AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6688
(904) 992-1776
A STOCK COMPANY

GROUP CANCER AND SPECIFIED DISEASE INSURANCE POLICY
NON-PARTICIPATING

American Heritage Life Insurance Company (referred to as we, us, or our) will provide benefits under this policy. We make this promise subject to all of the provisions of this policy.

The policyholder should read this policy carefully and contact us promptly with any questions. This policy is delivered in and is governed by the laws of the governing jurisdiction and consists of:

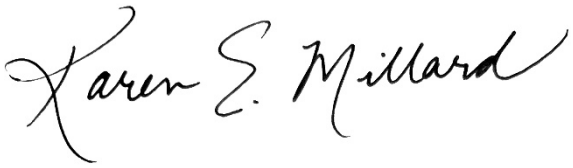
1. all policy provisions and any amendments and/or attachments issued; and
2. employees' signed enrollment forms, applications and evidences of insurability; and
3. the employer's signed application.

This policy may be changed in whole or in part. Only an executive officer of ours can approve a change. The approval must be in writing and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

NOTICE OF THIRTY (30) DAY RIGHT TO EXAMINE POLICY

You may, within 30 days after receipt of this policy, return it to us or to our agent. Upon such return of the policy, it will be void as of the effective date; any premium paid will be refunded.

Signed for American Heritage Life at its Home Office in Jacksonville, Florida on the Policy Effective Date.



SECRETARY



PRESIDENT

THIS IS LIMITED BENEFIT CANCER AND SPECIFIED DISEASE COVERAGE WHICH ONLY PROVIDES BENEFITS FOR CANCER AND SPECIFIED DISEASES AS DEFINED OR OTHER OPTIONAL BENEFITS DESCRIBED HEREIN

GVCP2VA

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CANCER AND SPECIFIED DISEASE PLAN
POLICY SPECIFICATIONS

POLICYHOLDER:	SUFFOLK PUBLIC SCHOOLS
POLICY NUMBER:	E1056
POLICY EFFECTIVE DATE:	July 1, 2025
POLICY ANNIVERSARY DATE:	July 1, 2026
GOVERNING JURISDICTION:	the state of Virginia and subject to the laws of that jurisdiction

ELIGIBLE CLASS(ES): All full-time active employees working at least 30 hours per week.

PLAN I - BENEFITS: See page 3A

ADDITIONAL BENEFITS: Cancer Screening: See Page 13C

INITIAL RATE: Monthly rate of $9.72 per employee for individual coverage or $16.16 per employee for family coverage.

PLAN II - BENEFITS: See page 3A

ADDITIONAL BENEFITS: Cancer Screening: See Page 13C
OPTIONAL BENEFIT(S): Intensive Care Unit: $200.00/day

INITIAL RATE: Monthly rate of $13.82 per employee for individual coverage or $423.36 per employee for family coverage.

PLAN III - BENEFITS: See page 3A

ADDITIONAL BENEFITS: Cancer Screening: See Page 13C
OPTIONAL BENEFIT(S): Cancer Initial Diagnosis: $1,000.00
Intensive Care Unit: $300.00/day

INITIAL RATE: Monthly rate of $22.78 per employee for individual coverage or $38.50 per employee for family coverage.

POLICY SPECIFICATIONS (CONTINUED)

RATE GUARANTEE DATE: 07/01/2027

PREMIUM DUE

Premium Due Dates: 07/01/2025 and the fifth day of each calendar month thereafter.

The policyholder must send all premiums on or before the premium due date to us. The premium must be paid in United States dollars.

Premium payments are required while the employee is receiving benefits except as provided in the Waiver of Premium benefit.

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES

These are the Policyholder's divisions, subsidiaries, or affiliates listed below. The policyholder may act for and on behalf of any and all of these in all matters that pertain to this plan. Every act done by, agreement made with, or notice given to the policyholder will be binding on them.

Name	Location (City And State)
None	

CANCER POLICY – GVCP2

SEE BENEFITS SECTION OF POLICY FOR DETAILS OF BENEFITS

	PLAN I - BENEFITS	AMOUNT
A.	CONTINUOUS HOSPITAL CONFINEMENT DAYS 1-70	 $100.00/DAY
B.	EXTENDED BENEFITS DAYS 70+	 UP TO $100.00/DAY
C.	GOVERNMENT/CHARITY HOSPITAL	$100.00/DAY
D.	PRIVATE DUTY NURSING SERVICES	UP TO $100.00/DAY
E.	EXTENDED CARE FACILITY	UP TO $100.00/DAY
F.	AT HOME NURSING	UP TO $100.00/DAY
G.	HOSPICE CARE 1. FREESTANDING HOSPICE CARE CENTER 2. HOSPICE CARE TEAM	 UP TO $100.00/DAY UP TO $100.00/VISIT
H.	RADIATION/CHEMOTHERAPY	UP TO $5,000.00/12 MONTHS
I.	BLOOD, PLASMA AND PLATELETS	UP TO $5,000.00/12 MONTHS
J.	SURGERY	UP TO $1,500.00 PER UNIT OF COVERAGE SEE SCHEDULE OF SURGICAL PROCEDURES 1 UNIT OF COVERAGE
K.	ANESTHESIA	UP TO 25% OF SURGERY BENEFIT
L.	BONE MARROW OR STEM CELL TRANSPLANT 1. AUTOLOGOUS TRANSPLANT 2. NON-AUTOLOGOUS TRANSPLANT 3. NON-AUTOLOGOUS TRANSPLANT FOR THE TREATMENT OF LEUKEMIA	 UP TO $500.00/12 MONTHS UP TO $1,250.00/12 MONTHS UP TO $2,500.00/12 MONTHS
M.	AMBULATORY SURGICAL CENTER	UP TO $250.00/DAY
N.	SECOND SURGICAL OPINION	UP TO $200.00
O.	INPATIENT DRUGS AND MEDICINE	UP TO $25.00/DAY
P.	PHYSICIAN'S ATTENDANCE	UP TO $50.00/DAY
Q.	AMBULANCE	UP TO $100.00/CONFINEMENT
R.	NON-LOCAL TRANSPORTATION	COACH FARE OR $0.40/MILE
S.	OUTPATIENT LODGING	UP TO $50.00/DAY UP TO $2,000.00/12 MONTHS
T.	FAMILY MEMBER LODGING AND TRANSPORTATION	UP TO $50.00/DAY COACH FARE OR $0.40/MILE
U.	PHYSICAL OR SPEECH THERAPY	UP TO $50.00/ DAY
V.	NEW OR EXPERIMENTAL TREATMENT	UP TO $5,000.00/12 MONTHS
W.	PROSTHESIS	UP TO $2,000.00/AMPUTATION
X.	COMFORT/ANTI-NAUSEA	UP TO $200.00/YEAR
Y.	WAIVER OF PREMIUM	AFTER 90 DAYS

CANCER POLICY – GVCP2

SEE BENEFITS SECTION OF POLICY FOR DETAILS OF BENEFITS

	PLAN II - BENEFITS	AMOUNT
A.	CONTINUOUS HOSPITAL CONFINEMENT DAYS 1-70	 $200.00/DAY
H.	EXTENDED BENEFITS DAYS 70+	 UP TO $200.00/DAY
I.	GOVERNMENT/CHARITY HOSPITAL	$200.00/DAY
J.	PRIVATE DUTY NURSING SERVICES	UP TO $200.00/DAY
K.	EXTENDED CARE FACILITY	UP TO $200.00/DAY
L.	AT HOME NURSING	UP TO $200.00/DAY
M.	HOSPICE CARE 3. FREESTANDING HOSPICE CARE CENTER 4. HOSPICE CARE TEAM	 UP TO $200.00/DAY UP TO $200.00/VISIT
K.	RADIATION/CHEMOTHERAPY	UP TO $5,000.00/12 MONTHS
L.	BLOOD, PLASMA AND PLATELETS	UP TO $5,000.00/12 MONTHS
M.	SURGERY	UP TO $1,500.00 PER UNIT OF COVERAGE SEE SCHEDULE OF SURGICAL PROCEDURES 2 UNITS OF COVERAGE
T.	ANESTHESIA	UP TO 25% OF SURGERY BENEFIT
U.	BONE MARROW OR STEM CELL TRANSPLANT 1. AUTOLOGOUS TRANSPLANT 2. NON-AUTOLOGOUS TRANSPLANT 3. NON-AUTOLOGOUS TRANSPLANT FOR THE TREATMENT OF LEUKEMIA	 UP TO $1,000.00/12 MONTHS UP TO $2,500.00/12 MONTHS UP TO $5,000.00/12 MONTHS
V.	AMBULATORY SURGICAL CENTER	UP TO $500.00/DAY
W.	SECOND SURGICAL OPINION	UP TO $400.00
X.	INPATIENT DRUGS AND MEDICINE	UP TO $25.00/DAY
Y.	PHYSICIAN'S ATTENDANCE	UP TO $50.00/DAY
Z.	AMBULANCE	UP TO $100.00/CONFINEMENT
AA.	NON-LOCAL TRANSPORTATION	COACH FARE OR $0.40/MILE
BB.	OUTPATIENT LODGING	UP TO $50.00/DAY UP TO $2,000.00/12 MONTHS
Y.	FAMILY MEMBER LODGING AND TRANSPORTATION	UP TO $50.00/DAY COACH FARE OR $0.40/MILE
Z.	PHYSICAL OR SPEECH THERAPY	UP TO $50.00/ DAY
AA.	NEW OR EXPERIMENTAL TREATMENT	UP TO $5,000.00/12 MONTHS
BB.	PROSTHESIS	UP TO $2,000.00/AMPUTATION
CC.	COMFORT/ANTI-NAUSEA	UP TO $200.00/YEAR
Y.	WAIVER OF PREMIUM	AFTER 90 DAYS

