



## CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina  
800.433.3036

The telephone number above is provided for making inquiries, obtaining information regarding coverage, and assistance in resolving complaints.

### **Endorsement to Policy and Certificate of Insurance**

This Endorsement alters the Policy and the Certificate to which it is attached. Unless specifically addressed by this Endorsement, all other Policy and Certificate provisions, definitions, and terms continue to apply.

Continental American Insurance Company's mailing addresses for claims and premium payments are changed as listed below.

**Notice of Claim and Proof of Loss** should be mailed to the Company at:

P.O. Box 84075, Columbus, Georgia, 31993-9103

**Premium Payments** should be mailed to the Company at:

P.O. Box 84069, Columbus, Georgia, 31908-4069

If applicable, references to 2801 Devine Street, Columbia, SC 29205 are deleted.

Signed for the Company at its Home Office,

Teresa White, President

J. Matthew Loudermilk, Secretary



## CONTINENTAL AMERICAN INSURANCE COMPANY

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The telephone number above is provided for making inquiries, obtaining information regarding coverage, and assistance in resolving complaints.

### **Group Accidental Injury Insurance Policy**

**This limited Plan provides supplemental benefits only. It does not constitute comprehensive health insurance coverage and does not satisfy the requirement of Minimum Essential Coverage under the Affordable Care Act.**

**This Plan provides the benefits listed in the Benefit Schedule. Please read it carefully.**

The Policyholder as shown on the Policy Schedule applied for coverage under this Group Accidental Injury Insurance Policy (the "Plan"). This Plan is issued by Continental American Insurance Company (the "Company," "CAIC," "we," "us," or "our"). Based on the Master Application and the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. (Please note that male pronouns—such as "he," "him," and "his"—are used for both males and females, unless the context clearly shows otherwise.) The Policyholder may add new Insureds from time to time, according to the Plan's terms.

You will notice that certain words and phrases (including some medical terms and the names of Plan documents) in this document are capitalized. The capitalized words refer to terms with very specific definitions as they apply to this insurance Plan.

This Plan is a legal contract between the Company and the Policyholder. All matter printed or written by the Company on the following pages is part of this Plan. This Plan is delivered in and is governed by the laws of the jurisdiction shown on the Policy Schedule.

In witness whereof, the Company executes this Plan at its home office in Columbia, South Carolina, on the Effective Date.

Signed for the Company at its Home Office,

A handwritten signature in black ink, appearing to read "Teresa White".

Teresa White, President

A handwritten signature in black ink, appearing to read "J. Matthew Loudermilk".

J. Matthew Loudermilk, Secretary

### **Group Accidental Injury Insurance Non-Participating**

*Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage.*

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## **SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION**

### PRIMARY INSURED

#### **Eligibility**

An Employee is eligible to be covered under this Plan if he is Actively at Work for the Policyholder and included in the class that is eligible for coverage, as shown on the Master Application.

When an Employee ends employment with the Employer and his coverage would otherwise terminate, that Employee may elect to continue his coverage under this Plan. Please see the **Portability Privilege** provision for further details.

**If this coverage is offered to members of a union, references to “Employee” throughout the Plan documents shall be considered to refer to union members who are Actively at Work for their employer.**

*Insureds* are defined as those who might be eligible for coverage under this Plan in the following categories:

- **Employee Coverage** – We insure only the Employee. The Employee is the *Primary Insured* under this Plan.
- **Employee and Spouse Coverage** – We insure the Employee and Spouse.
- **Employee and Children Coverage** – We insure the Employee and any Dependent Children.
- **Family Coverage** – We insure the Employee, Spouse, and any Dependent Children.

Employees should refer to *Type of Coverage* in their Certificate Schedule to determine who is covered under the Certificate.

Details for adding Insureds to Plan coverage are outlined in the Effective Date provision and the Dependent Coverage – Effective Date provision.

#### **Effective Date**

The Plan’s Effective Date is shown on the Policy Schedule. This Plan becomes effective on the Policy Effective Date at 12:01 a.m., as determined by the Policyholder’s address.

An eligible Employee must enroll in this Plan and agree to pay the required premiums for coverage to become effective. He must enroll within 31 days of the date he first becomes eligible for coverage. *The first premium must have been paid for coverage to become effective.*

The Employee’s Effective Date is the date his insurance takes effect. After we receive and approve the Application, That; that date is either:

- The date shown on the Certificate Schedule if the Employee is Actively at Work on that date, or
- The date the Employee returns to an Actively-at-Work status if he was not Actively at Work on the date shown on the Certificate Schedule.

#### **Termination of an Employee's Insurance**

An Employee's insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date (the last day of the Grace Period), if the premium has not been paid.
- The date he no longer belongs to an eligible class.

If an Insured’s coverage terminates, we will provide benefits for valid claims that arose while his coverage was active.

## DEPENDENT COVERAGE

### **Eligibility**

Dependents may be eligible for coverage under this Plan. **Employees should refer to the Type of Coverage on their Certificate Schedule to determine Dependent eligibility.** A *Dependent* is the Spouse of an Employee or the Dependent Child of an Employee. An eligible Spouse must be at least age 18 and not currently disabled or unable to work.

*Dependent Child* or *Dependent Children* means an Employee's or an Employee's Spouse's natural children, step-children, foster children, children subject to legal guardianship, legally adopted children, or Children Placed for Adoption, who are younger than age 26. However, we will continue coverage for Dependent Children insured under the Plan after the age of 26 if they are incapable of self-sustaining employment due to mental or physical handicap, and are chiefly dependent on a parent for support and maintenance. 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.

*Children Placed for Adoption* are children for whom the Employee has entered a decree of adoption or for whom he has initiated adoption proceedings. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. The Employee must continue to have custody pursuant to the decree of the court.

### **Effective Date**

- A Dependent may be added to the Plan after the Employee's Effective Date within 31 days after a Life Event or during an approved enrollment period.
- If Employee and Children **or** Family Coverage is already in force, no additional notice or premium is required to add another Dependent Child. For Employee and One Dependent coverage, only one Dependent will be covered.
- If Dependent Spouse or Dependent Child coverage is **not** in force, the Employee must complete an Application to add a Dependent to the Plan. The Company will assign a Dependent Effective Date for a Dependent's coverage after approving the Application. For Dependent coverage to become effective, the premium for the Dependent must be included in the premium payment. Spouse and Dependent Child coverage will begin on the date of the Life Event if notice was provided within 31 days after the Life Event.
- If Dependent Child coverage is not already in force, newborn children are automatically covered from the moment of birth for 60 days. Newly adopted children are automatically covered from the earlier of a) placement for adoption, b) the date of entry of an order granting custody of the child for the purposes of adoption, or c) the effective date of adoption, for 60 days. Newly placed foster children are automatically covered from placement in the foster home. To extend coverage beyond 60 days with no gap in coverage, the Employee must apply to the Company within the 60-day time period following the child's birth, adoption, or placement. No premium is due for the first 60 days of newborn/newly adopted/newly placed coverage.

### **Termination of Dependent Insurance**

Dependent coverage will terminate on the earliest of the following:

- When the Certificate terminates,
- On the premium due date following the date we receive the Employee's written request to terminate Dependent coverage,
- When premiums are no longer paid for Dependent coverage (subject to the Grace Period),
- For Spouse coverage, when the Insured no longer meets the definition of Spouse because of annulment or divorce, or
- For Dependent Child coverage, when the Child no longer qualifies as a Dependent because he reaches age 26 or other reason. (Dependent Children who reach age 26 will have coverage continued until the last day of the month in which they turn age 26.)

## **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,
- The number of participating Employees changes by 25% or more,
- The Policyholder fails to perform any of the obligations that relate to this Policy or that are required by applicable law,
- The Policyholder no longer offers coverage to a particular class of Employees,
- The Policyholder no longer serves a class of Employees who reside in a particular geographical area, or
- The Policyholder does not provide timely information that is reasonably required.

The Company will give the Policyholder 45 days' written notice prior to policy termination.

The **Policyholder** has the right to cancel the Plan at any time.

- To do this, the Policyholder must give the Company at least 45 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 receives premium payments after the Plan terminates, this will not reinstate the Plan.

**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.

## **Portability Privilege**

When an Employee is no longer a member of an eligible class and his coverage would otherwise end, he may elect to continue his coverage under this Plan. He may continue the coverage he had on the date his Certificate would otherwise terminate, including any in-force Spouse or Dependent Child coverage, without any additional underwriting requirements.

The following conditions must be met for an Employee to keep his Certificate in force:

- Within 31 days after the date his coverage would otherwise terminate, the Employee must notify the Company. Notification may be via written notice sent to P.O. Box 427, Columbia, South Carolina, 29202 or by calling the Customer Service number at 800.433.3036, and
- The Employee must pay the required premium directly to the Company no later than 31 days after the date his coverage would otherwise terminate and on each premium due date thereafter.

Insurance will end on the earlier of these dates:

- 31 days after the premium due date (the last day of the Grace Period), if the premium has not been paid, or
- The date the Group Policy is terminated.

However, coverage may not be continued if:

- The Employee failed to pay any required premium, or
- This Group Policy terminates.

