



INVITATION TO NEGOTIATE  
# 002-18  
EMPLOYEE BENEFITS INSURANCE PLANS

**ATTACHMENT 13**  
**GROUP ACCIDENT POLICY**



## CONTINENTAL AMERICAN INSURANCE COMPANY

Home Office: 2801 Devine Street, Columbia, South Carolina 29205  
(herein called Continental American)  
**800.433.3036**

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

### **GROUP ACCIDENTAL INJURY INSURANCE POLICY**

Southwest Florida Water Management District (“the Policyholder”) applied for coverage under this Group Insurance Policy (the “Plan”). This Plan is issued by Continental American Insurance Company (the “Company,” “we,” “us,” or “our”). Based on the Application and based on 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.)

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

### **This is a limited policy. Please read it carefully.**

This Plan becomes effective on the Effective Date at 12:01 a.m., as determined by the Policyholder's address. Plan Termination is governed by Section I. The Plan continues to be effective while premiums are paid, as provided in Section II.

The Plan's first Anniversary Date appears below. Subsequent anniversaries will be the same date each following year.

The Policyholder may add new Employees or Dependents from time to time, according to the Plan's terms.

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 below.

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,

**Group Policy Number** 17621  
**Effective Date** 1/1/2017  
**Jurisdiction** Florida

**Anniversary Date** 1/1/2018  
**Non-Participating**

## **Table of Contents**

<b>Section I</b>	-	Eligibility, Effective Date, and Termination
<b>Section II</b>	-	Premium Provisions
<b>Section III</b>	-	Definitions
<b>Section IV</b>	-	Benefit Provisions
<b>Section V</b>	-	Exclusions
<b>Section VI</b>	-	Claim Provisions
<b>Section VII</b>	-	General Provisions
<b>Section VIII</b>	-	Benefit Schedule
<b>Section IX</b>	-	Classifications and Schedule of Premiums
<b>Section X</b>	-	Incorporation of Rider Provisions

## **Section I – Eligibility, Effective Date, and Termination**

### **Eligibility**

A person is an eligible Employee under this Plan if he meets the following three requirements. He is:

1. An Employee of the Policyholder,
2. Engaged in full-time work, and
3. Included in the class of Employees eligible for coverage, as shown on the 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.*

Dependents are eligible for coverage under this Plan. A **Dependent** is:

- The Spouse of an Employee **or**
- The Dependent Child of an Employee. **Dependent Children** are an Employee's or an Employee's Spouse's natural children, step-children, legally adopted children, foster children, or children placed for adoption who are younger than age 26 (details included in the **Definitions** section).

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

- **Employee Coverage** – We insure only the Employee.
- **Employee and Spouse Coverage** – We insure the Employee and Spouse.
- **Employee and Child Coverage** – We insure the Employee and any Dependent Children.
- **Family Coverage** – We insure the Employee, Spouse, and any Dependent Children.

Any other additions to the Insured class must be added by Endorsement after applying to the Company.

### **Effective Date**

The Plan's Effective Date is shown on Page 1.

An Employee's Effective Date is the date his insurance takes effect. That date is either the date:

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

### **Plan Termination**

The Plan may terminate for any of the following reasons:

- The premium is not paid before the end of the Grace Period.
- The Company cancels the Plan any time after the end of the first premium year.
- The number of participating Employees is less than the number mutually agreed upon by the Company and the Policyholder in the signed master Application.

The Company must give 45 days' written notice of termination to the Policyholder's last known address. If we fail to provide the 45 days' notice, the coverage will remain in effect at the existing rates until 45 days after the notice is given or until the effective date of replacement coverage obtained by the Insured, whichever occurs first.

The Policyholder has the sole responsibility to notify Employees of the Plan's termination.

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. If the Plan terminates, we will provide coverage for claims arising from Covered Accidents that occurred while the Plan was in force.

### **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, if the premium has not been paid.
- The date he no longer meets the Plan's definition of an Employee.
- The date he no longer belongs to an eligible class.

If the Plan terminates, we will provide coverage for claims arising from Covered Accidents that occurred while the Plan was in force.

### **Portability Privilege**

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. The Employee may continue the coverage that he had on the date his employment ended, including any in-force Spouse or Dependent Child coverage.

- The following conditions must be met for an Employee to keep his Certificate in force:
  - Within 31 days after the date his insurance 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 the Certificate would otherwise terminate and on each premium due date thereafter.
- Insurance will end on the earlier of these dates:
  - 31 days after the date the Employee failed to pay any required premium
  - The date this 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 an Employee qualifies for this Portability Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate as shown in his previously issued Certificate.

## **Section II – Premium Provisions**

### **Premium Calculations**

The Schedule of Premiums determines the premium amount payable on any premium due date. The rates shown in this Schedule can be changed annually. The Company will give the Policyholder written notice 45 days before any change in rates becomes effective.

### **Premium Payments**

The first premiums are due on this Plan's Effective Date. After that, premiums are due on the first day of each month that the Plan remains in effect.

Aggregate premiums for this Plan should be paid to the Company at its Home Office in Columbia, South Carolina. 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.