CANCER POLICY – GVCP2

SEE BENEFITS SECTION OF POLICY FOR DETAILS OF BENEFITS

	PLAN III - BENEFITS	AMOUNT
A.	CONTINUOUS HOSPITAL CONFINEMENT DAYS 1-70	 $300.00/DAY
N.	EXTENDED BENEFITS DAYS 70+	 UP TO $300.00/DAY
O.	GOVERNMENT/CHARITY HOSPITAL	$300.00/DAY
P.	PRIVATE DUTY NURSING SERVICES	UP TO $300.00/DAY
Q.	EXTENDED CARE FACILITY	UP TO $300.00/DAY
R.	AT HOME NURSING	UP TO $300.00/DAY
S.	HOSPICE CARE	
	5. FREESTANDING HOSPICE CARE CENTER	UP TO $300.00/DAY
	6. HOSPICE CARE TEAM	UP TO $300.00/VISIT
N.	RADIATION/CHEMOTHERAPY	UP TO $10,000.00/12 MONTHS
O.	BLOOD, PLASMA AND PLATELETS	UP TO $10,000.00/12 MONTHS
P.	SURGERY	UP TO $1,500.00 PER UNIT OF COVERAGE SEE SCHEDULE OF SURGICAL PROCEDURES 3 UNITS OF COVERAGE
CC.	ANESTHESIA	UP TO 25% OF SURGERY BENEFIT
DD.	BONE MARROW OR STEM CELL TRANSPLANT	
	1. AUTOLOGOUS TRANSPLANT	UP TO $1,500.00/12 MONTHS
	2. NON-AUTOLOGOUS TRANSPLANT	UP TO $3,750.00/12 MONTHS
	3. NON-AUTOLOGOUS TRANSPLANT FOR THE TREATMENT OF LEUKEMIA	UP TO $7,500.00/12 MONTHS
EE.	AMBULATORY SURGICAL CENTER	UP TO $750.00/DAY
FF.	SECOND SURGICAL OPINION	UP TO $600.00
GG.	INPATIENT DRUGS AND MEDICINE	UP TO $25.00/DAY
HH.	PHYSICIAN'S ATTENDANCE	UP TO $50.00/DAY
II.	AMBULANCE	UP TO $100.00/CONFINEMENT
JJ.	NON-LOCAL TRANSPORTATION	COACH FARE OR $0.40/MILE
KK.	OUTPATIENT LODGING	UP TO $50.00/DAY UP TO $2,000.00/12 MONTHS
DD.	FAMILY MEMBER LODGING AND TRANSPORTATION	UP TO $50.00/DAY COACH FARE OR $0.40/MILE
EE.	PHYSICAL OR SPEECH THERAPY	UP TO $50.00/ DAY
FF.	NEW OR EXPERIMENTAL TREATMENT	UP TO $5,000.00/12 MONTHS
GG.	PROSTHESIS	UP TO $2,000.00/AMPUTATION
HH.	COMFORT/ANTI-NAUSEA	UP TO $200.00/YEAR
Y.	WAIVER OF PREMIUM	AFTER 90 DAYS

POLICYHOLDER PROVISIONS

RATE GUARANTEE
A change in premium rate will not take effect before the rate guarantee date shown on page 3. However, we may change premium rates at any time for reasons which affect the risk assumed, including those reasons shown below:

1. a change occurs in this plan design; or
2. a division, subsidiary, or affiliated company is added or deleted; or
3. the number of insureds changes by 25% or more; or
4. a new law or a change in any existing law is enacted which applies to this plan; or
5. less than 25% of those eligible for coverage are participating.

We will notify the policyholder in writing at least 30 days before a premium rate is changed. A change may take effect on an earlier date when both we and the policyholder agree in writing. Rates are guaranteed for 12 months after a premium revision.

PREMIUM INCREASES OR DECREASES
Premium increases or decreases which take effect during a policy month are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

INFORMATION REQUIRED FROM THE POLICYHOLDER
The policyholder must provide us with the following on a regular basis:

1. information about employees:
   a. who are eligible to become insured; and
   b. whose coverage changes; and
   c. whose coverage ends; and
2. any information that may be required to manage a claim; and
3. any other information that may be reasonably required.

Policyholder records that have a bearing, in our opinion, on this policy will be available for review by us at any reasonable time.

CANCELING POLICY
This policy can be canceled:

1. by us; or
2. by the policyholder.

We may cancel or offer to modify this policy, with at least 31 days written notice to the policyholder, if:

1. less than 25% of those eligible for coverage are participating; or
2. this policy has been in effect more than 12 months; or
3. the policyholder does not promptly provide us with information that is reasonably required; or
4. the policyholder fails to perform any of its obligations that relate to this policy; or
5. fewer than 5 employees are insured.

If the premium is not paid during the grace period, the policy will terminate automatically at the end of the grace period. The policyholder is liable for the premium for coverage during the grace period. The policyholder must pay us all premiums due for the full period each plan is in force.

The policyholder may cancel this policy by written notice delivered to us at least 31 days prior to the cancellation date. When both the policyholder and we agree, this policy or a plan can be canceled on an earlier date. If we or the policyholder cancels this policy, coverage will end at 12:00 midnight on the last day of coverage.

Cancellation of coverage by us is without prejudice to any continuous loss that commences while this policy was in force.

In the event coverage is terminated due to nonpayment of premium by the policyholder, no such coverage shall be terminated by us with respect to a covered individual unless and until the policyholder has been provided with a written or printed notice of termination, including a specific date, not less than fifteen days from the date of such notice, by which coverage will terminate if overdue premium is not paid. Coverage shall not be permitted to terminate for at least fifteen days after such notice has been mailed. We shall make reimbursement on all valid claims for services incurred prior to the date coverage is terminated.

GENERAL PROVISIONS

COST OF COVERAGE

The employee pays the cost of coverage.

CLASS(ES) OF EMPLOYEES/ELIGIBILITY FOR COVERAGE

The class(es) of employees eligible for coverage are shown on page 3.

ELIGIBILITY OF FAMILY MEMBERS

Family members eligible to be covered persons are:

1. the employee; and
2. the employee's spouse on the employee's effective date; and
3. unmarried children of the employee or the employee's spouse, including adopted children, children during pendency of adoption procedures and stepchildren, who are under 22 years old, or under 26 years old and full-time students at an educational institution of higher learning beyond high school.

A child born to the employee or covered spouse, while this policy is in force as a family policy, will be a covered person. This coverage begins at the moment of birth of such child for benefits otherwise payable to a covered person under this policy. Any person who becomes a family member after the effective date (except newborns) must be added by endorsement. No additional premium will be required for newborns or family members added by endorsement if this policy is in force as a family policy.

Under individual coverage, newborn children are automatically covered from the moment of birth for a period of 31 days. If the employee desires uninterrupted coverage for the newborn child (children), the employee must notify us within 31 days of the child's birth. Upon notification, we will convert the employee's coverage to family coverage and provide notification of the additional premium due. If the employee does not notify us within 31 days of the birth of the child, the temporary automatic coverage ends. If the employee has individual coverage and the employee marries and desires coverage for his or her spouse, the employee must notify us of the marriage within 31 days of the marriage and we will convert the coverage to family coverage and provide notification of the additional premium due.

The provisions of this section also apply to adopted children and children during pendency of adoption proceedings as follows:

1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by the employee has been entered within 31 days after the date of birth.
2. If adoption proceedings have been instituted by the employee within 31 days after the date of birth and the employee has temporary custody, coverage must be provided from the moment of birth.
3. For children other than newborns, if adoption proceedings have been completed, and a decree of adoption was entered within 1 year from the institution of the proceedings, coverage will begin upon temporary custody for 1 year, unless extended by the order of the court by reasons of the special needs of the child.

Coverage must be provided as long as the employee has custody of the child pursuant to decree of the court and required premiums are paid.

ELIGIBILITY DATE

If the employee is working for the employer in an eligible class, the date such employee is eligible for coverage is the later of:

1. the policy effective date; or
2. the date such employee becomes a member of the eligible class.

WHEN AN ELIGIBLE EMPLOYEE CAN ENROLL OR DISCONTINUE COVERAGE

1. The employee may apply for coverage during:
   a. his or her initial enrollment period; or
   b. at any other time, subject to evidence of insurability.
2. The employee may discontinue coverage at any time.

GENERAL PROVISIONS (CONT)

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability is required if the employee:

1. voluntarily canceled coverage and is reapplying; or
2. is applying for the coverage at any time after his or her initial enrollment period.

EFFECTIVE DATE OF COVERAGE

Coverage for each eligible employee is effective on the effective date shown on each certificate of insurance.

For any change in an employee's coverage that is subject to evidence of insurability, the change in coverage is effective on the date we approve such change in coverage.

For any change in coverage that is not subject to evidence of insurability, the change in coverage is effective on the date we receive such request for change in coverage.

CERTIFICATE OF COVERAGE

We will issue certificates of coverage to the policyholder for delivery to each employee. The certificate will provide a description of the coverage provided by this policy and will state:

1. the benefits provided under the group policy; and
2. to whom benefits are payable; and
3. the limitations, exclusions and requirements that apply to coverage under the policy.

If there is any discrepancy between the provisions of any certificate and the provisions of this policy, the provisions of this policy govern.