Notification of any changes in the Plan will be provided directly to each Insured by the Company.

If the Employee qualifies for this Portability Privilege, then the Company will apply the same Benefits, Premium Rate, and Plan Provisions as shown in his previously-issued Certificate. Notification of any changes in the Plan will be provided directly by the Company.

## **SECTION II – PREMIUM PROVISIONS**

### **Premium Payments**

**Premiums should be paid to the Company at its Home Office in Columbia, South Carolina.** The first premiums are due on the Plan's Effective Date. After that, premiums are due on the first day of each month that the Plan remains in effect.

Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period provision.

### **Premium Changes**

Unless we have agreed in writing not to increase premiums, the premium may change:

- On the Group Policy Anniversary Date based on renewal underwriting. (The Group Policy Anniversary Date is shown on the Policy Schedule and falls on the same date each year thereafter.)
- Whenever the terms or conditions of the Plan are modified. The new premium rates will apply only to premiums due on or after the rate change takes effect.

We will provide the Policyholder a 45-day advance written notice of any change in premiums.

### **Grace Period**

This Plan has a 31-day Grace Period. If a premium is not paid on or before its due date, the premium may be paid during the next 31 days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of its intention to discontinue the Plan. If the Plan is discontinued, the Plan's termination date will be the latest date for which premium has been paid.

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### SECTION III – DEFINITIONS

When the terms below are used in this Plan, the following definitions apply:

**Accidental Injury** means accidental bodily damage to an Insured resulting from an unforeseen and unexpected traumatic event. This must be the direct result of an accident and not the result of disease or bodily infirmity. A **Covered Accidental Injury** is an Accidental Injury that occurs while coverage is in force. A **Covered Accident** is an accident that occurs on or after an Insured's Effective Date while coverage is in force, and that is not specifically excluded by the Plan.

**Actively at Work** refers to an Employee's ability to perform his regular employment duties for a full normal workday. The Employee may perform these activities either at his employer's regular place of business or at a location where he is required to travel to perform the regular duties of his employment.

**Ambulatory Surgical Center** is defined as a licensed surgical center consisting of an operating room; facilities for the administration of general anesthesia; and a post-surgery recovery room in which the patient is admitted and discharged within a period of less than 24 hours.

**Calendar Year** means the period beginning on the Policy Effective Date and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

**Claimant** means a person who is authorized to make a claim under the Certificate.

**Doctor** is a person who is duly qualified as a practitioner of the healing arts acting within the scope of his license, and:

- Is licensed to practice medicine; prescribe and administer drugs; or to perform surgery, or
- Is a duly qualified medical practitioner according to the laws and regulations in the state in which Treatment is made.

A Doctor **does not** include the Insured or an Insured's Family Member.

For the purposes of this definition, **Family Member** includes the Employee's Spouse as well as the following members of the Employee's immediate family:

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

This includes step-Family Members and Family-Members-in-law.

**Employee** is a person who meets Eligibility requirements under **Section I – Eligibility, Effective Date, and Termination** and who is covered under this Plan. The Employee is the Primary Insured under this Plan.

**Hospital** means a place that meets all of the following criteria:

- Is legally licensed and operated as a Hospital,
- Provides overnight care of injured and sick people,
- Is supervised by a Doctor,
- Has full-time nurses supervised by a registered nurse, and
- Has on-site use of X-ray equipment, laboratory, and surgical facilities.

The term **Hospital** specifically excludes any facility, as listed below, not meeting the definition of Hospital as defined in this Plan:

- A nursing home,
- An extended-care facility,
- A skilled nursing facility,
- A rest home or home for the aged,
- A Rehabilitation Facility,
- A facility for the Treatment of alcoholism or drug addiction, or
- An assisted living facility.



**Hospital Intensive Care Unit** means a place that meets all of the following criteria:

- Is a specifically designated area of the Hospital called a Hospital Intensive Care Unit;
- Provides the highest level of medical care;
- Is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- Is separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement;
- Is permanently equipped with special life-saving equipment for the care of the critically ill or injured;
- Is under close observation by a specially trained nursing staff assigned exclusively to the Hospital Intensive Care Unit 24 hours a day; and
- Has a Doctor assigned to the Hospital Intensive Care Unit on a full-time basis.

The term *Hospital Intensive Care Unit* specifically excludes any type of facility, as listed below, not meeting the definition of Hospital Intensive Care Unit as defined in this Plan:

- Private monitored rooms,
- Surgical recovery rooms,
- Observation units, and
- The following step-down units:
  - A progressive care unit,
  - A sub-acute intensive care unit, or
  - An intermediate care unit.

**Intermediate Intensive Care Step-Down Unit** means any of the following:

- A progressive care unit,
- A sub-acute intensive care unit,
- An intermediate care unit, or
- A pre- or post-intensive care unit.

An Intermediate Intensive Care Step-Down Unit is **not** a Hospital Intensive Care Unit as defined in this Plan.

**Life Event** means an event that qualifies an Employee to make changes to benefits at times other than his enrollment period. Events qualifying as Life Events are established solely by the Policyholder.

**Rehabilitation Facility** is a unit or facility providing coordinated multidisciplinary physical restorative services. These services must be provided to inpatients under a Doctor's direction. The Doctor must be knowledgeable and experienced in rehabilitative medicine. Beds must be set up in a unit or facility specifically designated and staffed for this service. This is not a facility for the Treatment of alcoholism or drug addiction.

**Spouse** is an Employee's legal wife or husband, including a legally-recognized same-sex Spouse, or a person of either gender who is in a legally recognized and registered domestic partnership, civil union, reciprocal beneficiary relationship, or similar relationship with the Employee.

**Treatment** is the consultation, care, or services provided by a Doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines. Treatment does **not** include Telemedicine Services.

**Urgent Care** is a walk-in clinic that delivers ambulatory, outpatient care in a dedicated medical facility for illnesses or injuries that require immediate care but that are not serious enough to require a visit to an emergency room.

## **SECTION IV – BENEFIT PROVISIONS**

### **Initial Treatment Category**

#### **Initial Treatment Benefit**

We will pay the amount shown in the Benefit Schedule if an Insured receives Initial Treatment for a Covered Accidental Injury. This benefit is payable for Initial Treatment received under the care of a Doctor when an Insured visits a(n):

- Hospital emergency room with X-Ray.
- Hospital emergency room without X-Ray.
- Urgent Care facility with X-Ray.
- Urgent Care facility without X-Ray.
- Doctor's office or facility (other than a Hospital emergency room or Urgent Care) with X-Ray.
- Doctor's office or facility (other than a Hospital emergency room or Urgent Care) without X-Ray.

*Initial Treatment* means the first Treatment an Insured receives for a Covered Accidental Injury.

The Initial Treatment must be received within 168 hours after the Covered Accident for benefits to be payable. This benefit is not payable for Telemedicine services.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

#### **Ambulance Benefit**

We will pay the appropriate amount shown in the Benefit Schedule if, because of a Covered Accident, the Insured:

- Is injured, and
- Receives transportation by a professional ambulance service. This transportation must occur within 90 days after the accident for a benefit to be payable.

Ambulance service includes air ambulance service.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

#### **Major Diagnostic Testing Benefit**

We will pay the amount shown in the Benefit Schedule if, because of Injuries sustained in a Covered Accident, the Insured requires one of the following exams:

- Computerized tomography (CT scan).
- Computerized axial tomography (CAT).
- Magnetic resonance imaging (MRI).
- Electroencephalography (EEG).

These exams must be performed in a Hospital, a Doctor's office, a Medical Diagnostic Imaging Center, or an Ambulatory Surgical Center. The exam must be performed within six months after the accident for a benefit to be payable.

For the purposes of this Plan, a *Medical Diagnostic Imaging Center* is defined as a facility with the equipment to produce various types of radiologic and electromagnetic images, and a professional staff to interpret the images obtained.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

**Emergency Room Observation Benefit**

The daily benefit amount shown in the Benefit Schedule is payable for each 24-hour period of observation that, because of a Covered Accidental Injury, an Insured:

- Receives Treatment in a Hospital emergency room, and
- Is held in a Hospital for observation without being admitted as an inpatient, and
- Receives initial Treatment within 168 hours after the accident.

For periods of observation lasting fewer than 24 hours but more than four hours, a limited benefit amount as shown in the Benefit Schedule is payable.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

**Prescriptions Benefit**

We will pay the amount shown in the Benefit Schedule for a prescription filled. The prescription must meet three criteria: (1) be ordered by a Doctor due to a Covered Accidental Injury; (2) be dispensed by a licensed pharmacist; and (3) be medically necessary for the care and Treatment of the Insured due to a Covered Accidental Injury. The prescription must be received within six months after the accident for a benefit to be payable.

This benefit does not include benefits for: (a) therapeutic devices or appliances; (b) experimental drugs; (c) drugs, medicines or insulin used by or administered to a person while he is confined to a Hospital, rest home, extended-care facility, convalescent home, nursing home or similar institution; or (d) immunization agents, biological sera, blood or blood plasma.

This benefit is not payable for pain management techniques for which a benefit is paid under the Pain Management Benefit (if available).

