



**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**



**Allstate**

Workplace Division

**APPLICATION TO  
AMERICAN HERITAGE LIFE INSURANCE COMPANY**  
HOME OFFICE: 1776 AMERICAN HERITAGE LIFE DRIVE  
JACKSONVILLE, FLORIDA 32224  
A STOCK COMPANY

Policyholder Name: HARALSON COUNTY SCHOOLS  
Group Policy: 99471  
State of Delivery: Georgia  
Additional State Locations: None  
Insurance Plan Applied For: Group Voluntary Cancer/Specified Disease Policy

The policyholder hereby applies to American Heritage Life Insurance Company for the insurance provided by the group policy which is indicated above to be effective on the date specified on the Specifications Page of the group policy.

The policyholder hereby accepts the group policy with the signature shown below.

DATED AT: \_\_\_\_\_

ON: \_\_\_\_\_

SIGNED FOR BY THE POLICYHOLDER, THE \_\_\_\_\_  
(Employer)

BY: \_\_\_\_\_  
(Signature)



TITLE: \_\_\_\_\_

WITNESS: \_\_\_\_\_  
(Signature of Agent)\* (Print Agent's Name as Shown on License)\*

\_\_\_\_\_  
(Agent's License Number)\*

\*Where required by law

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**CANCER AND SPECIFIED DISEASE PLAN  
POLICY SPECIFICATIONS**

POLICYHOLDER: HARALSON COUNTY SCHOOLS  
 POLICY NUMBER: 99471  
 POLICY EFFECTIVE DATE: July 1, 2007  
 POLICY ANNIVERSARY DATE: July 1, 2008  
 GOVERNING JURISDICTION: the state of Georgia and subject to the laws of that jurisdiction

**ELIGIBLE CLASS(ES):** All full-time active employees working at least 20 hours per week for 30 consecutive days.

**BENEFITS:** See page 3A

<b>OPTIONAL BENEFIT(S):</b>	<u><b>BASIC</b></u>	<u><b>ENHANCED</b></u>
Cancer Initial Diagnosis:	\$3,000	\$5,000
Cancer Screening:	\$50/year	\$100/year

<b>INITIAL RATE:</b>	<u><b>BASIC</b></u>	<u><b>ENHANCED</b></u>
Monthly rate for individual:	\$12.36	\$26.04
Monthly rate for family:	\$20.96	\$43.96

**RATE GUARANTEE DATE:** 07/01/2010

**PREMIUM DUE**

The initial date agreed to between American Heritage Life Insurance Company and the Policyholder and each specified date 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 – GVCP2GA**  
**SEE BENEFITS SECTION OF POLICY FOR DETAILS OF BENEFITS**

<u>BENEFITS</u>	<u>BASIC AMOUNT</u>	<u>ENHANCED AMOUNT</u>
A. CONTINUOUS HOSPITAL CONFINEMENT DAYS 1-70	\$100/DAY	\$300/DAY
B. EXTENDED BENEFITS DAYS 70+	UP TO \$100/DAY	UP TO \$300/DAY
C. GOVERNMENT/CHARITY HOSPITAL	\$100/DAY	\$300/DAY
D. PRIVATE DUTY NURSING SERVICES	UP TO \$100/DAY	UP TO \$300/DAY
E. EXTENDED CARE FACILITY	UP TO \$100/DAY	UP TO \$300/DAY
F. AT HOME NURSING	UP TO \$100/DAY	UP TO \$300/DAY
G. HOSPICE CARE		
1. FREESTANDING HOSPICE CARE CENTER	UP TO \$100/DAY	UP TO \$300/DAY
2. HOSPICE CARE TEAM	UP TO \$100/VISIT	UP TO \$300/DAY
H. RADIATION/CHEMOTHERAPY	UP TO \$5,000/12 MONTHS	UP TO \$10,000/12 MONTHS
I. BLOOD, PLASMA AND PLATELETS	UP TO \$5,000/12 MONTHS	UP TO \$10,000/12 MONTHS
J. SURGERY	UP TO \$1,500 PER UNIT OF COV. SEE SCHED. OF SURG. PROC. 1 UNIT OF COVERAGE	UP TO \$1,500 PER UNIT OF COV. SEE SCHED. OF SURG. PROC. 3 UNITS OF COVERAGE
K. ANESTHESIA	UP TO 25% OF SURG. BENEFIT	UP TO 25% OF SURG. BENEFIT
L. BONE MARROW OR STEM CELL TRANSPLANT		
1. AUTOLOGOUS TRANSPLANT	UP TO \$500/12 MONTHS	UP TO \$1,500/12 MONTHS
2. NON-AUTOLOGOUS TRANSPLANT	UP TO \$1,250/12 MONTHS	UP TO \$3,750/12 MONTHS
3. NON-AUTOLOGOUS TRANSPLANT FOR THE TREATMENT OF LEUKEMIA	UP TO \$2,500/12 MONTHS	UP TO \$7,500/12 MONTHS
M. AMBULATORY SURGICAL CENTER	UP TO \$250/DAY	UP TO \$750/DAY
N. SECOND SURGICAL OPINION	UP TO \$200	UP TO \$600
O. INPATIENT DRUGS AND MEDICINE	UP TO \$25/DAY	UP TO \$25/DAY
P. PHYSICIAN'S ATTENDANCE	UP TO \$50/DAY	UP TO \$50/DAY
Q. AMBULANCE	UP TO \$100/CONFINEMENT	UP TO \$100/CONFINEMENT
R. NON-LOCAL TRANSPORTATION	COACH FARE OR \$0.40/MILE	COACH FARE OR \$0.40/MILE
S. OUTPATIENT LODGING	UP TO \$50/DAY UP TO \$2,000/12 MONTHS	UP TO \$50/DAY UP TO \$2,000/12 MONTHS
T. FAMILY MEMBER LODGING AND TRANSPORTATION	UP TO \$50/DAY COACH FARE OR \$0.40/MILE	UP TO \$50/DAY COACH FARE OR \$0.40/MILE
U. PHYSICAL OR SPEECH THERAPY	UP TO \$50/ DAY	UP TO \$50/ DAY
V. NEW OR EXPERIMENTAL TREATMENT	UP TO \$5,000/12 MONTHS	UP TO \$5,000/12 MONTHS
W. PROSTHESIS	UP TO \$2,000/AMPUTATION	UP TO \$2,000/AMPUTATION
X. COMFORT/ANTI-NAUSEA	UP TO \$200/YEAR	UP TO \$200/YEAR
Y. WAIVER OF PREMIUM	AFTER 90 DAYS	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 20% of those eligible for coverage are participating.

