



Coverage underwritten by

# CONTINENTAL AMERICAN LIFE INSURANCE COMPANY

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

800.433.3036

Please call the toll-free number above with any questions about this coverage.

## **Certificate of Insurance For Group Supplemental Hospital Indemnity 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 IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.**

**This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law.**

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

**Your Employer** (the “Policyholder”) applied for coverage under this Group Supplemental Hospital Indemnity Insurance Policy (the “Plan”). This Plan is issued by Continental American Insurance Company (the “Company,” “CAIC,” “we,” “us,” or “our”). For the purposes of this Plan, “you” (including “your” and “yours”) means you. Based on the application process 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.)

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.

We certify that you are insured under the Group Supplemental Hospital Indemnity Policy (the “Plan”). The Plan was issued to the Policyholder. The Certificate is subject to the Definitions, Exclusions, and other provisions of the Plan.

Certain provisions of the Plan are summarized in this Certificate. All provisions of the Plan, whether contained in your Certificate or not, apply to the insurance referred to by the Certificate.

This Certificate, on its Effective Date, automatically replaces any Certificate or Certificates previously issued to you under the Plan.

*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.*

## **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>	-	General Provisions

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

### Eligibility

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

*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.
- **Employee and Spouse Coverage** – We insure the Employee and spouse (as defined in the applicable rider).
- **Employee and Children Coverage** – We insure the Employee and any dependent children (as defined in the applicable rider).
- **Family Coverage** – We insure the Employee, spouse, and any dependent children (as defined in the applicable rider).

We will not insure anyone specifically excluded from coverage by Endorsement to the Certificate or by application, even if that person would otherwise be eligible for coverage.

Details for adding Insureds to your coverage are outlined in the Effective Date section.

### Effective Date

Your Employee Effective Date is shown on the Certificate Schedule.

Your Employee Effective Date is the date your insurance takes effect. After we receive and approve the Application, that date is either:

- The date shown on the Certificate Schedule if you are Actively at Work on that date, or
- The date you return to an Actively-at-Work status if you were not Actively at Work on the date shown on the Certificate Schedule.

### **If Employee and Spouse, Employee and Children, or Family Coverage is offered:**

- A Dependent may be added to the Plan after the Employee's Effective Date within 31 days of a Life Event or during an approved enrollment period.
- If Dependent Child Rider coverage **is already in force**, no additional notice or premium is required to add another dependent child.
- If Dependent Spouse Rider or Dependent Child Rider coverage is **not** in force, the Employee must complete an Application to add a Dependent to the Plan. The Company will assign a Dependent Rider 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.
- If Dependent Child Rider 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. To extend coverage beyond 60 days with no gap in coverage, the Employee must contact the Company within the 60-day time period following the child's birth or adoption. No premium is due for the first 60 days of newborn/newly adopted coverage.

A day begins at 12:01 a.m. standard time at the Employee's place of residence.

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

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

All outstanding premiums are due upon Plan termination.

**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.

## **Termination of Your Insurance**

Your insurance will terminate on whichever occurs first:

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

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

## **Portability Privilege**

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

To keep your coverage in force, you must:

- Notify the Company within 31 days after the date your coverage would otherwise terminate. You may notify us by sending written notice to P.O. Box 427, Columbia, South Carolina, 29202 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly to the Company no later than 31 days after the date your coverage would otherwise terminate and on each premium due date thereafter.

Your ported coverage will end on the earliest of the following 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 Plan is terminated.

If you qualify for this Portability Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate as shown in your previously-issued Certificate. 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 31-day advance written notice of any change in premiums.

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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. 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** means your ability to perform your regular employment duties for a full normal workday. You may perform these activities either at your Employer's regular place of business or at a location where you are required to travel to perform the regular duties of your employment.

**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.

**Dependent** means your spouse or dependent children, as defined in the applicable rider, who have been accepted for coverage.

**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 you or any of your Family Members.

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

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

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

**Employee** is a person who meets Eligibility requirements 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 not meeting the definition of Hospital as defined in this Plan, including but not limited to:

- 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 not meeting the definition of Hospital Intensive Care Unit as defined in this Plan, including but not limited to 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 you to make changes to benefits at times other than your 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.

**Related** – a Related Accidental Injury or Sickness is one that is in correlation to, or occurs as a result of, the initial Accidental Injury or Sickness, and would not otherwise have been sustained if that initial condition had not occurred.