### **Grace Period**

This Plan has a 31-day Grace Period. If a renewal 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.

## **Section III – Definitions**

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

***Accidental Injury or Injuries*** means bodily Injury or Injuries resulting from an unforeseen and unexpected traumatic event that meets the definition of *Covered Accident*.

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

***Calendar Year*** is defined as January 1 through December 31 of the same year.

***Covered Accident*** means an unforeseen and unexpected traumatic event resulting in bodily Injury. An event meets the qualifications of Covered Accident if it:

- Occurs on or after the Plan's Effective Date,
- Occurs while coverage is in force, **and**
- Is not specifically excluded.

***Dependent*** means the Spouse of an Employee **or** the Dependent Child of an Employee.

**Dependent Children** are an Employee's or an Employee's Spouse's natural children, step-children, legally adopted children, foster children, or children placed for adoption who are younger than age 26.

However, there is an exception to the age-26 limit listed above. This limit will not apply to any child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and is 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 child's 26th birthday.

If the Employee already has Dependent Children coverage in force, children born or placed in the Employee's home after the Effective Date of the Dependent Accident Rider will also be covered from the moment of birth or placement. No notice or additional premium is required.

**Doctor** is defined as a person who is:

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

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

**Employee** is a person who meets eligibility requirements under **Section I – Eligibility**, and who is covered under this Plan. The Employee is the primary Insured under this Plan.

**Family Member** includes the Employee's **Spouse** (who is defined as an Employee's legal wife or husband) as well as the following members of the Insured's immediate family:

- |            |          |           |
|------------|----------|-----------|
| • son      | • mother | • sister  |
| • daughter | • father | • brother |

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

**Full-time Work** means that an Insured spends at least 16 hours per week performing his occupational duties.

**Hospital** refers to a place that:

- 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;
- Has on-site or pre-arranged use of X-ray equipment, laboratory, and surgical facilities; **and**
- Maintains permanent medical history records.

A Hospital is **not**:

- A nursing home;
- An extended-care facility;
- A convalescent home;
- A rest home or a home for the aged;
- A place for alcoholics or drug addicts; **or**
- A mental institution.

**Hospital Intensive Care Unit** refers to a specifically designed Hospital facility that provides the highest level of medical care and is restricted to patients who are critically ill or injured. Hospital Intensive Care Units must be:

- Separate and apart from the surgical recovery room;
- Separate and apart from rooms, beds, and wards customarily used for patient confinement;
- Permanently equipped with special life-saving equipment to care for the critically ill or injured; **and**
- Under constant and continuous observation by nursing staffs assigned to the Intensive Care Unit on an exclusive, full-time basis.

**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.

**Rehabilitation Unit** is a unit of a Hospital 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 and staffed in a unit specifically designated for this service.

**Total Disability** or **Totally Disabled** means that due to an Accidental Injury the Insured is:

- Not able to perform the substantial and material duties of his occupation, **and**
- Receiving a Doctor's care that is appropriate for the condition causing the disability, **and**
- Not gainfully employed or occupied in any other occupation.

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

**Your Occupation** means the occupation in which the Insured is regularly engaged at the time he becomes disabled.



## Section IV – Benefit Provisions

The language in this provision matches that of the Certificate. As the Certificate is issued to the Insured, we included the use of "you" and "yours."

The benefit amounts payable under this section are shown in the Benefit Schedule.

### **Specific Injuries Benefits**

#### **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* refers 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 which 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.

#### **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 received treatment for a dislocation within 6 months of the Effective Date of his Certificate, this Plan will not cover any dislocation of the same joint during the first 12 months of coverage. If a dislocation of the same joint occurs after the first 12 months of coverage, we will cover that dislocation, but no subsequent dislocations of the same joint.

*Multiple dislocations* refers to more than one dislocation requiring either open or closed reduction in anyone 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.

If an Insured has **both** fracture and dislocation in the same accident, we will pay for both. However, we will pay no more than 200% of the benefit amount for the fractured bone or dislocated joint that has the higher dollar amount.

**Laceration Benefit**

If an Insured receives a laceration in a Covered Accident, we will pay the appropriate amount shown in the Benefit Schedule. The laceration must be repaired with stitches by a Doctor within 72 hours after the accident. The amount paid will be based on the length of the laceration.

The Insured may receive a laceration that does not require stitches. However, if that laceration is treated by a Doctor within 72 hours after the Covered Accident, we will pay the appropriate 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 72 hours after the accident, we will pay this benefit based on the largest single laceration which requires stitches, as shown in the Benefit Schedule.

**Concussion Benefit**

A *concussion* or *Mild Traumatic Brain Injury (MTBI)* is defined as a disruption of brain function resulting from a traumatic blow to the head. (Note: *Concussion* and *MTBI* are used interchangeably.)

If the Insured has a concussion from a Covered Accident, we will pay the amount shown for this benefit in the Benefit Schedule. The concussion must be diagnosed by a Doctor.

**Coma Benefit**

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

**Emergency Dental Work Benefit**

We will pay this benefit if the Insured has an Injury to sound 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.

