AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(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 to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA), and consists of:

1. all policy provisions and any amendments and/or attachments issued; and
2. the policyholder's signed application.

This policy may be changed in whole or in part. The approval must be in writing, signed by one of our executive officers and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

This policy is a legal contract between the policyholder and American Heritage Life Insurance Company.

Signed for American Heritage Life Insurance Company 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 AND
OTHER OPTIONAL BENEFITS
DESCRIBED HEREIN

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CANCER AND SPECIFIED DISEASE POLICY SPECIFICATIONS

POLICYHOLDER:	XYZ COMPANY, INC.
POLICY NUMBER:	GROUP 106
POLICY EFFECTIVE DATE:	January 1, 2009
POLICY ANNIVERSARY DATE:	January 1, 2010 and the first day of month each calendar year thereafter.
GOVERNING JURISDICTION:	The state of Kentucky and subject to the laws of that jurisdiction.

ELIGIBLE CLASS(ES): All full-time active employees or members working at least 30 hours per week excluding those who are insured under any other cancer or specified disease policy issued by American Heritage Life Insurance Company.

ELIGIBILITY WAITING PERIOD: None 3 Months

BENEFITS: See page 3A

OPTIONAL BENEFIT(S): Cancer Initial Diagnosis: $2,000.00
Wellness: $100.00/year

INITIAL RATE: Monthly rate of $XX.XX per employee or member for Individual Coverage; or
$XX.XX per employee or member for Individual and Spouse Coverage; or
$XX.XX per employee or member for Individual and Child(ren) Coverage; or
$XX.XX per employee or member for Family Coverage

RATE GUARANTEE DATE: 01/01/2010

PREMIUM DUE: 01/01/2009 and the first 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 or member is receiving benefits except as provided in the Waiver of Premium benefit.

COST OF COVERAGE: The policyholder pays the cost of the employee's or member's coverage.
The employee or member pays the cost of the dependent's coverage.
The employee or member and the policyholder share the cost of coverage.
The employee or member pays the cost of coverage.

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 policy. 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 AND SPECIFIED DISEASE POLICY – GVCP3KY

SEE BENEFITS SECTION OF POLICY FOR DETAILS OF BENEFITS

	BENEFITS	AMOUNT
A.	CONTINUOUS HOSPITAL CONFINEMENT	$200.00/DAY
B.	GOVERNMENT/CHARITY HOSPITAL	$200.00/DAY
C.	PRIVATE DUTY NURSING SERVICES	$200.00/DAY
D.	EXTENDED CARE FACILITY	$200.00/DAY
E.	AT HOME NURSING	$200.00/DAY
F.	HOSPICE CARE	
	1. FREESTANDING HOSPICE CARE CENTER	$200.00/DAY
	2. HOSPICE CARE TEAM	$200.00/VISIT
G.	RADIATION/CHEMOTHERAPY FOR CANCER	UP TO $10,000.00/12 MONTHS
H.	BLOOD, PLASMA AND PLATELETS	UP TO $10,000.00/12 MONTHS
I.	HEMATOLOGICAL DRUGS	UP TO $200.00/YEAR
J.	MEDICAL IMAGING	UP TO $500.00/YEAR
K.	SURGERY	UP TO $1,500.00 PER UNIT OF COVERAGE SEE SCHEDULE OF SURGICAL PROCEDURES 1 UNIT OF COVERAGE
L.	ANESTHESIA	25% OF SURGERY BENEFIT
M.	BONE MARROW OR STEM CELL TRANSPLANT	
	1. AUTOLOGOUS TRANSPLANT	$500.00/YEAR
	2. NON-AUTOLOGOUS TRANSPLANT	$1,250.00/YEAR
	3. NON-AUTOLOGOUS TRANSPLANT FOR THE TREATMENT OF LEUKEMIA	$2,500.00/YEAR
N.	AMBULATORY SURGICAL CENTER	$250.00/DAY
O.	SECOND OPINION	$200.00
P.	INPATIENT DRUGS AND MEDICINE	$25.00/DAY
Q.	PHYSICIAN'S ATTENDANCE	$50.00/DAY
R.	AMBULANCE	$100.00/CONFINEMENT
S.	NON-LOCAL TRANSPORTATION	COACH FARE OR $0.40/MILE
T.	OUTPATIENT LODGING	$50.00/DAY $2,000.00/12 MONTHS
U.	FAMILY MEMBER LODGING AND TRANSPORTATION	$50.00/DAY COACH FARE OR $0.40/MILE
V.	PHYSICAL OR SPEECH THERAPY	$50.00/DAY
W.	NEW OR EXPERIMENTAL TREATMENT	UP TO $5,000.00/12 MONTHS
X.	PROSTHESIS	UP TO $2,000.00/AMPUTATION
Y.	HAIR PROSTHESIS	$25.00/2 YEARS
Z.	NONSURGICAL EXTERNAL BREAST PROSTHESIS	$50.00/INITIAL PROSTHESIS
AA.	ANTI-NAUSEA	$200.00/YEAR
BB.	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 except 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.