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

**Pain Management Benefit**

We will pay the amount shown in the Benefit Schedule when an Insured is prescribed and receives:

- A nerve ablation and/or block, or
- An epidural injection administered into the spine.

The benefit is only payable for pain management techniques (as shown above) that are administered in a Hospital or Doctor's office, and are due to a Covered Accidental Injury. For a benefit to be payable, the pain management technique must be administered within six months after the Covered Accident. This benefit is not payable for an epidural administered during a surgical procedure.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

**Blood/Plasma/Platelets Benefit**

We will pay the amount shown in the Benefit Schedule for each day that an Insured receives blood, plasma, or platelets due to a Covered Accidental Injury. The Insured must receive the blood, plasma, or platelets within six months after the accident for a benefit to be payable.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

**Concussion Benefit**

We will pay the amount shown in the Benefit Schedule if the Insured has a concussion due to a Covered Accident. The concussion must be diagnosed by a Doctor. The diagnosis must be made within six months after the accident for a benefit to be payable.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

**Traumatic Brain Injury Benefit**

We will pay the amount shown in the Benefit Schedule if the Insured is diagnosed by a neurologist with Traumatic Brain Injury (TBI) due to a Covered Accident. *Traumatic Brain Injury (TBI)* is an injury that is caused by a traumatic blow to the head, neck, or shoulders and results in neurological deficit. To qualify as TBI, the neurological deficit must require:

- Treatment by a neurologist, and
- Prescribed course of physical, speech, and/or occupational therapy under the direction of a neurologist.

The diagnosis must be made within six months after the accident for a benefit to be payable.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

**Burns Benefit**

We will pay the amount shown in the Benefit Schedule if the Insured has burns in a Covered Accident. We will pay the Burns Benefit according to the percentage of body surface burned. The Insured must be treated for burns by a Doctor within six months after the accident for a benefit to be payable. First-degree burns are not covered.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

**Emergency Dental Work Benefit**

We will pay the amount shown in the Benefit Schedule if the Insured has an Accidental Injury to natural teeth as the result of a Covered Accident. We will pay for extraction or repair with a crown as shown in the Benefit Schedule. The dental work must be performed within six months of the accident for a benefit to be payable.

**Eye Injuries Benefit**

We will pay the amount shown in the Benefit Schedule for eye injuries requiring removal of a foreign body if, because of a Covered Accident, a Doctor removes a foreign body from the eye, with or without anesthesia.

**Dislocation Benefit**

*Dislocation* refers to a completely separated joint. If a joint is dislocated in a Covered Accident, and it is diagnosed and treated by a Doctor within 90 days after the accident, we will pay the amount shown in the Benefit Schedule.

If the dislocation requires open reduction, we will pay 200% of the amount shown in the Benefit Schedule.

We will pay benefits only for the first dislocation of a joint. We will not pay for recurring dislocations of the same joint. If the Insured dislocated a joint before the Effective Date of his Certificate and then dislocates the same joint again, it will not be covered by this Plan.

*Multiple dislocations* refer to more than one dislocation requiring either open or closed reduction in any one Covered Accident. For each covered dislocation, we will pay the amounts shown in the Benefit Schedule. However, we will pay no more than 200% of the benefit amount for the dislocated joint that has the higher dollar amount.

*Partial dislocation* is one in which the joint is not completely separated. If a Doctor diagnoses and treats the Accidental Injury as a partial dislocation, we will pay 25% of the amount shown in the Benefit Schedule for the affected joint. (*Partial dislocation* includes subluxation.)

**Laceration Benefit**

We will pay the amount shown in the Benefit Schedule if an Insured receives a laceration in a Covered Accident. The laceration must be repaired with stitches by a Doctor within 168 hours after the accident for a benefit to be payable. (*Stitches* can also include liquid skin adhesive.) The amount paid will be based on the length of the laceration. (Receiving stitches to repair a laceration is not payable under the Outpatient Surgery and Anesthesia Benefit or Inpatient Surgery and Anesthesia Benefit, if any.)

The Insured may receive Treatment for a laceration that does not require stitches. However, if that laceration is treated by a Doctor within 168 hours after the Covered Accident, we will pay the amount shown in the Benefit Schedule.

If the Insured suffers multiple lacerations in a Covered Accident, and the lacerations are repaired with stitches by a Doctor within 168 hours after the accident, we will pay this benefit based on the largest single laceration that requires stitches, as shown in the Benefit Schedule. However, we will pay no more than 200% of the benefit amount for the laceration that has the higher dollar amount.

**Fracture Benefit**

*Fracture* is a break in a bone that can be seen by X-ray. If a bone is fractured in a Covered Accident, and it is diagnosed and treated by a Doctor within 90 days after the accident, we will pay the appropriate amount shown in the Benefit Schedule.

If the fracture requires open reduction, we will pay 200% of the amount shown in the Benefit Schedule.

*Multiple fractures* refer to more than one fracture requiring either open or closed reduction. If these fractures occur in any one Covered Accident, we will pay the appropriate amounts shown in the Benefit Schedule for each fracture. However, we will pay no more than 200% of the benefit amount for the bone fractured that has the highest dollar amount.

*Chip fracture* refers to a piece of bone that is completely broken off near a joint. If a Doctor diagnoses the fracture as a chip fracture, we will pay 25% of the amount shown in the Benefit Schedule for the affected bone.

*Fracture* does not include stress fractures, which are tiny cracks in a bone that can arise by the repetitive application of force, or from normal use of a weakened bone. Benefits are not payable for stress fractures.

### **Outpatient Surgery and Anesthesia Benefit**

We will pay the daily benefit amount shown in the Benefit Schedule when, due to a Covered Accidental Injury, an Insured has an outpatient surgical procedure performed by a Doctor. "Surgical procedure" does not include laceration repair. If an outpatient surgical procedure is covered under another benefit in this Plan, we will pay the *higher* of that benefit amount **or** the Outpatient Surgery and Anesthesia Benefit. For a benefit to be payable, the surgery must be performed within one year after the Covered Accident.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

The surgery can be performed:

- In a Hospital on an outpatient basis,
- In an Ambulatory Surgical Center,
- In a Doctor's office, including Urgent Care facilities, or
- In an emergency room.

### **Facilities Fee for Outpatient Surgery Benefit**

We will pay the benefit amount shown in the Benefit Schedule if, due to a Covered Accidental Injury:

- An Insured has an outpatient surgical procedure performed in an Ambulatory Surgical Center or in a Hospital on an outpatient basis, and
- The Insured receives an Outpatient Surgery and Anesthesia Benefit under this Plan.

This benefit is payable in addition to any surgery benefits payable.

### **Inpatient Surgery and Anesthesia Benefit**

We will pay the daily benefit amount shown in the Benefit Schedule when, due to a Covered Accidental Injury, an Insured has an inpatient surgical procedure performed by a Doctor. The surgery must be performed while the Insured is confined to a Hospital as an inpatient. If an inpatient surgical procedure is covered under another benefit in this Plan, we will pay the *higher* of that benefit amount **or** the Inpatient Surgery and Anesthesia Benefit. For a benefit to be payable, the surgery must be performed within one year after the Covered Accident.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

### **Transportation Benefit**

We will pay the amount shown in the Benefit Schedule for transportation. The amount payable will be based on the type of transportation taken. This benefit is payable if, because of a Covered Accident, the Insured:

- Is injured, and
- Requires Doctor-recommended Hospital Treatment or diagnostic study that is not available in the Insured's resident city.

Use of such transportation must begin within six months after the Covered Accident date. The distance to the Hospital Treatment or diagnostic study must be greater than 100 miles from the Insured's residence.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

### **Coma Benefit**

We will pay the amount shown in the Benefit Schedule if the Insured is in a Coma lasting 30 days or more as the result of a Covered Accident. For the purposes of this benefit, *Coma* means a profound state of unconsciousness caused by a Covered Accident.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

## **Hospitalization Category**

### **Hospital Admission Benefit**

We will pay this benefit when an Insured is admitted to a Hospital and confined as an inpatient because of a Covered Accidental Injury. To be eligible to receive this benefit, an Insured must be admitted to a Hospital within six months of the date of the Covered Accident.

We will pay the Hospital Admission Benefit amount shown in the Benefit Schedule. We will not pay benefits for confinement to an observation unit, or for emergency room Treatment or outpatient Treatment. We will pay this benefit once per period of Hospital Confinement.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

### **Hospital Confinement Benefit**

We will pay the amount shown in the Benefit Schedule for each day that an Insured is confined to a Hospital as an inpatient as the result of a Covered Accidental Injury. To be eligible to receive this benefit, the Insured must be confined to a Hospital within six months of the date of the Covered Accident.

The length of time shown for Hospital Confinement in the Benefit Schedule is the maximum period for which an Insured can collect benefits for Hospital Confinements from Covered Accidental Injuries received in the same Covered Accident. This benefit is not payable for confinement to an observation unit or a Rehabilitation Facility.

If we pay benefits for confinement and the Insured becomes confined again within six months because of the same Accidental Injury, we will treat this confinement as the same period of confinement.