**Eye Injuries Benefit**

For eye injuries requiring surgical repair, we will pay the amount shown in the Benefit Schedule, if, because of a Covered Accident:

- The Insured injures an eye,
- A Doctor repairs the eye through surgery, **and**
- The eye surgery occurs within 90 days after the Accident.

For eye injuries requiring removal of a foreign body, we will pay the amount shown in the Benefit Schedule if a Doctor removes a foreign body from the eye, with or without anesthesia.

**Tendons and Ligaments Benefit**

We will pay the appropriate amount shown in the Benefit Schedule if a Covered Accident causes the Insured to:

- Tear, sever, or rupture a tendon or ligament;
- Receive Treatment from a Doctor within 60 days; **and**
- Have surgical repair within 90 days after the accident.

The amount paid will be based on the number (single or multiple) of tendons or ligaments repaired.

**Ruptured Disc Benefit**

We will pay the amount shown in the Benefit Schedule if a Covered Accident causes the Insured to:

- Rupture a disc in his spine,
- Receive Treatment from a Doctor within 60 days after the accident, **and**
- Have surgical repair by a Doctor within one year after the accident.

The amount paid will be based on when the accident occurred. See the Benefit Schedule for details.

**Torn Knee Cartilage Benefit**

We will pay the amount shown in the Benefit Schedule if the Insured is injured in a Covered Accident and:

- Accidental injuries result in torn knee cartilage,
- This Injury requires Doctor Treatment within 60 days from the accident date, **and**
- This Injury requires surgical repair within one year from the accident date.

The amount paid will be based on when the accident occurred. See the Benefit Schedule for details.

**Internal Injuries Benefit**

We will pay the amount shown in the Benefit Schedule if:

- A Covered Accident causes the Insured to have internal Injuries, and
- Those internal Injuries require open abdominal or thoracic surgery.

**Exploratory Surgery Benefit**

We will pay the amount shown in the Benefit Schedule if a Covered Accident causes the Insured to have exploratory surgery (without repair). The exploratory surgery must be required as the result of an Injury.

**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 Injury causes paralysis which lasts more than 90 days, **and**
- The paralysis is diagnosed by a Doctor within 90 days after the accident.

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

If this benefit is paid and the Insured later dies as a result of the same Covered Accident, we will pay the appropriate Death Benefit, less any amounts paid under the Paralysis Benefit.

**Burns Benefit**

We will pay the appropriate 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 72 hours after the accident. First-degree burns are not covered.

**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 90 days 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.

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, less any amounts paid under this benefit.

### **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.

We will pay the amount shown in the Benefit Schedule if the Insured is diagnosed with Post-traumatic Stress Disorder. This benefit is payable only once per Covered Accident.

### **Services Benefits**

#### **Blood/Plasma Benefit**

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

- Is injured **and**
- Receives blood or plasma within 90 days after the accident.

#### **Ambulance Benefit**

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

- Is injured **and**
- Requires transportation to a Hospital by a professional ambulance service. This transportation must occur within 90 days after the accident.

Ambulance service includes air ambulance service.

**Transportation Benefit**

We will pay the applicable amount shown in the Benefit Schedule for train, plane, or bus transportation. 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 90 days after the Covered Accident date. The distance to the Hospital Treatment or diagnostic study must be greater than 50 miles from the Insured's residence.

**Family Member Lodging Benefit**

We will pay this benefit in the amount and for the number of days shown in the Benefit Schedule. We will pay this benefit for each night's lodging in a motel/hotel room 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 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 local Doctor.

**Medical Fees Benefit**

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

- X-rays
- Doctor services

For benefits to be payable, because of a Covered Accident, the Insured must:

- Be injured **and**
- Receive initial Treatment from a Doctor within 72 hours after the accident.

We will pay the Medical Fees Benefit:

- For Treatment received due to injuries from a Covered Accident **and**
- For each Covered Accident up to one year after the accident date.

We will not pay the Medical Fees Benefit and the Accident Emergency Room Treatment Benefit for the same Covered Accident. We will pay the highest eligible benefit amount.

**Prosthesis Benefit**

Prosthetic devices must be used as the result of Injury from a Covered Accident. For Covered Accidents, we will pay the amount shown in the Benefit Schedule for each prosthetic device the Insured uses.

Prosthetic devices **not** covered include:

- Hearing aids.
- Wigs.
- Dental aids (including, but not limited to, false teeth).

**Appliances Benefit**

We will pay the amount shown in the Benefit Schedule if a Doctor advises the Insured to use a medical 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. *Medical appliance* means crutches, wheelchairs, leg braces, back braces, and walkers.

### **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 72 hours after the Covered Accident.
- The Insured receives Doctor-prescribed follow-up Treatment.
- The follow-up Treatment begins within 30 days after the Covered Accident or discharge from the Hospital.

We will pay for a maximum of 6 Treatments per Covered Accident.

### **Physical Therapy Benefit**

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

- The Insured receives initial Treatment within 72 hours after the Covered Accident.
- The Insured receives Doctor-prescribed physical therapy Treatment.
- The physical therapy Treatment begins within 30 days after the Covered Accident or discharge from the Hospital.
- The physical therapy Treatment takes place within 6 months after the Covered Accident.