ABSENT FROM WORK ON THE DATE COVERAGE WOULD NORMALLY BEGIN

If the employee is absent from work due to injury, sickness, temporary layoff or leave of absence, coverage for that employee begins on the date he or she returns to active employment. This applies to an employee's initial coverage, as well as any increase or addition to coverage that occurs after such employee's initial coverage is effective.

TERMINATION OF COVERAGE

The employee's coverage under the policy ends on the earliest of:

1. the date the policy is canceled; or
2. the last day of the period for which such employee made any required contributions; or
3. the last day such employee is in active employment; or
4. the date such employee is no longer in an eligible class; or
5. the date such employee's class is no longer eligible.

We will provide coverage for a payable claim that occurs while the employee is covered under the policy.

If the employee's spouse is a covered person, the spouse's coverage ends upon valid decree of divorce or death of the covered employee.

If the employee's child is a covered person, the child's coverage ends on the policy anniversary next following the date the child is no longer eligible. This is the earlier of: (a) when the child marries; or (b) reaches age 22 (26 if a full-time student attending an educational institution of higher learning beyond high school). Coverage does not terminate on an unmarried child who:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under this policy; and
3. is chiefly dependent upon the employee for support and maintenance.

Dependent coverage continues as long as this policy remains in force and the dependent remains in such condition. Proof of the incapacity and dependency of the child must be furnished within 60 days of the child's attainment of the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility.

If we accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, then coverage continues during the period for which such premium was accepted. This does not apply where such acceptance was based on a misstatement of age.

AGENCY

For purposes of the policy, the policyholder acts on its own behalf or as the employee's agent. Under no circumstances will the policyholder be deemed our agent.

GENERAL PROVISIONS (CONT)

CONVERSION PRIVILEGE

If the coverage of a covered employee terminates for reasons other than non-payment of premium, or if coverage of a spouse covered under this policy terminates due to divorce or death of the covered employee, or if coverage of a covered child terminates due to the child becoming married or reaching age 22 (26 if a full-time student), such covered person can obtain a policy of insurance (called the converted policy), without evidence of insurability. Obtaining that policy is subject to the following conditions:

1. Application for the converted policy must be made to us within 31 days (within 60 days of final divorce decree in case of divorce) after the coverage terminates. The effective date of the converted policy will be the date on which coverage under this policy terminates.
2. The converted policy premium is at the rate for the class of risk at the applicant's age for insurance provided as of the date of the conversion.
3. Any conditions excluded in this policy are excluded in the converted policy. No other pre-existing conditions are excluded. The Pre-Existing Condition Limitation and Contestability provisions are waived to the extent that such periods have been met under this policy. Benefits payable to the applicant under the converted policy are reduced by benefits payable under this policy.
4. The converted policy will be a similar policy or a policy providing lesser benefits at the applicant's option.

When conversion is due to divorce, other dependents covered under this policy may be covered under such new policy or under this policy as the employee and his former spouse may elect. They may not be covered under both policies.

If either this policy or a new policy is in force on the employee or his former spouse, and either of them re-marry, such new spouse may be covered under the appropriate policy. We must be advised of the re-marriage by the completion of a new application for such new spouse. This new application is subject to our approval. The employee or his former spouse must pay the premiums appropriate to such new policy in order to have it issued and maintained in force.

GRACE PERIOD

The policyholder is entitled to a grace period of 31 days for the payment of any premium due except for the first premium. The policy continues in force during the grace period, unless the policyholder gives us written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of this policy. The policyholder is liable to us for the payment of any pro rata premium for the time the policy is in force during a grace period.

ENTIRE CONTRACT

The contract consists of the following items:

1. the group policy; and
2. any amendments and endorsements; and
3. the applications and other written statements of the policyholder; and
4. the individual applications, enrollment forms, and evidences of insurability of the covered persons.

A copy of any application of the policyholder shall be attached at issue. Any statements made by the policyholder or by a covered person are representations and not warranties. No written statement made by any person insured shall be used in any contest unless a copy of the statement is furnished to the person or to his beneficiary or personal representative. A copy of any written statement, if applicable, will be furnished to the policyholder or the covered person or his beneficiary, if any, if a claim is denied based upon such a statement.

CONTESTABILITY

After 2 years from the effective date of this policy, no misstatement of the policyholder, made in any applications, can be used to void the policy. After 2 years from the effective date of any covered person’s coverage no misstatement of a covered person, made in writing, can be used to void coverage or deny a claim for loss incurred.

CLERICAL ERROR

Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums. Complete proof must be supplied by the policyholder documenting any clerical errors.

LEGAL ACTION

No legal action may be brought to obtain benefits under the policy:

1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 3 years from the time written proof of loss is required to have been furnished.

LIMITATIONS / EXCEPTIONS

A. PRE-EXISTING CONDITION LIMITATION

We do not pay for any loss due to a pre-existing condition as defined during the 12 month period beginning on the date that person became a covered person.

B. OTHER LIMITATIONS AND EXCEPTIONS

We do not pay for any loss except for losses due directly from cancer or a specified disease and any other conditions or diseases caused or aggravated by cancer or a specified disease. Diagnosis must be submitted to support each claim.

(This space intentionally left blank.)

BENEFITS INFORMATION

PAYMENT OF BENEFITS

If cancer or a specified disease is diagnosed on or after the covered person's effective date, we pay according to the benefits provisions in this policy, subject to the Limitations/Exceptions provision and all other provisions contained in this policy.

If cancer or a specified disease is diagnosed while the covered person is hospital confined, benefits begin retroactively to the day of admission or 10 days prior to the date of diagnosis if this is more favorable.

If positive diagnosis is made for cancer or a specified disease within 12 months after a tentative diagnosis, benefits are paid from the date of tentative diagnosis if the tentative diagnosis is made on or after the effective date, subject to the Pre-existing Condition Limitation provision.

If a covered person dies while an inpatient in a hospital and cancer or a specified disease is not diagnosed until after the covered person's death, benefits will begin retroactively to the day of admission, up to a maximum of 30 days prior to death.

SCHEDULE OF BENEFITS

We pay the following benefits for the necessary treatment of cancer or a specified disease, and for any other condition directly caused or aggravated by the cancer or specified disease. Treatment must be received in the United States or its territories.

For those benefits for which we pay actual charges up to a specified maximum amount, except benefits H., I., L., V. and W., if specific charges are not obtainable as proof of loss, we will pay 50% of the applicable maximum for the benefits payable.

No benefits are payable for the treatment of cancer or a specified disease except those expressly stated in this Schedule of Benefits.

A. Continuous Hospital Confinement. If a covered person is admitted to and confined as an inpatient in a hospital for the treatment of cancer or specified disease, we pay the amount shown on page 3A per day for each day. The maximum number of days payable is 70 days for each period of continuous hospital confinement.

B. Extended Benefits. If a covered person is confined in a hospital for the treatment of cancer or a specified disease for more than 70 days of continuous hospital confinement, we pay actual charges up to the amount shown on page 3A per day for: hospital room and board; medicine; laboratory tests; and other hospital charges. This benefit begins on the 71st day of continuous hospital confinement. This benefit is payable in lieu of all other benefits payable during the continuous hospital confinement beginning on the 71st day under the Schedule of Benefits (except the Waiver of Premium Benefit). This benefit continues as long as the covered person is continuously hospital confined.

C. Government or Charity Hospital. In lieu of all other benefits in this policy (except the Waiver of Premium Benefit), we pay the amount shown on page 3A per day for each day a covered person is confined to: 1.) a hospital operated by or for the U.S. Government (including the Veteran's Administration); or 2.) a hospital that does not charge for the services it provides (charity). The confinement must be for the treatment of cancer or specified disease.

D. Private Duty Nursing Services. While a covered person is an inpatient receiving cancer or specified disease treatment, we pay the actual charges, up to the amount shown on page 3A per day if such covered person requires the full-time services of a private nurse. Full-time means at least 8 hours of attendance during a 24 hour period. These services must be required and authorized by a physician for cancer or specified disease treatment and must be provided by a nurse.

E. Extended Care Facility. We pay actual charges up to the amount shown on page 3A per day for each day a covered person is confined in an extended care facility for the treatment of cancer or specified disease. Confinement in the extended care facility must be at the direction of the attending physician and must begin within 14 days after a covered hospital confinement. This benefit is limited to the number of days of the previous continuous hospital confinement.

F. At Home Nursing. While a covered person is receiving treatment for cancer or specified disease, we pay actual charges up to the amount shown on page 3A per day for private nursing care and attendance by a nurse at home. At home nursing services must be required and authorized by the attending physician and must begin within 14 days after a covered confinement as an inpatient in a hospital. This benefit is limited to the number of days of the previous continuous hospital confinement.

G. Hospice Care. When a covered person is:
1. diagnosed with cancer or a specified disease; and
2. determined by a physician to be terminally ill as a result of cancer or a specified disease; and
3. expected to live 6 months or less;

we pay one of the following two benefits for hospice care:

(1) ***Freestanding Hospice Care Center***. We pay actual charges up to the amount shown on page 3A per day for confinement in a licensed freestanding hospice care center. The covered person must be diagnosed by a physician as terminally ill and the attending physician must approve the confinement. This benefit is payable only if a covered person is admitted to a freestanding hospice care center within 14 days after a period of inpatient hospital confinement. Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or

(2) ***Hospice Care Team***. We pay actual charges up to the amount shown on page 3A per visit, limited to 1 visit per day, for home care services by a hospice care team. Home care services are hospice services provided in the patient's home. This benefit is payable only if: the covered person has been diagnosed as terminally ill; and the attending physician has approved such services; and home care services begin within 14 days after a period of hospital confinement. We do not pay for: food services or meals other than dietary counseling; or services related to well-baby care; or services provided by volunteers; or support for the family after the death of the covered person.