This benefit is payable for only one Hospital Confinement at a time, even if it is caused by more than one Covered Accidental Injury.

### **Hospital Intensive Care Benefit**

If an Insured is confined in a Hospital Intensive Care Unit because of a Covered Accidental Injury, we will pay the daily benefit amount shown in the Benefit Schedule. To be eligible to receive this benefit an Insured must be admitted to a Hospital Intensive Care Unit within six months of the date of the Covered Accident.

We will pay this amount for each day of such confinement, but not to exceed the maximum benefit period shown on the Benefit Schedule during any one period of confinement.

We will pay benefits for only one confinement in a Hospital Intensive Care Unit at a time, even if it is caused by more than one Covered Accidental Injury.

If we pay benefits for confinement in a Hospital Intensive Care Unit and an Insured becomes confined to a Hospital Intensive Care Unit again within six months because of the same Accidental Injury, we will treat this confinement as the same period of confinement.

This benefit is payable in addition to the Hospital Confinement Benefit.

**Intermediate Intensive Care Step-Down Unit Benefit**

If an Insured is confined in an Intermediate Intensive Care Step-Down Unit because of a Covered Accidental Injury, we will pay the daily benefit amount shown on the Benefit Schedule. The Insured must be admitted to an Intermediate Intensive Care Step-Down Unit within six months of the date of the Covered Accident.

We will pay this amount for each day of such confinement, not to exceed the maximum benefit period shown in the Benefit Schedule during any one period of confinement.

We will pay benefits for only one confinement in an Intermediate Intensive Care Step-Down Unit at a time, even if it is caused by more than one Covered Accidental Injury.

If we pay benefits for confinement in a Hospital's Intermediate Intensive Care Step-Down Unit and the Insured becomes confined to a Hospital's Intermediate Intensive Care Step-Down Unit again within six months because of the same condition, we will treat this confinement as the same period of confinement.

This benefit is payable in addition to the Hospital Confinement Benefit.

**Family Member Lodging Benefit**

We will pay this benefit in the amount and up to the maximum number of days shown in the Benefit Schedule. We will pay this benefit for each night's lodging in a motel/hotel/rental property for an adult member of the Insured's immediate family. For this benefit to be payable, because of a Covered Accident:

- The Insured must be confined to a Hospital for Treatment of an Accidental Injury,
- The Hospital and motel/hotel must be more than 100 miles from the Insured's residence, and
- The Treatment must be prescribed by the Insured's treating Doctor.

The Treatment must take place within six months after the Covered Accident for a benefit to be payable.

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## After Care Category

### Appliances Benefit

We will pay the amount shown in the Benefit Schedule if a Doctor advises the Insured to use a medical appliance.

*Medical appliance* means a cane, ankle brace, walking boot, walker, crutches, leg brace, wheelchair, knee scooter, body jacket, back brace, or cervical collar. (Refer to the Benefit Schedule for the amount payable for each type of appliance.) The medical appliance must be used as the result of an Injury received in a Covered Accident. It must be used as an aid in personal locomotion. Proof of Loss for this benefit must include discharge instructions.

For a benefit to be payable, the Doctor's advice to use a medical appliance must be within six months after the Covered Accident.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

### Accident Follow-Up Treatment Benefit

For injuries received in a Covered Accident, we will pay this benefit under the following conditions:

- The Insured receives initial Treatment within 168 hours after the Covered Accident.
- The Insured receives Doctor-prescribed follow-up Treatment.
- The follow-up Treatment begins within six months after the Covered Accident or discharge from the Hospital.

Follow-up Treatments do not include physical, occupational, or speech therapy. Chiropractic or acupuncture procedures are not considered Follow-up Treatment.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

### Post-Traumatic Stress Disorder Benefit

*Post-Traumatic Stress Disorder (PTSD)* is a mental health condition triggered by a Covered Accident. We will pay the amount shown in the Benefit Schedule if the Insured is diagnosed with Post-traumatic Stress Disorder. An Insured must meet the diagnostic criteria for PTSD, stipulated in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV-TR), and be under the active care of either a Psychiatrist or Ph.D.-level Psychologist. The diagnosis must take place within six months after the Covered Accident for a benefit to be payable.

For the purposes of this benefit:

- **Psychiatrist** is a Doctor of medicine who specializes in the diagnosis and Treatment of mental disorders.
- **Psychologist** is a clinical, mental health professional who works with patients. A Psychologist is not a Doctor of medicine who typically provides medical interventions and drug therapies, but provides analysis and counseling.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

**Rehabilitation Unit Benefit**

We will pay the daily benefit amount shown in the Benefit Schedule for each day that, due to a Covered Accidental Injury, an Insured receives Treatment as an inpatient at a Rehabilitation Facility. For this benefit to be payable, the Insured must be transferred to the Rehabilitation Facility for Treatment following an inpatient Hospital Confinement.

This benefit is limited to the Calendar Year Maximum and maximum days per Hospital Confinement shown in the Benefit Schedule. We will not pay the Rehabilitation Facility Benefit for the same days that the Hospital Confinement Benefit is paid. We will pay the highest eligible benefit.

**Therapy Benefit**

For injuries received in a Covered Accident, we will pay this benefit under the following conditions:

- The Insured receives initial Treatment within 168 hours after the Covered Accident.
- The Insured receives Doctor-prescribed therapy Treatment in one of the following categories: physical therapy provided by a licensed physical therapist, occupational therapy provided by a licensed occupational therapist, or speech therapy provided by a licensed speech therapist.
- The therapy Treatment begins within 90 days after the Covered Accident or discharge from the Hospital.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

**Chiropractic or Alternative Therapy Benefit**

For injuries received in a Covered Accident, we will pay this benefit under the following conditions:

- The Insured receives initial Treatment within 168 hours after the Covered Accident.
- The Insured receives acupuncture or chiropractic Treatment for the Covered Accident.
- The Treatment begins within 90 days after the Covered Accident or discharge from the Hospital.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

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## Life Change Events Category

### Dismemberment Benefit

We will pay the appropriate amount shown in the Benefit Schedule if, because of a Covered Accident, the Insured:

- Is injured, and
- Loses a hand, a foot, or sight within six months after the accident as a result of the Injury.

If the Insured loses one hand, one foot, or the sight of one eye in a Covered Accident, we will pay the single loss benefit shown in the Benefit Schedule.

If the Insured loses both hands, both feet, the sight of both eyes, or a combination of any two, we will pay the double loss benefit shown in the Benefit Schedule.

If the Insured loses one or more fingers or toes in a Covered Accident, we will pay the finger/toe benefit shown in the Benefit Schedule.

*Dismemberment* means:

- **Loss of a hand** –The hand is removed at or above the wrist joint; or
- **Loss of a foot** –The foot is removed at or above the ankle; or
- **Loss of sight** –At least 80% of the vision in one eye is lost (such loss of sight must be permanent and irrecoverable); or
- **Loss of a finger/toe** –The finger or toe is removed at or above the joint where it is attached to the hand or foot.

If the Insured does not qualify for the Dismemberment Benefit but loses at least one joint of a finger or toe, we will pay the Partial Dismemberment Benefit shown in the Benefit Schedule.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

If the Dismemberment Benefit is paid and the Insured later dies as a result of the same Covered Accident, we will pay the appropriate death benefit (if available), less any amounts paid under this benefit.

### Paralysis Benefit

*Paralysis* means the permanent loss of movement of two or more limbs. We will pay the appropriate amount shown in the Benefit Schedule if, because of a Covered Accident:

- The Insured is injured,
- The Accidental Injury causes paralysis which lasts more than 90 days, and
- The paralysis is diagnosed by a Doctor within six months after the accident.

The amount paid will be based on the number of limbs paralyzed.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

**Prosthesis Benefit**

We will pay the amount shown in the Benefit Schedule when an Insured receives a Prosthetic Device, prescribed by a Doctor, as a result of a Covered Accidental Injury.

For the purposes of this benefit, *Prosthetic Device/Prosthesis* means an artificial device designed to replace a missing part of the body.

This benefit is not payable for:

- Hearing aids, wigs, or dental aids (to include false teeth).
- Repair or replacement of Prosthetic Devices.\*
- Joint replacements.

The amount paid will be based on the number (single or multiple) of Prosthetics received.

\* We will pay this benefit again **once** to cover the replacement of a Prosthesis for which a benefit has been paid, provided the replacement takes place within three years of the initial benefit payment.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

**Residence/Vehicle Modification Benefit**

We will pay the amount shown on the Benefit Schedule for a permanent structural modification to an Insured's primary residence or vehicle when the Insured suffers total and permanent or irrevocable loss of one of the following, due to a Covered Accidental Injury:

- The sight of one eye;
- The use of one hand/arm; or
- The use of one foot/leg.