We will pay for a maximum of 6 physical therapy Treatments per Covered Accident. We will not pay this benefit for the same visit that the Accident Follow-up Treatment Benefit is paid.

### **Wellness Benefit**

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

- |                         |                          |                   |
|-------------------------|--------------------------|-------------------|
| • Annual physical exams | • eye examinations       | • PSA tests       |
| • mammograms            | • immunizations          | • ultrasounds     |
| • pap smears            | • flexible sigmoidoscopy | • 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 payable after premiums have been paid for 12 months and while the Insured's coverage is in force. This benefit is payable once each 12-month period.

### **Major Diagnostic Exams 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, and a charge is incurred:

- |                                     |                                       |
|-------------------------------------|---------------------------------------|
| • computerized tomography (CT scan) | • computerized axial tomography (CAT) |
| • magnetic resonance imaging (MRI)  | • electroencephalography (EEG)        |

These exams must be performed in a Hospital or a Doctor's office. This benefit is limited to one payment per Covered Accident.

### **Emergency Room Treatment Benefit**

We will pay the amount shown in the Benefit Schedule for injuries received in a Covered Accident if the Insured:

- Receives Treatment in a Hospital emergency room **and**
- Receives initial Treatment within 72 hours after the Covered Accident.

This benefit is payable only once per 24-hour period and only once per Covered Accident. We will not pay the Accident Emergency Room Treatment Benefit and the Medical Fees Benefit for the same Covered Accident. We will pay the highest eligible benefit amount.

**Emergency Room Observation Benefit**

We will pay the amount shown in the Benefit Schedule for injuries received in a Covered Accident if the Insured:

- Receives Treatment in a Hospital emergency room, **and**
- Is held in a Hospital for observation for at least 24 hours, **and**
- Receives initial Treatment within 72 hours after the accident.

This benefit is payable only once per 24-hour period and only once per Covered Accident. This benefit is paid in addition to Accident Emergency Room Treatment Benefit or the Medical Fees Benefit.

**Rehabilitation Unit Benefit**

We will pay the appropriate amount shown in the Benefit Schedule for injuries received in a Covered Accident if the Insured:

- Is admitted for a Hospital Confinement,
- Is transferred to a bed in a Rehabilitation Unit of a Hospital for Treatment, **and**
- Incurs a charge.

This benefit is limited to 30 days for each Insured per period of Hospital confinement. This benefit is also limited to a Calendar Year maximum of 60 days. We will not pay the Rehabilitation Unit Benefit for the same days that the Accident Hospital Confinement Benefit is paid. We will pay the highest eligible benefit.

**Hospital Benefits****Hospital Admission Benefit**

We will pay the Hospital Admission Benefit amount shown in the Benefit Schedule. We will pay this benefit when, because of a Covered Accident, the Insured:

- Is injured,
- Requires Hospital confinement, **and**
- Is confined to a Hospital for at least 24 hours within 6 months after the accident date.

We will pay this benefit once per Calendar Year. We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room Treatment or outpatient surgery or Treatment.

**Hospital Confinement Benefit**

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

- The Insured is injured, **and**
- Those injuries cause the Insured to be confined to a Hospital for at least 24 hours within 90 days after the accident.

The Benefit Schedule shows the maximum period for which the Insured can collect the Hospital Confinement Benefit for the same Injury. This benefit is payable once per Hospital confinement even if the confinement is caused by more than one Accidental Injury.

We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room Treatment or outpatient surgery or Treatment.

### **Hospital Intensive Care Benefit**

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

- The Insured is injured, **and**
- Those injuries cause the Insured to be confined to a Hospital Intensive Care Unit.

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

### **Accidental-Death Benefits**

#### **Accidental-Death Benefit**

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

- The Insured is injured, **and**
- The Injury causes the Insured to die within 90 days after the accident.

We will pay the Accidental-Death Benefit in addition to the Accidental Common-Carrier Death Benefit.

#### **Accidental Common-Carrier Death Benefit**

We will pay the amount shown in the Benefit Schedule if the Insured:

- Is a fare-paying passenger on a common carrier, as defined below, **and**
- Is injured in a Covered Accident, **and**
- Dies within 90 days after the Covered Accident.

*Common carrier means:*

- An airline carrier that is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports;
- A railroad train that is licensed and operated for passenger service only; **or**
- A boat or ship that is licensed for passenger service and operated on a regular schedule between established ports.

We will pay the Accidental Common-Carrier Death Benefit in addition to the Accidental-Death Benefit.

## **Section V – Exclusions**

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

- **War** – participating in war or any act of war, declared or not; participating in the armed forces of, or contracting with, any country or international authority. War does not include acts of terrorism. We will return the prorated premium for any period not covered by his Certificate when the Insured is in such service.
- **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 any related medical/surgical Treatment or diagnostic procedures for such illness.
- **Self-Inflicted Injuries** – injuring or attempting to injure yourself intentionally.
- **Racing** – riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.
- **Intoxication** – being legally intoxicated, or being under the influence of any narcotic, unless taken under the direction of a Doctor. (*Legally intoxicated* means that condition as defined by the law of the jurisdiction in which the accident occurred.)



- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job.
- **Sports** – participating in any professional or semi-professional organized sport.
- **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.

## **Section VI – Claim Provisions**

### **Notice of Claim**

The Insured must give written notice of claim:

- Within 60 days after a Covered Accident **or**
- As soon as reasonably possible.

Notice must include the Insured's name and the Certificate number. Notice can be mailed to the Company at:

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

### **Claim Forms**

When the Company receives notice of a claim, we will send the Insured forms so that he can file Proof of Loss (details included in the **Proof of Loss** section below). If the Company does not provide the forms within 15 working days, the Insured can meet Proof of Loss requirements by providing a written statement about the nature and extent of the loss. The Insured will also need to provide a statement by the treating Doctor. The Insured must provide this information within the time limit stated in the **Proof of Loss** section.

### **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). The Insured must provide Proof of Loss to the Company at:

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

The Insured must provide Proof of Loss documentation within 90 days after the date of the Covered Accident. However, the Company will not invalidate or reduce any claim if it was not reasonably possible for the Insured to provide this proof within the required time. The Insured must provide the proof as soon as reasonably possible. The Company will not accept proof any later than one year and three months after the Covered Accident, except in the absence of the Insured's legal mental capacity.

### **Claims Payment Timeframe**

Once we receive proper Proof of Loss, we will process the Insured's claim. If the claim can be paid, and a benefit provides for periodic payments, we will pay those benefits on a monthly basis. For other payable benefits, we will pay those claims as soon as we receive proper written proof.

### **Payment of Claims**

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

1. To any approved assignee;
2. To the Insured's beneficiary;
3. To the Insured's surviving Spouse;
4. To the Insured's estate.

### **Changing Your Beneficiary**

The Insured can ask us to change his beneficiary at any time. The request must be in writing, and the change must be approved by us. If approved, it will go into effect the day the Insured signs the request. The change will not have any bearing on payments made before we approved the request.

### **Unpaid Premium**

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

### **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.

### **Legal Action**

The Insured cannot 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.

## **Section VII – General Provisions**

### **Entire Contract Changes**

The *Entire Contract of Insurance* is made up of:

- This Policy,
- The Application,
- Certificates,
- Endorsements,
- Benefit agreements, **and**
- Riders (if any).

All statements (excluding fraudulent ones) that the Policyholder or an Insured have made in the Application will be considered representations, **not** warranties.

If statements on the Application require additional review, the Company will send a copy of the Application to:

- The Policyholder, **or**
- The Insured, **or**
- The Insured's beneficiary.

This will ensure that Policyholders have an opportunity to review the information they have provided in their Applications. The Company *will not* void insurance or reduce benefits (as a result of statements made on the Application) without sending Application copies as outlined above.

Changes to this Plan:

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

Any Rider, Endorsement, or Application that modifies, limits, or excludes coverage under this Plan must be signed by the Insured to be valid.

### **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.

### **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.

### **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 Certificate**

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 furnish all information and proofs which the Company may reasonably require with regard to the Plan.

### **Conformity With State Statutes**

Any Plan provision that conflicts with state statutes where this Plan was issued on its Effective Date is hereby amended to conform to the minimum requirements of those statutes.

## Section VIII – Benefit Schedule

<b>Specific Injuries Benefits</b>		<b>Plan I</b>
<b>Fracture</b>		
Hip/thigh		\$4,000
Vertebrae		3,600
Pelvis		3,200
Skull (depressed)		3,000
Skull (simple)		1,400
Leg		2,400
Foot/ankle/knee cap		2,000
Forearm/hand		2,000
Lower jaw		1,600
Shoulder blade/collar bone		1,600
Upper arm/upper jaw		1,400
Facial bones (except teeth)		1,200
Vertebral processes		800
Coccyx/rib/finger/toe		320
<b>Dislocation</b>		
Hip		3,000
Knee (not knee cap)		1,950
Shoulder		1,500
Foot/ankle		1,200
Hand		1,050
Lower jaw		900
Wrist		750
Elbow		600
Finger/toe		240
<b>Laceration</b>		
Over 6"		400
2" to 6"		200
Under 2"		50
Lacerations not requiring stitches		25
<b>Concussion</b>		200
<b>Coma</b>		10,000
<b>Emergency Dental Work</b>		
Repair with crown		150
Extraction		50
<b>Eye Injuries</b>		
Requiring surgical repair		250
Removal of foreign body		50

<b>Tendons/Ligaments</b>	
Single	400
Multiple	600
<b>Ruptured Disc</b>	
Injury occurs during first Certificate year	100
Injury occurs after first Certificate year	400
<b>Torn Knee Cartilage</b>	
Injury occurs during first Certificate year	100
Injury occurs after first Certificate year	400
<b>Internal Injuries</b>	1,000
<b>Exploratory Surgery</b> (without repair)	250
<b>Paralysis</b>	
Four limbs (quadriplegia)	10,000
Two limbs (paraplegia)	5,000
<b>Burns</b>	
<b>Second Degree</b>	
Less than 10%	100
At least 10% but less than 25%	200
At least 25% but less than 35%	500
35% or more	1,000
<b>Third Degree</b>	
Less than 10%	1,000
At least 10% but less than 25%	5,000
At least 25% but less than 35%	10,000
35% or more	20,000
<b>Dismemberment</b>	
Loss of hand, foot, or sight	
Single loss	12,500
Double loss	25,000
Loss of one or more fingers or toes	1,250
Partial amputation of finger or toe	100
<b>Post-Traumatic Stress Disorder</b>	200
<b><u>Services Benefits</u></b>	
<b>Blood/Plasma</b>	100
<b>Ambulance</b>	200
<b>Air Ambulance</b>	1,000