H. Radiation/Chemotherapy. We pay actual charges, up to the limit stated below for radiation therapy and chemotherapy received by a covered person as part of treatment for cancer or a specified disease.

This benefit is limited to the amount shown on page 3A per 12 month period beginning with the first day of benefit under this provision. Administration of radiation therapy or chemotherapy other than by medical personnel in a physician's office or hospital, including medications dispensed by a pump, will be limited to the costs of the drugs only, subject to the maximum amount payable per 12 month period explained above.

We only pay this benefit for cancer or specified disease treatment consisting of:
1. cancericidal chemical substances for the purpose of modification or destruction of cancer or a specified disease; and
2. X-ray radiation; and
3. radium and cesium implants; and
4. cobalt.

This benefit does not pay for: treatment planning; or treatment consultation; or treatment management; or the design and construction of treatment devices; or basic radiation dosimetry calculation; or any type of laboratory tests; or X-ray or other imaging used for diagnosis or disease monitoring; or the diagnostic tests related to these treatments. This benefit also does not pay for any devices or supplies including intravenous solutions and needles related to these treatments.

I. Blood, Plasma and Platelets. We pay actual charges, up to the limit stated below, for:
1. blood, plasma and platelets (including transfusions and administration charges); and
2. processing and procurement costs; and
3. cross-matching;

received by a covered person in conjunction with cancer or specified disease treatment. This benefit is limited to the amount shown on page 3A per 12 month period beginning with the first day of benefit under this provision. We do not pay for blood replaced by donors.

BENEFITS INFORMATION (CONT)

J. Surgery. When surgery is performed on a covered person:
1. for the purpose of treating a diagnosed cancer or specified disease; or
2. for the purpose of diagnosing cancer or specified disease and that surgery results in a diagnosis of cancer or specified disease; or
3. that is the first surgery performed subsequent to a diagnosis of cancer or specified disease that is performed for the purpose of verifying the complete removal of the cancer or specified disease.

We pay the actual charges, up to the amount listed in the Schedule of Surgical Procedures for the specific procedure per unit of coverage shown on page 3A. If any surgical procedure for the treatment or diagnosis of a cancer or specified disease other than those listed in the Schedule of Surgical Procedures is performed, we pay the actual charges, up to the unit value for the surgical procedure as set forth in the 1964 California Relative Value Schedule (C.R.V.S.) multiplied by $10.00 per unit of coverage. If the surgical procedure has no unit value or is not shown in the 1964 C.R.V.S., we pay the actual charges, up to an amount we reasonably determine to be consistent (based upon relative difficulty) with the Schedule of Surgical Procedures per unit of coverage. Two or more procedures performed at the same time through one incision or entry point are considered one operation; we pay the amount for the procedure with the greatest benefit. Payment will never exceed the maximum per unit of coverage. Surgery performed on an outpatient basis is paid at 150% of the scheduled benefit. This benefit does not pay for surgeries covered by other benefits in this Schedule of Benefits.

K. Anesthesia. We pay actual charges of an anesthetist not to exceed 25% of the amount paid for the Surgery Benefit (benefit J.) for anesthesia received.

L. Bone Marrow or Stem Cell Transplant. We pay the amounts shown on page 3A for the following types of bone marrow or stem cell transplants performed on a covered person for cancer or specified disease treatment:
1. A transplant which is other than non-autologous.
2. A transplant which is non-autologous for the treatment of cancer or specified disease other than Leukemia.
3. A transplant which is non-autologous for the treatment of Leukemia.

This benefit is payable only once per covered person per calendar year.

A non-autologous transplant is an allogeneic or syngeneic graft from one human being to another.

M. Ambulatory Surgical Center. We pay the actual charges for the use of an ambulatory surgical center, up to the amount shown on page 3A for a surgical procedure covered under the Surgery Benefit (benefit J.) that is performed at an ambulatory surgical center.

N. Second Surgical Opinion. If surgery is recommended by a physician due to the diagnosis of cancer or specified disease and the covered person chooses to obtain the opinion of a second physician, we pay the actual charges for the second opinion, up to the amount shown on page 3A. This second opinion must be: rendered prior to surgery being performed; and obtained from a physician not in practice with the physician rendering the original recommendation.

O. Inpatient Drugs and Medicine. We pay actual charges made by the hospital for drugs and medicine, related to cancer or specified disease treatment, while hospital confined up to the amount shown on page 3A per day, for each day of continuous hospital confinement. This benefit does not pay for drugs and/or medicine covered under the Radiation/Chemotherapy Benefit (benefit H).

P. Physician's Attendance. We pay actual charges for a visit by a physician while a covered person is receiving cancer or specified disease treatment during hospital confinement up to the amount shown on page 3A per day. This benefit is limited to one visit by one physician per day of hospital confinement. A visit means personal attendance by the physician. Admission to the hospital as an inpatient is required.

Q. Ambulance. We pay actual charges up to the amount shown on page 3A per continuous hospital confinement for transportation by a licensed ambulance service or a hospital owned ambulance to or from a hospital in which the covered person is confined for cancer or specified disease treatment.

BENEFITS INFORMATION (CONT)

R. Non-Local Transportation. We pay the following benefit for cancer or specified disease treatment at a hospital (inpatient or outpatient); or radiation therapy center; or chemotherapy or oncology clinic; or any other specialized freestanding treatment center nearest to the covered person's home, provided the same or similar treatment cannot be obtained locally: 1.) actual cost of round trip coach fare on a common carrier; or 2.) the amount shown on page 3A, up to 700 miles, for round trip personal vehicle transportation. Mileage is measured from the covered person's home to the nearest treatment facility as described above. "Non-Local" means a round trip of more than 70 miles from the covered person's home to the nearest treatment facility. We do not pay for: transportation for someone to accompany or visit the person receiving treatment; visits to a physician's office or clinic; or for services other than actual treatment.

S. Outpatient Lodging. We pay a daily lodging benefit when a covered person receives radiation or chemotherapy treatment for cancer or specified disease (benefit H.) on an outpatient basis, provided the specific treatment is authorized by the attending physician and cannot be obtained locally. The benefit is the actual cost of a single room in a motel, hotel, or other accommodations acceptable to us, up to the amount shown on page 3A per day during treatment. This benefit is limited to the amount shown on page 3A per 12 month period beginning with the first day of benefit under this provision. Outpatient treatment must be received at a treatment facility more than 100 miles from the covered person's home.

T. Family Member Lodging and Transportation. We pay the following benefits for one adult member of the covered person's family to be near the covered person, when a covered person is confined in a non-local hospital for specialized treatment for cancer or specified disease:

1. ***Lodging -*** The actual cost of a single room in a motel, hotel, or other accommodations acceptable to us, up to the amount shown on page 3A per day. This benefit is limited to 60 days for each period of continuous hospital confinement; and
2. ***Transportation*** - The actual cost of round trip coach fare on a common carrier or a personal vehicle allowance of the amount shown on page 3A per mile, up to 700 miles per continuous hospital confinement. Mileage is measured from the visiting family member's home to the hospital where the covered person is confined. We do not pay the Family Member Transportation Benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation Benefit (benefit R.), when the family member lives in the same city or town as the covered person.

U. Physical or Speech Therapy. We pay actual charges up to the amount shown on page 3A per day, for physical or speech therapy for restoration of normal body function.

V. New or Experimental Treatment. We pay actual charges, up to the limit stated below, for new or experimental treatment for cancer or specified disease when:

1. the treatment is judged necessary by the attending physician; and
2. no other generally accepted treatment produces superior results in the opinion of the attending physician.

This benefit is limited to the amount shown on page 3A per 12 month period beginning with the first day of treatment under this provision. This benefit does not pay if benefits are payable for treatment covered under any other benefit in this Schedule of Benefits.

W. Prosthesis. We pay actual charges up to the amount shown on page 3A for prosthetic devices which are prescribed as a direct result of surgery for cancer or specified disease treatment and which require surgical implantation. This benefit is limited to the amount shown on page 3A per covered person, per amputation.

X. Comfort/Anti-Nausea Benefit. We pay the actual charges, up to the amount shown on page 3A per calendar year for anti-nausea medication prescribed for a covered person by a physician in conjunction with cancer or specified disease treatment. We will not pay this benefit for medication administered while the covered person is an inpatient.

Y. Waiver of Premium. If, while this coverage is in force, the employee becomes disabled due to cancer first diagnosed after the effective date of coverage and remains disabled for 90 days, we pay premiums due after such 90 days for as long as the employee remains disabled. The term "disabled" means that the employee is:

1. unable to work at any job for which the employee is qualified by education, training or experience; and
2. not working at any job for pay or benefits; and
3. under the care of a physician for the treatment of cancer.

OPTIONAL BENEFIT(S)

Cancer Initial Diagnosis. We pay a one-time benefit when a covered person is diagnosed for the first time as having cancer other than skin cancer. The first diagnosis must occur after the effective date of coverage for that covered person. The benefit is the amount shown on page 3. The benefit is payable only once per covered person.

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OPTIONAL BENEFIT(S)

Intensive Care Unit.

A. Confinement. We pay the amount shown on page 3 for each day of continuous hospital intensive care unit confinement in a hospital intensive care unit for up to 45 days for each period of such confinement. A day is a 24 hour period. If confinement is for only a portion of a day, then a pro-rata share of the daily benefit is paid. We do not pay for intensive care if a covered person is admitted because of:

1. an attempted suicide; or
2. intentional self-inflicted injury; or
3. intoxication or being under the influence of drugs not prescribed or recommended by a physician; or
4. alcoholism or drug addiction.

