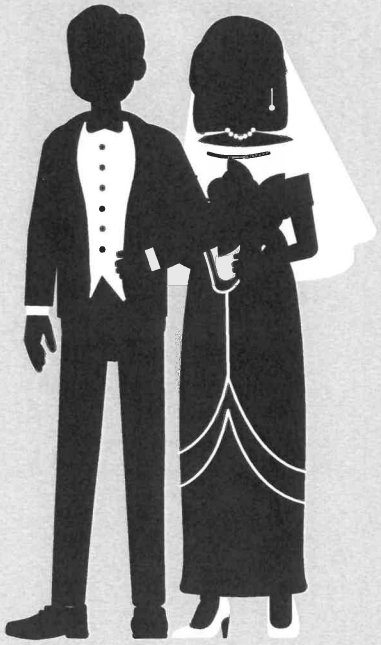
Prenuptial Agreement	Name Change	Will Preparation	Child Custody/Child Support
Average Cost: $1,500	Average Cost: $900	Average Cost: $2,000	Average Cost: $4,000

Total Cost: $8,400 | Annual LegalShield Membership: $300 | Savings: $8,100

Amounts based on LegalShield Provider Law Firm average rates. Exact costs are determined by law firms.
Savings are based on LegalShield annual membership fee of $300 per year.

Carl and Alison

As Carl and Alison plan their upcoming wedding and talk to various vendors, they come to the realization that they are likely going to end up spending thousands of dollars on their ceremony and festivities. They quickly discover that they will also need to enter into a growing number of contractually binding agreements with vendors such as the wedding planner, DJ, caterer, florist, and more. Having a LegalShield attorney that they can consult throughout the entire process helps ease their mind and protect their expenses.



Life Stage: Financial Decisions

Purchasing a new home is one of the biggest investments you will make in your life. The decisions made when buying a home can have lasting consequences, yet most adults go through this process on their own. Buying a home is expensive and many people simply don't think they can budget a lawyer on top of the investment of becoming a homeowner. Fortunately, LegalShield provides an affordable solution.

A legal plan can lead you through the ins and outs of buying a home (and also leasing one) while ensuring that you make responsible choices and investments. You can rest easier knowing that an attorney is available for consultation and to help review contracts or write letters on your behalf. Should the other party not hold up their end of the contract, your attorney will send a letter on your behalf.

Top Legal Needs Associated with Financial Decisions

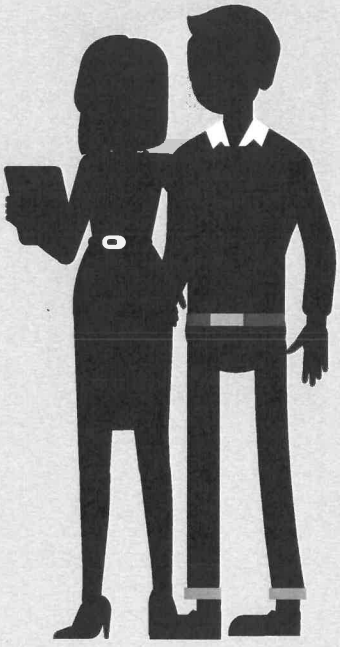
General Legal Consultation	General Contract Review	Prepare Purchase/Selling Agreement
Average Cost: $300/h	Average Cost: $750/h	Average Cost: $500/h

Total Cost: $1,550 | Annual LegalShield Membership: $300 | Savings: $1,250

Amounts based on LegalShield Provider Law Firm average rates. Exact costs are determined by law firms.
Savings are based on LegalShield annual membership fee of $300 per year.

Patty

Like many families, Patty is in the process of renting her first home with her husband before they commit to buying their dream home. Having a lawyer review the lease documents could potentially save the couple thousands while they search for a home to purchase. And when they are eventually ready to invest in buying a home, the same legal guidance will further keep costs down – empowering Patty and her husband to go through the process with more confidence and less stress.



Life Stage: Family Additions

Welcoming a new child to your family is one of life's most joyous and exciting events. But it can also be stressful. Regardless of whether he or she is your biological child, or adopted, you are bringing a new human being into your life who requires love, care and planning. And protecting your loved ones from the unknown can be demanding and costly. While overwhelmed with joy over your new child, you might not have stopped to think about the legal considerations that come with adding a new member to your family.

A LegalShield Provider Attorney will help you navigate your legal needs, giving you more time to enjoy the newest addition to your household, and peace of mind. We back you with a dedicated law firm to help protect your family with consultation on any personal legal matter.

Top Legal Needs Associated with Family Additions

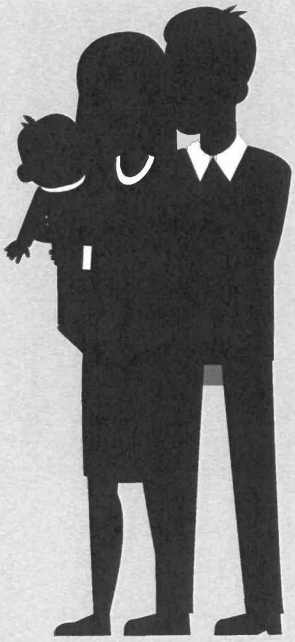
Will Preparation	Power of Attorney Preparation	Uncontested Adoption Representation
Average Cost: $2,000	Average Cost: $280	Average Cost: $1,800

Total Cost: $4,080 | Annual LegalShield Membership: $300 | Savings: $3,780

Amounts based on LegalShield Provider Law Firm average rates. Exact costs are determined by law firms.
Savings are based on LegalShield annual membership fee of $300 per year.

Michael

Following the very time-consuming and stressful process of adoption, Michael, along with his wife and their 3-year-old son, finally welcomed baby Alice into their family. Adding a baby to the family is a time of joy and cheer, but responsible parents also need to take the proper legal steps to care for their kids. Completing or updating a Will is essential for new parents and a provider law firm is there to help every step of the way. For Michael, preparing a Will isn't just about taking care of his assets, it's also about making sure his children are cared for should the unthinkable happen.



Life Stage: Living with Teenagers

During the teenage years, your child begins to gain more independence and is slowly exposed to new legal matters that weren't a concern when they were younger. Simply coming of driving age and getting behind the wheel greatly increases their responsibility and opens them up to further legal problems. Teens also tend to spend more time on the internet, and social media is a powerful tool that can follow them throughout their life. Don't let an ill-advised social post or cyberbullying set back your family.

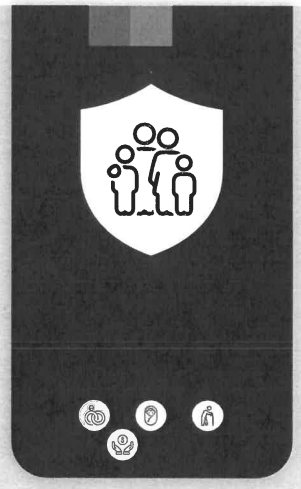
A LegalShield law firm can help mitigate the impact of your family's legal matters. An attorney is available to let you know what legal actions you can take if your child is being bullied, or to review contract agreements that may affect your child such as car purchases, cell phones and student housing. And if your teenager has a traffic-related matter, ranging from a citation to personal injuries resulting in an automobile accident, you can contact your LegalShield Provider Law Firm for assistance.

Top Legal Needs Associated with Teenagers

Representation in Traffic Matter	Review Agreements (car purchases, cell phones and student housing contracts)	General Legal Consultation
Average Cost: $700	Average Cost: $280	Average Cost: $300/h

Total Cost: $1,280 | Annual LegalShield Membership: $300 | Savings: $980

Amounts based on LegalShield Provider Law Firm average rates. Exact costs are determined by law firms. Savings are based on LegalShield annual membership fee of $300 per year.



Jim

After obtaining his driver's license, Jim's seventeen-year-old son, Shawn, recently began driving to school by himself. While late to class one morning, Shawn was caught speeding through a school zone and was issued a citation – which can be a costly legal matter. Thanks to our legal plan, Jim easily used the LegalShield app to take a picture of the ticket and send directly to a LegalShield Provider Law Firm for review. The provider attorney even attended traffic court to help reduce the number of points on Shawn's license.

1 in 5

of 16-year-old drivers has an accident within the first year of driving.*

*11 Facts About Teen Driving, DoSomething.org

Life Stage: Elder Care/End of Life

Many don't want to think about end of life needs because death can be an unpleasant topic. As a result, it's common for adults to avoid preparing for when they're gone. Not having a Will at your passing can impose an additional burden on your family, and your assets may be taken by the state. Anyone with people they love and cherished possessions should have a Will.

Our legal plans give you access to a law firm to help create, update or review your Will. You can do much more than simply stipulate who gets what. Parents can provide for their children and decide how they want them cared for when they are gone. Don't leave the burden of distributing your assets up to the ones you love — or the state.

Top Legal Needs Associated with Elder Care/End of Life

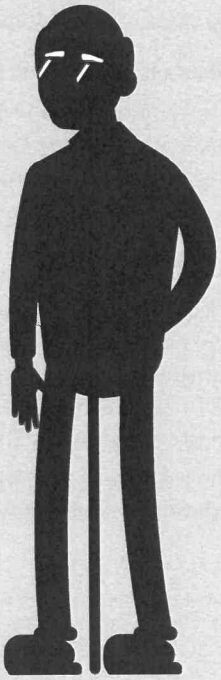
Will Preparation	Power of Attorney Preparation	General Document Review
Average Cost: $2,000	Average Cost: $280	Average Cost: $750

Total Cost: $3,030 | Annual LegalShield Membership: $300 | Savings: 2,730

Amounts based on LegalShield Provider Law Firm average rates. Exact costs are determined by law firms. Savings are based on LegalShield annual membership fee of $300 per year.

Frank

When Frank's father passed without having a Last Will and Testament, his family was left with disagreements related to the estate. Wanting to spare his children from a similar ordeal, Frank created a Will after starting a family of his own. Later in life, Frank discovered LegalShield and uses his membership to keep his Will up-to-date. Using the LegalShield mobile app, he easily initiates the process to make yearly updates as needed to his Will for big life changes such as divorce, remarriage, birth or adoption of a new grandchild, and new assets.



LegalShield provides access to legal services offered by a network of provider law firms to LegalShield members through membership based participation. Neither LegalShield nor its officers, employees or sales associates directly or indirectly provide legal services, representation or advice. See a plan contract at www.legalshield.com for specific state of residence for complete terms, coverage, amounts and conditions.