**Sickness** means an illness, infection, disease, or any other abnormal physical condition or pregnancy that is not caused solely by, or the result of, any injury. A **Covered Sickness** is one that is not excluded by name, specific description, or any other provision in this Plan. For a benefit to be payable, loss arising from the Covered Sickness must occur while the applicable Insured’s coverage is in force.

**Spouse** is your legal wife or husband who is listed on your Application. The term “Spouse” also includes a person who is in a legally recognized domestic partnership with you (as defined in California Family Code 297), a partner of a civil union, or similar relationship.

**Telemedicine Service** means a medical inquiry with a Doctor via audio or video communication that assists with a C80101CA

patient's assessment, diagnosis, and consultation.

**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.



## **SECTION IV – BENEFIT PROVISIONS**

### **Hospitalization Benefits**

#### **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 or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, 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 shown in the Benefit Schedule. We will only pay this benefit once for each Covered Accident or Covered Sickness per Calendar Year. If an Insured is confined to the Hospital because of the same or Related Accidental Injury or Sickness, we will not pay this benefit again in the same Calendar Year.

#### **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 or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, 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 resulting from Covered Sickness or from Covered Accidental Injuries received in the same Covered Accident.

If we pay benefits for confinement and the Insured becomes confined again within six months because of the same or a Related condition, 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, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

#### **Hospital Intensive Care Benefit**

If an Insured is confined in a Hospital Intensive Care Unit because of a Covered Accidental Injury or Covered Sickness, we will pay the daily benefit amount shown in the Benefit Schedule. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, 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, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

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 or a Related condition, 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 or Covered Sickness, we will pay the daily benefit amount shown on the Benefit Schedule. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, 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, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

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 or a Related condition, we will treat this confinement as the same period of confinement.

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

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**Mammography Benefit**

We will pay the amount shown in the Benefit Schedule for mammography tests performed while an Insured's coverage is in force. This benefit is payable as follows:

- A baseline mammogram for women ages 35 – 39, inclusive
- A mammogram for women ages 40 – 49, inclusive, every two years or more frequently based on the recommendation of the Insured's Doctor/Qualified Medical Professional.
- A mammogram every year for women ages 50 and over.

This benefit is limited to the maximum shown in the Benefit Schedule. We will pay this benefit regardless of the results of the test.

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## **SECTION V – EXCLUSIONS**

### **Exclusions**

We will not pay for loss due to:

- 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 or riot.
- Suicide – committing or attempting to commit suicide, while sane or insane.
- 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 voluntarily working at, or being engaged in, an illegal occupation or job.
- Sports – participating in any organized sport in a professional capacity.
- Custodial Care – this is non-medical care that helps individuals with the basic tasks of everyday life, the preparation of special diets, and the self-administration of medication which does not require the constant attention of medical personnel.
- Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including any resulting complications.
- Services performed by a Family Member.
- Services related to sterilization, in vitro fertilization, vasectomy or reversal of a vasectomy, or tubal ligation.
- Elective Abortion – an abortion for any reason other than to preserve the life of the person upon whom the abortion is performed.
- Dental Services or Treatment.
- Cosmetic surgery, except when due to:
  - Reconstructive surgery, when the service is related to or follows surgery resulting from a Covered Accidental Injury or a Covered Sickness; or when it is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease.
  - Reconstructive surgery, when the service is related to or follows mastectomy or lymph node dissection. This includes surgery to restore and achieve symmetry for the patient incidental to a mastectomy.

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## **SECTION VI - GENERAL PROVISIONS**

### **Entire Contract; Changes**

This policy, and the Application of the Policyholder, if any, constitute the entire contract between the parties, and any statement made by the Policyholder or by an Employee shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall avoid the insurance or reduce benefits under this policy or be used in defense to a claim hereunder unless it is contained in a written application, nor shall any such statement of the Policyholder, except a fraudulent misstatement, be used at all to void this policy after it has been in force for three years from the date of its issue, nor shall any such statement of any Employee eligible for coverage under the policy, except a fraudulent misstatement, be used at all in defense to a claim for loss incurred or disability commencing after the insurance coverage with respect to which claim is made has been in effect for three years from the date it became effective.

No change in this policy shall be valid unless approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or waive any of its provisions.

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

After three years from the date of issue of this policy, no misstatement of the Policyholder, except a fraudulent misstatement, made in his Application shall be used to void the policy; and after three years from the effective date of the coverage with respect to which any claim is made no misstatement of any Employee eligible for coverage under the policy, except a fraudulent misstatement, made in an application under the policy shall be used to deny a claim for loss incurred or disability commencing after expiration of such three years.