We do not pay for confinements in any care unit that does not qualify as a hospital intensive care unit. Progressive care units, sub-acute intensive care units, intermediate care units, and private rooms with monitoring, step down units and any other lesser care treatment units do not qualify as hospital intensive care units.

We do not pay this benefit for continuous hospital intensive care unit confinements that occur during a hospitalization that begins before the effective date of coverage.

B. Ambulance. We pay the actual charges, for transportation of a covered person by licensed air or surface ambulance service to a hospital for admission to an intensive care unit for a covered confinement. We do not pay this benefit if an ambulance benefit is paid under the Ambulance Benefit (benefit Q.) in the Schedule of Benefits.

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ADDITIONAL BENEFIT(S)

PSA Testing/Digital Rectal Examinations. For covered persons age 50 and over and for covered persons age 40 and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, we provide the following benefits.

1. The greater of actual charges or $50.00 for one PSA test in a 12 month period, in accordance with American Cancer Society guidelines.
2. The greater of actual charges or $50.00 for digital rectal examinations in accordance with American Cancer Society guidelines.

PSA testing means the analysis of a blood sample to determine the level of prostate specific antigen.

Other Cancer Screening Tests. We pay this benefit if a covered person has a cancer screening test performed. We pay $50.00 per calendar year per covered person for any one of the cancer screening tests. Each covered person is covered for no more than $50.00 per calendar year. We pay this benefit regardless of the result of the test. There is no limit as to the number of years we pay for cancer screening tests. The eligible cancer screening tests are:

1. Bone marrow testing; and
2. CA15-3 (cancer antigen 15-3-blood test for breast cancer); and
3. CA125 (cancer antigen 125 – blood test for ovarian cancer); and
4. CEA (carcinoembryonic antigen – blood test for colon cancer); and
5. Chest X-ray; and
6. Colonoscopy; and
7. Flexible sigmoidoscopy; and
8. Hemocult stool analysis; and
9. Mammography; and
10. Pap Smear; and
11. Serum Protein Electrophoresis (test for myeloma).

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SCHEDULE OF SURGICAL PROCEDURES
PER UNIT OF SURGERY COVERAGE

SURGICAL PROCEDURE	PROCEDURE CODE FOR 1964 C.R.V.S	PER UNIT OF SURGERY COVERAGE
BRAIN		
Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	61510	$1,250.00
Craniectomy, trephination, bone flap craniotomy; for excision of meningioma, supratentorial	61512	$1,500.00
Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion	61575	$1,250.00
Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computerized axial tomography	61751	$1,400.00
BREAST		
Biopsy of breast; needle core (separate procedure)	19100	$ 25.00
Biopsy of breast; incisional	19101	$ 150.00
Excision of malignant tumor (except 19140), male or female, one or more lesions	19120	$ 150.00
Mastectomy, partial	19160	$ 150.00
Mastectomy, simple, complete	19180	$ 300.00
Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle	19240	$ 600.00
DIGESTIVE SYSTEM		
Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with collection of specimen(s) by brushing or washing (separate procedure)	43235	$ 150.00
Gastrectomy, total; with esophagoenterostomy	43620	$1,000.00
Colectomy, partial; with anastomosis	44140	$ 800.00
Proctectomy; complete, combined abdominoperineal, with colostomy, one or two stages	45110	$1,000.00
Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	45378	$ 280.00
Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	45385	$ 500.00
EXTERNAL GENITALIA		
FEMALE		
Vulvectomy, simple; partial	56620	$ 400.00
Vulvectomy, simple; complete	56625	$ 550.00
Vulvectomy, radical, partial	56630	$ 800.00
Vulvectomy, radical, complete, with inguinofemoral, iliac, and pelvic lymphadenectomy	56640	$1,000.00

SCHEDULE OF SURICAL PROCEDURES (CONT)
PER UNIT OF SURGERY COVERAGE

SURGICAL PROCEDURES	PROCEDURE CODE FOR 1964 C.R.V.S	PER UNIT OF SURGERY COVERAGE
EXTERNAL GENITALIA (CONT)		
MALE		
Biopsy of testis, needle (separate procedure)	54500	$ 20.00
Orchiectomy, radical, for tumor; inguinal approach	54530	$ 400.00
LIVER		
Biopsy of liver; percutaneous needle	47000	$ 50.00
Biopsy of liver, wedge (separate procedure)	47100	$ 400.00
Hepatectomy, resection of liver; partial lobectomy	47120	$ 800.00
LUNG		
Bronchoscopy; with biopsy	31625	$ 200.00
Biopsy, lung or mediastinum, percutaneous needle	32405	$ 50.00
Removal of lung, total pneumonectomy	32440	$1,000.00
MUSCULOSKELETAL		
Biopsy, bone, trocar or needle; superficial (e.g., ilium, sternum, spinous process, ribs)	20220	$ 50.00
Excision of tumor, soft tissue of neck or thorax; deep, subfascial, intramuscular	21556	$ 100.00
Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical	63275	$1,000.00
PROSTATE		
Transurethral resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	52601	$ 800.00
Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy)	55801	$ 800.00
Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	55845	$1,300.00
SKIN		
Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); single lesion (pathology report required)	11100	$ 30.00
Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); each separate/additional lesion (pathology report required)	11101	$ 15.00

SCHEDULE OF SURGICAL PROCEDURE (CONT)
PER UNIT OF SURGERY COVERAGE

SURGICAL PROCEDURE	PROCEDURE CODE FOR 1964 C.R.V.S	PER UNIT OF SURGERY COVERAGE
SKIN (CONT)		
Excision, malignant lesion, trunk, arms, or legs; lesion diameter 0.5 cm. or less	11600	$ 60.00
Excision, malignant lesion, trunk, arms, or legs; lesion diameter 2.1 to 3.0 cm	11603	$ 120.00
Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm. or less	11620	$ 100.00
Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 2.1 to 3.0 cm.	11623	$ 250.00
Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 cm. or less	11640	$ 150.00
Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 2.1 to 3.0 cm.	11643	$ 300.00
Chemosurgery (Mohs' micrographic technique); first state, fresh tissue technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, and microscopic examination of specimens by the surgeon, of up to 5 specimens	17304	$ 200.00
UTERUS		
Colposcopy (vaginoscopy); with biopsy(s) of the cervix and/or endocervical curettage	57454	$ 60.00
Endometrial and/or endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)	58100	$ 30.00
Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	58120	$ 150.00
Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)	58150	$ 600.00
Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tubes(s), with or without removal of ovary(s)	58210	$1,000.00
Vaginal hysterectomy	58260	$ 600.00
VASCULAR INJECTION PROCEDURES		
Placement of central venous catheter for therapeutic reasons (subclavian, jugular, or other vein) (e.g., for hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2	36489	$ 100.00
Insertion of implantable venous access port, with or without subcutaneous reservoir	36533	$ 400.00
Removal of implantable venous access port and/or subcutaneous reservoir	36535	$ 150.00

CONTINUITY OF COVERAGE

IF THE EMPLOYEE IS NOT IN ACTIVE EMPLOYMENT WHEN THE EMPLOYER CHANGES GROUP INSURANCE CARRIERS TO AMERICAN HERITAGE LIFE

When the plan becomes effective, we provide coverage for an employee if:

1. he or she is not in active employment due as a result of cancer; and
2. he or she was covered by the prior group policy when it terminated; and
3. the prior group policy provided coverage for cancer.

Such coverage is subject to payment of premium.

Benefits under this provision will be limited to the amount that would have been paid by the prior carrier. We reduce benefits by any amount for which the prior carrier is liable.

IF AN EMPLOYEE HAS A LOSS DUE TO A PRE-EXISTING CONDITION AND THE EMPLOYER CHANGES GROUP INSURANCE CARRIERS TO AMERICAN HERITAGE LIFE

We may pay benefits if an employee's loss results from a pre-existing condition if the employee was:

1. in active employment and insured under this plan on its effective date; and
2. insured by the prior group policy when it terminated.

The prior group policy's coverage must be substantially similar to this plan and have been in effect within 60 days of this plan's effective date in order for this provision to apply.

In order to receive benefits the employee must satisfy the pre-existing condition provision under:

1. the American Heritage Life plan; or
2. the prior carrier's plan, if benefits would have been paid had that policy remained in force.

If such employee does not satisfy item 1 or 2 above, we will not pay any benefits.

If such employee satisfies either item 1 or 2, we will determine our payments according to the American Heritage Life policy provisions.

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CLAIMS INFORMATION

NOTICE OF CLAIM
We encourage the employee to notify us of claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of claim must be given to us within 20 days after the occurrence or commencement of any loss covered by this policy, or as soon as is reasonably possible. Notice given by or on behalf of the employee or the beneficiary to us at 1776 American Heritage Life Drive, Jacksonville, Florida 32224-6688, or to any authorized agent of ours, with the employee's name and certificate number, is notice to us.

The claim form is available from the employer, or he or she can request a claim form from us. If he does not receive the form from American Heritage Life within 15 days of his request, he may send American Heritage Life written proof of claim without waiting for the form.

FILING A CLAIM
The employee and the employer must fill out their own sections of the claim form and then give it to the attending physician. The physician should fill out his or her section of the form and send it directly to American Heritage Life.

PROOF OF CLAIM
If this policy provides for periodic payment of a continuing loss, written proof of loss must be furnished to us within 90 days after the end of each period for which we are liable. For any other loss, written proof must be given to us within 90 days after each loss. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to us no later than 1 year from the time specified unless the employee is legally incapacitated.