The modification must occur within one year after the accident.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

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## **SECTION V – EXCLUSIONS**

We will not pay benefits for Accidental Injury, disability, or death contributed to, caused by, or resulting from:

- **War** – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the Insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion, or civil state of belligerence. War does not include acts of terrorism.
- **Suicide** – committing or attempting to commit suicide, while sane or insane.
- **Sickness** – having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for:
  - Allergic reactions.
  - Any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings.
  - An error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure for any sickness.
  - Any related medical/surgical Treatment or diagnostic procedures for such illness.
- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally.
- **Racing** – riding in or driving any motor-driven vehicle in a race, stunt show, or speed test in a professional or semi-professional capacity.
- **Illegal Occupation** – voluntarily participating in, committing, or attempting to commit a felony or illegal act or activity, or voluntarily working at, or being engaged in, an illegal occupation or job.
- **Sports** – participating in any organized sport in a professional or semi-professional capacity for pay or profit.
- **Cosmetic Surgery** – having cosmetic surgery or other elective procedures that are not medically necessary or having dental Treatment except as a result of a Covered Accident.

For **24-Hour Coverage**, the following exclusions will not apply:

- An Injury arising from any employment.
- An Injury or sickness covered by Worker's Compensation.

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## **SECTION VI – CLAIM PROVISIONS**

### **Notice of Claim**

The Insured must give written notice of claim:

- Within 60 days after a Covered Accidental Injury, or
- As soon as reasonably possible.

When we receive written Notice of Claim, we will send a claim form. If the Claimant does not receive the claim form within 15 days after the notice is sent, written Proof of Loss can be sent to us without waiting for the form. Notice must include the Employee's name and the Certificate number. Notice can be mailed to the Company at the following address:

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

### **Proof of Loss**

*Proof of Loss* refers to documentation that supports a claim. (This information is often found in standardized medical documents, such as Hospital bills and operative reports. It can include a statement by the treating Doctor.) Proof of Loss establishes the nature and extent of the loss, the Company's obligation to pay the claim, and the Claimant's right to receive payment.

The Claimant must provide Proof of Loss to the Company at the following address:

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

Proof of Loss must be given to us within 90 days of the Covered Accidental Injury. Failure to give Proof of Loss within such time shall not invalidate or reduce any claim if such Proof of Loss is given as soon as reasonably possible. The Company will not accept Proof of Loss any later than one year after the Covered Accidental Injury unless the Claimant was legally incapacitated.

The Claimant will be responsible for the cost of obtaining a completed claim form. We may request additional Proof of Loss, such as records from Hospitals or Doctors. The Claimant will be responsible for the cost of obtaining these records.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

When we receive the claim and due Proof of Loss, we will review the Proof of Loss. If we approve the claim, we will pay the benefits subject to the terms of the Certificate.

### **Physical Examination and Autopsy**

The Company may have an Insured examined as often as reasonably necessary while a claim is pending. In the case of death, the Company may also require an autopsy, unless prohibited by law. The Company will cover all costs for exams and/or autopsy.

### **Time of Payment of Claims**

Benefits payable under the Certificate will be paid after we receive due Proof of Loss acceptable to us. We will pay, deny, or settle all clean claims\* within 30 calendar days after receiving the appropriate information.

\*Clean claims contain all information and/or documentation needed for processing. These claims do not require further information from the provider, the Employee, or the employer.

### **Payment of Claims**

We will pay all benefits to the Employee unless otherwise assigned. For any benefits that remain unpaid at the time of death, we will pay those benefits in the following order:

- To any approved assignee.
- To the Employee's beneficiary.
- To the Employee's surviving Spouse.
- To the Employee's estate.

### **Unpaid Premium**

When a claim is paid, we may deduct any premium due and unpaid from the claim payment.

### **Changing of Beneficiary**

A change in beneficiary must be submitted in writing to our Home Office in a form acceptable to us and signed by the Employee. Unless otherwise specified by the Employee, a change in beneficiary will take effect on the date the notice of change is signed. We will not be liable for any action taken before notice is received and recorded at the Home Office.

### **Claim Review**

If a claim is denied, the Employee will be given written notice of:

- The reason for the denial,
- The Plan provision that supports the denial, and
- His right to ask for a review of the claim.

### **Appeals Procedure**

No later than 60 days after notice of denial of a claim, the Employee, the Claimant, or an authorized representative of either must appeal any denial of benefits under the Plan by sending a written request for review of the denial to our Home Office.

### **Legal Action**

The Employee may not take Legal Action against us for benefits under this Plan:

- Within 60 days after he has sent us written Proof of Loss, or
- After the expiration of the applicable statute of limitations from the time written Proof of Loss is required to be given.

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## **SECTION VII – GENERAL PROVISIONS**

### **Entire Contract Changes**

This insurance is provided under a contract of Group Accidental Injury Insurance with the Policyholder. The Entire Contract of Insurance is made up of:

- The Policy;
- The Certificates of Insurance;
- The Application of the Policyholder, a copy of which is attached to and made part of the Policy when issued;
- The Applications, if any, of each Employee; and
- Any Riders, Endorsements, or Amendments to the Policy or Certificate.

All statements (excluding fraudulent ones) that the Policyholder or an Insured has made in the Application will be considered representations, not warranties. The Company will not void insurance or reduce benefits as a result of statements made on the Application without sending Application copies.

Changes to the Plan:

- Will not be valid unless approved in writing by an officer of the Company,
- Must be noted on or attached to the Contract, and
- May not be made by any insurance agent or producer (nor can an agent or producer waive any Plan provisions).

### **Misstatement of Age**

If an age has been misstated on the Application, the benefits will be those that the paid premium would have purchased at the correct age.

### **Successor Insured**

If an Employee dies while covered under his Certificate and his Spouse is also insured under this Plan at the time of the Employee's death, then his surviving Spouse may elect to become the Primary Insured. This would include continuation of any Dependent Child Rider coverage that is in force at that time.

To become the Primary Insured and keep coverage in force, the surviving Spouse must:

- Notify the Company in writing within 31 days after the date of the Employee's death; and
- Pay the required premium to the Company no later than 31 days after the date of the Employee's death, and on each premium due date thereafter.

If the Certificate does not cover a surviving Spouse, the Certificate will terminate on the next premium due date following the Employee's death.

### **Time Limit on Certain Defenses**

After two years from the Employee's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Employee's Application. This does not apply to fraudulent misstatements.

### **Clerical Error**

Clerical error by the Policyholder will not end coverage or continue terminated coverage. In the event of a clerical error, the Company will make a premium adjustment.

### **Individual Certificates**

The Company will give the Policyholder a Certificate for each Employee. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, and
- The rights and privileges under the Plan.



**Required Information**

The Policyholder will be responsible for furnishing all information and proofs that the Company may reasonably require with regard to the Plan.

**Conformity with State Statutes**

This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes.

## BENEFIT SCHEDULE

	Primary Insured	Spouse	Child(ren)
<b>Initial Treatment Category- High</b>			
<b>Initial Treatment Benefit</b>			
<i>Hospital emergency room with X-Ray</i>	\$250	\$250	\$250
<i>Hospital emergency room without X-Ray</i>	\$200	\$200	\$200
<i>Urgent Care facility with X-Ray</i>	\$250	\$250	\$250
<i>Urgent Care facility without X-Ray</i>	\$200	\$200	\$200
<i>Office or facility (other than a Hospital emergency room or Urgent Care) with X-Ray</i>	\$150	\$150	\$150
<i>Office or facility (other than a Hospital emergency room or Urgent Care) without X-Ray</i>	\$100	\$100	\$100
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
<b>Ambulance Benefit</b>	\$400	\$400	\$400
<i>Maximum number of payments per Covered Accident, per Insured</i>	No Max	No Max	No Max
<b>Air Ambulance Benefit</b>	\$1,200	\$1,200	\$1,200
<i>Maximum number of payments per Covered Accident, per Insured</i>	No Max	No Max	No Max
<b>Major Diagnostic Testing Benefit</b>	\$200	\$200	\$200
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
<b>Emergency Room Observation Benefit</b>			
<i>Per each 24 hour period of observation</i>	\$100	\$100	\$100
<i>Period of observation at least 4 hours and up to 24 hours</i>	\$50	\$50	\$50
<i>Maximum number of payments per Covered Accident, per Insured</i>	No Max	No Max	No Max
<b>Prescriptions Benefit</b>	\$5	\$5	\$5
<i>Maximum number of payments per Covered Accident, per Insured</i>	2	2	2
<b>Pain Management Benefit</b>	\$100	\$100	\$100
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
<b>Blood/Plasma/Platelets Benefit</b>	\$200	\$200	\$200
<i>Maximum number of payments per Covered Accident, per Insured</i>	3	3	3
<b>Concussion Benefit</b>	\$500	\$500	\$500
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
<b>Traumatic Brain Injury Benefit</b>	\$5,000	\$5,000	\$5,000
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
<b>Burns Benefit</b>			
<i>Second Degree</i>			
Less than 10%	\$100	\$100	\$100
At least 10% but less than 25%	\$200	\$200	\$200
At least 25% but less than 35%	\$500	\$500	\$500
35% or more	\$1,000	\$1,000	\$1,000
<i>Third Degree</i>			
Less than 10%	\$1,000	\$1,000	\$1,000
At least 10% but less than 25%	\$5,000	\$5,000	\$5,000
At least 25% but less than 35%	\$10,000	\$10,000	\$10,000
35% or more	\$20,000	\$20,000	\$20,000
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
<b>Emergency Dental Work Benefit</b>			
Repair with crown	\$200	\$200	\$200
Extraction	\$50	\$50	\$50
<b>Eye Injuries Benefit</b>	\$250	\$250	\$250
<b>Dislocation Benefit</b>			
Hip	\$3,000	\$3,000	\$3,000
Knee (not knee cap)	\$1,950	\$1,950	\$1,950
Shoulder	\$1,500	\$1,500	\$1,500
Foot/ankle	\$1,200	\$1,200	\$1,200

