



INVITATION TO NEGOTIATE
002-18
EMPLOYEE BENEFITS INSURANCE PLANS

ATTACHMENT 17
GROUP HOSPITAL INDEMNITY POLICY



CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

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

Endorsement to Policy and Certificate of Insurance

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

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

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

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

Premium Payments should be mailed to the Company at:

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

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

Signed for the Company at its Home Office,

Paul S. Amos II, President

J. Matthew Loudermilk, Secretary



CONTINENTAL AMERICAN INSURANCE COMPANY

PO Box 427, Columbia, South Carolina 29202
800.433.3036

The telephone number listed above is to supply information about coverage and to provide assistance in resolving complaints.

CERTIFICATE OF INSURANCE FOR SUPPLEMENTAL HOSPITAL INDEMNITY POLICY

**THIS CERTIFICATE IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE
IT IS DESIGNED TO SUPPLEMENT A MAJOR MEDICAL PROGRAM.**

CERTIFICATE INDEX

Definitions.....	Section I
Premiums and Individual Terminations	Section II
Benefit Provisions.....	Section III
Limitations and Exclusions.....	Section IV
Claim Provisions	Section V
General Provisions	Section VI
Benefit Schedule	Section VII
Certificate Schedule.....	Section VIII

We certify that you are insured under the Supplemental Hospital Indemnity Policy (herein called the Plan) issued to your employer, the policyholder, subject to the definitions, exclusions and other provisions of the Plan against loss resulting from Hospital Confinement.

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 Effective Date of your certificate is as shown in the Certificate Schedule if you are on that date actively at work for the policyholder. If not, this certificate will become effective on the next date you are actively at work as an eligible Employee. 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 is issued in consideration of the payment in advance of the required premium and of your statements and representations in the application. A copy of your application is attached and made a part of this certificate.

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

Signed for the Company at its Home Office,

Paul S. Amos II, President

J. Matthew Loudermilk, Secretary

SECTION I DEFINITIONS

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

We, Us, Our - means Continental American.

You and Your - refer to the person named in the Certificate Schedule.

Covered Person - means you if this certificate is issued as Individual coverage.

If this certificate is issued as:

1. Employee/Spouse coverage Covered Person means you and your legal spouse.
2. Single Parent Family coverage Covered Person means you and your covered dependent children, as defined in the applicable rider that have been accepted for coverage.
3. Family coverage Covered Person means you and your spouse and covered dependent children, as defined in the applicable rider, that have been accepted for coverage.

Injury or Injuries - means accidental bodily injury or injuries caused solely by or as the result of a covered accident.

Covered Accident - means an accident, which occurs on or after a covered person's Effective Date, while this certificate is in force, and which is not specifically excluded.

Sickness - means an illness, infection, disease or any other abnormal condition, which is not caused solely by or the result of an injury.

Covered Sickness - means an illness, infection, disease or any other abnormal physical condition which is not caused solely by or the result of any injury which:

1. Occurs while this policy is in force; and
2. Is not excluded by name or specific description in this certificate.

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.

On-The-Job Benefits - means the benefits we will pay if a covered accident occurs while you are working at any job for pay or benefits. These benefits are shown in the Benefit Schedule under On-The-Job.

Off-The-Job Benefits - means the benefits we will pay if a covered accident occurs while you are not working at any job for pay or benefits. These benefits are shown in the Benefit Schedule under Off-The-Job.

Monthly Benefit - means a specified amount paid for a period of one month, with any periods of less than one month paid at the daily rate of 1/30th of the monthly amount.

Doctor or Physician - means a person, other than yourself, or a member of your immediate family, who:

1. Is licensed by the state to practice a healing art;
2. Performs services which are allowed by his or her license; and
3. Performs services for which benefits are provided by this certificate.

Immediate Family - means your spouse, son, daughter, mother, father, sister, or brother.