PHYSICAL EXAMINATION AND AUTOPSY
We have the right, at our own expense, to have any covered person examined by a physician of our choosing, as often as may be reasonably required while a claim is pending. We may have an autopsy performed during the period of contestability, where it is not forbidden by law.

PAYMENT OF CLAIMS
After receiving written proof of loss, we pay all benefits then due under the Policy within 60 days. Benefits for any other loss covered by this policy are paid as soon as we receive proper written proof.

We will make payments to the employee unless he or she assigns such payments. Any amounts unpaid at the employee's death may, at our option, be paid either to the named beneficiary or to the employee's estate.

If benefits are payable to the employee's estate or a beneficiary who cannot execute a valid release, we can pay benefits up to $1,000, to someone related to the employee or beneficiary by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

ASSIGNMENT
An assignment of the coverage under this policy is not binding on us, unless:
1. it is a written request; and
2. it is received and recorded by us at our home office.

We are not responsible for the validity of any assignment. An assignment is subject to any payment we make or other action we take before we record the assignment. An assignment may not change the owner or beneficiary.

OVERPAID CLAIM
We have the right to recover any overpayments due to:
1. fraud; or
2. any error we make in processing a claim.

The employee must reimburse us in full. We will work with such employee to develop a reasonable method of repayment if he is financially unable to repay us in a lump sum.
We will not recover more money than the employee was paid. This provision applies only to overpayments made to an employee. Any overpayments made to any other person will be recovered from such person.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES – PAYOR OF LAST RESORT: The Department of Medical Assistance Services shall be the payor of last resort for persons eligible for medical assistance in the Commonwealth of Virginia. To the extent the Department of Medical Assistance Services has made payment for medical services where a third party has a legal obligation to make payment for such services, the Commonwealth shall automatically acquire all rights to such payment from the third party. The extent the Department of Medical Assistance Services is permitted by law to obtain recoveries from third parties, actions at law for such recoveries shall be decided under the same laws, rules and standards including applicable bases of liability and defenses as would apply if the individual receiving the services had brought the action directly; provided that nothing herein shall affect the sovereign immunity of the Commonwealth.

CLAIMS INFORMATION

CLAIM REVIEW

If a claim is denied, we will give written notice of:

1. the reason for denial; and
2. the policy provision that relates to the denial; and
3. the employee's right to ask for a review of his or her claim; and
4. any additional information that might allow us to change our decision.

The employee may, upon written request, read any reports that are not confidential. For a small fee, we will make copies of those reports for the employee's use.

APPEALS PROCEDURE

Prior to filing any lawsuit and within 60 days after denial of a claim, the employee or his or her beneficiary must appeal any denial of benefits under the policy by making a written request for review of the denial.

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GLOSSARY

Active Employment. Means the employee is working for the employer for earnings that are paid regularly and that he or she is performing the material and substantial duties of his or her regular occupation. The employee must be working at least the minimum number of hours as described under Eligible Class(es) in each plan.

The employee's work site must be:

1. the employer's usual place of business; or
2. an alternative work site at the direction of the employer; or
3. a location to which the job requires such employee to travel.

Normal vacation is considered active employment. Temporary and seasonal workers are excluded from coverage.

Ambulatory Surgical Center. A licensed surgical center consisting of: an operating room; facilities for the administration of general anesthesia; and a post surgery recovery room that the patient is admitted to and discharged from within the same working day. This includes an ambulatory surgical center that is a part of a hospital.

Autologous Bone Marrow Transplant. A procedure in which bone marrow is removed from a patient, stored, and then given back to the patient following intensive treatment.

Bone Marrow Transplant. A procedure to replace bone marrow destroyed by treatment with high doses of anticancer drugs or radiation. A transplant may be autologous (the person's own marrow saved before treatment), allogeneic (marrow donated by someone else), or syngeneic (marrow donated by an identical twin).

Cancer. The disease manifested by the presence of a malignancy characterized by the uncontrolled and abnormal growth and spread of malignant cells in any part of the body. This includes: Hodgkin's Disease; leukemia; lymphoma; carcinoma; sarcoma; or malignant tumor. It does not include other conditions which may be considered precancerous, such as: leukoplakia; actinic keratosis; carcinoid; hyperplasia; polycythemia; nonmalignant melanoma; moles; or similar diseases or lesions.

Common Carrier. Only the following: commercial airlines or; passenger trains; or intercity buslines. It does not include taxis; or intracity buslines; or private charter planes.

Continuous Hospital Confinement. One continuous confinement or two or more hospital confinements not separated by more than 30 days. If there are more than 30 days between confinements, they are considered separate confinements.

Continuous Hospital Intensive Care Unit Confinement. One continuous confinement or two or more hospital intensive care unit confinements not separated by more than 30 days. If there are more than 30 days between confinements, they are considered separate confinements.

Covered Person. Any of the following:

1. any eligible family member (including the employee) named in the enrollment form or evidence of insurability form and acceptable for coverage by us; or
2. any eligible family member added by endorsement after the effective date; or
3. a newborn child.

Date of Diagnosis. The earliest of the date of: tentative diagnosis; or clinical diagnosis; or the day the tissue specimen, culture(s) and/or titer(s) are taken, upon which the positive or tentative diagnosis of cancer or specified disease is made.

Employee. Means a person who is a citizen or resident of the United States or one of its territories in active employment with the employer.

Employer. Means the individual, company or corporation where the employee is in active employment, and includes any division, subsidiary, or affiliated company named in the policy.

Evidence of Insurability. Means a statement of the employee's medical history which we will use to determine if he or she is approved for coverage. Evidence of insurability will be provided at the employee's expense.

Extended Care Facility. A licensed nursing facility under the direction of a physician which provides continuous skilled nursing service under the supervision of a graduate registered nurse (R.N.) and maintains daily medical records on each patient. It does not include any institution, or part thereof, used primarily as a place for the aged, drug addicts, alcoholics, or rest.

GLOSSARY (CONT)

Freestanding Hospice Care Center. A center which is not a hospital, a wing, or section of a hospital, providing 24 hour a day care for the terminally ill under the medical direction of a physician.

Grace Period. Means the period of time following the premium due date during which premium payment may be made.

Hospital. A legally operated institution with established facilities (either on its premises or available to the hospital on a contractual, pre-arranged basis and under the supervision of a staff of one or more duly licensed physicians), for the care and treatment of sick and injured persons for diagnosis, surgery, and 24 hour nursing service. Hospital does not include:

1. any institution which is mainly a rest home, nursing home, convalescent home, or home for the aged; or
2. any institution which is mainly for the care and treatment of alcoholics or drug addicts, or mental or nervous disorders.

Hospital Intensive Care Unit. A hospital area of special care including cardiac or coronary care units, which at the time of admission is separate and apart from the surgical recovery room, other rooms, beds, or wards normally used for patient confinement. In addition the unit must provide the following:

1. 24 hour continuous nursing care attended by nurses assigned to the unit on a full time basis; and
2. direction and/or supervision by a full time physician director or a standing "intensive care" committee of the medical staff; and
3. special medical apparatus used to treat the critically ill.

Initial Enrollment Period. Means one of the following periods during which the employee may first apply in writing for coverage under this policy:

1. if the employee is eligible for coverage on the policy effective date, a period before the policy effective date as set by American Heritage Life and the employer; or
2. if the employee becomes eligible for coverage after the policy effective date, the period ending 31 days after the date he or she is first eligible to apply for coverage.

Insured. The person accepted for coverage by us who has completed and signed the enrollment form or evidence of insurability and whose name appears on the Certificate Specification Page.

Intoxication. A temporary state of being as determined by the laws of the state in which the loss occurred.

Material and Substantial Duties. Means duties that:

1. are normally required for the performance of the employee's regular occupation; and
2. cannot be reasonably omitted or modified, except that if the employee is required to work on average in excess of 40 hours per week, American Heritage Life will consider the employee able to perform that requirement if he or she is working or has the capacity to work 40 hours per week.

Nurse. Any one of the following who is not a member of the covered person's immediate family or employed by the hospital where the covered person is confined:

1. licensed practical nurse (L.P.N.); or
2. licensed vocational nurse (L.V.N.); or
3. graduate registered nurse (R.N.).

Pathologist. A legally licensed Doctor of Medicine certified by the American Board of Pathology to practice Pathological Anatomy.

Payable Claim. Means a claim for which we are liable under the terms of this policy.

Physician. Means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

We will not recognize the employee, his or her spouse, children, parents, or siblings as a physician for a claim.

Plan. Means a line of coverage under the policy.

GLOSSARY (CONT)

Policyholder. Means the employer to whom the policy is issued.

Positive Diagnosis (of cancer). A diagnosis by a licensed doctor of medicine certified by the American Board of Pathology to practice Pathological Anatomy, or an Osteopathic Pathologist. Diagnosis is based on a microscopic examination of fixed tissue, or preparations from the hemic system (except for skin cancer). We accept clinical diagnosis of cancer as evidence that cancer existed in a covered person when a pathological diagnosis cannot be made, provided medical evidence substantially documents the diagnosis and the covered person received definitive treatment for the cancer.

Positive Diagnosis (of a specified disease). A diagnosis by a qualified physician based on generally accepted diagnostic procedures and criteria.

Pre-Existing Condition. A disease or physical condition for which medical advice or treatment was received by the covered person during the 12 month period prior to the effective date of the covered person's coverage.

Re-Enrollment Period. A period of time as set by the employer and us during which the employee may apply, in writing, for coverage under this policy, or change coverage under this policy if he or she is currently enrolled.