James Madison University

LegalShield Service Definition Listing

Advice & Consultation	Provider Network

Attorney Advice & Consultation — Covered

LegalShield gives the member the ability to talk to an attorney on any of his/her legal matters without worrying about high hourly rates. The monthly membership fee provides access to legal advice on any legal matter, no matter how traumatic or trivial the issue.

Under this service, an attorney from the Provider Law Firm will discuss the situation with the member, explain the member's rights and options and recommend a course of action.

Letters and Phone Calls Written/Made on the Member's Behalf — Covered

If, after researching the member's legal situation, the Provider Law Firm handling the matter feels the best course of action to resolve the issue is to make a phone call or write a letter on the member's behalf the Provider Law Firm will do so at no additional cost to the member.

Personal Document Review — Covered

Our document review service provides members access to the Provider Law Firm for review of any legal documents that are 10 pages in length or less to include, but not limited to:

- Affidavits
- Deeds
- Demand letters
- Mortgages
- Notes
- Leases
- Contracts

Business Document Review — Covered

The Provider Law Firm will also review one business legal document of 10 pages or less per membership year that the member is signing on behalf of a business so long as the business is a sole proprietorship owned by the member.

Trial Defense — Covered

This membership provides representation to a member who is a defendant in a covered civil action or covered criminal action. The Provider Law Firm will provide advice and consultation regarding criminal and civil litigation matters and answer general questions. More specific services including representation in court and negotiation of settlement will be provided under the preferred member discount.

The Provider Law Firm will provide representation to the member or member's spouse as a defendant for a covered civil action or covered job related criminal action.

Please note the time required to give notice to courts to file an answer varies by state. You should consult with your Provider Law Firm as soon you are aware of a legal matter. This is a general overview of your legal plan coverage for illustration purposes only. See a plan contract for complete terms, coverage, amounts, conditions and exclusions. Some of the benefits are not available in New York and Washington and are not available in Canada.

If additional legal services are necessary beyond the amount of coverage provided based on the contract provisions then the member is entitled to the preferred member discount. The Provider Law Firm is the law firm designated by LegalShield to represent its members in your geographic area, and the Provider Law Firm may designate other law firms to provide covered services.

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Advice & Consultation (continued)

Provider Network

The action must be filed in a state or federal district court. The Provider Law Firm will provide services under the following schedule of hours based on membership year:

Covered

Year	Pre-Trial Hours	Trial Hours	Total Hours
1	2.5	57.5	60
2	3.0	117	120
3	3.5	176.5	180
4	4.0	236	240
5	4.5	295.5	300

Family Matters

Provider Network

Adoption

Covered

The Provider Law Firm will provide advice and consultation on how to obtain a birth certificate for the adopted child and answer questions related to adoption, such as:

- Financing your adoption
- The difference between interstate adoption and international adoptions
- Open versus closed adoptions
- Stepparent adoptions
- Surrogacy issues
- Re-adoption

More specific services will be provided under the preferred member discount such as:

- Obtaining the necessary consent of the parent who is giving up the child
- Filing the adoption petition
- Representing you in court
- Obtaining a new birth certificate indicating the new parent or parents

Child Custody/Child Support

Covered

The Provider Law Firm will provide advice and consultation on child custody and child support, such as:

- Statutory rights to/obligations of child support and custody
- Steps and procedures to initiate or modify child support
- Process and options to collect unpaid child support
- Rules, procedures and options for visitation and custody
- Collecting unpaid back child support
- What to expect in court

More specific services and representation in court will be provided under the preferred member discount.

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Family Matters (continued)	Provider Network

Guardianship or Conservatorship — Covered

The Provider Law Firm will provide advice and consultation on guardianship and conservatorship. Some examples are:

- How to determine if someone needs guardianship/conservatorship
- Am I eligible to be a guardian/conservator?
- What is temporary and permanent guardianship?
- When are guardianships available or necessary?

More specific services and representation in court will be provided under the preferred member discount.

Protection from Domestic Violence — Covered

The Provider Law Firm will provide advice, consultation and document review on issues regarding protection from domestic violence, victim protective orders, temporary restraining orders and similar issues. Also, the Provider Law Firm will provide advice on necessary filing of documentation with the appropriate police and county or district attorney's office. More specific coverage will be provided under the preferred member discount.

Juvenile Court Defense — Covered

The Provider Law Firm will provide advice and consultation on juvenile court matters, including advice on state and local laws on such as:

- Truancy
- Running away from home
- When to report Abuse/Neglect

More specific services and representation in court will be provided under the preferred member discount.

Name Change — Covered

The Provider Law Firm will provide advice and consultation on name changes such as:

- When and how to legally change a name
- An explanation of the documentation and information necessary
- The court process

More specific services and representation in court will be provided under the preferred member discount.

Prenuptial Agreement — Covered

The Provider Law Firm will provide advice and consultation and review prenuptial agreements and provide an explanation to questions such as:

- When is a prenup needed?
- Is a prenup enforceable in my state?
- How do I protect my children in a prenup?

More specific services and representation in court will be provided under the preferred member discount.

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Family Matters (continued)

	Provider Network
Divorce The Provider Law Firm will provide advice, consultation and document review. They will also address the following: • The distinction between a Contested and Uncontested divorce • Considerations of children and custody in divorce • General outline of state laws on division of property • The court process and timing involved in a divorce proceeding and what steps can be taken to speed up the process and reduce the cost. More specific services and representation in court will be provided under the preferred member discount.	Covered
Separation The Provider Law Firm will provide advice and consultation on separation and civil annulments, including: • Whether your state recognizes a legal separation and the requirements for a separation • The affect of an annulment on your family, business and children • What paperwork and legal proceedings are required for separations and annulments • What decisions need to be made More specific services and representation in court will be provided under the preferred member discount.	Covered
Elder Law Matters The Provider Law Firm will provide advice, telephone consultation and document review to members on elder law matters as it relates to the member, including what protections are available to senior citizens under state or local laws and rights and obligations under Medicare or Medicaid, and general legal information on nursing home options.	Covered
Immigration Matters The Provider Law Firm will provide advice, telephone consultation and document review to members on immigration issues, such as: • How to request citizenship, or a work or student Visa • The validity and duration of Visas and other papers This service also includes the Provider Law Firm writing a letter or making a phone call on behalf of the member. The Firm will review documents (up to 10 pages in length per document) that relate to immigration. More specific services will be provided under the preferred member discount.	Covered

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Family Matters (continued)	Provider Network
Incompetency Defense The Provider Law Firm will provide advice and consultation on any incompetency action and the legal necessity and requirements of any proceeding to determine or assess competency, and how mental or physical competency may be relevant in estate matters or guardianship matters. More specific services will be provided under the preferred member discount.	Covered

Auto	Provider Network
Driver's License Recovery This service provides a total of 2 ½ hours of attorney time at no additional charge in each of the following situations: member has been denied a driver's license or a driver's license has been cancelled, suspended or revoked by the Department of Public Safety or Department of Motor Vehicles where a right to appeal is provided by the statute; when legal assistance is needed to reinstate or maintain a driver's license because of job related matters; and when legal assistance is needed to reinstate or maintain a driver's license because of medical reasons.	Covered
Moving Traffic Violations The service provides defense of all covered non-criminal moving traffic violations. The Provider Law Firm must have five business days' notice for court representation. Service is available 15 days after enrollment.	Covered
Accidents This service provides defense of the member by the Provider Law Firm on any criminal charge for manslaughter, involuntary manslaughter, negligent homicide, or vehicular homicide, arising from the permitted use of a licensed motor vehicle.	Covered
Personal Injury Assistance The Provider Law Firm will provide the member with assistance up to, but not including, the filing of a lawsuit, to collect all personal injury and property damage claims of $2,000.00 or less for personal injuries or property damages received as a result of the member driving, riding in or being struck by a motor vehicle or boat.	Covered

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Estate Issues

Provider Network

Wills and Codicils (Including Simple Support Trust for Minor Child) — Covered

The member is entitled to have a standard last Will and testament prepared by the Provider Law Firm. The Provider Law Firm will provide a simple support trust for a minor child if it is included in the Will. The Provider Law Firm also provides annual reviews and makes any necessary changes each membership year. Wills for covered family members are $20.

Living Wills or Healthcare Directives — Covered

Living Wills are prepared for the member and spouse by the Provider Law Firm.

Healthcare Powers of Attorney — Covered

Healthcare powers of attorney are prepared for the member and spouse by the Provider Law Firm.

Trusts — Covered

The Provider Law Firm will provide advice and consultation on the types of trusts available (including revocable or living trust), and the general reasons to create a trust to protect family or assets. More specific services and trust document preparation will be provided under the preferred member discount.

Statutory Powers of Attorney — Covered

The Provider Law Firm will provide members and spouses with Statutory Powers of Attorney in those states which create such documents. Such documents can give someone power or rights to make certain decisions on your behalf.

$ Financial

Provider Network

Bankruptcy — Covered

Our Provider Law Firm will provide advice, telephone consultation and document review on bankruptcy regardless of whether you are the debtor or a creditor, including the differences between Chapter 7, 11 and 13, the requirements for filing any bankruptcy and any plan of reorganization, and the necessary documentation required for any bankruptcy filing. The Provider Law Firm, at their discretion, will review documents up to 10 pages and counsel the member to see if he/she is eligible to file bankruptcy.

More specific services and representation in court will be provided under the preferred member discount.

Consumer Protection Assistance — Covered

This service also includes the Provider Law Firm writing a letter or making a phone call on behalf of the member when deemed appropriate and helpful by the Provider Law Firm.

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Financial (continued)

	Provider Network
The Provider Law Firm will provide representation to the member or member's spouse as a defendant for a covered civil action or covered job related criminal action, including but not limited to situations such as: • Real Estate • Insurance • Construction • Consumer goods and services The action must be filed in a state or federal district court. The Provider Law Firm will provide services under the schedule of hours based on membership year. Please see the Trial Defense section for more details.	Covered

Litigation

	Provider Network
Debt Collection Defense The Provider Law Firm will engage with any creditor to limit creditor harassment prior to a civil litigation being filed. The Provider Law Firm will represent the member in the defense of a covered action for foreclosure, repossessions or debt collection based upon the number of hours available as defined by the membership year, as long as there is a meritorious defense. For example, the first membership year has up to 60 trial hours with 2.5 hours of pre-trial. The action must be filed in a state or federal district court. The Provider Law Firm will provide services under the schedule of hours based on membership year. Please see the Trial Defense section for more details.	Covered
Civil Lawsuits and Criminal Charges The Provider Law Firm will provide representation to the member or member's spouse as a defendant for a covered civil action or covered job related criminal action, including but not limited to situations such as: • Real Estate • Insurance • Construction • Consumer goods and services The action must be filed in a state or federal district court. The Provider Law Firm will provide services under the schedule of hours based on membership year. Please see the Trial Defense section for more details.	Covered
IRS Audit Representation Representation when you receive written notice of a covered audit or when we are required to appear at the IRS office. Members receive one hour of consultation, advice or assistance when notified of an audit or official notice by the IRS of examination in your office, home, or a local IRS office. The member will receive an additional 2.5 hours if settlement is not achieved within 30 days. If the case goes before a court, the member will receive 46.5 hours of Provider Law Firm	Covered

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services. Coverage for this service begins with the tax return due April 15 of the year the member enrolls.