We will notify the policyholder in writing at least 60 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 60 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 50 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.

## 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. 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 or adopted by the employee or the employee's 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 or from the date of final decree of adoption of such child for benefits otherwise payable to a covered person under this policy. Coverage for newly born or adopted children consists of coverage of sickness due to cancer and specified diseases, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities when due to cancer or specified diseases. 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 coverage is in force as family coverage.

### **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, which is when the child reaches age 22 (26 if a full-time student attending an educational institution of higher learning beyond high school).

Coverage does not terminate on a 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 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. Authorization by law to issue such a policy at the time and in the jurisdiction the person applying for conversion resides.
2. 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.
3. 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.
4. 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.
5. 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.

Any statements made by the policyholder or by a covered person, in the absence of fraud, are representations and not warranties. Only written statements signed by the policyholder or the covered person will be used in defense of a claim. 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 action at law or in equity may be brought to obtain benefits under the policy:

1. for at least 60 days after written 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.

## BENEFITS INFORMATION (CONT)

### 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)

**Cancer Screening.** We pay this benefit if a covered person has a cancer screening test performed. We pay the amount shown on page 3 per calendar year per covered person for any one of the cancer screening tests. Each covered person is covered for no more than the amount shown on page 3 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. PSA (prostate specific antigen – blood test for prostate cancer); and
12. Serum Protein Electrophoresis (test for myeloma).

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## SCHEDULE OF SURGICAL PROCEDURES

SURGICAL PROCEDURE	PROCEDURE CODE FOR 1964 C.R.V.S	PER UNIT OF SURGERY COVERAGE
<b>BRAIN</b>		
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
<b>BREAST</b>		
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
<b>DIGESTIVE SYSTEM</b>		
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
<b>EXTERNAL GENITALIA</b>		
<b>FEMALE</b>		
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)**

SURGICAL PROCEDURES	PROCEDURE CODE FOR 1964 C.R.V.S	PER UNIT OF SURGERY COVERAGE
<b>EXTERNAL GENITALIA (CONT)</b>		
<b>MALE</b>		
Biopsy of testis, needle (separate procedure).....	54500 .....	\$ 20.00
Orchiectomy, radical, for tumor; inguinal approach .....	54530 .....	\$ 400.00
<b>LIVER</b>		
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
<b>LUNG</b>		
Bronchoscopy; with biopsy.....	31625 .....	\$ 200.00
Biopsy, lung or mediastinum, percutaneous needle .....	32405 .....	\$ 50.00
Removal of lung, total pneumonectomy .....	32440 .....	\$1,000.00
<b>MUSCULOSKELETAL</b>		
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
<b>PROSTATE</b>		
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 lymphaden- ectomy, including external iliac, hypogastric and obturator nodes .....	55845 .....	\$1,300.00
<b>SKIN</b>		
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)**

<b>SURGICAL PROCEDURE</b>	<b>PROCEDURE CODE FOR 1964 C.R.V.S</b>	<b>PER UNIT OF SURGERY COVERAGE</b>
<b>SKIN (CONT)</b>		
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
<b>UTERUS</b>		
Colposcopy (vaginocopy); 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
<b>VASCULAR INJECTION PROCEDURES</b>		
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 10 working 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.