No claim for loss incurred or disability commencing after three years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made.

### **Grace Period**

A Grace Period of 31 days will be granted for the payment of premiums accruing after the first premium, during which Grace Period the policy shall continue in force, but the Policyholder shall be liable to the Company for the payment of the premium accruing for the period the policy continues in force.

### **Notice of Claim**

Written notice of claim must be given to us within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the Company at P.O. Box 427, Columbia, South Carolina, 29202, or to any authorized agent of the Company, with information sufficient to identify the insured Employee, shall be deemed notice to the Company.

### **Claims Forms**

The Company, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

### **Proofs of Loss**

Written proof of loss must be furnished to the Company, in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which the Company is liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Employee, later than one year from the time proof is otherwise required.

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

Indemnities payable under this policy for any loss other than loss for which this policy provides periodic payments will be paid to the insured Employee as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which this policy provides periodic payment will be paid to the insured Employee monthly and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

### **Payment of Claims**

We will pay all benefits to you 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 your beneficiary,
- To your surviving Spouse,
- To your estate.

### **Physical Examination and Autopsy**

The Company at its own expense shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

### **Legal Action**

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

### **Changing of Beneficiary**

The right to change of beneficiary is reserved to the insured Employee, and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary.

### **Misstatement of Age**

If the age of any individual covered under the policy has been misstated, the amount payable shall be such as the premium paid for the coverage of such individual would have purchased at the correct age.

### **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.

### **Claim Review**

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

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

### **Clerical Error**

Clerical error by the Policyholder will not end coverage or continue terminated coverage. In the event of such 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.

### **Successor Insured**

If you die while covered under this Certificate and your Spouse is also insured under this Plan at the time of your death, then your 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, your surviving Spouse must:

- Notify the Company in writing within 31 days after the date of your death; and
- Pay the required premium to the Company no later than 31 days after the date of your 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 your death.

### **California Department of Insurance Contact Information**

Please contact the California Department of Insurance if you have an issue that cannot be solved with Continental American Life Insurance Company.

**California Department of Insurance  
Consumer Communications Bureau  
300 South Spring Street, South Tower  
Los Angeles, CA 90013**

**Consumer Hotline  
1-800-927-Help (4357)  
or  
1-213-897-8921  
TDD Number  
1- 800-482-4TDD (4833)**



# CONTINENTAL AMERICAN LIFE INSURANCE COMPANY

P.O Box 427, Columbia, South Carolina 29205

800.433.3036

## 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 SECTION I – 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 SECTION I – 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 31 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 SECTION I – 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 SECTION I – 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 31 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,



Paul S. Amos II, President



J. Matthew Loudermilk, Secretary



Coverage underwritten by

# CONTINENTAL AMERICAN LIFE INSURANCE COMPANY

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

800.433.3036

Please call the toll-free number above with any questions about this coverage.

## **Dependent Children Benefit Rider To Certificate of Insurance for Group Supplemental Hospital Indemnity 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. Dependent Child coverage will become effective on the Effective Date of the Rider if the Dependent Child is Active on that date. Otherwise, the Effective Date will be deferred until the day following the date he becomes Active.

### **DEFINITIONS**

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

**Active** means a Dependent Child who is not confined in a Hospital and who is able to carry on regular activities customary of a person in good health of the same age and gender.

**Dependent Child or Dependent Children** means your or your Spouse's natural children, step-children (including existing children of new domestic partners), grandchildren who are in your legal custody and residing with you, foster children, children subject to legal guardianship, legally adopted children, or Children Placed for Adoption. Dependent Children must be younger than age 26.

**Children Placed for Adoption** are Children for whom you have entered a decree of adoption or for whom you have 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. You must continue to have custody pursuant to the decree of the court.

There is an exception to the age-26 limit above. This limit will not apply to any Dependent Child who is incapable of self-sustaining employment due to mental or physical handicap and is chiefly dependent on a parent for support and maintenance. You or your Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday.

Your natural Dependent Children born after the Effective Date of this Rider will be covered from the moment of live birth. No notice or additional premium is required.

## **BENEFITS**

If a Dependent Child qualifies for benefits under the Certificate to which this Rider is attached because of a Covered Accidental Injury or Covered Sickness, we will provide the benefits shown in the Certificate under the **Benefit Provisions** section.

## **GENERAL PROVISIONS**

If your Dependent Child's coverage terminates, we will provide benefits for valid claims that arose while his coverage was active.

