Aflac

Group Critical Illness

INSURANCE – PLAN INCLUDES BENEFITS FOR CANCER

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

THE CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

NOTICE TO BUYER: This insurance provides limited benefits in the event you are diagnosed with a Specified Critical Illness. The certificate is a supplement to and not a substitute for a Health Benefit Plan. You must have a Health Benefit Plan in order to purchase this insurance.

Aflac®

AFLAC GROUP CRITICAL ILLNESS

Aflac can help ease the financial stress of surviving a critical illness.

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

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

That's the benefit of an Aflac Group Critical Illness plan.

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

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

What you need, when you need it.

Group critical illness insurance pays cash benefits that you can use any way you see fit.

Here's why the Aflac Group Critical Illness plan may be right for you.

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

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

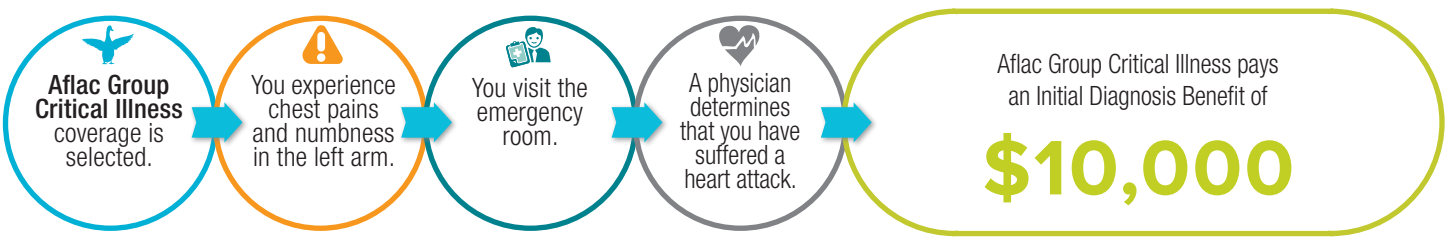
The Aflac Group Critical Illness plan benefits include:

- Critical Illness Benefit payable for:
  - Cancer
  - Heart Attack (Myocardial Infarction)
  - Stroke
  - Kidney Failure (End-Stage Renal Failure)
  - Major Organ Transplant
  - Bone Marrow Transplant (Stem Cell Transplant)
  - Sudden Cardiac Arrest
  - Coronary Artery Bypass Surgery
  - Non-Invasive Cancer
  - Severe Burn
  - Coma
  - Paralysis
  - Loss of Sight/Speech/Hearing

Features:

- Benefits are paid directly to you, unless otherwise assigned.
- Coverage is available for you, your spouse, and dependent children.
- Coverage may be continued (with certain stipulations). That means you can take it with you if you change jobs or retire.

How it works



Amount payable based on $10,000 Initial Diagnosis Benefit.

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

Benefits Overview

COVERED CRITICAL ILLNESSES:

CANCER (Internal or Invasive)	100%
HEART ATTACK (Myocardial Infarction)	100%
STROKE (Ischemic or Hemorrhagic)	100%
MAJOR ORGAN TRANSPLANT (25% of this benefit is payable for insureds placed on a transplant list for a major organ transplant)	100%
KIDNEY FAILURE (End-Stage Renal Failure)	100%
BONE MARROW TRANSPLANT (Stem Cell Transplant)	100%
SUDDEN CARDIAC ARREST	100%
SEVERE BURN*	100%
PARALYSIS**	100%
COMA**	100%
LOSS OF SPEECH / SIGHT / HEARING**	50%
NON-INVASIVE CANCER (once per insured)	25%
CORONARY ARTERY BYPASS SURGERY (once per insured)	25%

INITIAL DIAGNOSIS

We will pay a lump sum benefit upon initial diagnosis of a covered critical illness when such diagnoses is caused by or solely attributed to an underlying disease. Cancer diagnoses are subject to the cancer diagnosis limitation. Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

ADDITIONAL DIAGNOSIS

Once benefits have been paid for a covered critical illness, a 10% benefit is payable for each different critical illness when the dates of diagnosis are separated by less than 6 consecutive months.

For the diagnosis of a new critical illness that is separated from the prior, different critical illness by 6 consecutive months or more, we will provide a 100% benefit.

Cancer diagnoses are subject to the cancer diagnosis limitation.

REOCCURRENCE

Once benefits have been paid for a covered critical illness, a 10% additional benefit is payable for that same critical illness when the dates of diagnosis are separated by less than 6 consecutive months.

For the diagnosis of a reoccurrence of a critical illness that is separated by at least 6 consecutive months or more from the prior occurrence of that critical illness, we will provide a 100% benefit.

Cancer diagnoses are subject to the cancer diagnosis limitation.

*This benefit is only payable for a burn due to, caused by, and attributed to, a covered accident.
**These benefits are payable for loss due to a covered underlying disease or a covered accident.

CHILD COVERAGE AT NO ADDITIONAL COST

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

WAIVER OF PREMIUM

If you become totally disabled due to a covered critical illness prior to age 65, after 90 continuous days of total disability, we will waive premiums for you and any of your covered dependents. As long as you remain totally disabled, premiums will be waived up to 24 months, subject to the terms of the plan.

SUCCESSOR INSURED BENEFIT

If spouse coverage is in force at the time of the primary insured's death, the surviving spouse may elect to continue coverage. Coverage would continue at the existing spouse face amount and would also include any dependent child coverage in force at the time.

The plan has limitations and exclusions that may affect benefits payable. This brochure is for illustrative purposes only. Refer to your certificate for complete details, definitions, limitations, and exclusions.

CRITICAL ILLNESS INSURANCE

LIMITATIONS AND EXCLUSIONS, TERMS YOU NEED TO KNOW, AND NOTICES

LIMITATIONS AND EXCLUSIONS

All limitations and exclusions that apply to the plan also apply to the riders unless amended by the riders.

Cancer Diagnosis Limitation Benefits are payable for cancer and/or non-invasive cancer as long as the insured:

- Is treatment-free from cancer for at least 12 months before the diagnosis date; and
- Is in complete remission prior to the date of a subsequent diagnosis, as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the cancer.

EXCLUSIONS

We will not pay for loss due to:

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured;
- **Suicide** – committing or attempting to commit suicide, while sane or insane;
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job
- **Participation in Aggressive Conflict:**
  - War (declared or undeclared) or military conflicts;
  - Insurrection or riot
  - Civil commotion or civil state of belligerence
- **Illegal Substance Abuse:**
  - Abuse of legally-obtained prescription medication
  - Illegal use of non-prescription drugs
  - Services provided for alcohol and drug detoxification

Diagnosis, treatment, testing, and confinement must be in the United States or its territories.

All benefits under the plan, including benefits for diagnoses, treatment, confinement and covered tests, are payable only while coverage is in force.

TERMS YOU NEED TO KNOW

Bone Marrow Transplant (Stem Cell Transplant) means a procedure to replace damaged or destroyed bone marrow with healthy bone marrow stem cells. For a benefit to be payable, a Bone Marrow Transplant (Stem Cell Transplant) must be caused by at least one of the following diseases:

- Aplastic anemia
- Congenital neutropenia
- Severe immunodeficiency syndromes
- Sickle cell anemia
- Thalassemia
- Fanconi anemia
- Leukemia
- Lymphoma
- Multiple myeloma

The Bone Marrow Transplant (Stem Cell Transplant) benefit is not payable if the transplant results from a covered critical illness for which a benefit has been paid under this plan.

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

A malignant tumor characterized by:

- The uncontrolled growth and spread of malignant cells, and
- The invasion of distant tissue.