IRS Collection Defense — Covered

The Provider Law Firm will provide advice, consultation and document review, including advice regarding offers in compromise and payment arrangements, when you receive written notice that the Internal Revenue Service intends to collect past due taxes.

Identity Theft Defense — Covered

Our Provider Law Firm will provide advice and consultation on identity theft matters involving creditor actions. The Provider Law Firm will provide a phone call or letter to creditors, credit bureaus and financial institutions. They will also answer questions such as:

- Obtaining copies of documents related to theft
- Stopping collection of the fraudulent debts
- Placing fraud alerts on credit files
- Working with credit reporting agencies to block further fraudulent reports
- Dispute fraudulent information, investigate information and fix reports

More specific services will be provided under the preferred member discount.

Post Judgment Matters — Covered

The Provider Law Firm will provide advice and consultation on post judgment matters and answer general questions such as:

- Telephone consultation after a judicial proceeding to review a judgment or discuss how to execute on a judgment
- The right of appeal or how to collect or garnish a judgment debtor and when appropriate how to modify a judgment

More specific services will be provided under the preferred member discount.

Small Claims Assistance — Covered

This service provides phone advice and consultation for small claims proceedings including review of pleadings as allowed by state regulations, procedure, etc. The small claim action must be filed in a state or federal district court. The Provider Law Firm will provide services under the same schedule of hours as Trial Defense section.

Advice and counseling in the filing and presentation of a claim as a plaintiff in a Small Claims Court.

Advice and counseling in the defense of a claim in a Small Claims Court.

This applies to representation of a member as a defendant in a Small Claims Court in states which permit a party to be represented by an attorney in proceedings.

Please note the time required to give notice to courts to file an answer varies by state. You should consult with your Provider Law Firm as soon you are aware of a legal matter. This is a general overview of your legal plan coverage for illustration purposes only. See a plan contract for complete terms, coverage, amounts, conditions and exclusions. Some of the benefits are not available in New York and Washington and are not available in Canada.

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Property Disputes and Questions — Covered

The Provider Law Firm will provide advice, consultation and document review for all personal real estate matters including:

- Boundary or title disputes
- Landlord/tenant issues
- Security deposit disputes
- Property tax assessments
- Home equity loans
- Mortgage issues

More specific services will be provided under the preferred member discount.

Foreclosure, Repossession and Garnishment Defense — Covered

The Provider Law Firm will provide assistance in including advice concerning any creditor issue to limit creditor harassment. The Provider Law Firm may represent the member in the defense of a covered lawsuit in state or federal district court for foreclosure, repossessions or debt collection based upon the number of hours available as defined by the membership year, as long as, in the provider's independent judgment, there is a meritorious defense. For example, the first membership year has up to 60 trial hours with 2.5 hours of pre-trial.

Our Provider Law Firm will provide advice and consultation on any garnishment defense. More specific services and representation in court on garnishment proceedings will be provided under the preferred member discount.

Tenant Rental Issues — Covered

Enforcement and defense against covered disputes with your landlord about your rights, agreement or obligations as a renter/tenant for your primary residence including coverage for tenant eviction defense.

The action must be filed in a state or federal district court. The Provider Law Firm will provide services under the schedule of hours based on membership year. Please see the Trial Defense section for more details.

Boundary-Title Disputes — Covered

The Provider Law Firm may represent the member in the defense of a covered lawsuit in state or federal district court for boundary-title disputes (such as a dispute over the ownership or size or description of real property, a review of deed, plat maps or title rights, and disputes relating to easements or encroachments) based upon the number of hours available as defined by the membership year, as long as, in the provider's independent judgment, there is a meritorious defense. For example, the first membership year has up to 60 trial hours with 2.5 hours of pre-trial.

More specific services and representation in court will be provided under the preferred member discount.

Please note the time required to give notice to courts to file an answer varies by state. You should consult with your Provider Law Firm as soon you are aware of a legal matter. This is a general overview of your legal plan coverage for illustration purposes only. See a plan contract for complete terms, coverage, amounts, conditions and exclusions. Some of the benefits are not available in New York and Washington and are not available in Canada.

If additional legal services are necessary beyond the amount of coverage provided based on the contract provisions then the member is entitled to the preferred member discount. The Provider Law Firm is the law firm designated by LegalShield to represent its members in your geographic area, and the Provider Law Firm may designate other law firms to provide covered services.

LegalShield℠

Marketed by: Pre-Paid Legal Services, Inc. dba LegalShield℠ and subsidiaries; Pre-Paid Legal Casualty℠, Inc.; Pre-Paid Legal Access, Inc.; In FL: Pre-Paid Legal Services, Inc. of Florida; In VA: Legal Service Plans of Virginia; and PPL Legal Care of Canada Corporation

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Home (continued)	Provider Network
Property Tax Assessment The Provider Law Firm will provide advice, consultation and document review on property tax assessment issues, such as tax assessment review or appraisal by state or local tax authorities, or the annual assessment in connection with the sale or purchase of a home.	Covered
Zoning Applications The Provider Law Firm will provide advice, consultation and document review on zoning applications, which includes advice on county, city or state codes and ordinances and the general process for obtaining necessary variances or permits or licenses; review of building or construction codes of real property.	Covered
Mortgage Document Assistance Review of up to 10 pages of documents that have already been prepared by the lending institution will be provided by the Provider Law Firm.	Covered

Additional Benefits	Provider Network
24/7 Emergency Access After-hours legal consultation for covered legal emergencies such as: if the Covered Person is arrested or detained, seriously injured, served with a warrant, or if the state tries to take the member's child(ren).	Covered
Preferred Member Discount As with any benefit, not every item is covered under the detailed benefits. For those areas that are not expressly covered, our members have access to our Provider Law Firms at the 25% discount hourly rate.	Covered
Online Video Law Library Our Member's Only website has an online legal library of videos that focus on many of today's most common legal concerns.	Covered
Form Service Center Our members have access to several legal forms through our online Forms Service Center. The member can select the form needed, complete it and then send to his/her Provider Law Firm for review. Access to these documents is only a few clicks away.	Covered

Please note the time required to give notice to courts to file an answer varies by state. You should consult with your Provider Law Firm as soon you are aware of a legal matter. This is a general overview of your legal plan coverage for illustration purposes only. See a plan contract for complete terms, coverage, amounts, conditions and exclusions. Some of the benefits are not available in New York and Washington and are not available in Canada.

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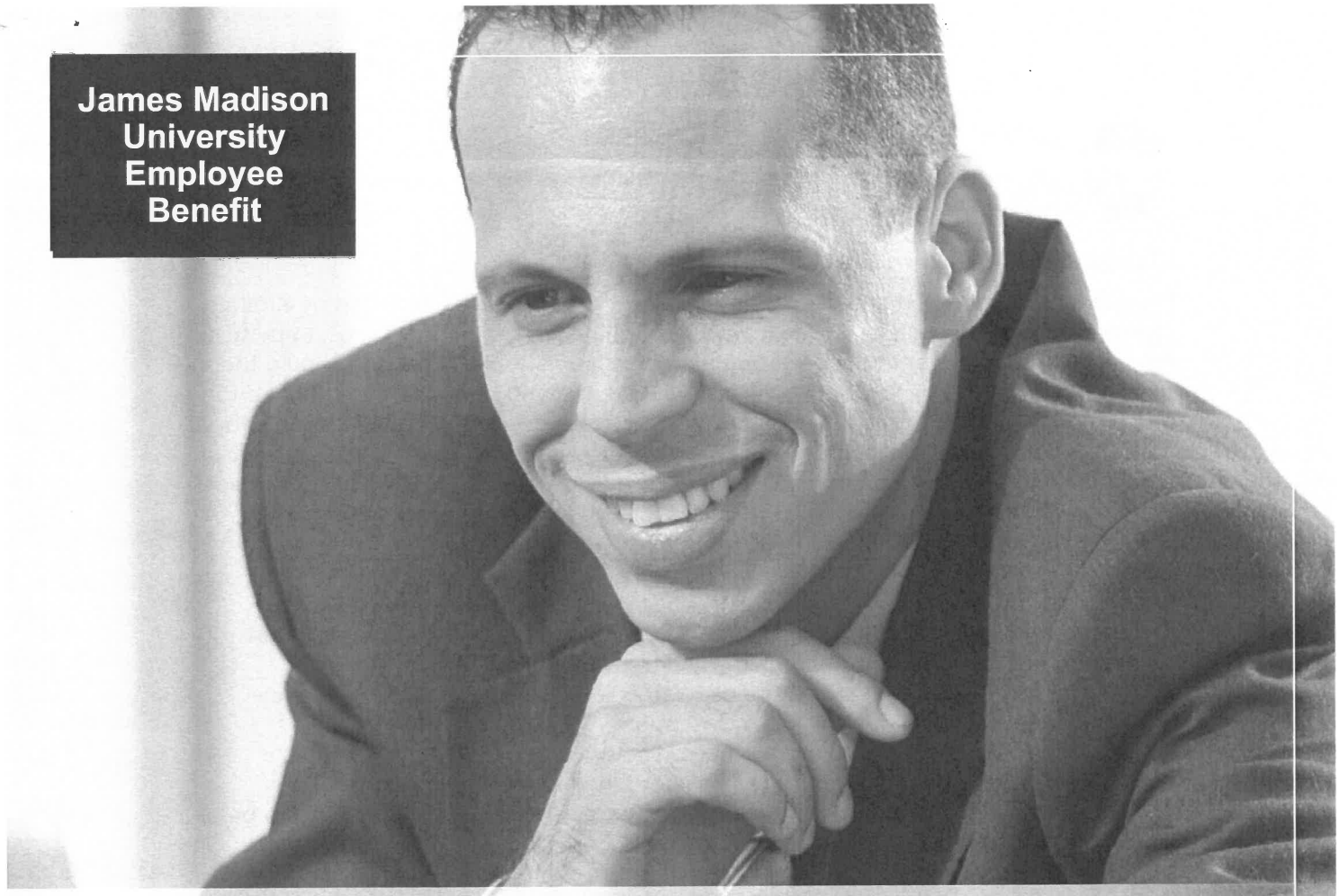
James Madison University Employee Benefit



IDShield Services and Features

IDShield offers one of the most comprehensive products on the market for protecting and restoring your identity. The following is a list of IDShield's specific services and features.