### TIME OF PAYMENT OF CLAIMS

Amounts due under this policy other than for loss of time are payable immediately upon receipt of proof of loss. With respect to amounts payable for other than loss of time, we will send notice to the employee within 15 days of receipt of due written proof of loss. If we do not pay the loss immediately upon receipt, this notice will state the reasons for withholding payment of the claim and will also provide an itemization of any information needed to process the claim or any portions of the claim which have not been paid. When all the requested information needed to process the claim has been received, we will then have 15 working days to process the claim or deny it, in whole or in part, giving the reasons we may have for denying the claim or any portion of the claim. We will pay interest at the rate of 18% per year on the amounts due under the terms of the policy if payments are not made in compliance with the requirements of this provision.

### PAYMENT OF CLAIMS

After receiving written proof of loss, we pay all benefits then due under this policy. 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.

## **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.

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

## GLOSSARY (CONT)

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

**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.



# Allstate.

Workplace Division

## ***Important Privacy Policy Notice***

At Allstate Workplace Division ("AWD"), 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 AWD 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?**

AWD does not sell your customer or medical information to anyone. We do not share it with companies or organizations outside of AWD 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 AWD. 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 AWD 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:

AWD  
Policyholder Services (Privacy Section)  
1776 American Heritage Life Drive  
Jacksonville, FL 32224-6688

**If you are an Internet user...**

Our website, [ahllcorp.com](http://ahllcorp.com), provides information about AWD, our products, and the agencies and brokers that represent us. You may also perform certain transactions on the website. When accessing [ahllcorp.com](http://ahllcorp.com), please be sure to read the Privacy Statement that appears there. To learn more, the [ahllcorp.com](http://ahllcorp.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:

AWD  
Policyholder Services (Privacy Section)  
1776 American Heritage Life Drive  
Jacksonville, FL 32224-6688

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

American Heritage Life Insurance Company  
First Colonial Insurance Company  
Bluegrass Life Insurance Company  
Acme United Insurance Company  
GLBNAHL 3/03



**Allstate**

Workplace Division

## **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 hereinafter referred to as Medical Information and to provide those customers with notice of our legal duties and privacy practices with respect to your Medical Information. If your state provides privacy protections that are more stringent than those provided by HIPAA, we will maintain your Medical Information in accordance with the more stringent state standard.

This Notice applies to "Medical Information" associated with "Health Plans" issued by:

- American Heritage Life Insurance Company

This Notice describes how we may use and disclose Medical Information to perform claims handling, payment, general insurance operations, and for other purposes that are permitted or required by law.

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 Medical Information that we maintain, including any information we created or received prior to issuing the new notice. If we do revise our Privacy Notice, copies will be sent to you if you are then currently insured under our Plan.

Medical 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 Medical Information **With Your Written Authorization**

Except as described in the next section of this Notice, we will not use or disclose your Medical Information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing at any time. However, any action already taken by the Plan or others in reliance on the authorization cannot be changed.

## Uses and Disclosures of Medical Information **Without Your Written Authorization**

**For Payment.** We may make use of and disclose your Medical 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 Medical 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.

**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 Medical 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 Medical 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 Medical 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.

**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 Medical 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 Medical Information without your authorization:

- We may release your Medical Information if required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings.
- We may release your Medical Information 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.
- We may release your Medical Information for public health activities, such as required reporting of disease, injury, birth and death and for required public health investigations.
- We may release your Medical Information 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.
- We may disclose your Medical Information to the Food and Drug Administration if necessary to report adverse events, product defects or to participate in product recalls.
- We may release your Medical Information to law enforcement officials as required by law to report wounds, injuries or crimes.

- We may release your Medical Information to coroners and/or funeral directors consistent with law.
- We may release your Medical Information for a national security or intelligence activity or, if you are a member of the military, as required by the armed forces.
- We may release your Medical Information to workers' compensation agencies if necessary for your workers' compensation benefit determination.

## **Your Rights**

**Right to Inspect and Copy Your Medical Information.** You may have access to our records that contain your Medical 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.

**Right to Amend Your Medical Information.** You have the right to request that we amend your Medical 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 Office 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 Medical Information.** Upon request, you may obtain an accounting of certain disclosures of your Medical 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 Medical 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 Medical Information.** You have the right to request restrictions on some of our uses and disclosures of your Medical Information for medical 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 Medical 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 Workplace Division  
Attn: HIPAA Privacy Officer  
1776 American Heritage Life Drive  
Jacksonville, Florida 32224