A disease meeting the diagnostic criteria of malignancy, as established by the American Board of Pathology. A pathologist must have examined and provided a report on the histocytologic architecture or pattern of the tumor, tissue, or specimen.

Cancer (internal or invasive) also includes:

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

The following are not considered internal or invasive cancers:

- Pre-malignant tumors or polyps
- Carcinomas in Situ
- Melanoma in Situ
- Melanoma that is diagnosed as
  - Clark's Level I or II,
  - Breslow depth less than 0.77mm, or
  - Stage 1A melanomas under TNM Staging

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

For the purposes of the plan, a Non-Invasive Cancer is:

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

Cancer or non-invasive cancer must be diagnosed in one of two ways:

1. Pathological Diagnosis is a diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This diagnosis must be made by a certified pathologist and conform to the American Board of Pathology standards.
2. Clinical Diagnosis is based only on the study of symptoms. A clinical diagnosis will be accepted only if:
   - A doctor cannot make a pathological diagnosis because it is medically inappropriate or life-threatening,
   - Medical evidence exists to support the diagnosis, and
   - A doctor is treating you for cancer or carcinoma in situ

Complete Remission is defined as having no symptoms and no signs that can be identified to indicate the presence of cancer.

Coronary Artery Bypass Surgery means open heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts and where such narrowing or blockage is attributed to coronary artery disease or acute coronary syndrome. This excludes any non-surgical procedure, such as, but not limited to, balloon angioplasty, laser relief, or stents.

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

Date of Diagnosis is defined as follows:

- Bone Marrow Transplant (Stem Cell Transplant): The date the surgery occurs.
- Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or carcinoma in situ is based on such specimens). This includes recurrence of a previously diagnosed cancer provided you are free of any signs or symptoms and are treatment free for that cancer for 12 consecutive months.
- Coronary Artery Bypass Surgery: The date the surgery occurs.
- Heart Attack (Myocardial Infarction): The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the heart attack (myocardial Infarction) definition.
- Kidney Failure (End-Stage Renal Failure): The date a doctor recommends that an insured begin renal dialysis.
- Major Organ Transplant: The date the surgery occurs.
- Non-Invasive Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or carcinoma in situ is based on such specimens). This includes recurrence of a previously diagnosed cancer provided you are free of any signs or symptoms and are treatment free for that cancer for 12 consecutive months.
- Stroke: The date the stroke occurs (based on documented neurological deficits and neuroimaging studies).
- Sudden Cardiac Arrest: The date the pumping action of the heart fails (based on the sudden cardiac arrest definition).
- Coma: The first day of the period for which a doctor confirms a coma that is due to one of the underlying diseases and that has lasted for at least seven consecutive days.
- Loss of Sight, Speech, or Hearing: The date the loss due to one of the underlying diseases is objectively determined by a doctor to be total and irreversible.
- Paralysis: The date a doctor diagnoses an insured with paralysis due to one of the underlying diseases as specified in this plan, where such diagnosis is based on clinical and/or laboratory findings as supported by the insured's medical records.
- Severe Burn: The date the burn takes place.

Dependent means your spouse or your dependent child. Spouse is your legal wife or husband, who is listed on your application. Dependent children are your or your spouse's natural children, step-children, foster children, legally adopted children, or children placed for adoption, who are younger than age 26 . Newborn children are automatically covered from the moment of birth.

There is an exception to the age-26 limit listed above. This limit will not apply to any dependent child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. The employee or the employee's spouse must furnish proof of this incapacity and dependency to the company within 31 days following the dependent child's 26th birthday.

Diagnosis (Diagnosed) refers to the definitive and certain identification of an illness or disease that:

- Is made by a doctor and
- Is based on clinical or laboratory investigations, as supported by your medical records.

Doctor is a person who is:

- Legally qualified to practice medicine,
- Licensed as a doctor by the state where treatment is received, and
- Licensed to treat the type of condition for which a claim is made.

A doctor does not include you or any of your family members.

For the purposes of this definition, family member includes your spouse as well as the following members of your immediate family:

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

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

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

Heart Attack (Myocardial Infarction) is the death of a portion of the heart muscle (myocardium) caused by a blockage of one or more coronary arteries due to coronary artery disease or acute coronary syndrome.

Heart Attack (Myocardial Infarction) does not include:

- Any other disease or injury involving the cardiovascular system.
- Cardiac arrest not caused by a heart attack (myocardial infarction).

Diagnosis of a Heart Attack (Myocardial Infarction) must include the following:

- New and serial electrocardiographic (ECG) findings consistent with heart attack (myocardial infarction), and
- Elevation of cardiac enzymes above generally accepted laboratory levels of normal. (In the case of creatine physphokinase (CPK) a CPK-MB measurement must be used.)

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

Kidney Failure (End-Stage Renal Failure) means end-stage renal failure caused by end-stage renal disease, which results in the chronic, irreversible failure of both kidneys to function.

Kidney Failure (End-Stage Renal Failure) is covered only under the following conditions:

- A doctor advises that regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) is necessary to treat the kidney failure (end-stage renal failure); or
- The kidney failure (end-stage renal failure) results in kidney transplantation.

Maintenance Drug Therapy means ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer due to primary treatment. It is meant to decrease the risk of cancer recurrence rather than the palliative or suppression of a cancer that is still present.

Major Organ Transplant means undergoing surgery as a recipient of a covered transplant of a human heart, lung, liver, kidney, or pancreas. A transplant must be caused by one or more of the following diseases:

- Bronchiectasis
- Cardiomyopathy
- Cirrhosis
- Chronic obstructive pulmonary disease
- Congenital Heart Disease
- Coronary Artery Disease
- Cystic fibrosis
- Hepatitis
- Interstitial lung disease
- Lymphangioleiomyomatosis.
- Polycystic liver disease
- Pulmonary fibrosis
- Pulmonary hypertension
- Sarcoidosis
- Valvular heart disease

A Major Organ Transplant benefit is not payable if the major organ transplant results from a covered critical illness for which a benefit has been paid.

Pathologist is a doctor who is licensed:

- To practice medicine, and
- By the American Board of Pathology to practice pathologic anatomy.

A Pathologist also includes an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Signs and/or symptoms are the subjective evidence of disease or physical disturbance observed by a doctor or other medical professional. The doctor (or other medical professional) must observe these signs and/or symptoms while acting within the scope of his license.

Stroke means 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. Stroke must be either:

- Ischemic: Due to advanced arteriosclerosis or arteriosclerosis of the arteries of the neck or brain, or vascular embolism, or
- Hemorrhagic: Due to uncontrolled hypertension, malignant hypertension, brain aneurysm, or arteriovenous malformation.

The stroke must be positively diagnosed by a doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

Stroke does not include:

- Head injury
- Chronic cerebrovascular insufficiency
- Reversible ischemic neurological deficits unless brain tissue damage is confirmed by neurological imaging

Stroke will be covered only if the Insured submits evidence of the neurological damage by providing:

- Computed Axial Tomography (CAT scan) images, or
- Magnetic Resonance Imaging (MRI).

Sudden Cardiac Arrest is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to coronary artery disease, cardiomyopathy, or hypertension.

Sudden Cardiac Arrest is not a heart attack (myocardial infarction). A sudden cardiac arrest benefit is not payable if the sudden cardiac arrest is caused by or contributed to by a heart attack (myocardial infarction).

Total Disability or Totally Disabled means you are:

- Not working at any job for pay or benefits,
- Under the care of a doctor for the treatment of a covered critical illness, and
- Unable to Work, which means either:
  - During the first 365 days of total disability, you are unable to work at the occupation you were performing when your total disability began; or
  - After the first 365 days of total disability, you are unable to work at any gainful occupation for which you are suited by education, training, or experience.