Hospital - means a place which:

1. Is legally licensed and operated as a hospital;
2. Provides overnight care of injured and sick people;
3. Is supervised by a doctor;
4. Has full-time nurses supervised by a registered nurse;
5. Has on-site or pre-arranged use of X-ray equipment, laboratory and surgical facilities; and
6. Maintains permanent medical history records.

A hospital is not:

1. A nursing home;
2. An extended care facility;
3. A convalescent home;
4. A rest home or a home for the aged;
5. A place for alcoholics or drug addicts; or
6. A mental institution.

Hospital Intensive Care Unit - means a place which:

1. Is a specifically designated area of the hospital called an intensive care unit that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
2. Is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement;
3. Is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
4. Is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a twenty four hour basis; and
5. Has a doctor assigned to the intensive care unit on a full-time basis.

A hospital intensive care unit is not any of the following step-down units:

1. A progressive care unit;
2. A sub-acute intensive care unit;
3. An intermediate care unit;
4. A private monitored room;
5. A surgical recovery room;
6. An observation unit; or
7. Any facility not meeting the definition of a hospital intensive care unit as defined in this policy.

Your Occupation - means the occupation in which you are regularly engaged at the time you become insured.

Actively at Work - to be considered actively at work, you must perform for a full normal workday the regular duties of your employment at the regular place of business of the group policyholder or at a location to which you may be required to travel to perform the regular duties of your employment.

Full-Time Work - means spending at least 16 hours per week performing your occupational duties.

Elimination Period - means the number of days of hospital confinement that must elapse before benefits become payable. The number of days is shown in the Benefit Schedule. Benefits are not payable, nor do they accrue, during an Elimination Period.

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

SECTION II

PREMIUMS AND INDIVIDUAL TERMINATIONS

PREMIUMS

The initial premium shown in the Certificate Schedule is the premium covering the period from the Effective Date to the next renewal date of this certificate. Renewal premiums will be in accordance with the schedule of premium rates in effect at the time of renewals as set forth in the Plan.

CERTIFICATE TERM

The first term of this certificate starts on the Effective Date in the Certificate Schedule. It ends on the first renewal date also shown. Later terms will be the periods for which renewal premiums are paid when due. All terms will begin and end at 12:01 A.M., Standard Time, at the policyholder's address. The renewal premium for each term will be due on the day preceding term end, subject to the grace period.

GRACE PERIOD

The Plan has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the next 31 days. During the grace period, coverage under the Plan will stay in force.

INDIVIDUAL TERMINATIONS

Your insurance will terminate on the earliest of:

1. The date the Plan is terminated;
2. On the 31st day after the premium due date if the required premium has not been paid;
3. On the date you cease to meet the definition of an Employee as defined in the Plan;
4. On the premium due date which falls on or first follows your 70th birthday; or
5. On the date you are no longer a member of an eligible class.

EXTENSION OF BENEFITS

Termination of any covered person's insurance under this certificate shall not prejudice his or her rights regarding any claim arising prior thereto. Benefits will be paid up to the applicable benefit maximum. If you have a covered accident or covered sickness, but do not have a claim/loss until after the Plan is terminated, benefits will be paid up to the applicable benefit maximum for that covered accident or sickness.

SECTION III

BENEFIT PROVISIONS

The benefit amounts payable are shown in the Benefit Schedule. Coverage terminates on the premium due date which falls on or first follows your 70th birthday; at that time all benefits cease regardless of the benefit maximum.

Hospital Confinement - We will pay this benefit in the amount shown in the Benefit Schedule, subject to the elimination period if any, when a covered person is confined to a hospital as a resident bed patient as the result of injuries received in a covered accident or because of a covered sickness. In order to receive this benefit for injuries received in a covered accident, the covered person must be confined to a hospital within 6 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 a covered person can collect benefits for hospital confinements resulting from covered sickness or from injuries received in the same covered accident. If a covered person is not confined to the hospital for a full month, we will pay benefits on a daily basis; daily benefits will be paid at the rate of 1/30th of the monthly amount.

