

▶ **Peace of Mind *and*  
Real Cash Benefits**



**GROUP ACCIDENT INSURANCE**

**AC1<sup>G</sup>**

NOTICE TO BUYER: This is an Accident-Only Policy. It does NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York Department of Financial Services. This policy is intended to supplement existing basic hospital, basic medical, or major medical coverage. It is not intended to replace or be issued in lieu of that coverage. **Underlying basic hospital, basic medical, or major medical coverage must be in force in order to purchase this accident-only coverage.**

IMPORTANT NOTICE — THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS. READ YOUR POLICY CAREFULLY.



# GROUP ACCIDENT INSURANCE

AF7700NY, AF7701NY, AF7710NY, AF7711NY

# AC1<sup>G</sup>

## Do you know how much a trip to the emergency room could cost you?

An accident insurance plan provides benefits to help cover the costs associated with unexpected bills. You don't budget for accidents if you're like most people. When a Covered Accident occurs, the last thing on your mind is the charges that may be accumulating while you're at the emergency room, including:

- The ambulance ride
- Use of the emergency room
- Surgery and anesthesia
- Stitches
- Casts
- Wheelchairs
- Crutches
- Bandages

You get the picture. These costs add up—fast. You hope they never happen, but at some point you may take a trip to your local emergency room. If that time comes, wouldn't it be nice to have an insurance plan that pays benefits regardless of any other insurance you have? This group accident plan does just that.



### FEATURES

- Non-occupational coverage
- No limit on the number of claims
- Pays regardless of any other insurance plans you may have
- Benefits available for your Spouse and/or Dependent Children
- Benefits for both inpatient and outpatient treatment of Covered Accidents
- Guaranteed issue (No underwriting is required to qualify for coverage.)
- Payroll deduction (Premiums are paid by convenient payroll deduction.)

## HOSPITAL BENEFITS

	<b>EMPLOYEE PLAN1</b>
<p><b>MEDICAL FEES (for each accident)</b> If an insured is injured in a Covered Accident and receives treatment within one year after the accident, we will pay up to the applicable amount for physician services, emergency room services, supplies, and X-rays. The total amount payable will not exceed the maximum shown per accident. Initial treatment must be received within 60 days after the accident. Spouse \$125; all plans. Children \$75 all plans.</p>	<b>\$125</b>
<p><b>AMBULANCE</b> Spouse and Children: \$100 all plans.</p>	<b>\$100</b>
<p><b>AIR AMBULANCE</b> If an insured requires transportation by a professional ambulance service to a hospital due to an injury in a covered accident within 90 days after a covered accident, we will pay the amount shown above. Spouse and Children: \$500 all plans.</p>	<b>\$500</b>
<p><b>BLOOD/PLASMA</b> If the insured receives blood or plasma within 90 days following a Covered Accident, we will pay the amount shown. Spouse and Children: \$200 all plans.</p>	<b>\$200</b>

## ACCIDENTAL-DEATH AND -DISMEMBERMENT (within 90 days)

	<b>EMPLOYEE PLAN 1</b>	<b>SPOUSE ALL PLANS</b>	<b>CHILD ALL PLANS</b>
<b>ACCIDENTAL-DEATH</b>	<b>\$25,000</b>	<b>\$10,000</b>	<b>\$5,000</b>
<b>ACCIDENTAL COMMON-CARRIER DEATH (plane, train, boat, or ship)</b>	<b>\$75,000</b>	<b>\$50,000</b>	<b>\$15,000</b>
<b>SINGLE DISMEMBERMENT</b>	<b>\$6,250</b>	<b>\$2,500</b>	<b>\$1,250</b>
<b>DOUBLE DISMEMBERMENT</b>	<b>\$25,000</b>	<b>\$10,000</b>	<b>\$5,000</b>
<b>LOSS OF ONE OR MORE FINGERS OR TOES</b>	<b>\$1,250</b>	<b>\$500</b>	<b>\$250</b>
<b>PARTIAL AMPUTATION OF FINGERS OR TOES (including at least one joint)</b>	<b>\$100</b>	<b>\$100</b>	<b>\$100</b>

If the Accidental Common-Carrier Death Benefit is paid, we will not pay the Accidental-Death Benefit.