Treatment or Medical Treatment is the consultation, care, or services provided by a doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

Treatment-Free From Cancer refers to the period of time without the consultation, care, or services provided by a doctor. This includes receiving diagnostic measures and taking prescribed drugs and medicines. Treatment does not include maintenance drug therapy or routine follow-up visits to verify whether cancer or carcinoma in situ has returned.

Severe Burn or Severely Burned means a burn resulting from fire, heat, caustics, electricity, or radiation. The burn must:

- Be a full-thickness or third-degree burn, as determined by a doctor. A Full-Thickness Burn or Third-Degree Burn is the destruction of the skin through the entire thickness or depth of the dermis (or possibly into underlying tissues). This results in loss of fluid and sometimes shock.
- Cause cosmetic disfigurement to the body's surface area of at least 35 square inches.
- Be caused solely by or be solely attributed to a covered accident.

Coma means a state of continuous, profound unconsciousness, lasting at least seven consecutive days, and characterized by the absence of:

- Spontaneous eye movements,
- Response to painful stimuli, and
- Vocalization.

Coma does not include a medically-induced coma. To be payable as an Accident benefit, the coma must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, the coma must be caused solely by or be solely attributed to one of the following diseases:

- Brain Aneurysm
- Diabetes
- Encephalitis
- Epilepsy
- Hyperglycemia
- Hypoglycemia
- Meningitis

Paralysis or Paralyzed means the permanent, total, and irreversible loss of muscle function to the whole of at least two limbs. To be payable as an Accident benefit, the paralysis must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, paralysis must be caused solely by or be solely attributed to one or more of the following diseases:

- Amyotrophic lateral sclerosis
- Cerebral palsy
- Parkinson's disease,
- Poliomyelitis

The diagnosis of paralysis must be supported by neurological evidence.

Loss of Sight means the total and irreversible loss of all sight in both eyes. To be payable as an Accident benefit, loss of sight must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of sight must be caused solely by or be solely attributed to one of the following diseases:

- Retinal disease
- Optic nerve disease
- Hypoxia

Loss of Speech means the total and permanent loss of the ability to speak. To be payable as an Accident benefit, loss of speech must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of speech must be caused solely by or be solely attributable to one of the following diseases:

- Alzheimer's disease
- Arteriovenous malformation

Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of hearing does not include hearing loss that can be corrected by the use of a hearing aid or device. To be payable as an Accident benefit, loss of hearing must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of hearing must be caused solely by or be solely attributed to one of the following diseases:

- Alport syndrome
- Autoimmune inner ear disease
- Chicken pox
- Diabetes
- Goldenhar syndrome
- Meniere's disease
- Meningitis
- Mumps

YOU MAY CONTINUE YOUR COVERAGE

Your coverage may be continued with certain stipulations. See certificate for details.

TERMINATION OF COVERAGE

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

NOTICES

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

Notice to Consumer: The coverages provided by Continental American Insurance Company (CAIC) represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. CAIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.

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CONTINENTAL AMERICAN INSURANCE COMPANY

P.O Box 427, Columbia, South Carolina 29202
800.433.3036

SPECIFIED DISEASE INSURANCE - OUTLINE OF COVERAGE

Group Policy C21100MA

This Policy is a Group Policy which was issued in Massachusetts. THIS IS A LIMITED POLICY.

Caution: The issuance of this Specified Critical Illness Certificate is based upon your responses to the questions in the application. If your answers were incorrect or untrue as of the date you signed the application, we have the right to deny benefits or rescind the Certificate subject to the Time Limit on Certain Defenses section of your Certificate. The best time to clear up any questions is now, before a claim arises! If for any reason, any of your answers are incorrect, contact us at our Home Office: P.O Box 427, Columbia, South Carolina 29202.

SUMMARY OF POLICY FEATURES

This Policy:

1. Is not a Medicare Supplement Policy.
2. Is not subject to automatic premium increases as you get older.
3. May be subject to across the board premium increases for all Certificateholders in your class.
4. Does not offer an option to purchase inflation protection.
5. Does not offer an option to purchase nonforfeiture protection.
6. Does contain special age limitations for purchase.
7. Offers a Waiver of Premium after 90 days of Total Disability.

PURPOSE OF OUTLINE OF COVERAGE. An Outline of Coverage provides a very brief description of the important features of the coverage. You should compare this Outline of Coverage to Outlines of Coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the Group Policy contains actual contractual provisions. This means that your Certificate sets forth in detail the rights and obligation of both you and the carrier. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR CERTIFICATE CAREFULLY!

TERM UNDER WHICH THE CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

Termination of Your Insurance

Your insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date, if the premium has not been paid.
- The date you no longer belong to an eligible class.

Insurance for a covered Spouse or Dependent Child will terminate on the earliest of any of the reasons listed above, or:

- The premium due date following the date the covered Spouse or Dependent Child no longer qualifies as a Dependent.
- The premium due date following the date we receive your written request to terminate coverage for your Spouse or all Dependent Children.

If your coverage terminates, we will provide benefits for valid claims that arose while your coverage was active.

Portability Privilege

When you are no longer a member of an eligible class and your coverage would otherwise end, you may elect to continue your coverage under this Plan. You may continue the coverage you had on the date your Certificate would otherwise terminate, including any in-force Spouse or Dependent Child coverage.

To keep your coverage in force, you must:

- Notify the Company in writing within 31 days after the date your coverage would otherwise terminate, and
- Pay the required premium to the Company no later than 31 days after the date your coverage would otherwise terminate. You must continue to pay us the required premium and on each premium due date that follows.

Ported coverage will end on the earliest of the following dates:

- 31 days after the date you fail to pay any required premium; or
- The date the Group Plan is terminated.

If you qualify for this Portability Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate as shown in your previously issued Certificate.

Waiver of Premium Benefit

If you become Totally Disabled as defined in this Plan due to a covered Critical Illness, we will waive premiums for you and any currently covered Dependents (this includes any Riders that are in force).

Total Disability or ***Totally Disabled*** means you are:

- Not working at any job for pay or benefits,
- Under the care of a Doctor for the Treatment of a covered Critical Illness, and
- ***Unable to Work***, which means either:
    - During the first 365 days of Total Disability, you are unable to work at the occupation you were performing when your Total Disability began; or
    - After the first 365 days of Total Disability, you are unable to work at any gainful occupation for which you are suited by education, training, or experience.

After 90 days of Total Disability, all Plan premiums will be waived if:

- Your Total Disability began before your age of 65;
- Your Total Disability has continued without interruption for at least 90 days, during which time you and/or the Policyholder have paid premiums; and
- You provide proof of Total Disability as required by us. Satisfactory Proof of Loss for Total Disability must be provided at least once every 12 months.

Pending our approval of a claim for the Waiver of Premium Benefit, premiums should be paid as they are due. Premiums that were paid for the first 90 days of Total Disability will be refunded after your claim for this benefit is approved.

Waiver of Premium will continue until the earliest of the following:

- The premium due date following your 65th birthday,
- The date the Company has waived premiums for a total of 24 months of Total Disability,
- The date you refuse to provide proof of continuing Total Disability,
- The date your Total Disability ends, or
- The date coverage ends according to the Termination provisions in **Section I – Eligibility, Effective Date, and Termination.**

If you are still eligible for coverage when you return to Active Work, coverage for any Insured may be continued if premium payments are resumed.

Plan Termination

The Company has the right to cancel the Plan on any premium due date for the following reasons:

- The premium is not paid before the end of the Grace Period,
- The number of participating Employees is less than the number mutually agreed upon by the Company and the Policyholder in the signed Master Application,

- The Policyholder does not provide timely information or meet any obligations required by this Plan and applicable law, or
- The Company cancels the Plan any time after the end of the first policy year. To do this, the Company must give the Policyholder 31 days' written notice.

