

**For the Employees of
MOHAWK INDUSTRIES, INC.**

Aflac Accidental Injury Plan Effective January 1, 2020



Coverage is underwritten by Continental American Insurance Company, a proud member of the Aflac family of insurers.



CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205
800.433.3036

CERTIFICATE OF INSURANCE FOR NON-PARTICIPATING GROUP ACCIDENTAL INJURY POLICY

**This is accident-only coverage.
It does not pay benefits for loss from sickness.**

**(Coverage for sickness may be included in a separate Rider,
requiring additional premiums.)**

Your Employer (“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. Your Application is maintained on a file and made part of this Certificate. (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.

Please read your certificate carefully.

We certify that you are insured under the Group Accidental Injury Policy (the “Plan”). The Plan was issued to your employer, the Policyholder. This coverage provides benefits for loss resulting from Accidental Injury. 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.

The Certificate Effective Date is shown in the Certificate Schedule. This Certificate will remain in effect for the period for which the premium has been paid. This Certificate may be continued for further periods as stated in the Plan.

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

Table of Contents

SECTION I	-	Eligibility, Effective Date, and Termination
SECTION II	-	Premium Provisions
SECTION III	-	Definitions
SECTION IV	-	Benefit Provisions
SECTION V	-	Exclusions
SECTION VI	-	Claim Provisions
SECTION VII	-	General Provisions
SECTION VIII	-	Benefit Schedule
SECTION IX	-	Certificate Schedule

Section I – Eligibility, Effective Date, and Termination

Eligibility

You are an eligible Employee under this Plan if you meet the following three requirements. You are:

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.

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

- Your Spouse or
- The Dependent Child of you or your Spouse. *Dependent Children* are your or your Spouse's natural children, step-children, legally adopted 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

Your Certificate Effective Date is the date your insurance takes effect. That date is either the date:

- Shown on the Certificate Schedule if you are Actively at Work on that date, or
- You return to an Actively-at-Work status if you are 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. To do this, the Company must give 60 days' written notice.
- The number of participating Employees is less than the number mutually agreed upon by the Company and the Policyholder in the signed master Application.

The Policyholder has the sole responsibility to notify you 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

Your insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date, if the premium has not been paid.
- The date you no longer meet the Plan's definition of an Employee.
- The date you no longer belong 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 you end employment with the Employer and your coverage would otherwise terminate, you may elect to continue your coverage under this Plan. You may continue the coverage that you had on the date your employment ended, including any in-force Spouse or Dependent Child coverage.

- To keep your Certificate in force, you must:
 - Apply to the Company in writing within 31 days after the date his insurance would otherwise terminate; **and**
 - Pay the required premium 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 you failed to pay any required premium
 - The date this Group Policy is terminated
- However, coverage may not be continued if:
 - You failed to pay any required premium, **or**
 - This Group Policy terminates.

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.

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 31 days before any change in rates becomes effective.

Premium Increase

The Company will notify the Policyholder and each employer group or subgroup insured under the Policy of the maximum amount of a group premium increase. This will be done no less than 60 days before the premium increase becomes effective.

Premium Payments

The first premium is 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 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 may be required to travel to perform the regular duties of your 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 your Spouse or your Dependent Child. **Dependent Children** are your or your Spouse's natural children, step-children, legally adopted 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 due to mental or physical handicap and is dependent on a parent for support. You or your Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Child's 26th birthday.

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 you or your 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
- daughter
- mother
- father
- sister
- brother

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

Full-time Work means that you spend at least 30 hours per week performing your 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.

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. 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.

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 you are regularly engaged at the time you become disabled.

Section IV – Benefit Provisions

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

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

Benefits are payable only for Injuries resulting from non-occupational Accidents that occur while this Policy and the Employee's Certificate are in force. Unless stated, covered expenses, event or loss must occur within 30 days after the accident and while the Employee's Certificate is in force.

Medical Expense Benefit

We will pay the actual expenses up to the amount shown in the Benefit Schedule if a Covered Accident causes the Insured to require treatment:

- by a Physician; or;
- in an Emergency Room.
- Have surgical repair within 90 days after the accident.

Payment will not exceed the amount shown in the Certificate for any one Accident. Treatment in an Emergency Room is subject to a \$50 Emergency Room deductible shown in the Certificate.

Ambulance Benefit (ground or air)

We will pay actual expenses up to the amount shown in the Benefit Schedule if, because of a Covered Accident, the Insured requires ground Ambulance transportation:

- to a hospital within a 100-mile radius; or
- from a hospital to the Insured's home.

We will pay actual expenses up to the amount shown in the Benefit Schedule if, because of a Covered Accident, the Insured requires air or ground Ambulance transportation on an emergency basis:

- in the opinion of the Insured's attending physician; and
- from a hospital to the Insured's home.

The total benefits payable for all ground and/or air Ambulance Services in connection with any one accident will not exceed the amount shown in the Certificate Schedule.

Hospital Indemnity Benefit (per day)

We will pay the Hospital Indemnity Benefit shown in the Benefit Schedule if, because of a Covered Accident an Insured requires hospital confinement and incurs a room charge.

If the Insured is discharged from the hospital and readmitted because of the same accident, We will pay additional benefits when the readmission:

- starts within 30 days of the accident; or
- starts within 7 days following the end of a prior hospitalization; and
- starts while the Employee's certificate is in force.