PREMIUM INCREASES OR DECREASES

Premium increases or decreases may take effect any time subject to the Rate Guarantee provision. If they take effect during a policy month, they 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 or members:
   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 or members are insured; or
6. the policyholder fails to pay any premium within the 31 day grace period.

If the premium is not paid during the grace period, this 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 this policy 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 can be canceled on an earlier date. If canceled, coverage will end at 12:00 midnight on the last day of coverage.

If this policy is canceled, the cancellation will not affect a payable claim incurred prior to cancellation.

GENERAL PROVISIONS

ELIGIBILITY OF DEPENDENTS

Eligible dependents are:

1. the employee's or member's legal spouse or domestic partner; and
2. unmarried children of the employee or member including adopted children from the moment of placement in the residence, stepchildren, children of a domestic partner or legal ward 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. The employee's or member's children must be dependent on the employee or member for support or reside with the employee or member over 50% of the time in a regular parent-child relationship and be named on the enrollment or evidence of insurability form.

After the effective date, any person (except newborns) who becomes an eligible dependent can be added to this policy if we are notified within 31 days after they become eligible.

If the insured employee or member has Individual Coverage or Individual and Child(ren) Coverage, then marries and desires coverage for his or her spouse, we must be notified within 31 days of the marriage. We will change the coverage to Individual and Spouse Coverage or Family Coverage and provide notification of the additional premium due. If we are not notified within 31 days of the marriage, then evidence of insurability will be required for the spouse.

If the insured employee or member has Individual Coverage or Individual and Child(ren) Coverage, then establishes a domestic partnership and desires coverage for his or her domestic partner, we must be notified within 31 days of the date the domestic partnership was formed. We will change the coverage to Individual and Spouse Coverage or Family Coverage and provide notification of the additional premium due. If we are not notified within 31 days of the date a domestic partnership was formed, then evidence of insurability will be required.

A child born to the insured employee or member or spouse or domestic partner, while Individual and Child(ren) Coverage or Family Coverage is in force, will be eligible for coverage. This coverage begins at the moment of birth of such child and benefits will be the same as provided for any other person covered under this policy. No additional premium will be required for newborns added if Individual and Child(ren) Coverage or Family Coverage is in force at the time the newborn is added.

If the insured employee or member has Individual Coverage or Individual and Spouse Coverage, newborn children are automatically covered from the moment of birth for a period of 31 days. If the insured employee or member desires uninterrupted coverage for a newborn child, the insured employee or member must notify us within 31 days of that child's birth. Upon notification, we will convert the insured employee's or member's Individual Coverage to Individual and Child(ren) Coverage or Individual and Spouse Coverage to Family Coverage and provide notification of additional premium due. If the insured employee or member does not notify us within 31 days of the birth of the child, the temporary automatic coverage ends.

An adopted child or child pending adoption will be covered as follows, as long as Individual and Child(ren) Coverage or Family Coverage is in force:

1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by the insured employee or member has been entered within 31 days after the date of birth.
2. If adoption proceedings have been instituted by the insured employee or member within 31 days after the date of birth and the insured employee or member has temporary custody, coverage is 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 insured employee or member 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 or if a person is a member of the policyholder's union or association, the date such employee or member is eligible for coverage is the later of:

1. this policy's effective date; or
2. the date such person becomes a member of the eligible class and completes any applicable eligibility waiting period.

GENERAL PROVISIONS (Continued)

WHEN AN ELIGIBLE EMPLOYEE OR MEMBER CAN ENROLL, CHANGE OR DISCONTINUE COVERAGE

1. The employee or member 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 or member may increase coverage at any time, subject to evidence of insurability.
3. The employee or member may discontinue coverage at any time.

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability is required at the time of enrollment.
Evidence of insurability is also required if:
1. the employee or member:
   a. voluntarily canceled coverage and is reapplying; or
   b. is applying for the coverage, or an increase in the amount of coverage, at any time after his or her initial enrollment period; or
2. an eligible dependent did not enroll within 31 days of eligibility.