The Policyholder has the right to cancel the Plan on any premium due date.

- To do this, the Policyholder must give the Company at least 31 days' written notice.
- The Plan will end on the date in the written notice or the date the Company receives the notice, whichever is later.

All outstanding premiums are due upon Plan termination. If the Company accepts premium payments after the Plan terminates, this will not reinstate the Plan; we will refund any excess premium.

The Policyholder has the sole responsibility of notifying Certificateholders in writing of the Plan's termination as soon as reasonably possible. If the Plan terminates, it—and all Certificates and Riders issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

TERMS UNDER WHICH THE CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

If you are not satisfied with the Certificate, you may return it within 10 days from the date you receive it. We will then refund any premium you have paid and this Certificate and all Riders and attachments will be considered never to have been in effect.

All outstanding premiums are due upon Plan termination. If the Company accepts premium payments after the Plan terminates, this will not reinstate the Plan; we will refund any excess premium.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the Company.

Neither Continental American Insurance Company nor its agents represent Medicare, the federal government, or any state government.

BENEFITS PROVIDED BY THIS CERTIFICATE.

Critical Illness Benefit

Initial Diagnosis

We will pay the Critical Illness benefit when an Insured is Diagnosed with one of the Critical Illnesses shown in the Certificate Schedule, and when such Diagnosis is caused by or solely attributed to an underlying disease as identified herein. We will pay this benefit if:

- The Date of Diagnosis is while his coverage is in force, and
- The Certificate does not exclude the illness or condition by name or by specific description.

If an Initial Diagnosis claim is for a Diagnosis of Cancer, the Insured:

- Must be Treatment-Free From Cancer for at least 12 months before the Diagnosis Date; and
- Must be in Complete Remission prior to the date of a subsequent Diagnosis as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the Cancer.

Benefits will be based on the Face Amount in effect on the Critical Illness Date of Diagnosis.

Additional Diagnosis

Once benefits have been paid for a Critical Illness, a 10% benefit is payable for each **different** Critical Illness when:

- The Date of Diagnosis for the new Critical Illness is separated from the prior, different Critical Illness by less than 6 consecutive months, and
- The new Critical Illness is not caused or contributed to by a Critical Illness for which benefits have been paid.

If an Additional Diagnosis claim is for a Diagnosis of Cancer, the Insured:

- Must be Treatment-Free From Cancer for at least 12 months before the Diagnosis Date; and
- Must be in Complete Remission prior to the date of a subsequent Diagnosis as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the Cancer.

For the Diagnosis of a new Critical Illness that is separated from the prior, different Critical Illness by 6 consecutive months or more, and is not caused or contributed to by a Critical Illness for which benefits have been paid, we will provide a 100% benefit.

Reoccurrence

Once benefits have been paid for a Critical Illness, a 10% additional benefit is payable for that same Critical Illness when:

- The Date of Diagnosis for the Reoccurrence of that Critical Illness is separated from the prior occurrence of that Critical Illness by less than 6 consecutive months, and
- The Critical Illness is not caused or contributed to by a Critical Illness for which benefits have been paid.

If a Reoccurrence claim is for a Diagnosis of Cancer, the Insured:

- Must be Treatment-Free From Cancer for at least 12 months before the Diagnosis Date; and
- Must be in Complete Remission prior to the date of a subsequent Diagnosis as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the Cancer.

For the Diagnosis of a Reoccurrence of a Critical Illness that is separated by at least 6 consecutive months or more from the prior occurrence of that Critical Illness, and is not caused or contributed to by a Critical Illness for which benefits have been paid, we will provide a 100% benefit.

Partial Benefits

Partial Benefits are payable if the Date of Diagnosis is while the Insured's coverage is in force, and the Certificate does not exclude the illness or condition by name or by specific description.

Non-Invasive Cancer

We will pay the amount shown in the Certificate Schedule **once** for the Diagnosis of a Non-Invasive Cancer. This benefit is payable in addition to all other applicable benefits.

Coronary Artery Bypass Surgery

We will pay the amount shown in the Certificate Schedule **once** for Coronary Artery Bypass Surgery. This benefit is payable in addition to all other applicable benefits.

LIMITATIONS AND EXCLUSIONS

Exclusions

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

- **Self-Inflicted Injuries –** injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured.
- **Suicide –** committing or attempting to commit suicide, while sane or insane.
- **Illegal Acts –** participating or attempting to participate in an illegal activity, or working at an illegal job.
- **Participation in Aggressive Conflict** of any kind, including:
    - War (declared or undeclared) or military conflicts.
    - Insurrection or riot.
    - Civil commotion or civil state of belligerence.
- **Illegal substance abuse, which includes the following:**
    - Abuse of legally-obtained prescription medication.
    - Illegal use of non-prescription drugs.
    - Services provided for alcohol and drug detoxification.

RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of care services will likely increase over time, you should consider whether and how the benefits of this Plan may be adjusted.

- Benefit levels under this Plan will not increase over time.
- You are not guaranteed an option to buy additional coverage.
- There will not be any additional premium charge imposed.

NONFORFEITURE BENEFITS. As an Accident and Sickness Policy, this Policy does not have a cash value associated with life insurance products.

PREMIUM

Please see the Schedule page of your Certificate for the total annual premium for the Policy.

COMPLAINTS. If you have a compliant, call your agent. If you are not satisfied, you may call or write the Massachusetts Division of Insurance, Consumer Services Section, One South Station, 5th Floor, Boston, MA 02110-2208.

The Commonwealth of Massachusetts
Executive Office of Elder Affairs
One Ashburton Place, 5th Floor
Boston, Massachusetts 02108

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

ALICE F. BONNER
Secretary

Tel: (617) 727-7750
Fax: (617) 727-9368
www.mass.gov/elders

Massachusetts Bulletin for People with Medicare
January 2016

Health Insurance Options for People with Medicare

- Original Medicare (Part A and Part B)
- Medicare Supplement Insurance (Medigap)
- Medicare Advantage Plans (Medicare Part C)
- Medicare Prescription Drug Coverage (Medicare Part D)
- Employer, Union, Retiree, other group health insurance coverage
- COBRA
- Veterans Health Benefits
- Military Benefits (TRICARE)
- Indian Health Services

Programs for People with Limited Income and Resources

- Extra Help Paying for Medicare Prescription Drug Coverage (Part D)
- Medicare Savings Programs (help with Medicare costs)
- Prescription Advantage (prescription drug insurance assistance program for Massachusetts residents)
- MassHealth (Medicaid)

This Bulletin provides basic health insurance information for people eligible for Medicare.

Contact your plan benefits administrator for information about employer, union, retiree, or other group health coverage. Contact your local Veterans Service Officer for Veterans and TRICARE health insurance information. Contact the Indian Health Services for health information for American Indians and Alaska Natives.

Medicare

Medicare is a Federal Government health insurance program administered by the Centers for Medicare and Medicaid Services (CMS) for people:

- age 65 or older under
- age 65 with certain disabilities

Medicare has **4** parts:

- **Part A (Medicare Hospital Insurance)**
  Helps pay for inpatient care in hospitals, skilled nursing facilities, hospice, home health care and other services.

- **Part B (Medicare Medical Insurance)**
  Helps pay for outpatient medical services including doctor visits, medical equipment, home health care, outpatient care, and some preventive services.

- **Part C (Medicare Advantage Plan)**
  Medicare Advantage Plans include Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
  Some Medicare Advantage Plans may offer Medicare Part D, prescription drug coverage at additional charge and other services not covered by Medicare.
  Medicare Advantage Plans (like HMOs, PPOs) are sold by private health insurance companies approved by Medicare.