All confinements for any one accident are subject to the maximum period limitation of 30 days.

We will pay a Hospital Indemnity Benefit of one day if the hospitalization lasts 18 or more hours but less than 24 hours and there is no room and board charge.

Accidental Death, Dismemberment and Loss of Sight Benefit

We will pay the appropriate amount shown in the Benefit Schedule if, within 90 days of a covered accident and while the employee's certificate is in force, injuries cause an insured to suffer one or more of the losses shown in the Benefit Schedule.

We will provide the benefit for the larger or largest such loss if an accident results in two or more losses covered by this benefit.

Dismemberment and Loss of Sight 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.

Total Disability Premium Waiver Benefit (Employee Only)

We will waive Premiums due after Total Disability starts if a Covered Employee is Totally Disabled:

- Continuously for six months; and
- Starting while the Employee's Certificate is in force; and
- Starting prior to Attained Age 60; and
- As the result of Injuries suffered in a covered Accident.

We will waive Premiums:

- Due after Total Disability begins; and
- Using the mode of payment in effect when Total Disability started.

If Total Disability ends and then begins again:

- Within seven days; and
- Because of the same Accident;

We will reinstate waiver of Premiums from the date that Total Disability begins again. For any one Accident, We will waive Premiums for the Maximum Period shown in the Schedule. However, if the Employee is Totally Disabled as a result of a sprained, strained or lame back, or any intervertebral disk conditions, Premiums will not be waived.

Section V – Exclusions

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

- Any condition covered by a Workers' Compensation or occupational disease law; or
- Suicide, while sane or insane, or attempted suicide; or
- Intentionally self-inflicted Injury; or
any act of war whether or not declared; or participation in a riot, or insurrection; or
- Injury sustained while on full-time active duty (other than for two months or less training) in any military, naval or air force. When the Employee gives Us written notice, any unearned Premium will be refunded pro-rata for any period not covered by the Policy due to this exclusion; or
- Injury occurring prior to the Employee's Date of Certificate; or
- Voluntary inhalation of gas or fumes or asphyxiation therefrom; or
- Voluntary taking of poison; or
- Injury while engaged in an illegal occupation; or
- Aviation, except flight in a regularly scheduled passenger aircraft; or
- Being intoxicated in accordance with the laws of his or her state of residence; or
- Alcoholism; or
- Being under the influence of any narcotic, drug or sedative unless administered and used in accordance with the instructions of a Physician; or
- Participation in a felony; or
- Dental care or treatment unless caused by Injury to natural teeth; or
- All sicknesses including pregnancy, illness, mental illness or emotional disorders, bodily infirmity, rest cure, convalescent care or rehabilitation. Complications of pregnancy that are the result of accidental Injury are covered; or
- Injury while practicing for or participating in competitive rodeo; or
- Injury while sky diving, hang gliding, parachuting, or scuba diving; or
- Driving in any race or speed test or while testing an automobile or vehicle on any racetrack or speedway; or
- Hernia, carpal tunnel syndrome or any complication therefrom; or any bacterial infection (except pyogenic infections which shall occur with and through an accidental cut or wound).

If the Employee is Totally Disabled as a result of a sprained, strained or lame back, or any intervertebral disk conditions premiums will not be waived under the Total Disability Waiver of Premium Benefit.

Accidental death, dismemberment or loss of sight must:

- Result directly from accidental bodily Injury and independently of disease or bodily infirmity or any other cause; and
- Occur within 90 days from the date of such Injury and;
- Occur while the Policy and the Employee's Certificate are in force.

Section VI – Claim Provisions

Notice of Claim

You must give written notice of claim:

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

Notice must include your 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 you forms so that you can file Proof of Loss (details included in the **Proof of Loss** section below). If the Company does not provide the forms within 10 working days, you can meet Proof of Loss requirements by providing a written statement about the nature and extent of the loss. You will also need to provide a statement by the treating Doctor. You 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). You must provide Proof of Loss to the Company at:

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

You 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 you to provide this proof within the required time. You 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 your 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 after processing. We will process electronic claims within 15 working days and paper claims within 30 calendar days.

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:

1. To any approved assignee;
2. To your beneficiary;
3. To your surviving spouse;
4. To your estate.

Changing Your Beneficiary

You can ask us to change your 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 you sign 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

You cannot take legal action against us for benefits under this Plan:

- Within 60 days after you have sent us written Proof of Loss; **or**
- More than 3 years from the time written proof 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 your Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on your 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

Medical Expense Benefit	\$1,500 per accident
Ambulance Benefit (Ground or Air)	\$750 per accident
Hospital Indemnity Benefit (per day)	\$225
Accidental Death, Dismemberment, and Loss of Sight	\$15,000
Accidental Loss of Life	100%
Any combination of loss of two or more: Hands, feet, or sight of eyes	100%
Single loss of hand, foot or loss of sight	50%
Multiple loss of fingers and/or toes	10%
Single loss of a finger or toe	5%
Total Disability Premium Waiver benefit (Employee Only)	Yes

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.

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.

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. **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 • 2801 Devine Street • Columbia, South Carolina 29205 1-800-433-3036 toll-free