<b>Transportation</b>	
Train or Plane	300
Bus	150
<b>Family Member Lodging</b>	100/per night
Maximum Benefit Period: 30 days	
<b>Medical Fees</b>	125
<b>Prosthesis</b>	500
<b>Appliances</b>	100
<b>Accident Follow-Up Treatment</b>	30
Maximum of 6 Treatments per Covered Accident	
<b>Physical Therapy</b>	30
Maximum of 6 Treatments per Covered Accident	
<b>Wellness</b>	50
Once per 12-month period	
<b>Major Diagnostic Exams</b>	200
<b>Emergency Room Treatment</b>	200
<b>Emergency Room Observation</b>	100
<b>Rehabilitation Unit</b>	75/day
Maximum Benefit Period: 30 days per Hospital confinement	
Limited to 60-day Calendar-Year maximum	
<b><u>Hospital Benefits</u></b>	
<b>Hospital Admission</b>	1,000
Payable once per Calendar Year	
<b>Hospital Confinement</b>	200/day
Maximum Benefit Period: 365 days	
<b>Hospital Intensive Care</b>	400/day
Maximum Benefit Period: 30 days	
<b><u>Accidental-Death Benefits</u></b>	
<b>Accidental Death</b>	50,000
<b>Accidental Common-Carrier Death</b>	100,000

## **Section IX – 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 16 hours per week**.

## **Section X – Incorporation of Rider Provisions**

The attached listed Certificate Riders are made a part of this Policy.

<b><u>Rider Name</u></b>	<b><u>Form Number</u></b>
Dependent Accident Rider	CAI7853FL

**GROUP ACCIDENT<sup>+</sup> INSURANCE**  
Policy Series CA7800

**AC<sup>G</sup>**

**Florida**

HIGH OPTION - 24 HOUR PLAN	Semimonthly (24pp/yr)
Employee	\$9.59
Employee and Spouse	\$14.43
Employee and Dependent Children	\$16.79
Family	\$21.63

*Wellness Benefit included in Rates*

**Please Note:** Premiums and benefits shown are accurate as of publication. They are subject to change.



**We've got you  
under our wing.®**

aflacgroupinsurance.com | 1.800.433.3036

Underwritten by:  
Continental American Insurance Company  
2801 Devine Street | Columbia, South Carolina 29205

Published: Oct-15

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## CONTINENTAL AMERICAN INSURANCE COMPANY

Home Office: 2801 Devine Street, Columbia, South Carolina 29205  
(herein called Continental American)  
**800.433.3036**

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

### **DEPENDENT ACCIDENT RIDER TO CERTIFICATE OF INSURANCE FOR ACCIDENTAL INJURY**

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

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

Unless amended by this Rider, all Certificate definitions, exclusions, limitations, terms, and other provisions apply.

#### **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, which is shown in the Rider Schedule following this Rider.

#### **Definitions**

When the terms below are used in this Rider, the following definitions will apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

***Dependent*** means your Spouse or child (or children) who is:

- Named in the Application for this Rider, **and**
- For whom a premium is paid.

***Spouse*** is your legal wife or husband.

This Rider will be issued to your spouse only if he or she is at least age 18 and is not currently disabled or unable to work.

#### **Benefits**

If a Dependent is injured in a Covered Accident, we will provide the benefits contained in the Certificate under the Benefits Section. We will pay the appropriate benefit amounts shown in the Dependent Benefit Schedule issued with this Rider.

## **General Provisions**

We will still pay benefits for any accident that occurred while your dependent was covered under this Rider, if:

- Your Spouse's coverage is terminated because of annulment or divorce, **or**
- A Dependent Child's coverage is terminated because he reaches age 26.

## **Time Limit on Certain Defenses**

After this Rider has been in force for a two-year period, we will not contest the statements made in the Application.

## **Contract**

This Rider is part of the Certificate. It will terminate when the Certificate terminates, or when premiums are no longer paid for this Rider.

This Rider is subject to all of the terms of the Certificate to which it is attached unless any such terms are inconsistent with the terms of this Rider.