**Accidental Injury** means bodily injury caused solely by or as the result of a Covered Accident.

**Covered Accident** means an accident that occurs on or after the Effective Date, while the certificate is in force, and that is not specifically excluded.

## ADDITIONAL BENEFITS EMPLOYEE//SPOUSE//CHILD BENEFITS • ALL PLANS

<p><b>HOSPITAL ADMISSION</b> <b>\$1,000</b> We will pay this benefit when an insured is injured in a covered accident and the injury requires Hospital confinement as a resident bed patient within six months of the date of the covered Accident. We will not pay this benefit for confinement to an observation unit, or for emergency room Treatment or outpatient Treatment. We will pay this benefit once per calendar year.</p>	<p><b>HOSPITAL CONFINEMENT (per day)</b> <b>\$160</b> If an insured is injured in a Covered Accident and the injury causes him or her to be confined to a Hospital within 90 days after the Covered Accident, we will pay the amount shown above for each day that the employee is confined to a hospital. The length of time shown for hospital confinement in the certificate benefit schedule is the maximum period for which the insured can collect benefits for Hospital confinements resulting from the same injury.</p>
<p><b>HOSPITAL INTENSIVE CARE (per day)</b> <b>\$400</b> We will pay this benefit amount for up to 30 days per Covered Accident. This benefit is payable in addition to the Hospital Confinement benefit above.</p>	<p>This benefit is payable once per day per Hospital confinement even if the confinement is caused by more than one Accidental Injury.</p>
<p><b>PROSTHESIS</b> <b>\$500</b> If an insured requires the use of a prosthetic device due to injuries received in a Covered Accident, we will pay this benefit. Hearing aids, wigs, or dental aids, including but not limited to false teeth, are not covered.</p>	<p><b>APPLIANCES</b> <b>\$100</b> We will pay this benefit when an insured is advised by a physician to use a medical appliance due to injuries received in a Covered Accident. Benefits are payable for crutches, wheelchairs, leg braces, back braces, and walkers.</p>

This brochure is a brief description of coverage and is not a contract. Read your certificate carefully for exact terms and conditions.

## ADDITIONAL BENEFITS EMPLOYEE//SPOUSE//CHILD BENEFITS • ALL PLANS

### TRANSPORTATION

Train or Plane: \$400 // Bus: \$200

If hospital treatment or diagnostic study is recommended by the insured's physician and is not available in the insured's city of residence, we will pay the amount shown. Transportation must begin within 90 days from the date of the Covered Accident.

The distance to the hospital must be greater than 50 miles from your residence.

### ACCIDENT FOLLOW-UP TREATMENT

\$50

We will pay this benefit for up to six treatments per Covered Accident, per insured for follow-up treatment. The insured must have received initial treatment within 72 hours of the accident, and the follow-up treatment must begin within 30 days of the Covered Accident or discharge from the hospital. This benefit is not payable for the same visit that the Physical Therapy Benefit is paid.

### PHYSICAL THERAPY

\$50

We will pay this benefit for up to six treatments per Covered Accident, per insured for treatment from a physical therapist. The insured must have received initial treatment within 72 hours of the accident, and physical therapy must begin within 30 days of the Covered Accident or discharge from the hospital. Treatment must take place within six months after the accident. This benefit is not payable for the same visit that the Accident Follow-Up Treatment Benefit is paid.

### FAMILY LODGING BENEFIT (per night)

\$100

If an insured is required to travel more than 100 miles from his or her home for inpatient treatment of injuries received in a Covered Accident, we will pay this benefit for an immediate adult family member's lodging. Benefits are payable up to 30 days per accident and only while the insured is confined to the hospital. The treatment must be prescribed by the insured's local physician.

## LIMITATIONS AND EXCLUSIONS

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.

We will not pay benefits for services rendered by a member of an employees' Immediate Family.

We will not pay benefits for loss from Sickness or the medical or surgical treatment of Sickness, except for an infection that is the result of a Covered Accident.