Specified Disease. Only any one of the following:

(1) Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
(2) Muscular Dystrophy
(3) Poliomyelitis
(4) Multiple Sclerosis
(5) Encephalitis
(6) Rabies
(7) Tetanus
(8) Tuberculosis
(9) Osteomyelitis
(10) Diphtheria
(11) Scarlet Fever
(12) Cerebrospinal Meningitis (bacterial)
(13) Brucellosis
(14) Sickle Cell Anemia
(15) Thallasemia
(16) Rocky Mountain Spotted Fever
(17) Legionnaire's Disease (confirmation by culture or sputum)
(18) Addison's Disease
(19) Hansen's Disease
(20) Tularemia
(21) Hepatitis (Chronic B or Chronic C with liver failure or hepatoma)
(22) Typhoid Fever
(23) Myasthenia Gravis
(24) Reye's Syndrome
(25) Primary Sclerosing Cholangitis (Walter Payton's Liver Disease)
(26) Lyme Disease
(27) Systemic Lupus Erythematosus
(28) Cystic Fibrosis
(29) Primary Biliary Cirrhosis

Stem Cell Transplant. A method of replacing immature blood and bone marrow cells that were destroyed by cancer treatment. The stem cells are given to the person after treatment to help the bone marrow recover and continue producing healthy blood cells.

Temporary Layoff or **Leave of Absence.** Means the employee is absent from active employment for a period of time that has been agreed to in advance in writing by the employer.

Normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

Tentative Diagnosis. A tentative diagnosis is established based upon dated medical records which indicate a diagnosis of a probable or possible cancer or specified disease.

We, Us, and **Our.** American Heritage Life Insurance Company.

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

Endorsement

This Endorsement is made part of the Policy to which it is attached. It is subject to all of the provisions, limitations and exclusions of the Policy, not inconsistent with this Endorsement.

All references to the eligibility and termination of dependents are revised to the following:

Eligible dependents are the insured employee's:
1. legal spouse; and
2. children.

A child is a person under age 26 who is:
1. the insured employee's natural or adopted son or daughter, stepson or stepdaughter; or
2. a foster child who is placed with the insured employee by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.

If the insured employee's spouse is a covered person, his or her spouse's coverage ends upon valid decree of divorce or the insured employee's death.

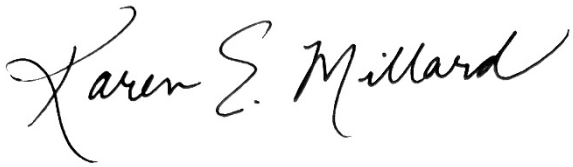
Coverage for a child will end on the issue day of the month that follows when the child: (a) reaches age 26; or (b) otherwise does not meet the requirements of an eligible dependent.

Coverage does not end for an incapacitated dependent child who:
1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under the policy; and
3. is chiefly dependent upon the insured employee for support and maintenance.

Coverage for an incapacitated dependent child continues as long as the policy remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished, in writing, to us when the child reaches the limiting age of eligibility. Thereafter, such proof must be furnished as often as may be required, but no more often than annually after the 2 year period following the child's attainment of the limiting age for eligibility.

Issue day means the same day of the month as the policy date.

All other requirements of the policy not specifically stated within this endorsement still apply.



Secretary



Important Privacy Policy Notice

At Allstate Benefits ("AB"), we value you as a customer. We also share your concerns about privacy. We are sending this notice to explain how we treat personal information ("customer information") that is not public. This is information that we obtain from you or other sources when we provide you with products and services.

We want you to know that: we respect your privacy; and we protect your information.

- We do not sell customer information.
- We do not share your information with: persons; companies; or organizations outside of AB that would use that information to contact you about their products and services.
- We expect persons or organizations that provide services on our behalf to keep your information confidential. We also expect them to use your information only to provide the services we've asked them to perform.
- We communicate to our employees about the need to protect your information. We have established safeguards (these are physical, electronic and procedural) to protect this information.

Below are answers to questions that you might have about privacy. You may be wondering...

What do we do with your information?

AB does not sell your customer or medical information to anyone. We do not share it with companies or organizations outside of AB that would use that information to contact you about their own products and services. If this were to change, we would offer you the option to opt out of this type of information sharing. Also, we would obtain your consent before we share medical information for marketing purposes.

Your agent or broker may use your information to help you with your insurance needs. We may also communicate with you about products, features, and options in which you have expressed an interest. Without your consent, we may provide your information to persons or organizations in and out of AB. This would be done as permitted or required by law. We may do this to:

- Fulfill a transaction you have requested.
- Service your policy.
- Market our products to you.
- Investigate or handle claims.
- Detect or prevent fraud.
- Participate in insurance support organizations (Information from a report by an insurance support organization may be retained by that organization and distributed to other persons.).
- Comply with lawful requests from regulatory and law enforcement authorities.

These persons or organizations may include:

- Our affiliated companies.
- Companies that perform services, including marketing, on our behalf.
- Other financial institutions with which we have an agreement for the sale of financial products.
- Other insurance companies to perform their role in an insurance transaction involving you.
- Businesses that conduct actuarial or research studies.
- Persons requesting information pursuant to a subpoena or court order.
- Your agent or broker.
- An employer, if your premiums are payroll deducted.
- The creditor who sold you insurance, if your policy is credit insurance.

What kind of customer information do we have, and where did we get it?
Much of the information that we have about you comes from you. When you perform certain transactions, you may give us information such as your name, address, and Social Security number. These transactions include when you submit: an application for insurance; a request for insurance; a request for products and services we offer; or a request for an insurance quote. We may have contacted you by telephone or mail for additional information. We keep information about the types of services you purchase from us and our affiliates. Examples of this include premiums, fund values, and payment history. We may collect information from outside sources such as consumer reporting agencies and health care providers. The information we collect may include the following:

- Motor vehicle reports.
- Credit reports.
- Medical information.

How do we protect your customer information?
We expect any company with whom we share your information to use it only to provide the service we have asked them to perform. Information about you is also available within AB to those individuals who may need to use it to fulfill and service the needs of our customers. We communicate the need to protect your information to all employees and agents. We especially communicate this need to individuals who have access to it. Plus, we have established physical, electronic, and procedural safeguards to protect your information. Note that if your relationship with us ends, your information will remain protected. This protection will be provided according to our privacy practices outlined in this Important Notice.

How can you find out what information we have about you?
You may request to see, or obtain by mail, the information about you in our records. If you believe that our information is incomplete or inaccurate, you may request that we correct, add to, or delete from the disputed information. In order to fulfill your request, we may make arrangements to copy and disclose your information to you on our behalf. This may be done with an insurance support organization or a consumer reporting agency. You may also request a more complete description of the entities to which we disclose your information, or the conditions that might warrant such disclosures. Please send any of the requests listed above in writing to:

AB
Policyholder Services (Privacy Section)
1776 American Heritage Life Drive
Jacksonville, FL 32224-6687

If you are an Internet user …
Our website, www.allstatebenefits.com, provides information about AB, our products, and the agencies and brokers that represent us. You may also perform certain transactions on the website. When accessing www.allstatebenefits.com, please be sure to read the Privacy Statement that appears there. To learn more, the www.allstatebenefits.com Privacy Statement provides information relating to your use of the website. This includes, for example:

1) our use of online collecting devices known as “cookies”;
2) how we collect information such as IP address (the number assigned to your computer when you use the Internet), browser and platform types, domain names, access times, referral data, and your activity while using our site;
3) who should use our website;
4) the security of information over the Internet;
5) links and co-branded sites.

We hope you have found this notice helpful. If you have any questions or would like more information, please don’t hesitate to contact your agent or write us at:

AB
Policyholder Services (Privacy Section)
1776 American Heritage Life Drive
Jacksonville, FL 32224-6687

This notice is being provided on behalf of the following companies:

American Heritage Life Insurance Company
Bluegrass Life Insurance Company
Acme United Insurance Company
SMA Life Assurance Company
Holiday Life Insurance Company
Kentucky Home Mutual
Keystone State Life
National Guardian Life



NOTICE OF PRIVACY PRACTICES

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.

EFFECTIVE APRIL 14, 2003

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of our Plan's customers' Protected Health Information, to provide those customers with notice of our legal duties and privacy practices with respect to Protected Health Information, and to send notification to affected customers if there is a breach of unsecured Protected Health Information. If your state provides privacy protections that are more stringent than those provided by HIPAA, we will maintain your Protected Health Information in accordance with the more stringent state standard.

This Notice applies to "Protected Health Information" associated with "Health Plans" issued by American Heritage Life Insurance Company.

This Notice describes how we may use and disclose Protected Health Information to perform claims handling, payment, general insurance operations, and for other purposes that are permitted or required by law. Use or disclosure of your Protected Health Information for the purposes described in this Notice may be made in writing, orally, or by electronic means.

We are required to abide by the terms of this Notice. However, we may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all of your Protected Health Information that we maintain, including any information we created or received prior to issuing the new notice. If we make a material revision to our Privacy Notice, copies will be sent to you if you are then currently insured under our Plan.

Protected Health Information means information about you that is created or received by us and during the administration of coverage under the Plan, which identifies you or for which there is a reasonable basis to believe the information can be used to identify you and that relates to:

1) the past, present or future physical or mental health condition of the individual; or
2) the provision of health care to the individual; or
3) the past, present or future payment for the provision of health care to the individual.