### **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 Supplemental Hospital Indemnity Certificate. It will terminate:

- When the Certificate terminates,
- On the premium due date following the date the covered Child no longer qualifies as a Dependent,
- When the covered Dependent Child reaches age 26 (details in the **Definitions** section of this Rider),
- On the premium due date following the date we receive your written request to terminate coverage for your Child, or
- When premiums are no longer paid for this Rider.

Signed for the Company at its Home Office,



Paul S. Amos II, President



J. Matthew Loudermilk, Secretary



Coverage underwritten by

# CONTINENTAL AMERICAN LIFE INSURANCE COMPANY

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

800.433.3036

Please call the toll-free number above with any questions about this coverage.

## **Dependent Spouse Benefit Rider To Certificate of Insurance for Group Supplemental Hospital Indemnity 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. Dependent Spouse coverage will become effective on the Effective Date of the Rider if the Dependent Spouse is Active on that date. Otherwise, the Effective Date will be deferred until the day following the date he becomes Active.

### **DEFINITIONS**

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

*Active* means a Dependent Spouse who is not confined in a Hospital and who is able to carry on regular activities customary of a person in good health of the same age and gender.

*Dependent Spouse* is your legal wife or husband, as well as a person who is in a legally recognized domestic partnership with you (as defined in California Family Code 297), a partner of a civil union, or similar relationship, who is at least age 18 and is listed on your Application.

### **BENEFITS**

If a Dependent Spouse qualifies for benefits under the Certificate to which this Rider is attached because of a Covered Accidental Injury or Covered Sickness, we will provide the benefits shown in the Certificate under the **Benefit Provisions** section.

### **GENERAL PROVISIONS**

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

### **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 Supplemental Hospital Indemnity Certificate. It will terminate:

- When the Certificate terminates,
- On the premium due date following the date the covered Spouse no longer qualifies as a Dependent,
- On the premium due date following the date we receive your written request to terminate coverage for your Spouse, or
- When premiums are no longer paid for this Rider.

Signed for the Company at its Home Office,



Paul S. Amos II, President



J. Matthew Loudermilk, Secretary

## **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. 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).

**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. 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 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. 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 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.

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 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.

## **PRIVACY PRACTICES**

Protecting your privacy is very important to Aflac.<sup>1</sup> We try to follow each of these practices in everything we do.

- \* **We do not sell, rent, lease, or otherwise release your personal data for purposes not related to our products and services.**<sup>2</sup> Your data is very important to us. We provide this data only to our employees, agents, and certain third parties; we do this to allow them to help us develop and provide our products and services.
- \* **We work to keep your data correct and secure.** We design our business systems to properly gather, store, and process your data. We also work to secure your data and to control internal and external access to it.
- \* **We expect our agents and employees to respect your data.** Aflac policies and practices help make sure that our employees and agents protect your data. Our employees and agents who break these policies and practices are subject to disciplinary action.

## **PRIVACY NOTICE**

Aflac provides this notice to tell you about the current privacy practices of Aflac. **You do not need to do anything in response to this notice. This notice is merely to tell you how we safeguard your data.**

### **Collection of Data**

As part of our normal procedures, we need to collect data about you. We use this data to determine if you are eligible for our products and services, and to perform our insurance functions. We may collect data about you that includes:

- \* Data from you (including names, addresses, and financial and medical record data)
- \* Data about your transactions with Aflac or our agents (including claims and payment data)
- \* Data from:
  - \* Consumer reporting agencies (including credit ratings and credit history)
  - \* Motor vehicle records agencies (including accident reports and violations)
  - \* Investigators (including data about general character and participation in hazardous activities)
  - \* Insurance support organizations such as the Medical Information Bureau, Inc. (including claims, health, and insurance application histories)
  - \* Health care providers (including health history)
  - \* Employers (including salary and benefits data)
  - \* Family members

You have the right to access and correct the data collected about you; an exception is data related to a claim or to a legal proceeding.

### **Disclosure of Data**

Aflac may share the data we collect, as described before. We may also share data about your dealings with us (such as your coverage, premiums, and payment history) with our agents. We may also share it with other third parties who perform services or functions for us. These functions may include marketing our products. We may also show the data we collect to other third parties as you authorize or as allowed by law.

Aflac may collect data from businesses that provide insurance support services. We may also disclose data to these businesses. These businesses may retain this data and disclose it to others.

Aflac will not use or share with other parties any personal medical record data about you for any purpose except:

- \* For us (or others on our behalf) to perform insurance functions
- \* As the law permits or requires
- \* As you have authorized

<sup>1</sup>American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively "Aflac," "we," or "us")

<sup>2</sup>For this document Data is defined as "nonpublic personal information" and includes privileged information.