- **Part D (Medicare Prescription Drug Coverage)**
  Helps pay for outpatient prescription drugs. Medicare prescription drug plans are sold by private insurance companies approved by Medicare.

There are 2 ways to get Medicare coverage:

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(1) Original Medicare is fee-for-service coverage administered directly by Medicare. Original Medicare covers Medicare **Part A (Hospital)** and **Part B (Medical)** services. Under Original Medicare, you have the choice of doctors, hospitals and other providers that accept Medicare.

You may purchase optional **Medicare Supplement (Medigap)** insurance from a private company or have employer or other health insurance to help pay for deductibles and coinsurance in Original Medicare.

You may decide to purchase a **Medicare Prescription Drug plan (Part D)** to help pay for outpatient prescription drugs.

(2) Medicare Advantage Plan (like an HMO or PPO)

Medicare Advantage Plans (MA-PD) cover Medicare **Part A and Part B** Services. MA-PDs are sold by private companies approved by Medicare and usually charge a monthly premium.
Some plans offer additional benefits not covered by Medicare.
Most plans require use of network doctors, hospitals and other providers.
Most MA-PDs offer Medicare prescription drug coverage (Part D) at additional cost. Some plans do not offer drug coverage (MA plans)
You must be enrolled in Medicare A and B, pay plan premiums, deductibles, copays and coinsurance.
(Medicare Supplement Insurance cannot be sold to MA-PD enrollees)

Medicare Advantage Plans sold in Massachusetts

- **Health Maintenance Organizations (HMO)**
  Must be a resident of the plan's service area and use provider network
- **Preferred Provider Organization (PPO)**
  Must be a resident of the plan's service area
  May use out-of-network Medicare providers at higher cost sharing
- **Point-of Service (HMO/POS)**
  Must be a resident of the plan's service area.
  May use out-of-network Medicare providers at higher cost sharing
- **Private Fee-for-Service (PFFS)**

May use any Medicare provider that agrees to treat patient.
The Plan determines provider and patient payment for the services.

- **Special Needs Plan (SNP)**
  For people with Medicare and Medicaid or special conditions

Medicare Prescription Drug Coverage (Part D)

Medicare prescription drug coverage (Part D) helps pay for prescription drugs. Medicare prescription drug plans are sold by private companies approved by Medicare. Each plan can vary in cost and specific drugs covered.
Medicare Prescription Drug Plans (PDPs) are stand-alone plans for enrollees in **Original Medicare**.
Most **Medicare Advantage Plans** offer optional Medicare prescription drug coverage.

Medicare Supplement Insurance (Medigap)

Medicare Supplement Insurance (also called Medigap Insurance) is sold by private insurance companies to help pay health care costs that Original Medicare does not cover such as deductibles and coinsurance.

Some Medigap insurers may include coverage for services that are not covered by Original Medicare.

Two standard Medigap policies are offered to Massachusetts residents**:**

Medicare Supplement Core & **Medicare Supplement 1**

Medicare Supplement Insurance (Medigap) for Massachusetts residents is regulated by federal and state laws including the following:

- Medigap policies must be clearly identified as **"Medicare Supplement Insurance"**
- Policies and text are standard for all insurers, Basic benefits are the same, some may offer additional benefits

- Medigap insurance is guaranteed renewable and cannot be cancelled unless the beneficiary stops paying the premium or provides false information on the application.
- Medigap insurers cannot refuse to sell a policy, exclude or limit coverage, or require a waiting period before coverage starts due to existing health problems.
- Medigap insurers must offer the same premium to all policyholders and cannot charge a different premium based on age or health.

Medicare Select Plan

- Medicare Select Plans are Medicare supplement plans that require the use of a provider network

The Massachusetts Division of Insurance monitors insurance companies authorized to sell insurance in Massachusetts, For information contact:

Massachusetts Division of Insurance
617-521-7794/www.state.ma.us/doi

Programs for People with Limited Income and Resources

Extra Help for Medicare Prescription Drug Coverage (Part D) also known as the Limited Income Subsidy (LIS) is a federal program that helps Medicare beneficiaries with limited income and assets pay some of the costs for Medicare prescription drug coverage (Part D).

For more information or to enroll in Extra Help, contact **Social Security** at: **1-800-772-1213** or visit **www.socialsecurity.gov**

Medicare Savings Program (MassHealth Buy-In) are federal programs that help pay Medicare premiums and Part A and Part B deductibles and coinsurance for Massachusetts residents with limited income and assets and not receiving other MassHealth benefits.

For more information about Medicare Savings Programs contact:

MassHealth Customer Service

1-800-841-2900

(TTY: 1-800-497-4648 for people with partial or total hearing loss)

Prescription Advantage/State Pharmacy Assistance Program (SPAP)

Is a state program that help people with limited income and/or medical condition and age pay for prescription drugs.

Prescription Advantage is funded by state legislation and is administered by the Massachusetts Executive Office of Elder Affairs.

For information about eligibility and enrollment contact:

Prescription Advantage Customer Service

1-800-AGE-INFO (1-800-243-4636) press 2

www.prescriptionadvantage.com

(TTY: 1-800-610-0241 for people with partial or total hearing loss)

MassHealth

MassHealth provides a wide range of medical services and other benefits. These programs are authorized by state and federal laws and help pay medical costs for people with limited income and resources and meet other eligibility requirements.

- **MassHealth Standard** provides a full range of health care benefits.
- **MassHealth CommonHealth** for people with disabilities whose income is too high to be eligible for MassHealth Standard.
- **MassHealth Frail Elder Waiver Program** provides coordinated community based services to frail elders living in the community.
- **MassHealth Personal Care Attendant Services (PCA)** helps people with long-term disabilities live independently at home.

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- **Program for All-inclusive Care for the Elderly (PACE)**
  PACE providers deliver needed medical and support services to people living in the community.

MassHealth Plans for Dual Eligible (MassHealth & Medicare)

Senior Care Options (SCO) is a coordinated health plan that combines Medicare and Medicaid health care with long term care supports for consumers 65 and older.

One Care (Integrated Care Organization or ICO) is a coordinated care demonstration project in Massachusetts that combines Medicare and MassHealth services with long term care supports for consumers 21-64 years old with disabilities. Enroll through MassHealth.

MassHealth Long-Term Care (LTC) covers LTC costs for individuals living in LTC facilities

For information or questions about eligibility and enrollment:

MassHealth Customer Service
1-800-841-2900/www.mass.gov/masshealth
(TTY: 1-800-497-4648 for people with partial or total hearing loss)

Helpful Numbers

Massachusetts Executive Office of Elder Affairs
To directly connect with elder services in your area call and press or say:
1-800-AGE-INFO (1-800-243-4636)

- to connect to your local elder service agency or caregiver program: Press 1
- to connect to Prescription Advantage-state prescription drug program: Press 2
- to connect to your regional SHINE Program: Press 3
- to report elder abuse, neglect or financial exploitation: Press 4
- all other matters: Press 5

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MassHealth
1-800-841-2900/www.mass.gov/masshealth
TTY: 800-497-4648
MassHealth provides a wide range of health care services that pay for all or part of the health care cost for people with limited income and resources. Call MassHealth for One Care enrollment.

MassHealth Senior Care Options (SCO)
1-888-885-0484/www.mass.gov/masshealth
TTY: 1-888-821-5225
A health plan that combines Medicare and Medicaid services with home services.

Massachusetts Division of Insurance
617-521-7794/www.state.ma.us/doi
Regulates insurance companies authorized to sell insurance in Massachusetts.