This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accident, more than one covered sickness or a covered accident and a covered sickness.

Hospital Admission - We will pay this benefit when a covered person is admitted to a hospital and confined as a resident bed patient because of injuries received in a covered accident or because of a covered sickness. In order to receive this benefit for injuries received in a covered accident, a covered person must be admitted to a hospital within 6 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 for a period of confinement. We will only pay this benefit once for each covered accident or covered sickness. If a covered person is confined to the hospital because of the same or related injury or sickness, we will not pay this benefit again.

Hospital Intensive Care - If a covered person is confined in a hospital intensive care unit due to an injury received in a covered accident or because of a covered sickness, we will pay the daily benefit amount shown on the Benefit Schedule. In order to receive this benefit for a covered accident, a covered person must be admitted to a hospital intensive care unit within 6 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's intensive care unit at a time, even if it is caused by more than one covered accident, more than one covered sickness or a covered accident and a covered sickness.

If we pay benefits for confinement in a hospital's intensive care unit and a covered person become confined to a hospital's intensive care unit again within 6 months because of the same or related condition, we will treat this confinement as the same period of confinement.

Medical Fees- If a covered person is injured in a covered accident and receive treatment from a physician within one year after the accident, we will pay the amount shown in the Benefit Schedule for:

1. Emergency room services and supplies.
2. X-rays.
3. Appliances.
4. Physician services.

We will pay for these services the amount shown for medical fees in the Benefit Schedule, for each covered accident.

This benefit is payable if a covered person receives initial treatment within 60 days after the covered accident.

If a covered person receives treatment for a covered accident as stated above, at a facility where no charges are made (for example, a government or Veterans Administration Hospital), we will pay the amount shown in the Benefit Schedule for each day a covered person is treated in this facility for this benefit.

Hospital Emergency Room/Physician Benefit – If a covered person is injured in a covered accident or have treatment as the result of a covered sickness, we will pay the benefit as shown in the Benefit Schedule for Physician's charges, Laboratory fees, X-rays and Injections/Medications. This benefit is subject to the calendar year maximum shown in the Benefit Schedule.

Wellness Benefit - We will pay the amount shown on the Benefit Schedule page per calendar year when a covered person visits a doctor and the covered person is neither injured nor sick.

Accidental Death- If you are in a covered accident and the injury causes you to die within 90 days after the accident, we will pay the appropriate Accidental Death Benefit shown in the Benefit Schedule.

SECTION IV

LIMITATIONS AND EXCLUSIONS

Pregnancy will not be covered if conception was before the Effective Date of your Certificate. Pregnancy will be covered as any other sickness when date of conception is after your Effective Date of coverage.

EXCLUSIONS

We will not pay benefits for loss contributed to, caused by, or resulting from:

1. War – declared or undeclared or military conflicts, participation in an insurrection or riot, or civil commotion. This exclusion does not include acts of terrorism. We will return the prorated premium for any period not covered by this certificate when you are in such service.
2. Suicide - committing or attempting to commit suicide, while sane or insane.
3. Self-inflicted Injuries - injuring or attempting to injure yourself intentionally.
4. Traveling - traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, Bermuda, and Jamaica.
5. Racing - Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
6. Aviation - operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those which are not motor-driven.
7. Intoxication - being legally intoxicated, or being under the influence of any narcotic, unless such is taken under the direction of a physician.
8. Illegal activities or participation in an illegal occupation.
9. Sports - participating in any organized sport: professional or semi-professional.
10. Routine physical exams and rest cures.
11. Custodial care. This is care meant simply to help people who cannot take care of themselves.
12. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
13. Services performed by a relative.
14. Services related to sex change, sterilization, in vitro fertilization, reversal of a vasectomy or tubule ligation.
15. A service or a supply furnished by or on behalf of any government agency unless payment of the charge is required in the absence of insurance.
16. Elective abortion.
17. Treatment, services, or supplies received outside the United States and its possessions or Canada.
18. Injury or Sickness that was paid by Worker's Compensation.
19. Dental services or treatment.