We will not pay benefits for loss, injury, or death contributed to, caused by, or resulting from: 1. War - participating in war or act of war (whether declared or undeclared), participation in a felony, riot or insurrection, or service in the Armed Forces or units auxiliary thereto; 2. Suicide/Self-Inflicted Injuries - suicide, attempted suicide, or intentionally self-inflicted injuries; 3. Traveling - outside the United States, its possessions or the countries of Canada and Mexico, except under the Accidental Common Carrier Death Benefit; 4. Aviation - other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline; 5. Intoxication - being intoxicated or under the influence of any narcotic, unless administered on the advice of a Physician; 6. Illegal Acts - commission of or attempt to commit a felony, or being engaged in an illegal occupation; 7. Cosmetic Surgery - 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; 8. Dental - dental care or Treatment, except for such care or Treatment due to Accidental Injury to sound natural teeth within 12 months of a Covered Accident, and except for dental care or Treatment necessary due to congenital disease or anomaly; 9. injury or sickness covered by Worker's Compensation.

**Treatment** means consultation, care, or services provided by a physician, including diagnostic measures, and taking prescribed drugs and medicines.

**You and Your** refer to an employee as defined in the

plan.

**Spouse** Means an employee's legal spouse who is between the ages of 18 and 64. Whenever the term "spouse" or any other term that denotes the spousal relationship is used or defined, the same-sex spouse of a New York Employee who has entered into a marriage legally performed outside the state of New York, shall be included in such use or definition.

**Dependent Children** Means an employee's natural children, stepchildren, or legally adopted children who are under age 26. Coverage provided under any Employee and Children or Family coverage will include any other Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the mental hygiene law) or physical handicap and who became so incapacitated prior to age 26. You must furnish proof of such incapacity and dependency to Aflac New York within 31 days of the Dependent Child's 26th birthday. You must furnish proof of continued incapacity and dependency at Aflac New York's request, but not more often than annually, after the two-year period following the Dependent Child's 26th birthday.

This term includes a Child who: 1. is the newborn Child of an Employee, Spouse; 2. is adopted by or placed for adoption (including any waiting period prior to the finalization of the Child's adoption) with, or is party in a suit of adoption by the covered Employee; or 3. is required to be provided coverage by the covered Employee or his Spouse under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (Section 609 a).

Newborn Children are automatically covered from the moment of birth, and adopted Children are covered from the earlier of the date of petition or any waiting period prior to the finalization of adoption (except that newly born infants adopted by You are covered from the moment of birth if You take physical custody of the infant upon the infant's release from the Hospital and You file a petition

of adoption within 30 days of birth) provided no notice of revocation to the adoption has been filed pursuant to section one hundred fifteen-b of the domestic relations law and consent to the adoption has not been revoked.

If an employee's children are covered under the dependent rider, children born or placed in the employee's home after the Effective Date of this Rider will also be covered from the moment of birth or placement. No notice or additional premium is required.

### TERMINATION

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.

### EFFECTIVE DATE

The **Effective Date** for an employee is as follows: (1) An employee's insurance will be effective on the date shown on the Certificate Schedule, provided the employee is then actively at work. (2) If an employee is not actively at work on the date coverage would otherwise become effective, the Effective Date of his or her coverage will be the date on which such employee is first thereafter actively at work.

### EXTENSION OF HOSPITAL BENEFITS

If an employee's coverage under this plan is terminated, an extension of Hospital Confinement or Hospital Intensive Care Benefits will be provided during a period of total disability for confinements commencing during the 31 days after termination of coverage for the injury causing the total disability.

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

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The certificate to which this sales material pertains may be written only in English; the policy prevails if interpretation of this material varies. This brochure is a brief description of coverage and is not a contract. Read your certificate carefully for exact terms and conditions. You're welcome to request a full copy of the plan certificate through your employer or by reaching out to our Customer Service Center. This brochure is subject to the terms, conditions, and limitations of Policy Forms AF7700NY, AF7701NY, AF7710NY, and AF7711NY.

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