Identity Consultation Services

Members have unlimited access to identity consultation services provided by Kroll's Licensed Private Investigators. The Investigator will advise members on best practices for identity management tailored to the member's specific situation, and should there be an identity theft event, the investigator will recommend that a case be opened for restoration. Our IDShield advisors and licensed private investigators are available for all matters Monday-Friday, 7 a.m. to 7 p.m. Central Time at 888-494-8519. In the event of a personal identity theft emergency, advisors are available at 866-696-0927 to direct you to an investigator 24/7/365. All members are eligible to receive the following consultative services:

Privacy and Security Best Practice

- Consult on best practices for the use and protection of a consumer's Social Security number and Personal Identifying Information (PII)
- Provide consultation on current trends related to identity theft and fraud issues
- Discuss best practices for financial transactions
- Consult on best practices for consumer privacy
- Discuss tactics and best practices while shopping and communicating online
- Provide the knowledge to best protect the member from identity theft and to be aware of their rights under federal and state laws
- Help members interpret and analyze their credit report
- Take steps to reduce pre-approved credit card offers
- Consult with members regarding a public record inquiry or background search
- Credit Freeze consultation
- Consultation on common scams and schemes, including email and social media

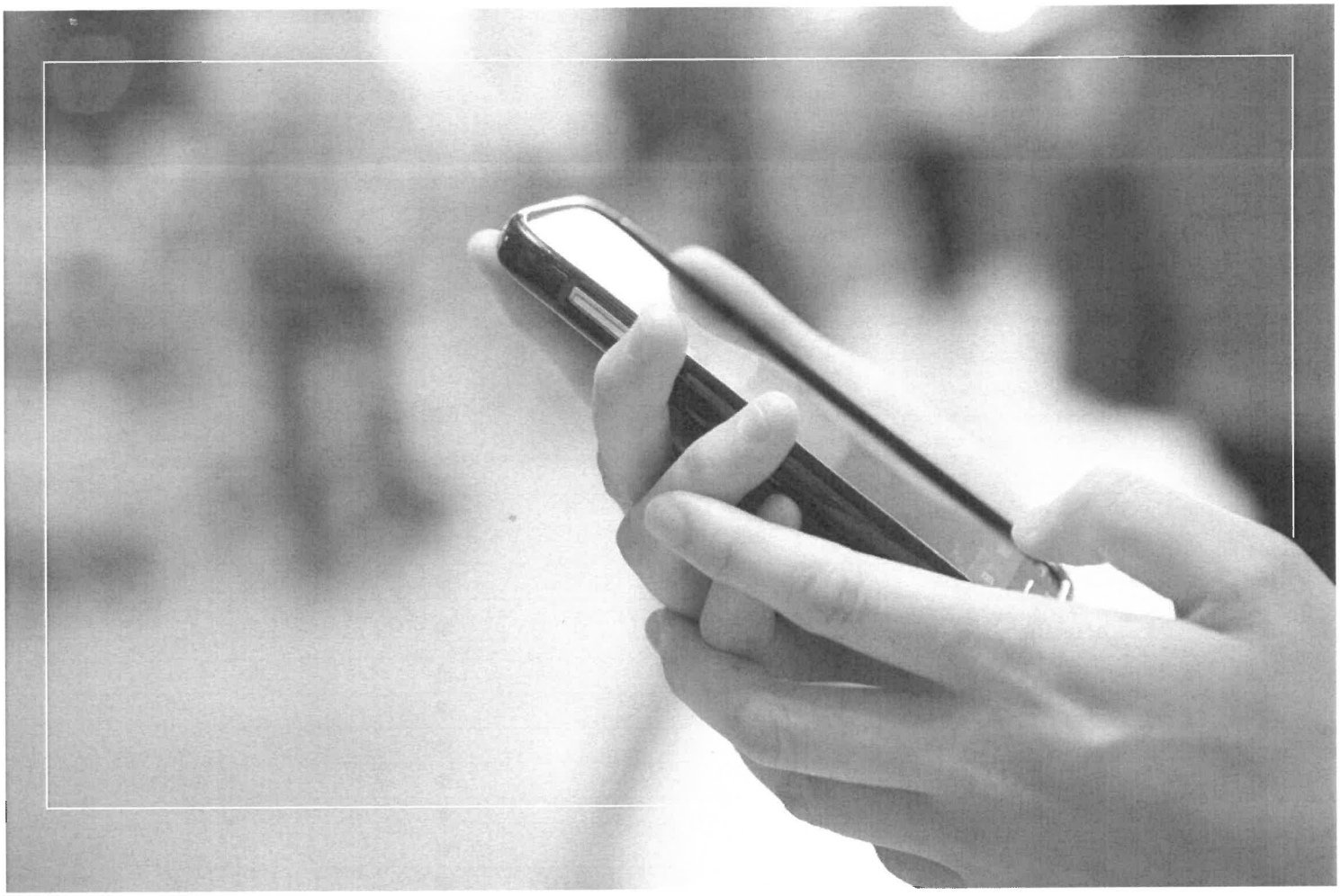
Event-Driven Consultation Support

- Lost/stolen wallet assistance
- Data Exposure/Data Breach safeguards
- With member's permission, facilitate the placement of 90-day fraud security alerts with credit reporting agencies; if permission is not given, provide a list of contact phone numbers for placing fraud alerts

Alerts and Notifications

- Monthly identity theft updates to help educate and protect
- Data breach notifications

Pre-existing Stolen Identity Event Limitations — If the victim either had knowledge of, or reasonably should have had knowledge of, the misuse of his/her identity, credit, or other personal information based on information provided, or reasonably available, to the individual prior to enrollment in the program (each a "Prior Misuse"), such Prior Misuse or the consequences caused by it are not covered by the restoration services. However, individuals who have merely experienced the loss or unauthorized exposure of personal identifiers, including credit or debit card data, such as a data breach event, with no indication of actual misuse or identity theft resulting from that event, are not subject to the Prior Misuse exclusion hereunder.



Confirm Identity Fraud and Its Severity

- Social Security Number Fraud Detection — Use Social Security Number Skip Trace technique to investigate the member's name and Social Security Number in identifying potentially fraudulent activity; Skip Trace employs industry-unique database access afforded by the credentials of Kroll's Licensed Investigators
- Consultation and education on Criminal and Medical Identity Theft
- Discovery and consultation on Deceased and Minor Identity Theft
- Sex Offender Searches

Emergency Access—Identity Theft Emergency Situations

- Confirmed Check Fraud
- Criminal ID Theft
- Employment Fraud
- ID Theft Discovered through a Monitoring Alert or Otherwise
- Medical ID Theft
- Minor ID Theft
- New Account Opened
- Payday Loan
- Scam That Resulted in ID Theft
- IRS/Tax Fraud
- Utilities Fraud
- Passport, Personal Information Stolen while Traveling outside of U.S.

Pre-existing Stolen Identity Event Limitations — If the victim either had knowledge of, or reasonably should have had knowledge of, the misuse of his/her identity, credit, or other personal information based on information provided, or reasonably available, to the individual prior to enrollment in the program (each a "Prior Misuse"), such Prior Misuse or the consequences caused by it are not covered by the restoration services. However, individuals who have merely experienced the loss or unauthorized exposure of personal identifiers, including credit or debit card data, such as a data breach event, with no indication of actual misuse or identity theft resulting from that event, are not subject to the Prior Misuse exclusion hereunder.

Potential Emergencies

Call Type	Next Business Day	Potential Emergency	Not Fraud Related
Lost or Stolen Credit/Debit Card or Unauthorized Charges Member should place fraud alerts right away and let the Investigator follow up	●		
Breached/Compromised Data Precautionary Call Member should place fraud alerts right away and let the Investigator follow up	●		
Unconfirmed ID Theft*	●		
Confirmed Check Fraud		●	
Criminal ID Theft		●	
Employment Fraud		●	
ID Theft Discovered Through a Monitoring Alert or Otherwise		●	
Medical ID Theft		●	
Minor ID Theft		●	
New Account Opened		●	
Payday Loan		●	
Scam That Resulted In ID Theft		●	
IRS/Tax Fraud		●	
Utilities Fraud		●	
Passport, Personal Information Stolen while traveling outside of US		●	

*If identity theft is only suspected and not confirmed, Investigators on-call after hours will not be able to make the telephone calls necessary to confirm the probability of actual fraud. The best, and most productive, Investigator experience occurs during normal business hours when corporate fraud departments are open and conference calls may be conducted.

Consultation Services are limited to the solutions, best practices, legislation, and established industry and organizational procedures in place in the United States and Canada as determined beneficial or productive by a Kroll Licensed Private Investigator.

Privacy Monitoring

Black Market Website Surveillance (Internet Monitoring)

Monitors global black market websites, IRC (internet relay chat) channels, chat rooms, peer-to-peer sharing networks, and social feeds for a member's Personally Identifiable Information (PII), looking for matches of:

- Name

Pre-existing Stolen Identity Event Limitations — If the victim either had knowledge of, or reasonably should have had knowledge of, the misuse of his/her identity, credit, or other personal information based on information provided, or reasonably available, to the individual prior to enrollment in the program (each a "Prior Misuse"), such Prior Misuse or the consequences caused by it are not covered by the restoration services. However, individuals who have merely experienced the loss or unauthorized exposure of personal identifiers, including credit or debit card data, such as a data breach event, with no indication of actual misuse or identity theft resulting from that event, are not subject to the Prior Misuse exclusion hereunder.

- Date of birth
- Social Security Number
- Emails (up to 10)
- Phone numbers (up to 10)
- Driver's License number
- Passport Number
- Medical ID numbers (up to 10)

When an exact match for the monitored information is found, the member is alerted with an email notification. The detail of the alert can be accessed via the service portal dashboard.

Address Change Verification

Keeps track of a personal mailing address and alerts when a change of address has been requested through the United States Postal Service. An initial baseline report is provided of activity within the last 18 months, and monitoring thereafter provides alerts whenever a new change of address request is made. The detail of the alert can be accessed through the member dashboard on www.myidshield.com. This service can be accessed immediately by the member via the service portal dashboard.