Evidence of insurability is required if:
1. the employee or member:
   a. voluntarily canceled coverage and is reapplying; or
   b. is applying for the coverage, or an increase in the amount of coverage, at any time after his or her initial enrollment period.
2. an eligible dependent did not enroll within 31 days of eligibility.

EFFECTIVE DATE OF COVERAGE

Coverage for each eligible employee or member is effective at 12:01 a.m. on the effective date shown on the certificate of insurance issued to that person.

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

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.

WHEN AN EMPLOYEE IS ABSENT FROM WORK OR A MEMBER IS NOT ENGAGED IN ACTIVE EMPLOYMENT ON THE EFFECTIVE DATE OF COVERAGE

If an employee or member is absent from work due to disability, injury, sickness, temporary layoff, leave of absence or Family and Medical Leave of Absence, coverage for that person begins on the date they meet the definition of active employment. This applies to such person's initial coverage, as well as any increase or addition to coverage that occurs after such person's initial coverage is effective.

CERTIFICATES OF INSURANCE

We will issue certificates of insurance for each insured employee or member. The certificate will provide a description of the insurance provided by this policy and will state:
1. the benefits provided; and
2. to whom benefits are payable; and
3. the limitations, exclusions and requirements that apply to coverage under this policy.

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

GENERAL PROVISIONS (Continued)

TERMINATION OF COVERAGE

The insured employee's or member's coverage under the certificate ends on the earliest of:
1. the date this policy is canceled; or
2. the last day of the period for which such employee made any required premium payments; or
3. the last day such insured employee or member is in active employment or membership, except as provided under the "Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence" provision; or
4. the date such insured employee or member is no longer in an eligible class; or
5. the date such insured employee's or member's class is no longer eligible.

We will provide coverage for a payable claim incurred while the insured employee or member is covered under this policy.

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

If the insured employee's or member's domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or death of the insured employee or member.

Coverage for a dependent child ends on the certificate 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); or (c) otherwise does not meet the requirements of an eligible dependent. 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 insured employee or member for support and maintenance.

The child's coverage continues as long as the insured employee's or member's coverage remains in force and the child 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, such premium will be refunded, coverage will terminate and claims will not be paid. There may be no refund due if the insured employee or member has Individual and Child(ren) Coverage or Family Coverage and there are other eligible dependents covered under this policy.

AGENCY

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

TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE

If an insured employee or member ceases active employment or terminates membership because of a temporary layoff or leave of absence while coverage is in force, we will continue the insured employee's or member's coverage in accordance with the personnel practices of the policyholder, if premium payments continue and the policyholder approved the leave in writing. Coverage will be continued for 3 months following the date the insured employee or member ceases active employment or membership.

If the insured employee's or member's coverage ends while on a Family and Medical Leave of Absence, his or her coverage will be reinstated when he or she returns to active status.

We will not:
1. apply a new pre-existing conditions limitation ; or
2. require evidence of insurability.

GENERAL PROVISIONS (Continued)

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. any individual applications, enrollments, evidence of insurability or other statements of the insured employee.

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 a 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 or her personal representative, if any, if such written statement will be used in defense of a claim.

INCONTESTABILITY

Misrepresentations, omissions and incorrect statements will not prevent a recovery under the policy unless it is either:
1. fraudulent; or
2. material either to the acceptance of the risk, or to the hazard assumed by us; or
3. we in good faith would either not have issued the policy or would not have issued it at the same premium rate, or would not have issued a policy in as large amount or would not have provided coverage with respect to the hazard resulting from the loss, if the true facts had been made known to us as required either by the application for the policy or otherwise.

DISCRETIONARY AUTHORITY, IF GOVERNED BY ERISA

The following applies only when the administration of this policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

We have the discretion and authority to construe disputed or seemingly inconsistent provisions of this policy and to make all decisions regarding eligibility and/or entitlement to coverage or benefits. Whenever we make reasonable determinations which are not arbitrary or capricious in the administration of this policy, such determinations shall be final and conclusive.

LEGAL ACTION

No legal action may be brought to obtain benefits under this 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.

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 and/or benefits available. Complete proof must be supplied by the policyholder documenting any clerical errors.

UNPAID PREMIUM

Upon the payment of a claim under this policy, any unpaid premium may be deducted.