Aflac will not further share any data about former customers of Aflac other than as allowed by law.

**Confidentiality and Security**

Aflac limits access to your data to only those employees who need it to do their jobs. Our employees who misuse data are subject to disciplinary action. We do not share your data with any outside third parties unless we have informed you that we will share it, you have authorized us to share it, or if allowed by law.

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

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we issue a Notice of Privacy Practices – Protected Health Information. If you would like a copy, please send a written request to: Aflac, ATTN: Privacy Office, P.O. Box 427, Columbia, SC 29202.

Continental American Insurance Company (Aflac), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. Aflac 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 • P.O. Box 427 • Columbia, South Carolina 29202 1-800-433-3036 toll-free



Coverage underwritten by

# CONTINENTAL AMERICAN LIFE INSURANCE COMPANY

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

800.433.3036

Please call the toll-free number above with any questions about this coverage.

## **Dependent Spouse Benefit Rider To Certificate of Insurance for Group Supplemental Hospital Indemnity 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. Dependent Spouse coverage will become effective on the Effective Date of the Rider if the Dependent Spouse is Active on that date. Otherwise, the Effective Date will be deferred until the day following the date he becomes Active.

### **DEFINITIONS**

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

*Active* means a Dependent Spouse who is not confined in a Hospital and who is able to carry on regular activities customary of a person in good health of the same age and gender.

*Dependent Spouse* is your legal wife or husband, as well as a person who is in a legally recognized domestic partnership with you (as defined in California Family Code 297), a partner of a civil union, or similar relationship, who is at least age 18 and is listed on your Application.

### **BENEFITS**

If a Dependent Spouse qualifies for benefits under the Certificate to which this Rider is attached because of a Covered Accidental Injury or Covered Sickness, we will provide the benefits shown in the Certificate under the **Benefit Provisions** section.

### **GENERAL PROVISIONS**

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

### **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 Supplemental Hospital Indemnity Certificate. It will terminate:

- When the Certificate terminates,
- On the premium due date following the date the covered Spouse no longer qualifies as a Dependent,
- On the premium due date following the date we receive your written request to terminate coverage for your Spouse, or
- When premiums are no longer paid for this Rider.

Signed for the Company at its Home Office,



Paul S. Amos II, President



J. Matthew Loudermilk, Secretary



Coverage underwritten by

# CONTINENTAL AMERICAN LIFE INSURANCE COMPANY

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- We have accepted your Application, and
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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. Dependent Child coverage will become effective on the Effective Date of the Rider if the Dependent Child is Active on that date. Otherwise, the Effective Date will be deferred until the day following the date he becomes Active.

### **DEFINITIONS**

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

**Active** means a Dependent Child who is not confined in a Hospital and who is able to carry on regular activities customary of a person in good health of the same age and gender.

**Dependent Child or Dependent Children** means your or your Spouse's natural children, step-children (including existing children of new domestic partners), grandchildren who are in your legal custody and residing with you, foster children, children subject to legal guardianship, legally adopted children, or Children Placed for Adoption. Dependent Children must be younger than age 26.

**Children Placed for Adoption** are Children for whom you have entered a decree of adoption or for whom you have 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. You must continue to have custody pursuant to the decree of the court.

There is an exception to the age-26 limit above. This limit will not apply to any Dependent Child who is incapable of self-sustaining employment due to mental or physical handicap and is chiefly dependent on a parent for support and maintenance. You or your Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday.

Your natural Dependent Children born after the Effective Date of this Rider will be covered from the moment of live birth. No notice or additional premium is required.

## **BENEFITS**

If a Dependent Child qualifies for benefits under the Certificate to which this Rider is attached because of a Covered Accidental Injury or Covered Sickness, we will provide the benefits shown in the Certificate under the **Benefit Provisions** section.

## **GENERAL PROVISIONS**

If your Dependent Child's coverage terminates, we will provide benefits for valid claims that arose while his coverage was active.

### **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 Supplemental Hospital Indemnity Certificate. It will terminate:

- When the Certificate terminates,
- On the premium due date following the date the covered Child no longer qualifies as a Dependent,
- When the covered Dependent Child reaches age 26 (details in the **Definitions** section of this Rider),
- On the premium due date following the date we receive your written request to terminate coverage for your Child, or
- When premiums are no longer paid for this Rider.

Signed for the Company at its Home Office,



Paul S. Amos II, President



J. Matthew Loudermilk, Secretary