Security Monitoring

Black Market Website Surveillance (Internet Monitoring)

Monitors global black market websites, IRC (internet relay chat) channels, chat rooms, peer to peer sharing networks, and social feeds for a member's Personally Identifiable Information (PII), looking for matches of:

- SSN
- Credit card numbers (up to 10)
- Bank account numbers (up to 10)

When an exact match for the monitored information is found, the member is alerted with an email notification. The detail of the alert can be accessed through the member dashboard on www.myidshield.com.

Court Records Monitoring

Detects criminal activity that may be associated with an individual's personal information, alerting them to signs of potential criminal identity theft. This service searches for online court records that match the member's name and date of birth from county courts, Department of Corrections (DOC), Administration of the Courts (AOC), and other legal agencies—approximately 350 million criminal records searched. Court records are sourced from county, state and federal data sources. County records are sourced from the 250 most populous counties along with arrest records, court records, correctional records and State Department records. If an incident appears associated with the member's information, they will be notified via alert.

Pre-existing Stolen Identity Event Limitations — If the victim either had knowledge of, or reasonably should have had knowledge of, the misuse of his/her identity, credit, or other personal information based on information provided, or reasonably available, to the individual prior to enrollment in the program (each a "Prior Misuse"), such Prior Misuse or the consequences caused by it are not covered by the restoration services. However, individuals who have merely experienced the loss or unauthorized exposure of personal identifiers, including credit or debit card data, such as a data breach event, with no indication of actual misuse or identity theft resulting from that event, are not subject to the Prior Misuse exclusion hereunder.

Credit Monitoring

Members have access to continuous credit monitoring through TransUnion only. Monitoring can be accessed immediately by the member via the service portal dashboard. Credit activity will be reported promptly to the member via an email alert. Monitoring does not affect an individual's credit score, nor does it appear as a hard inquiry on his or her credit report when accessed by a third party. The credit monitoring service will alert members to activity up to and including new delinquent accounts, fraud alerts, improved account, new account, new address, new bankruptcy, new employment, new account inquiry, and new public records.

Credit Inquiry Alerts

Members will be notified via email when a creditor requests their TransUnion credit file for the purposes of opening a new credit account. Alerts may also be triggered when a creditor requests a member's credit file for changes that would result in a new financial obligation, such as a new cell phone account, a lease for a new apartment, or even for an application for a new mortgage. Inquiry alerts can be helpful in determining when an identity thief is opening a new account without the member's authorization.

Pre-existing Stolen Identity Event Limitations — If the victim either had knowledge of, or reasonably should have had knowledge of, the misuse of his/her identity, credit, or other personal information based on information provided, or reasonably available, to the individual prior to enrollment in the program (each a "Prior Misuse"), such Prior Misuse or the consequences caused by it are not covered by the restoration services. However, individuals who have merely experienced the loss or unauthorized exposure of personal identifiers, including credit or debit card data, such as a data breach event, with no indication of actual misuse or identity theft resulting from that event, are not subject to the Prior Misuse exclusion hereunder.

Quarterly Credit Score Tracker

A quarterly credit score from TransUnion that plots the member's score quarter-by-quarter on a graph. Upon enrollment and quarterly thereafter, members will be able to see how their credit scores have changed over time, along with score factors that provide insight into what events may have caused their specific credit score to change.

Payday Loan Monitoring

Alerts the subscriber when their personal information is associated with short-term, payday, or similar cash-advance loans. The service monitors 21,000 online, rent-to-own, and payday lender storefronts for unauthorized activity. An initial report is provided, and monitoring continues on a monthly basis. An alert is generated whenever new loans or inquiries are detected.

Minor Identity Protection

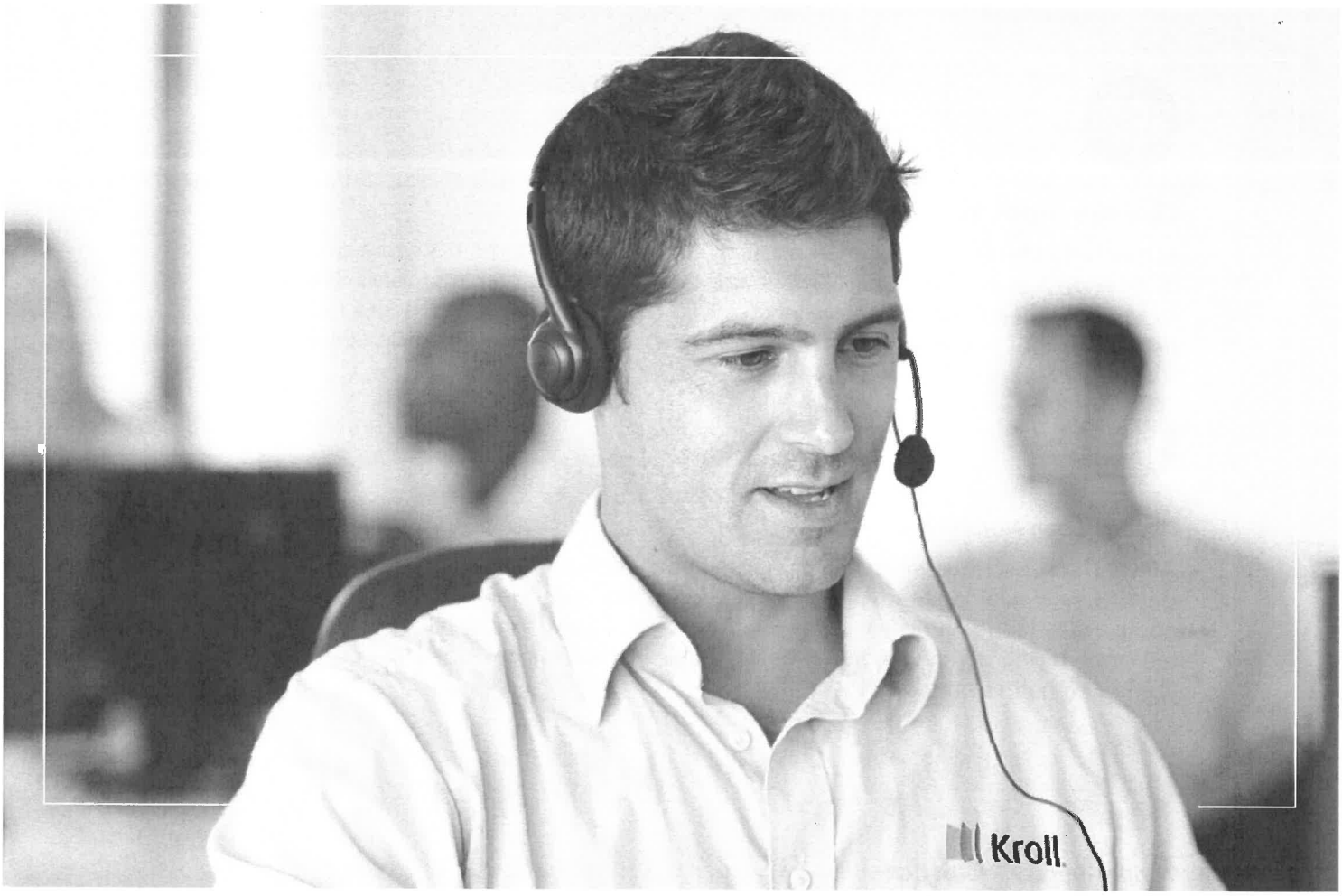
(Formerly Safeguard for Minors) Allows parents/guardians of up to 8 minors under the age of 18 to monitor for potential fraudulent activity associated with their child's SSN. Unauthorized names, aliases and addresses that become associated with a minor's name and date of birth may be detected. The service monitors public records in all 50 states, including real estate data, new mover information, property and recorder of deed registration, county assessor/record data, internet job site providers, state occupational license data providers, voter information, public records/court proceedings, bankruptcies, liens, and judgments. Parents/guardians are provided a baseline scan, subsequent alerts and notifications thereafter.

Identity Restoration

Licensed Investigators

Kroll's Licensed Private Investigators perform the bulk of the restoration work required to restore a member's identity to pre-theft status. The following list outlines Kroll's typical identity restoration process. Please note that each case is unique, and Kroll Licensed Private Investigators will typically address a variety of issues during a restoration case.

Pre-existing Stolen Identity Event Limitations — If the victim either had knowledge of, or reasonably should have had knowledge of, the misuse of his/her identity, credit, or other personal information based on information provided, or reasonably available, to the individual prior to enrollment in the program (each a "Prior Misuse"), such Prior Misuse or the consequences caused by it are not covered by the restoration services. However, individuals who have merely experienced the loss or unauthorized exposure of personal identifiers, including credit or debit card data, such as a data breach event, with no indication of actual misuse or identity theft resulting from that event, are not subject to the Prior Misuse exclusion hereunder.



Within one business day of receiving a fully executed Limited Power of Attorney and copies of the Member's Social Security card, driver's license, identity theft police report and most recent utility statement—complete with the Member's current name and address—Kroll shall:

- Notify the Social Security Administration (SSA), the Federal Trade Commission (FTC), and the U.S. Postal Inspection Service in cases where there is evidence the U.S. Postal Service was used in connection with the suspected fraud
- Place/confirm that 90-day fraud security alerts have been placed with the three credit bureaus

After receiving the Credit Authorization Form, Kroll shall:

- Order a copy of the Member's credit report
- Review credit history and document if fraud includes items such as:
  - Public records: liens, judgments, bankruptcies
  - Credit accounts: new and/or derogatory
  - Addresses
  - Prior employment
- Issue Fraud Alert and notification of fraud dispute—Work with affected financial institutions, collection agencies, check clearinghouse companies, landlords and property managers, and/or credit card companies, where warranted

Pre-existing Stolen Identity Event Limitations — If the victim either had knowledge of, or reasonably should have had knowledge of, the misuse of his/her identity, credit, or other personal information based on information provided, or reasonably available, to the individual prior to enrollment in the program (each a "Prior Misuse"), such Prior Misuse or the consequences caused by it are not covered by the restoration services. However, individuals who have merely experienced the loss or unauthorized exposure of personal identifiers, including credit or debit card data, such as a data breach event, with no indication of actual misuse or identity theft resulting from that event, are not subject to the Prior Misuse exclusion hereunder.