Hand	\$1,050	\$1,050	\$1,050
Lower jaw	\$900	\$900	\$900
Wrist	\$750	\$750	\$750
Elbow	\$600	\$600	\$600
Finger/toe	\$240	\$240	\$240
<b>Laceration Benefit</b>			
Over 15 centimeters	\$800	\$800	\$800
5 to 15 centimeters	\$400	\$400	\$400
Under 5 centimeters	\$100	\$100	\$100
Lacerations not requiring stitches	\$50	\$50	\$50
<b>Fracture Benefit</b>			
Hip/thigh	\$4,000	\$4,000	\$4,000
Vertebrae	\$3,600	\$3,600	\$3,600
Pelvis	\$3,200	\$3,200	\$3,200
Skull (depressed)	\$3,000	\$3,000	\$3,000
Skull (simple)	\$1,400	\$1,400	\$1,400
Leg	\$2,400	\$2,400	\$2,400
Foot/ankle/knee cap	\$2,000	\$2,000	\$2,000
Forearm/hand/wrist	\$2,000	\$2,000	\$2,000
Lower jaw	\$1,600	\$1,600	\$1,600
Shoulder blade/collar bone	\$1,600	\$1,600	\$1,600
Upper arm/upper jaw	\$1,400	\$1,400	\$1,400
Facial bones (except teeth)	\$1,200	\$1,200	\$1,200
Vertebral processes	\$800	\$800	\$800
Coccyx/rib/finger/toe	\$320	\$320	\$320
Sternum	\$3,600	\$3,600	\$3,600
Sacral/Sacrum	\$800	\$800	\$800
<b>Outpatient Surgery and Anesthesia Benefit</b>			
<i>Hospital Outpatient or Ambulatory Surgical Center</i>	\$400/day	\$400/day	\$400/day
<i>Doctor's Office or Emergency Room</i>	\$50/day	\$50/day	\$50/day
<i>(Maximum is applicable only to Doctor's office or Emergency Room)</i>			
<i>Maximum number of payments per Covered Accident, per Insured</i>	2	2	2
<b>Facilities Fee for Outpatient Surgery Benefit</b>	\$100	\$100	\$100
<i>Payable once per each eligible Outpatient Surgery and Anesthesia Benefit</i>			
<b>Inpatient Surgery and Anesthesia Benefit</b>	\$1,000/day	\$1,000/day	\$1,000/day
<i>Maximum number of payments per Covered Accident, per Insured</i>	No Max	No Max	No Max
<b>Transportation Benefit</b>			
Plane	\$500	\$500	\$500
Any Ground Transportation	\$200	\$200	\$200
<i>Maximum number of payments per Covered Accident, per Insured</i>	3	3	3
<b>Coma Benefit</b>	\$10,000	\$10,000	\$10,000
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1

**BENEFIT SCHEDULE**

	<b>Primary Insured</b>	<b>Spouse</b>	<b>Child(ren)</b>
<b>Hospitalization Category - High</b>			
<b>Hospital Admission Benefit</b>	\$1,250	\$1,250	\$1,250
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
<b>Hospital Confinement Benefit</b>	\$300/day	\$300/day	\$300/day
<i>Maximum Benefit Period: 365 days</i>			
<b>Hospital Intensive Care Benefit</b>	\$400/day	\$400/day	\$400/day
<i>Maximum Benefit Period: 30 days</i>			
<b>Intermediate Intensive Care Step-Down Unit Benefit</b>	\$200/day	\$200/day	\$200/day
<i>Maximum Benefit Period: 30 days</i>			
<b>Family Member Lodging Benefit</b>	\$200/day	\$200/day	\$200/day
<i>Maximum Benefit Period: 30 days</i>			

**BENEFIT SCHEDULE**

	<b>Primary Insured</b>	<b>Spouse</b>	<b>Child(ren)</b>
<b>After Care Category - High</b>			
<b>Appliances Benefit</b>			
<i>Cane</i>	\$40	\$40	\$40
<i>Ankle Brace</i>	\$40	\$40	\$40
<i>Walking Boot</i>	\$100	\$100	\$100
<i>Walker</i>	\$100	\$100	\$100
<i>Crutches</i>	\$100	\$100	\$100
<i>Leg Brace</i>	\$100	\$100	\$100
<i>Wheelchair</i>	\$400	\$400	\$400
<i>Knee Scooter</i>	\$400	\$400	\$400
<i>Body Jacket</i>	\$400	\$400	\$400
<i>Back Brace</i>	\$400	\$400	\$400
<i>Cervical Collar</i>	\$100	\$100	\$100
<i>Maximum number of payments per Covered Accident, per Insured</i>	No Max	No Max	No Max
<b>Accident Follow-Up Treatment Benefit</b>	\$50	\$50	\$50
<i>Maximum number of payments per Covered Accident, per Insured</i>	6	6	6
<b>Post-Traumatic Stress Disorder Benefit</b>	\$200	\$200	\$200
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
<b>Rehabilitation Unit Benefit</b>	\$100/day	\$100/day	\$100/day
<i>Maximum Benefit Period per Hospital confinement</i>	31 days	31 days	31 days
<i>Calendar Year Maximum</i>	62 days	62 days	62 days
<b>Therapy Benefit</b>	\$50	\$50	\$50
<i>Maximum number of payments per Covered Accident, per Insured</i>	10	10	10
<b>Chiropractic or Alternative Therapy Benefit</b>	\$30	\$30	\$30
<i>Maximum number of payments per Covered Accident, per Insured</i>	6	6	6

**BENEFIT SCHEDULE**

	<b>Primary Insured</b>	<b>Spouse</b>	<b>Child(ren)</b>
<b>Life Change Events Category- High</b>			
<b>Dismemberment Benefit</b>			
<i>Loss of hand, foot, or sight:</i>			
Single loss	\$12,500	\$5,000	\$2,500
Double loss	\$25,000	\$10,000	\$5,000
Loss of one or more fingers or toes	\$1,250	\$500	\$250
Partial amputation of finger or toe	\$125	\$125	\$125
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
<b>Paralysis</b>			
Four limbs (quadriplegia)	\$10,000	\$10,000	\$10,000
Two limbs (paraplegia)	\$5,000	\$5,000	\$5,000
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1
<b>Prosthesis Benefit</b>			
<i>Single</i>	\$3,000	\$3,000	\$3,000
<i>Multiple</i>	\$6,000	\$6,000	\$6,000
<b>Residence/Vehicle Modification Benefit</b>	\$2,000	\$2,000	\$2,000
<i>Maximum number of payments per Covered Accident, per Insured</i>	1	1	1

**POLICY SCHEDULE**

**Group Policyholder:** City of Fort Lauderdale

**Group Policy Number:** 24781

**Group Policy Effective Date:** 01/01/2019

**Group Policy Anniversary Date:** 01/01/2020

**Jurisdiction:** Florida

**24-Hour Coverage**

\*Initial premium includes the premium for any Riders purchased at the same time as the coverage provided by an Employee's Certificate.

This Plan is delivered in and governed by the laws of the jurisdiction shown above.

**INCORPORATION OF RIDER PROVISIONS**

The attached listed Riders are made a part of this Plan.

**Rider Name**

Wellness Rider

Portability Privilege Amendment

**Form Number**

C70301FL

CAICCLASSPORTFL

**OCCUPATIONAL CLASSIFICATIONS AND SCHEDULE OF PREMIUMS**

Benefit-eligible employees are classified as such in the Master Application as being **Actively at Work** and **working full-time, a minimum of 30 hours per week.**



**RATES TABLE FOR: CITY OF FORT LAUDERDALE - GP-5899 / GROUP ACCIDENT - PLAN-38552**

**DEDUCTION FREQUENCY : Monthly (12pp / yr)**

Deduction Frequency

**Monthly (12pp / yr)**

Employee Periodic Cost

**\$17.35**

Employee And Spouse Periodic Cost

**\$28.99**

Employee And Child Periodic Cost

**\$36.58**

Family Periodic Cost

**\$48.22**



# CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina  
800.433.3036

The telephone number above is provided for making inquiries, obtaining information regarding coverage, and assistance in resolving complaints.

## **Portability Privilege Amendment**

This Amendment is part of the form to which it is attached. Unless amended by this document, all definitions, exclusions, limitations, terms, and other provisions apply. For the purpose of this Amendment, “you” (including “your” and “yours”) refers to the Insured named in the Certificate Schedule.

### **Effective Date**

This Amendment becomes effective on the Effective Date of the form to which it is attached.