20. Cosmetic surgery, except when due to medically necessary reconstructive plastic surgery.
21. Mental or emotional disorders without demonstrable organic disease.
22. Substance abuse.

SECTION V

CLAIM PROVISIONS

Notice of Claim - Written notice of claim must be given to us within 60 days after the covered accident or covered sickness, or as soon as reasonably possible. The notice must be sent to us at our Home Office in Columbia, South Carolina. The notice should include the name of the covered person and the certificate number.

Claim Forms - When we receive notice of a claim, we will send you the forms for filing proof of loss. If these forms are not sent to you within 15 days, you will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated on the Proof of Loss Section.

Proof of Loss - You must give us written proof within 90 days after the loss for which you are seeking benefits. If it is not reasonably possible to give written proof in the time required, we shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one year from the covered condition unless you were legally incapacitated during that time.

Time Of Payment Of Claims - After we receive written proof of loss, we will pay all benefits then due. Benefits for any other loss covered by this certificate will be paid as soon as we receive proper written proof.

Payment Of Claims - Benefits will be paid to you. All of the benefits due will be paid to you unless you assign them elsewhere. Any benefits unpaid at the time of your death will be paid in the following order:

1. To any approved assignee.
2. Your beneficiary.
3. Your surviving spouse.
4. 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, any premium due and unpaid may be deducted from the claim payment.

Physical Examination And Autopsy - At our expense, we can require a covered person to have a physical examination as often as reasonably necessary while a claim is pending, or an autopsy in the case of death, where allowed by law. This will be done at our expense.

Legal Action - You cannot take legal action against us for benefits under this certificate:

1. Within 60 days after you have sent us written proof of loss; or
2. More than the applicable statute of limitations after the time written proof is required to be given.

SECTION VI

GENERAL PROVISIONS

Entire Contract - The entire contract consists of:

1. The Plan;
2. The application of the policyholder; and
3. Your application(s).

All statements made in such application(s) shall, in the absence of fraud, be deemed representations and not warranties. No statement will be used in defense of a claim under this certificate unless:

- a. The statement is in writing signed by the policyholder or by you; and
- b. A copy of that statement is given to the policyholder or to you or to your beneficiary.

Addition of New Employees – Employees hired after the initial enrollment date can apply for coverage annually during open enrollment if the employee meets the following criteria:

- a. Has worked for the Policyholder for 90 continuous days.
- b. The employee is working at least 20 hours per week.

Contract Changes - No change in this certificate is valid unless approved by our Home Office and unless such approval is endorsed by an officer and attached to this certificate. No agent has the authority to change this certificate or to waive any of its provisions.

Misstatements of Age - If you incorrectly stated your age in the application, the benefits will be such as the premium paid would have purchased at the correct age. If, based on your correct age, we would not have issued your certificate, then our responsibility will be to refund the excess premium paid, if any.

Time Limit On Certain Defenses - We rely of the statements you made in the application when issuing this certificate. After this certificate has been in force for two years, we cannot cancel it or refuse to pay benefits because of any misstatements in the application unless you fraudulently made them.

Conformity With State Statutes - Any provision of this certificate which, on the Effective Date, is in conflict with the laws of the state in which it was issued, will be amended to conform to the minimum requirements of those laws.

SECTION VII**BENEFIT SCHEDULE****BENEFIT SCHEDULE*****Plan A**

HOSPITAL CONFINEMENT Maximum 30 days per confinement	\$450
HOSPITAL ADMISSION Payable once per admission	\$250
HOSPITAL INTENSIVE CARE Maximum 30 days per confinement	\$450
MEDICAL FEES Internal Limits: X-Rays Laboratory Physician Services	\$300
HOSPITAL EMERGENCY ROOM/ PHYSICIAN – per visit Maximum 6 visits per calendar year	\$50
WELLNESS BENEFIT	\$50
ACCIDENTAL DEATH	\$5,000

*Plan may include Accidental Death benefits under attached Policy.