- Issue Fraud Victim Statements—Work with all three credit bureaus to restore credit accuracy and place seven-year fraud victim statements with the permission of the victim

Where warranted, Kroll will:

- Search victim's local county criminal data to detect criminal activity being committed in member's name
- Use the U.S. Criminal Records Indicator to search a wide variety of national criminal databases
- Search victim's state's Department of Corrections records, court records, and arrest logs from numerous states
- Perform a driver license search using public records and commercially available data to find associated reports from numerous states
- Perform a Social Security trace to look for additional addresses that may be attached to the victim's name
- Perform a death indicator search using public records and commercially available data sources to determine if the victim has been reported as deceased for insurance fraud or other reasons
- Perform a check-clearinghouse search to determine if victim's name has been submitted as having been involved in fraudulent banking activities
- Notify the DMV and instruct victim on proper procedures in dealing with the DMV
- Notify and work with creditors who have extended credit due to misuse of the victim's identifying information
- Notify and work with the collection agencies of those creditors
- Notify and work with law enforcement personnel, both local and federal

If disputes are not resolved according to the victim's legal rights, Kroll may escalate disputes to the appropriate government/regulatory agencies, including:

- Federal Trade Commission
- State Attorney General office by state
- Consumer Financial Protection Bureau
- Association of Collection Professionals International
- Comptroller of the Currency
- Federal Reserve Bank
- Office of Thrift Supervision
- Office of the Inspector General
- Provide the additional assistance of investigators who can reasonably assist based on the victim's issues

In all cases, Kroll provides:

- Follow-up credit reports
- Subscriber updates

Pre-existing Stolen Identity Event Limitations — If the victim either had knowledge of, or reasonably should have had knowledge of, the misuse of his/her identity, credit, or other personal information based on information provided, or reasonably available, to the individual prior to enrollment in the program (each a "Prior Misuse"), such Prior Misuse or the consequences caused by it are not covered by the restoration services. However, individuals who have merely experienced the loss or unauthorized exposure of personal identifiers, including credit or debit card data, such as a data breach event, with no indication of actual misuse or identity theft resulting from that event, are not subject to the Prior Misuse exclusion hereunder.

Restoration Preparation

Benefit	Limited POA	No POA
Assist in organizing details of issues	■	■
Explain fraud victim's rights	■	■
Educate you on the process and your responsibilities	■	■
Assist in gathering and completing paperwork, including police reports	■	■
Send Fraud Packet to victim List of Contact Numbers (for immediate fraud alerts): Equifax Fraud Center • Experian Fraud Center • TransUnion Fraud Center • Federal Trade Commission • Social Security Administration • United States Postal Service	■	■
Issue Fraud Alert to all three credit repositories	■	■
Provide fraud victim assistance material	■	■
Assist you with questions as you work through the process	■	■

Restoration Process

Within 24 hours of receiving the signed Limited Power of Attorney, Kroll will:

Benefit	Limited POA	No POA
Issue Fraud Alert to Social Security Administration (SSA)	■	■
Issue Fraud Alert to Federal Trade Commission (FTC)	■	■
Issue Fraud Alert to U.S. Postal Service (USPS)	■	■

After receiving both signed Limited Power of Attorney and tri-merged credit report, Kroll will:

Benefit	Limited POA	No POA
Issue Fraud Victim statements and work with all three national repositories (Experian, TransUnion, Equifax) to restore credit accuracy	■	■
Review credit history with you and verify if fraud includes items like: • Public Records (Liens, judgments, bankruptcies) • Credit Accounts (New and/or derogatory) • Address • Prior employment	■	■
Issue Fraud Alert to and work with affected financial institutions and credit card companies	■	■

Whenever A Fraud Issue Warrants

Benefit	Limited POA	No POA
Determine if creditors extended credit due to misuse of your identifying information	■	■
Confirm creditor contact information	■	■
Contact creditors and collection agencies to dispute all fraudulent accounts	■	■
Notify and work with the collection agencies of creditors holding fraudulent accounts	■	■
Turn over any current accounts to fraud, requesting affidavits of documentation forwarded to you	■	■
Search Criminal Data in your country of residence to look for criminal activity being committed in your name	■	■
Search U.S. Criminal Records indicator to search a wide variety of national criminal databases	■	■
Search Department of Motor Vehicles records in your state	■	■
Perform a Social Security trace to look for additional addresses that may be attached to your name	■	■
Perform a Social Security Death Index search to verify if you have been submitted to Social Security	■	■
Determine if you have been submitted as having been involved in fraudulent banking activities	■	■
Assist you in working with law enforcement personnel	■	■
Use licensed attorneys where appropriate to perform these duties	■	■
Offer additional assistance that can be reasonably provided based on your issue	■	■
Provide a list of attorneys who may be able to help you with legal issues—any subsequent relationship is exclusively between you and the attorney	■	■

Case Closing Process

Benefit	Limited POA	No POA
Provide a tri-merged credit bureau report follow up 120 days after resolution of your identity theft issues	■	■
Update member	■	■
Continue restoration until complete	■	■
Responsibility for Kroll's Fraud Solutions Practice will cease when Kroll receives verification from you that the issue is resolved	■	■

Pre-existing Stolen Identity Event Limitations — If the victim either had knowledge of, or reasonably should have had knowledge of, the misuse of his/her identity, credit, or other personal information based on information provided, or reasonably available, to the individual prior to enrollment in the program (each a "Prior Misuse"), such Prior Misuse or the consequences caused by it are not covered by the restoration services. However, individuals who have merely experienced the loss or unauthorized exposure of personal identifiers, including credit or debit card data, such as a data breach event, with no indication of actual misuse or identity theft resulting from that event, are not subject to the Prior Misuse exclusion hereunder.

Theft Restoration Service Exclusions

The following are excluded from the Services:

Legal Remedy—Any Stolen Identity Event where the member is unwilling or unable to prosecute or otherwise bring a civil or criminal claim against any person culpable or reasonably believed to be culpable for the fraud or its consequences.

Dishonest Acts—Any dishonest, criminal, malicious or fraudulent acts, if the member(s) that suffered the fraud personally participated in, directed or had knowledge of such acts.

Financial Loss—Any direct or indirect financial losses attributable to the Stolen Identity Event, including but not limited to, money stolen from a wallet, unauthorized purchases of retail goods or services online, by phone, mail or directly.

Pre-Existing Stolen Identity Event Limitations—Any circumstance wherein the member had knowledge of, or reasonably should have had knowledge of a pre-existing Stolen Identity Event based on information provided to them prior to enrollment in the program.

Business—The theft or unauthorized or illegal use of any business name, DBA or any other method of identifying business (as distinguished from personal) activity.

Third Parties Not Subject to U.S. or Canadian Law—Restoration services do not remediate issues with third parties not subject to United States or Canadian law that have been impacted by an individual's Stolen Identity Event, such as financial institutions, government agencies, and other entities.

Pre-existing Stolen Identity Event Limitations — If the victim either had knowledge of, or reasonably should have had knowledge of, the misuse of his/her identity, credit, or other personal information based on information provided, or reasonably available, to the individual prior to enrollment in the program (each a "Prior Misuse"), such Prior Misuse or the consequences caused by it are not covered by the restoration services. However, individuals who have merely experienced the loss or unauthorized exposure of personal identifiers, including credit or debit card data, such as a data breach event, with no indication of actual misuse or identity theft resulting from that event, are not subject to the Prior Misuse exclusion hereunder.

IDShield Guarantee

Service Guarantee

We don't give up until your identity is restored.

We're confident in our ability to help protect your identity, but no one can prevent all identity theft. If you become a victim of identity theft while an IDShield member, we'll spend up to $5 million using Kroll's industry-leading licensed private investigators to do whatever it takes for as long as it takes to help recover and restore your identity to its pre-theft status.

You will have access to our U.S.-based Member Services agents during business hours and in emergency situations, 24 hours a day, 7 days a week, 365 days a year. And Kroll's Licensed Private Investigators are available to support you every step of the way.

Our industry-leading identity restoration experts are ready and waiting to help restore your identity. Unlike other providers in the market, we don't waste time retaining an insurer to restore your identity as we have a fully integrated partnership allowing Kroll's Licensed Private Investigators to handle your identity restoration needs.

We understand how important it is to be prepared for the worst. We are ready to take action immediately.

Contact:

Ken Roebuck
IDShield
Business Vice President
757.334.1294
roebuck@legalshieldassociate.com
or 24/7 at
roebucklegalshield@icloud.com

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LegalShield

529 savings payroll deduction
Program highlights

CAPITAL GROUP® | AMERICAN FUNDS®

Saving for education just got easier

Business owners of all sizes who are seeking an easy way to help employees save for education expenses can offer a 529 education savings plan for a lifetime of learning

- **Easy setup and maintenance** so you can focus on your business
- **Inexpensive program** to enhance your benefits package at no cost to the business
- **Quality investments** to help employees build a diversified portfolio
- **Convenient features for employees** to help them pursue education goals

Easy setup and maintenance

Your financial advisor can help you establish a payroll-deduction 529 program. It's a tax-favored investment vehicle that can help attract, motivate and retain employees. Once it's set up, there's little required of you. You don't even have to be concerned with the following:

- Contributions automatically deducted from employee paychecks.
- No IRS reports to complete.
- Employees manage their accounts directly with Capital Group, home of American Funds.

No costs for your business

A 529 education savings plan with payroll deductions is an easy way for many business owners to initiate a benefits program at their company, or augment an existing one. In other words, business owners would not have to deal with the following costs.

- No cost for setup and maintenance, unless your payroll provider charges to establish a payroll bridge.
- Funded directly from employee paychecks.
- No employer contributions required.

Quality investments

- American Funds College Target Date Series®
- American Funds Portfolio Series℠
- Several American Funds available in CollegeAmerica® are good options for those seeking to build customized portfolios.

Convenient features for employees

- Employees have the ability to determine how much and how often to invest.
- Convenient automated contributions through payroll deduction.
- Employees don't incur up-front costs because they invest in Class 529-E shares offered only through an employer-sponsored plan.
- No rollover required after a job change, and account owner can continue to make contributions.

If withdrawals from 529 plans are used for purposes other than qualified education expenses, the earnings will be subject to a 10% federal tax penalty in addition to federal and, if applicable, state income tax. States take different approaches to the income tax treatment of withdrawals. For example, withdrawals for K-12 expenses may not be exempt from state tax in certain states. Please consult your tax advisor for state-specific details.

Investments are not FDIC-insured, nor are they deposits of or guaranteed by a bank or any other entity, so they may lose value.