### **Portability Privilege**

The following language replaces the ELIGIBILITY provision found under ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION of the Master Policy and the Certificate of Insurance:

#### **ELIGIBILITY — CLASSES OF COVERAGE**

##### **Class I**

All full-time and part-time benefit-eligible Employees are eligible for Class I coverage. That eligibility extends to their spouses and children under age 26.

##### **Class II**

A Class I primary insured is eligible for Class II coverage if he:

- Was previously insured under Class I; **and**
- Is no longer employed by the Policyholder.

The Employee must elect Class II coverage under the Portability Privilege within 31 days after the date for which his class I eligibility would otherwise terminate.

Only Dependents covered under Class I coverage are eligible for continued coverage under Class II.

Class II insureds cannot continue coverage through the employer’s payroll deduction process. They must remit premiums directly to the Company.

The following language replaces the TERMINATION OF THE PLAN provision found under ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION of the Master Policy.

#### **TERMINATION OF THE PLAN**

The Plan will cease if the premium is not paid before the end of the Grace Period.

After the end of the first Plan year, the Company has the right to cancel the Plan. To do so, the Company must give 45 days written notice that the plan will end on the date before the next premium due date.

The Policyholder has the right to cancel the Plan on the date before any premium due date by giving 31 days written notice.

Upon such termination, Class I and Class II coverage will be affected as follows:

**Class I**

If terminated, this Plan and all certificates issued under this class will terminate on such date at 12:01 a.m. Standard Time at the Policyholder's address. This will be without prejudice to the rights of any Insured regarding any claim arising while the Plan is in force.

The Policyholder has the sole responsibility to notify Class I Employees of such termination. When notice of termination is received by the Company, the Portability Privilege under Class I coverage is no longer available.

**Class II**

The group policy will remain active, and coverage under Class II will continue as long as premiums are paid, subject to the premium grace period. Notification of any changes in the plan will be provided directly to each insured by the Company. The Policyholder will lose any rights and obligations under the Plan.

The following language replaces the TERMINATION OF AN EMPLOYEE'S INSURANCE provision found under ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION of the Master Policy and the Certificate of Insurance.

**TERMINATION OF AN EMPLOYEE'S INSURANCE**

An Employee's insurance will terminate on the earliest of the following:

1. The date the Plan is terminated, for Class I insureds;
2. The 31<sup>st</sup> day after the premium due date if the required premium has not been paid;
3. The date he ceases to meet the definition of an Employee as defined in the Plan, for Class I insureds; **or**
4. The date he is no longer a member of the Class eligible for coverage.

Insurance for Dependents will terminate on the earliest of the following:

1. The date the Plan is terminated, for Dependents of Class I insureds;
2. The 31<sup>st</sup> day after the premium due date, if the required premium has not been paid;
3. The date the Spouse or Dependent Child ceases to be a dependent; **or**
4. The premium due date following the date we receive the Employee's written request to terminate coverage for his Spouse and/or all Dependent Children.

Termination of the insurance on any Insured will not prejudice his rights regarding any claim arising prior to termination.

The following language replaces the PORTABILITY PRIVILEGE provision found under ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION of the Master Policy and the Certificate of Insurance.

**PORTABILITY PRIVILEGE**

Under the Portability Privilege provision, when coverage would otherwise terminate because an Employee ends his employment, coverage may be continued. He may exercise the Portability Privilege when there is a change to his coverage class. The Employee — and any covered dependents — will continue the coverage that is in-force on the date employment ends. The continued coverage will be provided under Class II.

The premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least 45 days before any change is to take effect.

The Employee may continue the coverage until the earlier of:

- The date he fails to pay the required premium; **or**
- The date the class of coverage is terminated.

Coverage may not be continued:

- If the Employee fails to pay any required premium; **or**
- If the Company receives notice of Class I plan termination.

## **General Provisions**

### **Time Limit on Certain Defenses**

After two years from the Insured's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Insured's Application. This does not apply to fraudulent misstatements.

### **Contract**

This Amendment is part of the form to which it is attached. It will terminate when that form terminates.

This Amendment is subject to all of the terms of the form to which it is attached unless those terms are inconsistent with this Amendment.

Signed for the Company at its Home Office,



**Teresa White, President**



**J. Matthew Loudermilk, Secretary**



# CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

The telephone number above is provided for making inquiries, obtaining information regarding coverage, and assistance in resolving complaints.

## **Wellness Rider To Certificate of Insurance for Group Accidental Injury Insurance Policy**

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- We have accepted your Application, and
- You have paid the additional premium for this Rider.

This Rider is subject to all the definitions, exclusions, limitations, terms, and other provisions of the Certificate to which it is attached, unless those terms are inconsistent with this Rider.

### **EFFECTIVE DATE**

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date.

### **WELLNESS BENEFIT**

We will pay the amount shown in the Benefit Schedule for the following:

- Annual physical exams.
- Mammograms.
- Pap smears.
- Eye examinations.
- Immunizations.
- Flexible sigmoidoscopy.
- PSA tests.
- Ultrasounds.
- Blood screening.

This benefit is only payable for Wellness Tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

This benefit is limited to the maximum number of payments shown in the Benefit Schedule.

### **GENERAL PROVISIONS**

#### **Time Limit on Certain Defenses**

After two years from the Insured's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Application. This does not apply to fraudulent misstatements.

### **CONTRACT**

This Rider is part of the Group Accidental Injury Insurance Policy. It will terminate when:

- The Certificate terminates, or
- Premiums are no longer paid for this Rider.

Signed for the Company at its Home Office,

Teresa White, President

J. Matthew Loudermilk, Secretary

**WELLNESS RIDER BENEFITS SCHEDULE**

	Primary Insured	Spouse	Child
<b>Wellness</b>	\$50	\$50	\$50
<i>Maximum number of payments per Calendar Year, per Insured</i>	2	2	2

## **AFLAC CUSTOMER PRIVACY POLICY**

Protecting the privacy and confidentiality of information about our customers is very important to American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac"). Accordingly, Aflac has developed and adopted this "Customer Privacy Policy" which is designed to ensure that our collection and use of customer information complies with the following commitments:

- **Aflac does not sell, rent, lease or otherwise disclose nonpublic personal information (NPI) of its customers for purposes unrelated to Aflac products and services.** Our customers' NPI is of paramount importance to us. Therefore, we provide your NPI only to our affiliates, employees, agents and third parties as necessary to facilitate the development and delivery of our insurance and employee benefit products and services. Aflac may also provide your NPI to its affiliates for marketing purposes consistent with the terms disclosed herein (see *Sharing Information*, below).
- **Aflac works to ensure information integrity and security.** We use technology tools and design our business practices to help ensure that our customers' NPI is properly gathered, stored and processed. We also work to maintain the security of our customers' NPI through the use of technology and our business practices.
- **Aflac expects its agents and employees to respect customer NPI.** Aflac has adopted internal policies and procedures designed to ensure that employees and agents adhere to Aflac's privacy policies and otherwise protect our customers' NPI. Both employees and agents are subject to censure, dismissal, or termination for violation of these policies.

This Customer Privacy Policy applies to those individuals who receive our products and services, as well as to individuals who provide us with NPI in the course of submitting an application to us for our products and services. .

### **PRIVACY NOTICE**

Aflac provides this notice to let you know about our current privacy practices with respect to the collection, sharing and protection of your NPI. **You do not need to do anything in response to this notice, unless you would like to prohibit the use of your NPI by our affiliates to market products and services to you, as described below.**

#### **Collecting Information**

As part of Aflac's normal underwriting and operating procedures, Aflac (and our agents acting on our behalf) needs to obtain information to determine an individual's eligibility for our products and services, and to perform our insurance functions. Aflac and our agents may collect NPI about Aflac's customers, including:

- Information from our customers (including names, addresses, and financial and health information).
- Information about our customers' transactions with Aflac or our agents (including claims and payment information).
- Information from or about your transactions with nonaffiliated third parties (including, but not limited to, accident reports, claims, health and insurance application histories, health history, and salary data).

#### **Sharing Information**

- Aflac shares the NPI it collects about you, as described above, among Aflac and its affiliates so that Aflac and its affiliates may perform their everyday business functions, such as processing your transactions and claims, or otherwise maintaining your policies. Aflac also reserves the right to share your NPI with its affiliates to enable Aflac affiliates to market their products and services directly to you. You can prevent the use of your NPI for this purpose by following the "opt-out" procedure described below, "*Opting Out of Information Sharing*."
- Aflac does not share, and does not reserve the right to share, customer NPI with nonaffiliated third parties except as permitted or required by applicable law.
- Aflac agents will share your NPI only while acting on Aflac's behalf and, furthermore, will share your NPI only to the extent Aflac itself is permitted to do so.
- Neither Aflac nor its agents will disclose the NPI of former customers unless the disclosure is authorized by or at the request of the former customer, or is otherwise permitted or required by law.

#### **Opting Out of Information Sharing**

As described above, Aflac shares your NPI when permitted or required by law. You are not able to limit Aflac's ability to share your NPI for these purposes.