CONTINENTAL AMERICAN INSURANCE COMPANY

PO Box 427, Columbia, South Carolina 29202
800.433.3036

The telephone number listed above is to supply information about coverage and to provide assistance in resolving complaints.

DEPENDENT CHILDREN BENEFIT RIDER TO CERTIFICATE OF INSURANCE FOR SUPPLEMENTAL HOSPITAL INDEMNITY COVERAGE

This rider is a part of the certificate to which it is attached. We have issued this rider to you because: (1) you paid the additional premium for this rider; and (2) we relied on the application you made. Unless amended by this rider, Certificate Definitions, other Provisions and terms apply to 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 becomes effective, this rider will have a later Effective Date, which will be shown in the Dependent Rider Schedule issued with this rider. The insurance of a dependent will become effective on the rider date if such person is active on that date. Otherwise, the Effective Date will be deferred until the day following the date he or she becomes active.

DEFINITIONS

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

YOU, YOUR Means the insured named in the Dependent Rider Schedule.

CHILD or CHILDREN Means your natural child(ren), step-children, legally adopted child(ren), foster child(ren), or child(ren) placed for adoption, who until the end of the calendar year in which the child reaches age 25 meets the following criteria:

1. Chiefly dependent on you for support;
2. Living with you; or
3. The child is a full-time or part-time student.

"Child or Children" also includes child(ren), regardless of age, who:

1. Are incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
2. Are chiefly dependent upon you or your spouse for support and maintenance.

If your children are covered under this Rider, your children born after the Effective Date of this Rider will also be covered from the moment of live birth. Adopted children shall be covered from the time of placement in your residence. If you enter into an adoption agreement before a child's birth, coverage shall begin for that child from the moment of birth regardless of the validity of the adoption agreement. Ultimate placement of the child with you is required. No notice or additional premium is required.

A child of a covered dependent, other than your spouse, will be covered for 18 months from birth, adoption, or placement.

DEPENDENT

Means your child or children covered under this rider.

ACTIVE

"Active" as used refers a dependent 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 sex.

TREATMENT

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

BENEFITS

If a dependent qualifies for benefits under the certificate to which this rider is attached because of a covered accident or a covered sickness, we will provide the benefits contained in the certificate under the Benefit Provisions. The appropriate benefit amounts payable for the dependent are shown in the Benefit Schedule issued with this rider.

ACCIDENTAL DEATH

If your insured dependent is in a covered accident and the injury causes that dependent to die within 90 days after the accident, we will pay the appropriate Accidental Death Benefit shown in the Benefit Schedule

ADDITIONAL BENEFIT

Well Baby Care -We will pay the amount shown on the Benefit Schedule page per visit. Pays for up to 4 visits per calendar year per insured baby. (Our definition of a baby is a dependent child 12 months of age or younger.)

LIMITATIONS AND EXCLUSIONS

Pregnancy will not be covered if conception was before the Effective Date of the Rider. Pregnancy will be covered as any other sickness when date of conception is after your Effective Date of coverage.

EXCLUSIONS

We will not pay benefits for loss contributed to, caused by, or resulting from:

1. War – declared or undeclared, or military conflicts, participation in an insurrection or riot, or civil commotion. This exclusion does not include acts of terrorism. We will return the prorated premium for any period not covered by this certificate when you are in such service.
2. Suicide - committing or attempting to commit suicide, while sane or insane.
3. Self-inflicted Injuries - injuring or attempting to injure yourself intentionally.
4. Traveling - traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, Bermuda, and Jamaica.
5. Racing - Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
6. Aviation - operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those which are not motor-driven.