Signed for the Company at its Home Office,



**Paul S. Amos II, President**



**J. Matthew Loudermilk, Secretary**

## Dependent Benefit Schedule

	Plan I
<b><u>Specific Injuries Benefits</u></b>	
<b>Fracture</b>	
Hip/thigh	\$4,000
Vertebrae	3,600
Pelvis	3,200
Skull (depressed)	3,000
Skull (simple)	1,400
Leg	2,400
Foot/ankle/knee cap	2,000
Forearm/hand	2,000
Lower jaw	1,600
Shoulder blade/collar bone	1,600
Upper arm/upper jaw	1,400
Facial bones (except teeth)	1,200
Vertebral processes	800
Coccyx/rib/finger/toe	320
<b>Dislocation</b>	
Hip	3,000
Knee (not knee cap)	1,950
Shoulder	1,500
Foot/ankle	1,200
Hand	1,050
Lower jaw	900
Wrist	750
Elbow	600
Finger/toe	240
<b>Laceration</b>	
Over 6"	400
2" to 6"	200
Under 2"	50
Lacerations not requiring stitches	25
<b>Concussion</b>	200
<b>Coma</b>	10,000
<b>Emergency Dental Work</b>	
Repair with crown	150
Extraction	50
<b>Eye Injuries</b>	
Requiring surgical repair	250
Removal of foreign body	50

**Tendons/Ligaments**

Single	400
Multiple	600

**Ruptured Disc**

Injury occurs during first Certificate year	100
Injury occurs after first Certificate year	400

**Torn Knee Cartilage**

Injury occurs during first Certificate year	100
Injury occurs after first Certificate year	400

**Internal Injuries**

1000

**Exploratory Surgery** (without repair)

250

**Paralysis**

Four limbs (quadriplegia)	10,000
Two limbs (paraplegia)	5000

**Burns****Second Degree**

Less than 10%	100
At least 10% but less than 25%	200
At least 25% but less than 35%	500
35% or more	1000

**Third Degree**

Less than 10%	1000
At least 10% but less than 25%	5000
At least 25% but less than 35%	10,000
35% or more	20,000

**Specific Injuries Benefits****Dismemberment**

Loss of hand, foot or sight	Spouse	Dependent Child
Single loss	5,000	2,500
Double loss	10,000	5,000

Loss of one or more fingers or toes	500	250
Partial amputation of finger or toe	100	100

**Post-Traumatic Stress Disorder**

200

200

**Services Benefits****Blood/Plasma**

100

<b>Ambulance</b>	200		
<b>Air Ambulance</b>	1000		
<b>Transportation</b>			
Train or Plane	300		
Bus	150		
<b>Family Member Lodging</b>	100/per night		
Maximum Benefit: 30 days			
<b>Medical Fees</b>	<b>Spouse</b>	<b>Dependent Child</b>	
Maximum per accident	125	75	
<b>Prosthesis</b>	500		
<b>Appliances</b>	100		
<b>Accident Follow-Up Treatment</b>	30		
Maximum of 6 treatments per Covered Accident			
<b>Physical Therapy</b>	30		
Maximum of 6 treatments per Covered Accident			
<b>Wellness</b>	50		
Once per 12-month period			
<b>Major Diagnostic Exams</b>	200		
<b>Emergency Room Treatment</b>	200 /day		
Payable once per 24-hour period			
<b>Emergency Room Observation</b>	<b>Spouse</b>	<b>Dependent Child</b>	
	100	100	
<b>Rehabilitation Unit</b>	75		
Maximum Benefit Period: 30 days per hospital confinement			
Limited to 60-day, calendar-year maximum			
<b><u>Hospital Benefits</u></b>			
<b>Hospital Admission</b>	1,000		
Payable once per calendar year			
<b>Hospital Confinement</b>	200/day		
Maximum Benefit: 365 days			
<b>Hospital Intensive Care</b>	400/day		
Maximum Benefit: 30 days			

**Accidental Death Benefits**

	<b>Spouse</b>	<b>Dependent Child</b>
<b>Accidental Death</b>	25,000	5,000
<b>Accidental Common-Carrier Death</b>	50,000	15,000



## CONTINENTAL AMERICAN INSURANCE COMPANY

PO Box 427, Columbia, South Carolina 29202  
800.433.3036

### NOTICE OF NON-INSURED BENEFITS ENDORSEMENT

**This Endorsement is added to and part of the Certificate to which it is attached.**

From time to time, Continental American Insurance Company (CAIC) may offer or provide goods and/or services that are not related to insurance. These goods and services, which could be offered or provided to some people who apply for CAIC coverage or become insured by CAIC, may include (but are not limited to) the following:

- Enrollment services
- Educational services
- Benefit statement services
- Payroll or plan administration services

The services listed above will fall under the same benefit plan that includes or is related to the applicable CAIC coverage, individual wellness programs, and related services.

In addition, CAIC may arrange for third-party service providers (such as pharmacies, optometrists, dentists, and accountants) to provide discounted goods and services to people who apply for CAIC coverage or who become insured by CAIC.

Though CAIC has arranged these goods, services, and/or third-party provider discounts, the third-party providers—**not CAIC**—are liable to applicants/insureds for these goods and services. CAIC is not responsible for providing the goods and/or services, nor is CAIC liable to applicants/insureds for the negligent provision of these goods and/or services by third-party service providers.