Elder Protective Services Elder Abuse Hotline (24 hour/7 days)
1-800-922-2275
A statewide program is administered by the Executive Office of Elder Affairs. Protective Service Agencies investigates reports of elder abuse and provide protective services to abused elders.

Attorney General of Massachusetts
Elder Hotline: 1-888-243-5337/www.ago.state.ma.us
The Attorney General of Massachusetts is the state's chief law enforcement Officer. The Hotline provides information about elder-related issues and programs.

Massachusetts Medicare Advocacy Project (MAP)
1-800-323-3205
Provides Medicare beneficiaries free legal advice and legal representation for appealing medical decisions.

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MCPHS University Pharmacy Outreach Program
1-866-633-1617/www.mcphs.edu/pharmacyoutreach
Provides free prescription drug information and referrals. The Pharmacy Outreach Program is a public service of the MCPHS and EOEA.

Social Security Administration
1-800-772-1213/www.ssa.gov
Contact SSA to enroll in Medicare and for information and issues about Social Security and other related programs.

Massachusetts Health Connector
1-877-623-6765/www.betterhealthconnector.com
Health insurance, assistance and on-line application for people without insurance or small businesses; dental plan list for anyone.

SHINE (Serving Health Insurance Needs of Everyone)
1-800-243-4636 Press or say 3
www.800ageinfo.com

SHINE, a State Health Insurance Assistance Program (SHIP), provides information, counseling and assistance to **Medicare beneficiaries** and their families regarding Medicare and other health insurance issues.
SHINE Health Insurance Counselors are trained and certified by the Massachusetts Executive Office of Elder Affairs (EOEA). SHINE is administered by EOEA in partnership with elder service agencies, councils on aging, independent living centers and community based programs.
SHINE is partially funded by the Administration on Community Living.

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Standard Medigap Plans
Available in Massachusetts
in 2016

Comparison of Plans	Core	Supplement 1
Basic Benefits Included In All Plans:		
Hospitalization Part A Co-payments		
Days 61 - 90: $322 per day	X	X
Days 91-150: $644 per day	X	X
365 Additional Lifetime Hospital days - Paid in full	X	X
Part B Coinsurance - Coverage of coinsurance, in most cases, 20% of approved amount	X	X
Parts A and B Blood First 3 pints	X	X
Additional Benefits	**Core**	**Supplement 1**
Part A Deductible for Hospital Days 1 - 60 $1288 per benefit period		X
Skilled Nursing Facility Coinsurance Days 21-100 - $161.00 per day		X
Part B Annual Deductible - $166		X
Foreign Travel - For Medicare-covered services needed while traveling abroad.		X
Inpatient Days in Mental Health Hospitals In addition to Medicare's coverage of 190 lifetime days and less any days previously covered by plan in same benefit period	60 days per calendar year	120 days per benefit period

IMPORTANT NOTICE:

Medicare Supplement premium rates are required to be in effect for not less than 12 months. Effective dates may vary by Carrier.

Medicare Supplement Plans
Offered in Massachusetts
in 2016

Medigap Carriers Please note that rates may change in 2016	**Medicare Supplement Core**	**Medicare Supplement 1**
Blue Cross & Blue Shield of MA (Medex™) 1-800-678-2265 sales/apps 1-800-258-2226 member services 1-800-522-1254 (TDD) www.bluecrossma.com (continuous open enrollment)	**$93.70**	**$182.45**
Optional Preventive Care Benefits Rider	**$5.75**	**$5.75**
Fallon Health & Life Assurance Company 1-866-330-6380 sales/apps 1-800-868-5200 member services TRS 711 **www.fallonhealth.org/medsupp** (continuous open enrollment)	**$119.00**	**$216.00**
HNE Insurance Company 1-877-443-3314 1-800-439-2370 (TDD/TTY) www.hne.com (continuous open enrollment)	**$105.00**	**$193.00**
HPHC Insurance Company, Inc. 1-800-782-0334 sales/apps 1-877-907-4742 member services 1-888-259-8276 (TDD) www.harvardpilgrim.org (continuous open enrollment)	**$109.00**	**$210.00**

Medicare Supplement Plans Offered in Massachusetts in 2016

Medigap Carriers Please note that rates may change in 2016	**Medicare Supplement Core**	**Medicare Supplement 1**
Humana Insurance Company 1-800-872-7294 sales/apps 1-800-866-0581 member services 1-800-833-3301 (TDD) www.humana-medicare.com (continuous open enrollment)	**$157.24** **($163.45 effective 05/01/16)**	**$243.60** **($260.51 effective 05/01/16)**
Humana Insurance Company HEALTHY LIVING (including dental and vision benefits) 1-800-872-7294 sales/applications 1-800-866-0581 member services 1-800-833-3301 (TDD) www.humana-medicare.com (continuous open enrollment)	**$170.59** **($176.80 effective 05/01/16)**	**$256.95** **($273.86 effective 05/01/16)**
Transamerica Life Insurance Company For eligibility & plan information: 1-800-247-1771 (Group Medicare Supplement Insurance sponsored for members of various participating industry, trade, professional and other special interest associations.) (continuous open enrollment)	**$111.16**	**$192.28**
Transamerica Premier Life Insurance Company 1-800-458-5736 (Group Medicare Supplement insurance sponsored exclusively for eligible members of the American Medical Association.) www.amainsure.com (continuous open enrollment)	**$97.46**	**$168.58**

Medicare Supplement Plans Offered in Massachusetts in 2016

Medigap Carriers Please note that rates may change in 2016	**Medicare Supplement Core**	**Medicare Supplement 1**
Tufts Insurance Company 1-800-714-3000 sales/apps 1-800-701-9000 member services TDD 1-800-208-9562 (member services) 1-888-899-8977 (sales/apps) www.tuftsmedicarepreferred.org (continuous open enrollment)	**$104.76**	**$194.00**
United Healthcare Insurance Company Only for members of AARP (American Association of Retired Persons) 1-800-523-5800 (continuous open enrollment)	**$122.75**	**$219.25**

Medigap Carriers Please note that rates may change in 2016	**Medicare Select****
Blue Cross & Blue Shield of Massachusetts HMO Blue, Inc. 1-800-258-2226 member services 1-800-522-1254 (TDD) www.bluecrossma.com (continuous open enrollment)	**$136.42**

** Medicare Select Plans are Medicare Supplement Insurance Plans that require the use of a provider network. Medicare Select In-network benefits will be the same as the Medicare Supplement Core benefits or Medicare Supplement 1 benefits, based on the member's choice of PCP.

In addition to the above-noted Medicare Supplemental plans, Massachusetts residents may enroll in Medicare Advantage Plans as well as Part D Prescription Drug Plans with the Centers for Medicare and Medicaid Services ("CMS"). For further information regarding these plans please visit the following website: https://www.medicare.gov/find-a-plan/questions/home.aspx

Medicare Advantage Plans Offered in Massachusetts in 2016

	Plan Name	Plan Type	Monthly Premium	Drugs	Doctor Choice	Counties
AARP Medicare Complete Provided by United Healthcare Phone: 1-800-555-5757 TTY: 711	Medicare Complete Plan 1	HMO	$0.00	Yes	Plan Doctors for Most Services	Bristol Essex Hampden Middlesex Norfolk Plymouth Suffolk
	Medicare Complete Plan 2	HMO	$45.00	Yes	Plan Doctors for Most Services	Bristol Essex Hampden Middlesex Norfolk Plymouth Suffolk
	Medicare Complete Choice	PPO	$50.00	Yes	Any Doctor	Barnstable Berkshire Bristol Dukes Essex Franklin Hampden Hampshire Middlesex Nantucket Norfolk Plymouth Suffolk Worcester
Blue Cross Blue Shield of Massachusetts Phone: 1-800-678-2265 TTY: 1-800-522-1254	Medicare HMO Blue PlusRx	HMO	$235.50	Yes	Plan Doctors for Most Services	Barnstable Bristol Essex Franklin Hampden Hampshire Middlesex Norfolk Plymouth Suffolk Worcester