CollegeAmerica can help your employees

CollegeAmerica accounts are a tax-advantaged way to save for eligible education expenses such as room and board, required books and supplies, and tuition for higher education, as well as K-12 tuition. CollegeAmerica's unique combination of benefits includes:

Tax advantages

- Employees won't pay federal taxes or, in almost every case, state taxes on withdrawals if they're used for qualified expenses.
- Many states allow a deduction from or credit against state taxes for all or part of the contributions. Such deductions may be disallowed in the event of non-qualified withdrawals. State tax treatment varies.

Flexibility

- Employees can open an account for any beneficiary, no matter how much they earn.
- They can use the assets to pay for qualified expenses at eligible K-12 schools (up to $10,000), community colleges, undergraduate and graduate schools, and trade schools around the country, or for technical and professional training.
- They can continue investing until an account's value reaches $500,000 – for each beneficiary.
- Employees can open an account for as little as $25 using an employer-sponsored 529 plan.

Our 529 plan has been among Morningstar's highly rated advisor-sold 529 college savings plans since 2004, the year they began issuing ratings.[1]

Low fees and solid track record

- CollegeAmerica's fees are among the lowest for advisor-sold 529 college saving plans.[2]
- Equity funds have beaten their Lipper peer indexes in 81% of 10-year periods and 94% of 20-year periods.[3] Fixed income funds have helped investors achieve diversification through attention to correlation between bonds and equities.[4] Fund management fees have been among the lowest in the industry.[5]

Control

- A CollegeAmerica account stays in the employee's name, and the employee can control the timing and amount of withdrawals.
- They can change the account beneficiary as often as they like without worrying about taxes or penalties, as long as both beneficiaries are in the same family.

The advantages of a CollegeAmerica Plan

	Coverdell Education Savings Account	UGMA/UTMA Account	Taxable Investment Account
People of all income levels can contribute.		✓	✓
Withdrawals for qualified expenses are free from federal taxes.	✓		
State tax deductions/credits for residents of some states. Tax deductions may be disallowed in the event of non-qualified withdrawals.			
Account owner always controls the account.			✓
Beneficiary changes permitted.	✓		n/a

Investors should carefully consider investment objectives, risks, charges and expenses. This and other important information is contained in the fund prospectuses, summary prospectuses and the CollegeAmerica Program Description, which can be obtained from a financial professional and should be read carefully before investing. CollegeAmerica is distributed by American Funds Distributors, Inc. and sold through unaffiliated intermediaries. Depending on your state of residence, there may be an in-state plan that provides tax and other benefits not available through CollegeAmerica. Before investing in any state's 529 plan, investors should consult a tax advisor.

[1] "Rating the Top 529 College Savings Plans," October 2019. Morningstar ratings are based on the following criteria: process, performance, price, people and parent.

[2] Source: 529 College Savings Quarterly Fee Analysis, ISS Market Intelligence, Fourth Quarter 2019. CollegeAmerica's fees were in the top quartile of 30 and 18 plans based on the average annual asset-based fees for national advisor-sold and fee-based advisor-sold 529 plans, respectively.

[3] Based on Class 529-E share results for rolling periods through December 31, 2019. Periods covered are the shorter of the fund's lifetime or since the comparable Lipper index inception date (except Capital Income Builder and SMALLCAP World Fund, for which the Lipper average was used). Expenses differ for each share class, so results will vary. Class 529-E shares were first offered on February 15, 2002. Class 529-E share results prior to the date of first sale are hypothetical based on the results of the original share class of the fund without a sales charge, adjusted for typical estimated expenses. Results for certain funds with an inception date after February 15, 2002, also include hypothetical returns because those funds' Class 529-E shares sold after the funds' date of first offering. Please see **capitalgroup.com** for more information on specific expense adjustments and the actual dates of first sale.

[4] Based on Class 529-E share results, as of December 31, 2019. All 11 of the fixed income American Funds that have Class 529-E shares and that have been in existence for the three-year period showed a three-year correlation below 0.2. Standard & Poor's 500 Composite Index was used as an equity market proxy. Correlation based on monthly total returns. Correlation is a statistical measure of how two securities move in relation to each other. A correlation ranges from –1 to 1. A positive correlation close to 1 implies that as one security moves, either up or down, the other security will move in "lockstep," in the same direction. A negative correlation close to –1 indicates that the securities have moved in the opposite direction.

[5] On average, our management fees were in the lowest quintile 65% of the time, based on the 20-year period ended December 31, 2019, versus comparable Lipper categories, excluding funds of funds.

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CollegeAmerica is a nationwide plan sponsored by Virginia529™

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ABLEAmerica[SM]

Tax-advantage savings plan for individuals with disabilities

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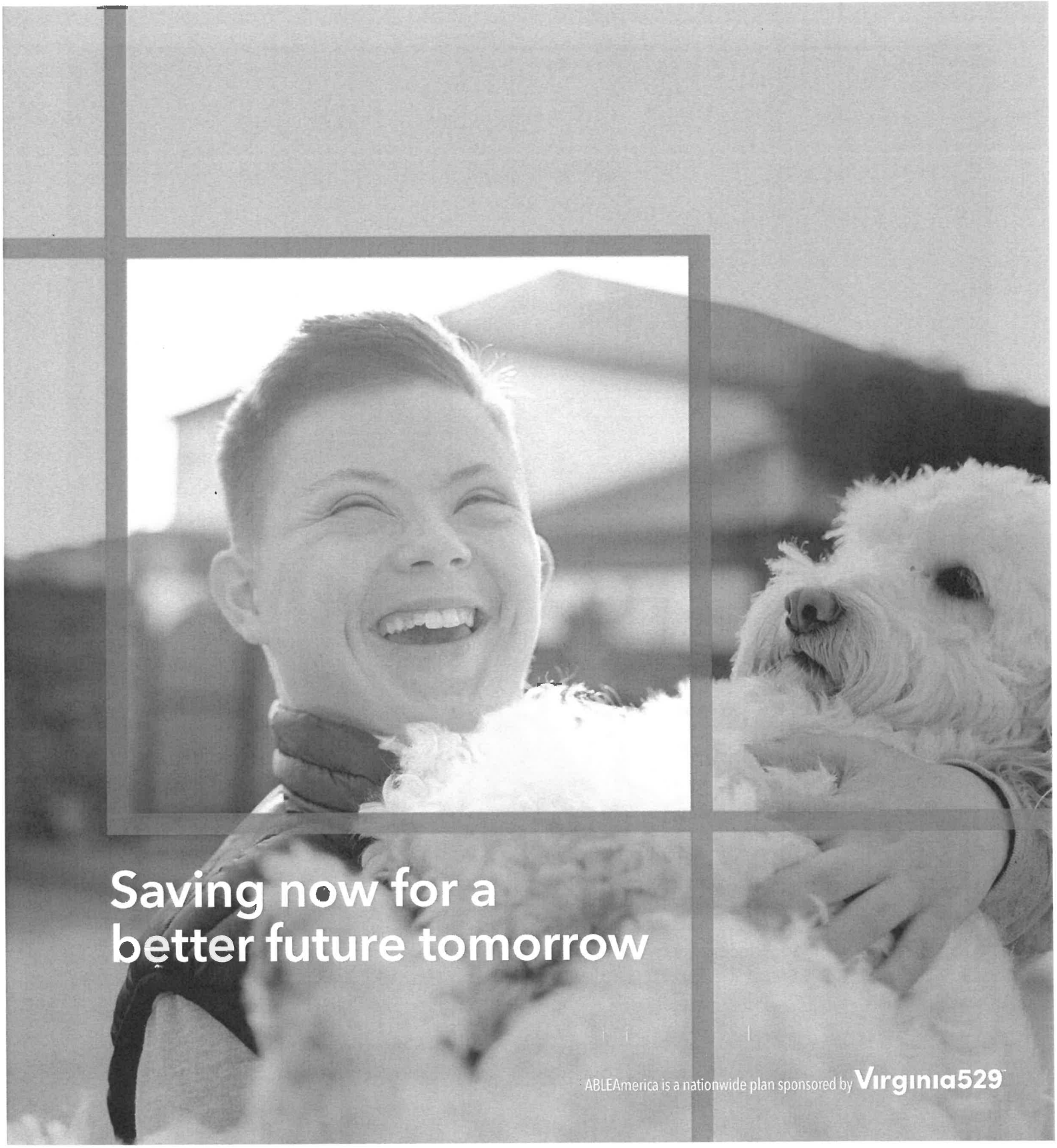
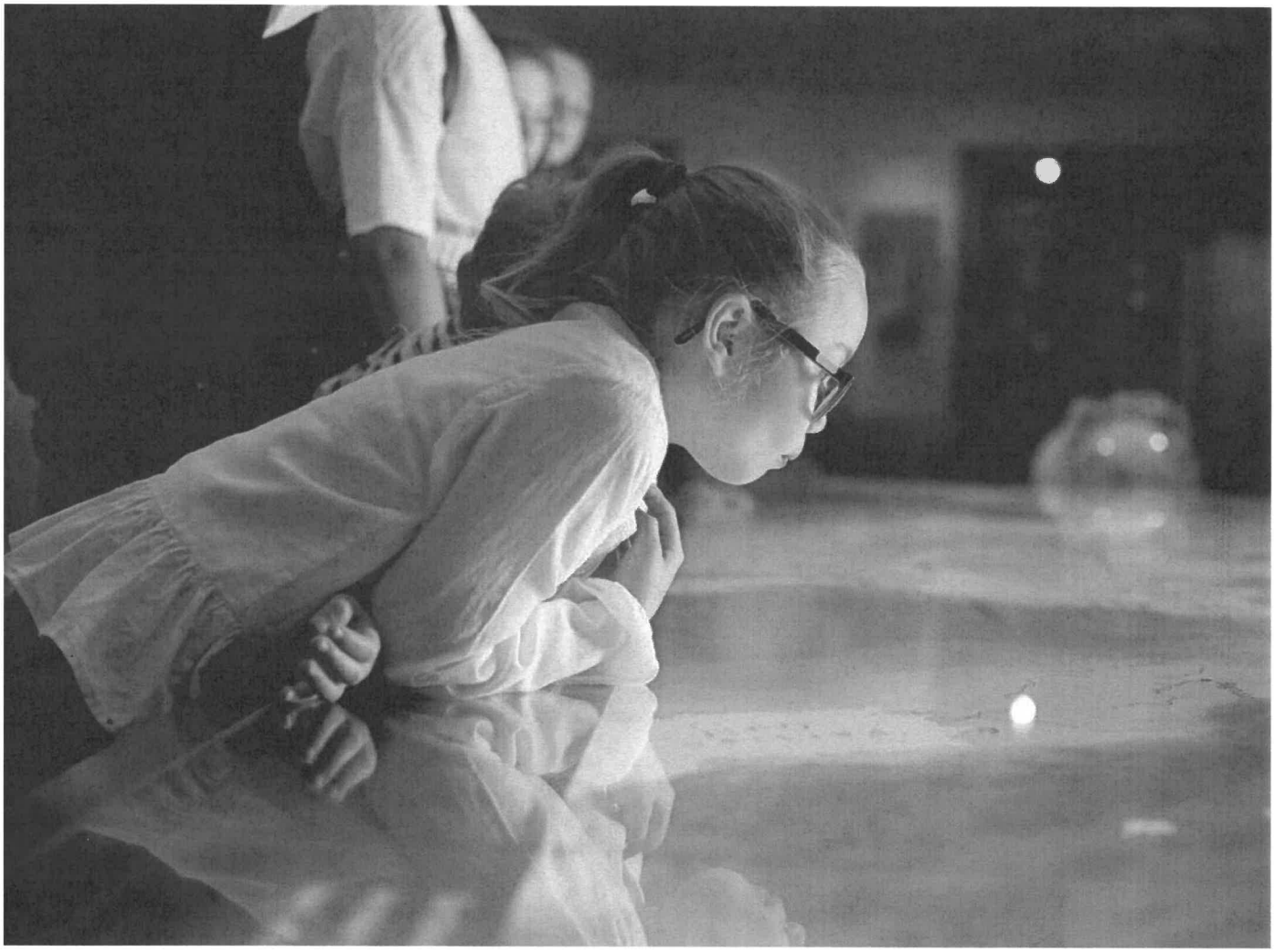