Signed for the Company at its Home Office,

Paul S. Amos II, President

J. Matthew Loudermilk, Secretary

***For assistance or information about this notice, call 800.433.3036.***

## **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 (CAIC), and Continental American Life Insurance Company (collectively, “we,” “our,” or “Aflac”). This Notice describes how CAIC 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 CAIC 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 CAIC: 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 CAIC 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. Unless permitted by HIPAA, we are prohibited from using or disclosing your PHI that is genetic information for underwriting purposes.



**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 CAIC to share PHI with your spouse or others, you may exercise your right to request a restriction on CAIC'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, CAIC 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. 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 CAIC or a Business Associate of CAIC 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 CAIC. Access request forms are available from CAIC at the address below. We may charge you a fee for copying and postage.

**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 CAIC 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 CAIC 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 CAIC at the telephone number or address below.

**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 CAIC 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 CAIC at the telephone number or address below.

**Complaints** – If you believe your privacy rights have been violated, you can file a complaint with CAIC 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 CAIC's Privacy Office by writing to: CAIC, Attn: Privacy Office, P.O. Box 427, Columbia, SC 29202, or by calling 1-800-433-3036.

## **EFFECTIVE DATE**

This Notice is effective August 16, 2013.

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. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups situated in California, coverage is underwritten by Continental American Life Insurance Company. For groups situated in New York, coverage is underwritten by American Family Life Assurance Company of New York.

Continental American Insurance Company • 2801 Devine Street • Columbia, South Carolina 29205 1-800-433-3036 toll-free

## **PRIVACY PRACTICES**

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, Continental American Insurance Company (CAIC), and Continental American Life Insurance Company collectively, "Aflac"). Accordingly, we strive to comply with each of the following practices in everything we do:

- **We do not sell, rent, lease or otherwise disclose personal information of our customers for purposes unrelated to our products and services.** The personal information of our customers is of paramount importance to us. Therefore, we provide this information only to our employees, agents and third parties as required to allow them to help us develop and provide our insurance and employee benefit products and services.
- **We work to ensure information integrity and security.** We use technology tools and design our business practices to help ensure that the personal information of our customers is properly gathered, stored and processed. We also work to maintain the security of, and internal and external access to, the personal information of our customers through the use of technology and our business practices.
- **We expect our agents and employees to respect the personal information of our customers.** Aflac has business policies and practices in place to help ensure that our employees and agents carry out these practices and otherwise protect personal information about our customers. Both employees and agents are subject to censure, dismissal, or termination for violation of these policies.

These Privacy Practices apply to our U.S. customers. Due to legal and cultural differences, our practices may vary outside the United States.

## **PRIVACY NOTICE**

Aflac and our agents provide this notice to let you know about the current privacy practices of Aflac and our agents. **You do not need to do anything in response to this notice. This notice is merely to inform you about how we safeguard your information.**

### **Collection of 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 nonpublic personal information (which includes both nonpublic personal financial information and nonpublic personal health information) about Aflac's customers, including:

- Information from our customers (including names, addresses, financial and health information).
- Information about the customers' transactions with Aflac or our agents (including claims and payment information).
- Information from consumer reporting agencies (including creditworthiness and credit history); motor vehicle records agencies (including accident reports and violations); investigators (including information regarding general character and participation in hazardous activities); insurance support organizations such as the Medical Information Bureau, Inc. (including claims, and health and insurance application histories); and the customers' health care providers (including health history), employers (including salary and benefits information), and family members.

### **Disclosure of Information**

Aflac may disclose the nonpublic personal financial information we collect, as described above, as well as information about your transactions with us (such as your plan coverage, premiums, and payment history) to our agents or other third parties who perform services or functions on our behalf, including in some circumstances the marketing of Aflac products. We may also disclose the nonpublic personal financial information we collect to other third parties as authorized by you, or as required or permitted by law.

Our agents will make disclosures of our customers' nonpublic personal financial information only while acting on Aflac's behalf and, furthermore, will make such disclosures only as Aflac itself is permitted to make.

Neither Aflac nor our agents will use or share with other parties any nonpublic personal health information about Aflac customers for any purpose other than disclosures for the performance of insurance functions by Aflac or on our behalf, disclosures that are permitted or required by law, or disclosures that the customer has authorized.

Neither Aflac nor our agents will further disclose any nonpublic personal information about a former customer of Aflac other than as may be required or permitted by law.

### **Confidentiality and Security**

Aflac and our agents will safeguard, according to strict standards of security and confidentiality, any information we collect, receive or maintain about Aflac's customers. Aflac maintains administrative, technical, and physical safeguards to ensure the security and confidentiality of our customer information and records, to protect against anticipated threats or hazards to such records, and to protect against unauthorized access to or use of such information or records.

Internally, Aflac limits access to our customers' information to only those employees who need access to the information to perform their job functions. Employees who misuse information are subject to disciplinary actions. Externally, we do not disclose customer information to any third parties unless we have previously informed the customer of the disclosure, have been authorized to do so by the customer, or are required or permitted to make the disclosure by law or our regulators.

### **NOTICE OF INFORMATION PRACTICES**

Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, 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: Continental American Insurance Company, 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 Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), copies are available by sending a written request to: Continental American Insurance Company, ATTN: Privacy Office, P.O. Box 427, Columbia, SC 29202.

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