	Plan Name	Plan Type	Monthly Premium	Drugs	Doctor Choice	Counties
Blue Cross Blue Shield of Massachusetts (continued)	Medicare HMO Blue Value Rx	HMO	$29.00	Yes	Plan Doctors for Most Services	Barnstable Bristol Essex Franklin Hampden Hampshire Middlesex Norfolk Plymouth Suffolk Worcester
	Medicare HMO Blue FlexRx	HMO-POS	$99.00	Yes	Plan Doctors for Most Services	Barnstable Bristol Essex Franklin Hampden Hampshire Middlesex Norfolk Plymouth Suffolk Worcester
	Medicare PPO Blue PlusRx	PPO	$180.50	Yes	Any Doctor	Barnstable Bristol Essex Franklin Hampden Hampshire Middlesex Norfolk Plymouth Suffolk Worcester
	Medicare PPO Blue ValueRx	PPO	$59.00	Yes	Any Doctor	Barnstable Bristol Essex Franklin Hampden Hampshire Middlesex Norfolk Plymouth Suffolk Worcester
	Medicare PPO Blue SaverRx	PPO	$0.00	Yes	Any Doctor	Barnstable; Bristol Essex; Franklin Hampden; Hampshire; Middlesex; Norfolk Plymouth; Suffolk Worcester

	Plan Name	Plan Type	Monthly Premium	Drugs	Doctor Choice	Counties
Erickson Advantage Phone: 1-800-774-9671 TTY: 711	Erickson Advantage Signature with Drugs	HMOPOS	$190.00	Yes	Plan Doctors Only	Essex Plymouth
	Erickson Advantage Signature without Drugs	HMO-POS	$149.00	No	Plan Doctors Only	Essex Plymouth
	Erickson Advantage Freedom	HMO-POS	$49.00	Yes	Plan Doctors Only	Essex Plymouth
Fallon Community Health Plan Phone: 1-888-377-1980 TTY: 711	Fallon Senior Plan Plus Enhanced Rx	HMO	$152.00	Yes	Plan Doctors Only	Bristol Middlesex Norfolk Plymouth
	Fallon Senior Plan Plus Enhanced Rx	HMO-POS	$110.00	Yes	Plan Doctors Only	Hampden Hampshire
	Fallon Senior Plan Plus Enhanced Rx	HMO	$244.00	Yes	Plan Doctors Only	Franklin Worcester
	Fallon Senior Plan Plus Enhanced Rx	HMO	$166.00	Yes	Plan Doctors Only	Essex Suffolk
	Fallon Senior Plan Plus Enhanced Rx	HMO	$201.00	Yes	Plan Doctors Only	Barnstable
	Fallon Senior Plan Saver	HMO	$27.00	No	Plan Doctors Only	Bristol Middlesex Norfolk Plymouth
	Fallon Senior Plan Saver	HMO	$19.00	No	Plan Doctors Only	Essex Suffolk
	Fallon Senior Plan Saver	HMO	$61.00	No	Plan Doctors Only	Franklin Worcester
	Fallon Senior Plan Saver	HMO	$0.00	No	Plan Doctors Only	Hampden Hampshire
	Fallon Senior Plan Saver	HMO	$65.00	No	Plan Doctors Only	Barnstable
	Fallon Senior Plan Saver Enhanced Rx	HMO	$46.00	Yes	Plan Doctors Only	Bristol Middlesex Norfolk Plymouth
	Fallon Senior Plan Saver Enhanced Rx	HMO	$30.00	Yes	Plan Doctors Only	Hampden Hampshire
	Fallon Senior Plan Saver Enhanced RX	HMO	$79.00	Yes	Plan Doctors Only	Franklin Worcester
	Fallon Senior Plan Saver Enhanced Rx	HMO	$86.00	Yes	Plan Doctors Only	Barnstable

	Plan Name	Plan Type	Monthly Premium	Drugs	Doctor Choice	Counties
Fallon Community Health Plan (continued)	Fallon Senior Plan Saver Enhanced Rx	HMO	$56.00	Yes	Plan Doctors Only	Essex Suffolk
	Fallon Senior Plan Super Saver Rx	HMO	$0.00	Yes	Plan Doctors Only	Barnstable Bristol Essex Franklin Hampden Hampshire Middlesex Norfolk Plymouth Suffolk Worcester
	Fallon Senior Plan Standard	HMO	$134.00	No	Plan Doctors Only	Franklin Worcester
	Fallon Senior Plan Standard Enhanced Rx	HMO	$184.00	Yes	Plan Doctors Only	Franklin Worcester
Harvard Pilgrim Healthcare Phone: 1-888-609-0692 TTY: 1-800-720-3480	Stride Value Rx Plus	HMO	$138.00	Yes	Plan Doctors Only	Bristol Essex Middlesex Norfolk Plymouth Suffolk Worcester
	Stride Value Rx	HMO	$48.00	Yes	Plan Doctors Only	Bristol Essex Middlesex Norfolk Plymouth Suffolk Worcester

	Plan Name	Plan Type	Monthly Premium	Drugs	Doctor Choice	Counties
Health New England Phone: 1-413-787-0010 TTY: 1-800-439-2370	HNE Medicare Basic No Rx	HMO	$27.00	No	Plan Doctors Only	Berkshire Franklin Hampden Hampshire
	HNE Medicare Basic Rx	HMO	$83.00	Yes	Plan Doctors Only	Berkshire Franklin Hampden Hampshire
	HNE Medicare Plus Rx	HMO	$114.00	Yes	Plan Doctors Only	Berkshire Franklin Hampden Hampshire
	HNE Medicare Premium No Rx	HMO	$97.00	No	Plan Doctors Only	Berkshire Franklin Hampden Hampshire
	HNE Medicare Premium Rx	HMO	$164.00	Yes	Plan Doctors Only	Berkshire Franklin Hampden Hampshire
	HNE Medicare Value	HMO	$28.00	Yes	Plan Doctors Only	Berkshire Franklin Hampden Hampshire
Tufts Health Plan Phone: 1-877-218-4835 TTY: 1-888-899-8978	Medicare Preferred HMO Basic	HMO	$33.00	No	Plan Doctors Only	Worcester
	Medicare Preferred HMO Basic	HMO	$34.00	No	Plan Doctors Only	Essex Suffolk
	Medicare Preferred HMO Basic Rx	HMO	$0.00	Yes	Plan Doctors Only	Hampden Hampshire

	Plan Name	Plan Type	Monthly Premium	Drugs	Doctor Choice	Counties
Tufts Health Plan (continued)	Medicare Preferred HMO Basic Rx	HMO	$35.90	Yes	Plan Doctors Only	Barnstable Bristol Middlesex Norfolk Plymouth
	Medicare Preferred HMO Basic Rx	HMO	$55.90	Yes	Plan Doctors Only	Essex Suffolk
	Medicare Preferred HMO Basic Rx	HMO	$65.60	Yes	Plan Doctors Only	Worcester
	Medicare Preferred HMO Prime No Rx	HMO	$130.00	No	Plan Doctors Only	Barnstable Bristol Middlesex Norfolk Plymouth
	Medicare Preferred HMO Prime No Rx	HMO	$52.00	No	Plan Doctors Only	Hampden Hampshire
	Medicare Preferred HMO Prime No Rx	HMO	$154.00	No	Plan Doctors Only	Essex Suffolk
	Medicare Preferred HMO Prime No Rx	HMO	$148.00	No	Plan Doctors Only	Worcester
	Medicare Preferred HMO Prime Rx	HMO	$154.40	Yes	Plan Doctors Only	Barnstable Bristol Middlesex Norfolk Plymouth
	Medicare Preferred HMO Prime Rx	HMO	$76.40	Yes	Plan Doctors Only	Hampden Hampshire
	Medicare Preferred HMO Prime Rx	HMO	$178.40	Yes	Plan Doctors Only	Essex Suffolk
	Medicare Preferred HMO Prime Rx	HMO	$183.50	Yes	Plan Doctors Only	Worcester
	Medicare Preferred HMO Prime Rx Plus	HMO	$110.20	Yes	Plan Doctors Only	Hampden Hampshire