Life with a disability has its own challenges and rewards. That's why we've designed ABLEAmerica to help meet your needs and reach your goals.



GOAL: GROWTH

Building savings

Sarah's daughter, Mia, was diagnosed with epilepsy. Knowing that it is more expensive than ever to raise a child,* not to mention a child with special needs, Sarah began to worry about the additional costs associated with caring for Mia later in life, such as education and/or on-going medical care. Sarah talked with her financial advisor about how best to prepare and decided to invest in growth-oriented funds to build savings for Mia's future.

* Expenditures on Children by Families, 2015. U.S. Department of Agriculture, Center for Nutrition Policy and Promotion.

Investments are not FDIC-insured, nor are they deposits of or guaranteed by a bank or any other entity, so they may lose value.

Building blocks for a better life

WHO IS ELIGIBLE?

- ABLE accounts are available to U.S. citizens and permanent residents who can legally own securities, including individuals who are blind or disabled from a condition that began prior to age 26.
- Those who meet the age requirement and may be eligible for SSI or SSDI benefits because of their disability.
- Individuals with a written, signed diagnosis from a licensed physician.

WHO OWNS THE ACCOUNT?

- The beneficiary*

WHO CAN CONTRIBUTE?

Anyone can contribute to an ABLE account, including:

- Parents
- Grandparents
- Extended family
- Friends
- Beneficiary
- Charity/trust

A better path forward

Until recently, people with disabilities and their families may have faced a hard choice: either save for the future or qualify for federal disability benefits. That changed under the Achieving a Better Life Experience (ABLE) Act, which was signed into law in 2014.

BEFORE ABLE	WITH ABLE
Can only have $2,000 in savings to qualify for need-based government programs	

* If the beneficiary cannot or chooses not to establish and manage the account, an individual legally authorized to act on his or her behalf (such as a parent, legal guardian, or person acting under a power of attorney) may open and manage the account.

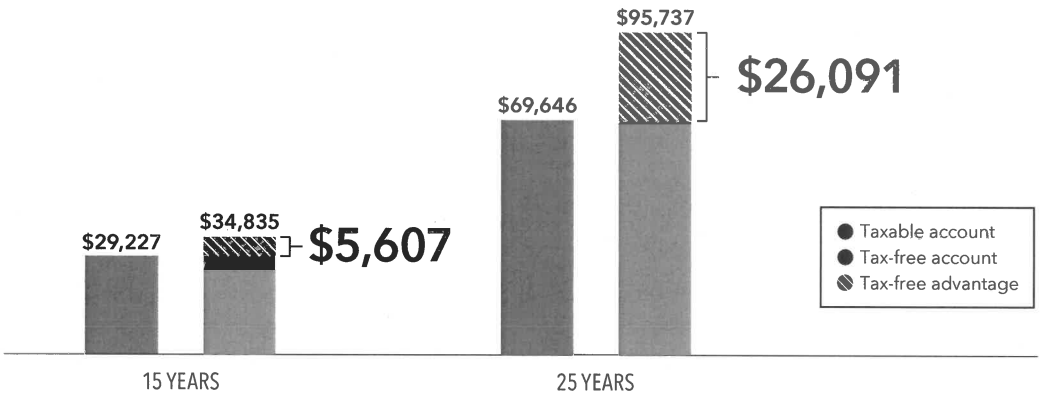
Fostering health, independence and quality of life

With an ABLEAmerica account, individuals with disabilities can make tax-free withdrawals for qualified disability expenses (QDEs). A QDE includes, but is not limited to:

- Basic living expenses
- Health and wellness
- Housing
- Financial management
- Transportation
- Education and training
- Employment training
- Assistive technology
- Legal fees
- Professional services

Give your savings a tax-free advantage

Imagine you saved $100 a month in a tax-free ABLE account. Over time, you would have a higher balance than if you invested the same amount in a taxable account (assuming no withdrawals were taken).



Assumes an 8% average annual rate of return (compounded monthly) for both investments and a 25% income tax rate. (The typical mutual fund investor falls into the 25% tax bracket.) Example assumes taxes were paid annually out of account. Your tax rate may vary. Current minimum tax rates on capital gains and dividends could make taxable investment returns higher, thus reducing the difference between the two ending values. Results shown are hypothetical and are not intended to represent an investment in a specific fund. Your investment experience will differ. Regular investing does not ensure a profit or protect against loss. You should consider your willingness to keep investing when share prices are declining.

People living with disabilities may face extra costs of living, often totaling several thousand dollars more per year. These costs may add up over time, creating a significant financial burden on households.

Source: "Extra Costs of Living with a Disability: A Review and Agenda for Research" (April 1, 2017). Disability and Health Journal.

GOAL: GROWTH AND INCOME

Paying expenses now and saving for later

A car accident in his teens left Marco with lasting physical complications. Several years ago, his financial advisor suggested an ABLE account to help meet his financial goals. Today, Marco invests his assets in growth-and-income portfolios, taking tax-free withdrawals to pay for his transportation and assistive technology needs now, while also saving for the future.

GOAL: PRESERVATION AND INCOME

Preparing for a rainy day

Sandy was diagnosed with autism as a child. Now in her 20s, she lives independently and works part-time, relying on government need-based programs for the rest of her income. Although Sandy has put most of her ABLE investments in growth funds, she also asked her financial advisor for ideas on how to protect her assets during market declines and help pay emergency expenses. After discussing her options, she decided to make additional investments in preservation-and-income funds.

Investments aligned with your goals

Your advisor can help you find the right fit

Selecting the right investments can be challenging. We believe that working with a financial advisor, who can weigh the benefits and considerations of each investment, is the best way to make these types of decisions. As the nation's only advisor-sold ABLE plan, we've backed up that belief with a well-designed solution to help you reach your goals.

ABLEAmerica offers investment options managed by American Funds from Capital Group to help you build and protect your savings. Low expenses mean more of your money goes to work for you or your loved one.

INVESTOR GOALS

Build wealth

Spend wealth

Conserve wealth

INVESTMENT OBJECTIVES

Growth Long-term growth of capital		Growth and income Long-term growth of capital and income		Preservation and income Current income and capital preservation	
American Funds Global Growth Portfolio℠	**CGGGX**	**American Funds Growth and Income Portfolio℠**	**CGNGX**	**American Funds Preservation Portfolio℠**	**CPPGX**
American Funds Growth Portfolio℠	**CGQGX**	**American Funds Moderate Growth and Income Portfolio℠**	**CBAGX**	**American Funds U.S. Government Money Market Fund℠**	**AAZXX**
		American Funds Conservative Growth and Income Portfolio℠	**CIPGX**		

The ABLEAmerica advantage

- The nation's only advisor-sold ABLE account gives you access to professional advice and helps you build a comprehensive plan
- Wide-ranging investment options allow you to put more money to work to pursue your goals
- Broadly diversified objective-based investments allow you to select portfolios tailored to your goals and needs

Work with your financial advisor to build a better life with ABLEAmerica.

The Capital Advantage®

Since 1931, Capital Group, home of American Funds, has helped investors pursue long-term investment success. Our consistent approach – in combination with The Capital System℠ – has resulted in a superior long-term track record.

Aligned with investor success

We base our decisions on a long-term perspective, which we believe aligns our goals with the interests of our clients. Our portfolio managers average 28 years of investment experience, including 22 years at our company, reflecting a career commitment to our long-term approach.[1]

The Capital System

The Capital System combines individual accountability with teamwork. Funds using The Capital System are divided into portions that are managed independently by investment professionals with diverse backgrounds, ages and investment approaches. An extensive global research effort is the backbone of our system.

American Funds' superior outcomes

Equity funds have beaten their Lipper peer indexes in 88% of 10-year periods and 96% of 20-year periods.[2] Fixed income funds have helped investors achieve diversification through attention to correlation between bonds and equities.[3] Fund management fees have been among the lowest in the industry.[4]

[1] Portfolio manager experience as of December 31, 2019.

[2] Based on Class A share results for rolling periods through December 31, 2019. Periods covered are the shorter of the fund's lifetime or since the comparable Lipper index inception date (except Capital Income Builder and SMALLCAP World Fund, for which the Lipper average was used). Expenses differ for each share class, so results will vary. Please see capitalgroup.com for more information on specific expense adjustments and the actual dates of first sale.

[3] On average, our management fees were in the lowest quintile 65% of the time, based on the 20-year period ended December 31, 2019, versus comparable Lipper categories, excluding funds of funds.

You could lose money by investing in the money market fund. Although the fund seeks to preserve the value of your investment at $1.00 per share, it cannot guarantee it will do so. An investment in the fund is not insured or guaranteed by the Federal Deposit Insurance Corporation or any other government agency. The fund's sponsor has no legal obligation to provide financial support to the fund, and you should not expect that the sponsor will provide financial support to the fund at any time.

Past results are not predictive of future results. Investing for short periods makes losses more likely.

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