##### *Affiliate Marketing Opt Out*

If you would prefer not to receive marketing materials from Aflac's affiliates about their products or services, you can opt out of such affiliate marketing by either (1) calling 1.800.433.3036; or (2) visiting [www.aflacgroupinsurance.com](http://www.aflacgroupinsurance.com) and downloading, completing, and returning the Affiliate Marketing Opt-Out Form to Aflac at the referenced address. If you opt-out and later change your mind, please let Aflac know and we will change your choice. Your opt out does not prevent Aflac

from sending you information about products or services offered by Aflac or its affiliates. Similarly, your opt out will not prevent an Aflac affiliate from using NPI received from Aflac to market affiliate products and services to you if (a) you have a pre-existing relationship with such affiliate, or (b) you contact such affiliate directly and request information about such affiliate's products or services.

### **Confidentiality and Security**

Aflac and its agents safeguard customer (and former customer) NPI by maintaining administrative, technical, and physical safeguards to ensure the security and confidentiality of such NPI. This includes having security practices in place to protect against anticipated threats or hazards, and to protect against unauthorized access to or use of customer and former customer NPI.

Aflac limits access to NPI to only those employees who need access to such information to perform their job functions. Employees who misuse NPI are subject to disciplinary actions. Aflac provides privacy training and awareness to all of its employees.

### **NOTICE OF INFORMATION PRACTICES**

California, Connecticut, Georgia, Illinois, Kansas, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia require insurers and agents to describe their information practices in addition to providing a Privacy Notice. There is significant overlap between the two notices, but in general our Information Practices include the following: Aflac may obtain information about you and any other persons proposed for insurance. Some of this information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. Residents of these states have the right to access and correct the information collected about them except information that relates to a claim or to a civil or criminal proceeding. They also have the right to receive the specific reason for an adverse underwriting decision in writing. If you wish to have a more detailed explanation of our information practices required by your state, please submit a written request to Aflac, ATTN: Privacy Office, P.O. Box 427, Columbia, SC 29202.

### **STATE SPECIFIC DISCLOSURES**

Customer NPI shall be collected, used and stored in accordance with applicable federal privacy laws. To the extent that the privacy laws of a Customer's state of residence are more protective of the Customer's NPI than federal privacy laws, Aflac will protect the Customer's NPI in accordance with such state law.

**Attention Washington Residents:** You have the right to limit disclosures of your nonpublic personal information under the circumstances described in WAC 284-04-510. For instance, you may request in writing that Aflac limit the disclosure of nonpublic personal information to specified individuals if the disclosure of the information to those individuals could jeopardize your safety. In addition, you may also request, in writing, that Aflac limit certain disclosures of information regarding reproductive health, sexually transmitted diseases, chemical dependency and mental health. For more information or if you wish to submit a request, please write to: Aflac, ATTN: Privacy Office, P.O. Box 427, Columbia, SC 29202.

### **NOTICE OF PRIVACY PRACTICES - PROTECTED HEALTH INFORMATION**

If you would like a copy of Aflac's *Notice of Privacy Practices - Protected Health Information*, issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), copies are available by visiting Aflac's website, [www.aflacgroupinsurance.com](http://www.aflacgroupinsurance.com), or sending a written request to: Aflac, ATTN: Privacy Office, P.O. Box 427, Columbia, SC 29202.



## **NOTICE OF PRIVACY PRACTICES – PROTECTED HEALTH INFORMATION**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.** The terms of this Notice of Privacy Practices – Protected Health Information (“Notice”) apply to Protected Health Information (defined below) associated with Health Plans (defined below) issued by American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, Continental American Insurance Company and Continental American Life Insurance Company (collectively, “we,” “our,” or “Aflac”) <sup>1</sup>. This Notice describes how Aflac may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) to maintain the privacy of Protected Health Information and to provide our policyholders and certificateholders with notice of our legal duties and privacy practices concerning Protected Health Information. In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of Protected Health Information, as set forth below, we will restrict our uses or disclosure of your Protected Health Information in accordance with the more stringent standard. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, we will mail copies of revised notices to all policyholders and certificateholders then covered by a Health Plan. Copies of our current Notice may be obtained by contacting Aflac at the telephone number or address below, or on our Web site at [www.aflacgroupinsurance.com](http://www.aflacgroupinsurance.com).

### **DEFINITIONS**

**Health Plan** means, for purposes of this Notice, the following plans issued by Aflac: dental, specified disease (e.g., cancer), hospital indemnity and other coverages that meet the definition of Health Plan contained in HIPAA. The following products are not considered Health Plans: coverage only for accident, or disability income insurance, or any combination thereof, life insurance, and other coverages that do not meet the definition of Health Plan contained in HIPAA.

**Protected Health Information (“PHI”)** means individually identifiable health information, as defined by HIPAA, that is created or received by Aflac and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased, unless the person has been deceased more than 50 years.

### **USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION**

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

**Uses and Disclosures for Payment** – We may make requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims. We may also disclose your PHI for the payment purposes of a health care provider or another Health Plan.

**Uses and Disclosures for Health Care Operations** – We may use and disclose your PHI as necessary for our health care operations. Examples of health care operations include underwriting, premium rating, or other activities relating to the creation, renewal, or replacement of a Health Plan, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to your Health Plan. Although underwriting falls within the definition of health care operations, we will not use or disclose genetic information for purposes of underwriting. Genetic information is defined under the Genetic Information Nondiscrimination Act (GINA).

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<sup>1</sup> *With respect to its Health Plans, American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York and Continental American Insurance Company are affiliated covered entities (see 45 CFR 164.105).*

**Family and Friends Involved in Your Care** – If you are available and do not object, we may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals. For example, we may use our professional judgment to disclose PHI to your spouse concerning the processing of a claim. If you do not wish Aflac to share PHI with your spouse or others, you may exercise your right to request a restriction on Aflac’s disclosures of your PHI (see below).

**Business Associates** – Certain aspects and components of our services are performed through contracts with outside persons or organizations. Examples of these outside persons and organizations include our duly-appointed insurance agents and vendors that help us process your claims. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations.

**Other Products and Services** – We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your PHI for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing Health Plan coverage, and about health-related products and services that may add value to your Health Plan.

**Other Uses and Disclosures** – We may make certain other uses and disclosures of your PHI without your authorization:

- We may use or disclose your PHI for any purpose required by law. For example, Aflac may be required by law to use or disclose your PHI to respond to a court order.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for cadaveric organ, eye or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to workers' compensation agencies for your workers' compensation benefit determination.
- We will, if required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.

**Your Authorization** – Except as outlined above, we will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. Specifically, most uses and disclosures of psychotherapy notes, uses or disclosures for marketing purposes and disclosures that constitute a sale of PHI require an authorization. You have the right to revoke that authorization in writing except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining insurance, and we have the right, under other law, to contest a claim under the plan itself.

- The following are examples of when your authorization would be required prior to use and disclosure:
  - Most uses and disclosures of your psychotherapy notes.
  - Uses and disclosures of your PHI for marketing purposes.
  - Uses and disclosures that constitute a sale of PHI.

**Breach of Unsecured PHI** – If Aflac or a Business Associate of Aflac causes a breach to occur that involved your unsecured PHI, we are required by law to notify you of the incident.

## **RIGHTS THAT YOU HAVE**

**Access to Your PHI** – You have the right to copy and/or inspect certain PHI that we maintain about you. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI and must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). We must provide you with access to your PHI in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a form or format agreed upon by you and Aflac. Access request forms are available from Aflac at the address below. We may charge you a fee for copying and postage. We may deny your request for access in certain very limited circumstances, such as request to access psychotherapy notes.

**Amendments to Your PHI** – You have the right to request that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your representative, and must state the reasons for the amendment/correction request. Amendment request forms are available from Aflac at the address below.

**Accounting for Disclosures of Your PHI** – You have the right to receive an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, your accounting requests must be in writing and signed by you or your representative. Accounting request forms are available from Aflac at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request within the same 12-month period.

**Restrictions on Use and Disclosure of Your PHI** – You have the right to request restrictions on certain of our uses and disclosures of your PHI for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. HIPAA does not require us to agree to your request but we will accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. Requests for a restriction (or termination of an existing restriction) may be made by contacting Aflac at the telephone number or address below.

However, we are authorized by law to refuse to honor any request to restrict disclosures for treatment, payment or health care operations. Nonetheless, we will comply with a restriction request if (i) the disclosure is to the Health Plan for purposes of carrying out payment or healthcare operations, except as otherwise required by law, (ii) the PHI relates solely to a health care item or service for which the healthcare provider involved has been paid out-of-pocket in full.

**Request for Confidential Communications** – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to Aflac at the address below.

**Right to a Copy of the Notice** – You have the right to a paper copy of this Notice upon request by contacting Aflac at the telephone number or address below.

**Complaints** – If you believe your privacy rights have been violated, you can file a complaint with Aflac in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

## **FOR FURTHER INFORMATION**

If you have questions or need further assistance regarding this Notice, you may contact Aflac's Privacy Office by writing to: Aflac, Attn: Privacy Office, P.O. Box 427, Columbia, SC 29202, or by calling 1-800-433-3036.

## **EFFECTIVE DATE**

This Notice is effective January 6, 2017.