	Plan Name	Plan Type	Monthly Premium	Drugs	Doctor Choice	Counties
Tufts Health Plan (continued)	Medicare Preferred HMO Prime Rx Plus	HMO	$188.20	Yes	Plan Doctors Only	Barnstable Bristol Middlesex Norfolk Plymouth
	Medicare Preferred HMO Prime Rx Plus	HMO	$212.20	Yes	Plan Doctors Only	Essex Suffolk
	Medicare Preferred HMO Value No Rx	HMO	$96.00	No	Plan Doctors Only	Barnstable Bristol Middlesex Norfolk Plymouth
	Medicare Preferred HMO Value No Rx	HMO	$22.00	No	Plan Doctors Only	Hampden Hampshire
	Medicare Preferred HMO Value No Rx	HMO	$117.00	No	Plan Doctors Only	Essex Suffolk
	Medicare Preferred HMO Value No Rx	HMO	$109.00	No	Plan Doctors Only	Worcester
	Medicare Preferred HMO Value Rx	HMO	$120.30	Yes	Plan Doctors Only	Barnstable Bristol Middlesex Norfolk Plymouth
	Medicare Preferred HMO Value Rx	HMO	$46.30	Yes	Plan Doctors Only	Hampden Hampshire
	Medicare Preferred HMO Value Rx	HMO	$141.30	Yes	Plan Doctors Only	Essex Suffolk
	Medicare Preferred HMO Value Rx	HMO	$144.60	Yes	Plan Doctors Only	Worcester
	Medicare Preferred HMO Saver Rx	HMO	$0.00	Yes	Plan Doctors Only	Barnstable Bristol Essex Middlesex Norfolk Plymouth Suffolk Worcester

HMO = Health Maintenance Organization A type of plan in which you can only go to doctors, hospitals and other providers that belong to the plan network, except in an emergency.

MSA = Medical Savings Account A plan that has two parts. The first part is a high-deductible Medicare Advantage MSA Health Plan. This health plan won't begin to pay covered costs until you have met the annual deductible, which varies by plan. The second part is a Medical Savings Account into which Medicare deposits money that you may use to pay health care costs.

PPO = Preferred Provider Organization A type of plan in which you pay less if you use doctors, hospitals, and other providers that belong to the plan network. You can use doctors, hospitals, and other providers outside of the network for an additional cost.

PFFS = Private Fee for Service A type of Medicare Health Plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare Program, decides how much it will pay and how much you will pay for the services you have. Under this type of plan you may pay more or less for Medicare-covered benefits and you may have extra benefits that Original Medicare Plan doesn't cover.

SCO = Senior Care Option A voluntary program that combines health care services with social support services to help low-income seniors maintain their health and stay in their own homes. With SCO, a team of medical professionals works together to provide you with care that is individually tailored to meet your needs. You must be 65 years of age or older and eligible for MassHealth (Medicaid) to join; you may also have Medicare.

SNP = Special Needs Plan A special type of Medicare Advantage Plan that provides all Medicare Part A and Part B health care and services to people who can benefit the most from things like special care for chronic illnesses, care management of multiple diseases, and focused care management. These plans may limit membership to people in certain institutions (like a nursing home), eligible for both Medicare and Medicaid, or with certain chronic or disabling condition.

Medicare Prescription Drug Plans
Offered in Massachusetts in 2016

Company	Prescription Drug Plan	Monthly Premium	Annual Deductible	Customer Service Phone Number
Aetna	• Medicare Rx Saver	$25.60	$360	Phone: 1-855-338-7030 TTY/TDD: 711
Blue Medicare Rx	• Blue MedicareRx Value Plus • Blue MedicareRx Premier	$49.60 $127.60	$315 $0	Phone: 1-877-479-2227 TTY: 711
Envision RxPlus	• Envision Rx Plus Silver • Envision Rx Plus Clear Choice	$33.30 $33.50	$360 $0	Phone: 1-866-250-2005 TTY/TDD: 711
Express Scripts Medicare	• Express Scripts Medicare Choice • Express Scripts Medicare Value	$72.20 $49.00	$360 $360	Phone: 1-866-477-5704 TTY: 1-800-716-3231
First Health Part D	• First Health Part D Premier Plus • First Health Part D Value Plus	$69.70 $34.40	$0 $0	Phone: 1-855-389-9688 TTY/TDD: 711
Humana Insurance Company	• Humana Walmart – RX Plan • Humana Preferred Rx Plan • Humana Enhanced	$18.40 $28.20 $64.20	$360 $360 $0	Phone: 1-800-706-0872 TTY/TDD: 711

Company	Prescription Drug Plan	Monthly Premium	Annual Deductible	Customer Service Phone Number
SilverScript	• Choice • Plus	$24.90 $77.60	$0 $0	Phone: 1-866-552-6106 TTY/TDD: 711
Symphonix Health	• PrimeSaver Rx • Value Rx	$39.70 $27.80	$200 $360	Phone: 1-855-355-2280 TTY/TDD: 711
Transamerica Life Insurance Company	• Transamerica MedicareRx Classic	$118.80	$360	Phone: 1-877-527-1958 TTY/TDD: 711
United HealthCare Insurance Company	• AARP Medicare Rx Saver Plus • AARP Medicare Rx Preferred	$31.20 $55.40	$360 $0	Phone: 1-888-867-5564 TTY/TDD: 711
WellCare	• WellCare Classic • WellCare Extra	$30. 90 $52.70	$360 $0	Phone: 1-888-293-5151 TTY: 1-888-816-5252

CONTINENTAL AMERICAN INSURANCE COMPANY

P.O Box 427, Columbia, South Carolina 29202
800.433.3036

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement Insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them.
These include:

- hospitalization
- physician services
- hospice care
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

Before you Buy This Insurance

+ Check the coverage in **all** health insurance and long-term care insurance policies you already have.

+ For more information about Medicare and Medicare Supplement Insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

+ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

NOTICE TO APPLICANT
REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS INSURANCE

According to your Employee Application, you intend to lapse or otherwise terminate your present Policy and replace it with a Policy to be issued by Continental American Insurance Company. For your own information and protection, certain facts should be pointed out to you which could affect your rights to coverage under the new Policy.

1. Health conditions which you may presently have may not be covered under the new Policy. This could result in a claim for benefits being denied which may have been payable under your present Policy.

2. Even though some of your present health conditions may be covered under the new Policy, these conditions may be subject to certain Waiting Periods under the new Policy before coverage is effective.

3. Questions in the Employee Application for the new Policy must be answered truthfully and completely; otherwise, the validity of the Policy and the payment of any benefits thereunder may be voided.

4. It may be to your advantage to secure the advice of your present carrier or its agent regarding the proposed replacement of your present Policy. This is your right, under the Policy you have chosen.

The above "Notice to Applicant" was delivered to me on _____.
Date

_____
Applicant