Uses and Disclosures of Protected Health Information With Your Written Authorization

Except as described in the next section of this Notice, we will not use or disclose your Protected Health Information for any purpose unless you have signed a form authorizing the use or disclosure. For example, most uses and disclosures of psychotherapy notes, uses and disclosures of Protected Health Information for marketing purposes, and disclosures that constitute a sale of Protected Health Information will be made only with your authorization. You have the right to revoke that authorization in writing at any time, except to the extent that we have already taken action in reliance on the authorization; or the authorization was obtained as a condition of obtaining coverage, to the extent that other law allows the insurer to contest a claim under the policy or the policy itself.

Uses and Disclosures of Protected Health Information Without Your Written Authorization

For Payment. We may make use of and disclose your Protected Health Information without your written authorization as may be necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims or certify these services are covered under your Plan.

For Plan Administrative Operations. We may make use of and disclose your Protected Health Information without your written authorization as necessary for our Plan administrative operations. Plan administrative operations include our usual business activities, examples of which are management, licensing, peer review, quality improvement and assurance, enrollment, underwriting, reinsurance, compliance, auditing, rating, claims handling, complaint handling and other functions related to your Plan. We are prohibited from using or disclosing genetic information for underwriting purposes.

To Individuals Involved In Your Care. We may, without your written authorization, for the purposes of treatment, payment or Plan administrative operations, disclose the fact that you are covered under a Plan or that payment has been processed to a family member, other relative, your close personal friend or any other person you may identify. In these circumstances, we would not disclose any Protected Health Information which is not directly relevant to that person's involvement with your care or with payment for your care.

If you have designated a person to receive information regarding payment of the premium or pay premium via credit card, we may inform that person or credit card facility when your premium has not been paid or received by us.

We may also disclose limited Protected Health Information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

To Our Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations. Examples of these may include, but are not limited to our duly appointed insurance agents, financial auditors, reinsurers, legal services, enrollment and billing services, claim payment and medical management services. We may provide access to your Protected Health Information without your written authorization to one or more of these outside persons or organizations who assist us with payment or Plan administrative operations. We require these business associates to appropriately safeguard the privacy of your information.

To Plan Sponsors. If you are enrolled in a group health plan, we may share summary health information with your employer, union, or other employee organization that sponsors and maintains the group health plan, for purposes of obtaining premium bids; or modifying, amending, or terminating the group health plan; or enrollment and disenrollment information. Summary health information excludes genetic information.

For Other Products and Services. We may contact you without your written authorization to provide information regarding Plan upgrades or additional benefits that may be of interest to you. For example, we may use the fact that you currently are insured under a Plan for the purpose of communicating to you about changes to our Plan or products that could enhance or add value to existing coverage.

For Disclosure With Authorization. Unless otherwise excluded in this notice, we will not disclose any other Protected Health Information to any person or entity not specifically mentioned elsewhere in this Notice without your express written authorization.

For Other Uses and Disclosures. We are permitted or required by law to make some other uses and disclosures of your Protected Health Information without your authorization. We may release your Protected Health Information:

- if required by law to a government authorized health oversight agency or company conducting audits, investigations, or civil or criminal proceedings.

- if required to do so by a court or administrative ordered subpoena or discovery request. In most cases you will have notice of such a release.

- for public health activities, such as required reporting of disease, injury, birth and death and for required public health investigations.

- as required by law if we suspect child abuse or neglect or if we believe you to be a victim of abuse, neglect or domestic violence.

- to the Food and Drug Administration if necessary to report adverse events, product defects or to participate in product recalls.

- to law enforcement officials as required by law to report wounds, injuries or crimes.

- to coroners, medical examiners and/or funeral directors consistent with law.

- for a national security or intelligence activity or, if you are a member of the military, as required by the armed forces.

- to workers' compensation agencies or similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Your Rights

Right to Inspect and Copy Your Protected Health Information. You may have access to our records that contain your Protected Health Information in order to inspect and obtain copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from our Privacy Officer and submit the completed form to our Privacy Office. If you request copies, we may charge you copying and mailing costs. If you request a copy of your Protected Health Information in electronic form, we will provide it to you electronically only if the record is readily producible in electronic form.

Right to Amend Your Protected Health Information. You have the right to request that we amend your Protected Health Information maintained in our enrollment, payment, claims adjudication and case or medical management records, or other records we use to make decisions about you. If you desire to amend these records, please obtain an amendment request form from our Privacy Officer and submit the completed form to our Privacy Office. We will comply with your request unless special circumstances apply. If your physician or other health care provider created the information that you desire to amend, you should contact the provider to amend the information.

Right to an Accounting of the Disclosures of Your Protected Health Information. Upon request, you may obtain an accounting of certain disclosures of your Protected Health Information made by us on or after April 14, 2003, excluding disclosures made earlier than six years before the date of your request. If you request an accounting more than once during any 12 month period, we will charge you a reasonable fee for the subsequent accounting statements.

Right to Request Confidential Communications. We will accommodate your reasonable request to receive communications of your Protected Health Information from us by alternative means of communication or at alternative locations if the request clearly states that disclosure of that information could endanger you.

Right to Request Restrictions on Use and Disclosure of Your Protected Health Information. You have the right to request restrictions on some of our uses and disclosures of your Protected Health Information to family members and others involved in your care or payment for care; or some of our uses and disclosures used to carry out treatment, payment, or Plan administrative operations, by notifying us of your request for a restriction in writing mailed to the contact identified at the end of this Notice. Your request must describe in detail the restriction you are requesting. We are not required to agree to your restriction request but will attempt to accommodate your requests. We retain the right to terminate an agreed-to restriction. In the event of a termination of an agreed-to restriction by us, we will notify you of such termination, but the termination will only be effective for Protected Health Information we receive after we have notified you of the termination. You also have the right to terminate any agreed-to restriction by contacting us using the "Contact Information" provided at the end of this Notice.

Personal Representatives. You may exercise your rights through a personal representative who will be required to produce evidence of his or her authority to act on your behalf. Proof of authority may be made by a notarized power of attorney, a court order of appointment of the person as your legal guardian or conservator, or if you are the parent of a minor child. We reserve the right to deny access to your personal representative.

Right to Receive Paper Copy of this Notice. You may obtain a copy of this Notice. You may obtain a paper copy of this Notice even if you agreed to receive such notice electronically. Please contact us and we will mail it to you.

Complaints

If you believe your privacy rights have been violated, you can file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Plan, send it in writing to the "Contact Information" at the address listed at the end of this Notice. There will be no retaliation for filing a complaint.

You may obtain a copy of this Notice by writing to us at the contact address below.

Contact Information

If you have questions or need further assistance regarding this Notice, you may contact:

Allstate Benefits
Attn: HIPAA Privacy Officer

1776 American Heritage Life Drive
Jacksonville, Florida 32224

Or, you may telephone the Customer Care Center at 1-800-521-3535.

NOTICE OF PROTECTION PROVIDED BY VIRGINIA LIFE, ACCIDENT AND SICKNESS INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or accident and sickness insurance company (including a health maintenance organization) licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values

- Health Insurance
  - $500,000 for health benefit plans
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of accident and sickness insurance benefits

- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000, except for health benefit plans, for which the limit is increased to $500,000.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association's website at *www.valifega.org*, or contact:

VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.
1503 Santa Rosa Road, Suite 101
Henrico, VA 23229-5105
804-282-2240

STATE CORPORATION COMMISSION
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157
804-371-9741
Toll Free Virginia only: 1-800-552-7945
http://scc.virginia.gov/boi/index.aspx

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia law, then Virginia law will control.

IMPORTANT INFORMATION
REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, you may contact the insurance company issuing this insurance at the following address and telephone number:

American Heritage Life Insurance Company
1776 American Heritage Life Drive
Jacksonville, Florida 32224
1-800-521-3535

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Virginia Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218
Toll-Free Phone (VA only): 1-800-552-7945
Toll Free Phone: 1-877-310-6560
Local Phone: 1-804-371-9741
TDD: 1-804-371-9206
Fax: 1-804-371-9944

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy/certificate number available.

ATTACH THIS NOTICE TO YOUR POLICY/CERTIFICATE:

This notice is for information only and does not become a part of the policy/certificate.

AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687

NOTICE OF NON-INSURANCE VALUE-ADDED PRODUCTS OR SERVICES

American Heritage Life Insurance Company ("we," "us," "our") may arrange for third party vendors to offer or provide value-added products or services to eligible covered persons insured with us at no or reduced cost.

The value-added products or services offered or provided are:

- Not specified in the policy or certificate;
- Related to the insurance coverage; and
- Primarily designed to satisfy one or more of the following:
  - Provide loss mitigation or loss control;
  - Reduce claim costs or claim settlement costs;
  - Provide education about liability risks or risk of loss to persons or property;
  - Monitor or assess risk, identify sources of risk, or develop strategies for eliminating or reducing risk;
  - Enhance health;
  - Enhance financial wellness through items such as education or financial planning services;
  - Provide post-loss services;
  - Incent behavioral changes to improve the health or reduce the risk of death or disability of a policyholder, potential policyholder, certificate holder, potential certificate holder, insured, potential insured, or applicant; or
  - Assist in the administration of the employee or retiree benefit insurance coverage.

The cost for the value-added products or services may be either billed directly to you or remitted to us by the policyholder, as agreed to by the policyholder.

Third party vendors are solely liable for providing the value-added products or services. We will not be responsible for third party vendors providing or failing to provide the value-added products or services to eligible covered persons. We will not be liable to eligible covered persons for the negligent provision of the value-added products or services by third party vendors.

The value-added products or services may automatically terminate with the policy or certificate. We reserve the right to terminate, modify, or replace any value-added products or services at any time with 31 days' advance written notice to the policyholder.