7. Intoxication - being legally intoxicated, or being under the influence of any narcotic, unless such is taken under the direction of a physician.
8. Illegal activities or participation in an illegal occupation.
9. Sports - participating in any organized sport: professional or semi-professional.
10. Routine physical exams and rest cures.
11. Custodial care. This is care meant simply to help people who cannot take care of themselves.
12. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
13. Services performed by a relative.
14. Services related to sex change, sterilization, in vitro fertilization, reversal of a vasectomy or tubal ligation.
15. A service or a supply furnished by or on behalf of any government agency unless payment of the charge is required in the absence of insurance.
16. Elective abortion.
17. Treatment, services, or supplies received outside the United States and its possessions or Canada.
18. Injury or Sickness that was paid by Worker's Compensation.
19. Dental services or treatment.
20. Cosmetic surgery, except when due to medically necessary reconstructive plastic surgery.
21. Mental or emotional disorders without demonstrable organic disease.
22. Substance abuse.

GENERAL PROVISIONS

If your dependent child's coverage is terminated because of marriage or attainment of the limiting age, we will still pay benefits for any covered accident or sickness which occurred while the dependent was covered under this rider.

TIME LIMIT ON CERTAIN DEFENSES

After this rider has been in force for a period of two years it shall become incontestable as to the statements contained in the application.

CONTRACT

This rider is part of the certificate, and will terminate when the certificate terminates, or when premiums are no longer paid for this rider.

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

Signed by the Company at its Home Office,



Paul S. Amos II, President



J. Matthew Loudermilk, Secretary

DEPENDENT RIDER SCHEDULE

PLEASE SEE CERTIFICATE SCHEDULE.

WELL BABY CARE
Maximum 4 visits per baby
per calendar year

\$25 per visit



CONTINENTAL AMERICAN INSURANCE COMPANY

PO Box 427, Columbia, South Carolina 29202
800.433.3036

Child or Children Definition Rider

This rider is a part of the document to which it is attached. Unless amended by this rider Policy, Certificate and Dependent Rider Definitions, Exclusions and Limitations, other term and provisions apply to this rider.

The definition of Child or Children is deleted and replaced by the following:

Child or Children means your natural children, step-children, foster children, legally adopted children or children placed for adoption, who are under age 26 (or age 30 if applicable).

Coverage on a Child will terminate on the child's 26th birthday.

Coverage may continue under the following circumstances:

- Attainment of the limiting age does not terminate the coverage of the child while the child continues to be both incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the employee for support and maintenance. Proof of such incapacity and dependency must be furnished to the Company within thirty-one (31) days following such 26th birthday.
- Once a child reaches age 26, coverage may continue until the end of the calendar year in which the child reaches the age of 30, if the child:
 - Is unmarried and does not have a dependent of his or her own;
 - Is a resident of this state or a full-time or part-time student; and
 - Is not covered under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

Newborn children shall automatically be covered from the moment of birth. You must notify us of the birth of a child within 31 days of the birth in order to have the coverage extended beyond 31 days. Adopted children or foster children shall be covered from the time of placement in your residence. If you enter into an adoption agreement before a child's birth, coverage shall begin for that child from the moment of birth regardless of the validity of the adoption agreement. Ultimate placement of the child with you is required. You must notify us within 31 days in order to have the coverage extended beyond 31 days. A child of a covered dependent, other than your spouse, will be covered for 18 months from birth, adoption, or placement.

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

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

Signed by the Company at its Home Office,

Paul S. Amos II, President

J. Matthew Loudermilk, Secretary



Rate sheet prepared by Web User on 10/2/2012 2:22:56 PM.

Florida Payroll Premium rates are Semi-Monthly.

Aflac Group coverage is underwritten by Continental American Insurance Company (CAIC). 1-800-433-3036

The rates shown on this insert page are for illustration purposes only; they do not imply coverage.
For more information about policy/plan benefits and limitations, please refer to the accompanying product brochure for each insurance policy/plan listed below.

CAIC GROUP HOSPITAL INDEMNITY Plan A - Series 8500

	Premium
Employee	\$20.07
Employee & Spouse	\$39.13
Employee & Child	\$35.12
Family	\$54.18