EFFECT OF PRIOR COVERAGE ON LOSSES FOR PRE-EXISTING CONDITIONS

We may pay benefits if an insured employee's or member's claim results from a pre-existing condition if he or she 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 coverage that was provided under the prior group policy 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 insured employee or member must satisfy the pre-existing condition provision under:
a. the American Heritage Life plan; or
b. the prior carrier's plan, if benefits would have been paid had that policy remained in force.

If item a. or b. above is not satisfied, we will not pay any benefits resulting from a pre-existing condition.

If item a. is satisfied, we will determine our payment according to our policy provisions.

GENERAL PROVISIONS (Continued)

IF AN INSURED EMPLOYEE OR MEMBER HAS A LOSS DUE TO A PRE-EXISTING CONDITION AND CHANGES FROM INDIVIDUAL INSURANCE THROUGH AMERICAN HERITAGE LIFE TO GROUP INSURANCE THROUGH AMERICAN HERITAGE LIFE

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

1. in active employment and insured under this plan on its effective date; and
2. insured by the prior individual insurance policy with American Heritage Life when it terminated.

The coverage that was provided under the prior individual policy 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 insured employee or member must satisfy the pre-existing condition provision under:

a. the American Heritage Life plan; or
b. the prior individual insurance policy through American Heritage Life, if benefits would have been paid had the policy remained in force.

If item a. or b. above is not satisfied, we will not pay any benefits resulting from a pre-existing condition.

If item a. or b. is satisfied, we will determine our payments according to our policy provisions.

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CONTINUATION OF INSURANCE (COBRA)

(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES OR MEMBERS)

This section provides for continuation as mandated by federal law for all benefits. It applies if a covered person's insurance would otherwise end due to one of the following events, called a qualifying event.

1. Termination of employment (other than by reason of gross misconduct), or of an insured employee's or member's eligibility due to reduction in his or her hours. Insurance may be continued for any covered person, except for domestic partners and their covered dependents.
2. The death of an insured employee or member. Insurance may be continued for any covered person, except for domestic partners and their covered dependents.
3. Divorce or legal separation. Insurance may be continued for a covered spouse whose insurance would otherwise end. However, COBRA does not extend continuation of coverage to domestic partners and their dependents).
4. The insured employee or member becoming eligible for Medicare. Insurance may be continued for any covered dependents who are not entitled to Medicare, except for domestic partners and their covered dependents.
5. A child ceasing to be an eligible dependent as defined in this policy. Insurance may be continued for that child.
6. The policyholder files a Chapter 11 Bankruptcy petition. Insurance may be continued for any insured retiree and his or her covered dependents. But this only applies if the insurance ends or is substantially reduced within 1 year before or after the filing for bankruptcy.

To choose this continuation of insurance, a person must be insured under this policy on the day before the qualifying event. In the case of bankruptcy, the person must also be: (a) an employee or member who retired on or before the date insurance ends or is substantially reduced; or (b) a dependent of the retiree on the day before the bankruptcy.

A person will not be denied continuation solely because he or she is covered under another group cancer and specified disease policy or eligible for Medicare on the date the qualifying event occurs.

COVERAGE CONTINUED

The insurance being continued is subject to all terms and provisions of this policy that do not conflict with this section. The insurance will be the same as that provided under this policy for other persons in the same insurance class in which such person would have been if the qualifying event had not occurred. The continued insurance will be subject to any changes to this policy affecting the benefits of such class following the qualifying event.

NOTIFICATION AND PAYMENT REQUIREMENTS

The insured employee or member or other qualifying dependents have the responsibility to inform the policyholder of: (a) divorce; (b) legal separation; or (c) a child losing eligibility under this policy. This notice must be made within 60 days of the qualifying event. Failure to provide this notification within 60 days will result in the loss of the right to continue the insurance.

The policyholder has the responsibility of notifying the plan administrator of: (a) an insured employee's or member's death, termination of employment, or reduction in hours; or (b) the policyholder's bankruptcy. This notice must be made within 30 days of the qualifying event.

The plan administrator will notify the qualifying person of the right to continue within 14 days of the notice described above. The person will then have 60 days to elect to continue his or her insurance. Failure to elect to continue insurance within 60 days after a person is notified by the plan administrator will result in loss of the right to continue such insurance.

The qualifying person will be required to pay a premium for the continued insurance to the policyholder. He or she will have 45 days from the date of election to pay the initial premium due. All further premiums will be due on a monthly basis with a 31 day grace period.

CONTINUATION OF INSURANCE (COBRA) – (Continued)

(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES OR MEMBERS)

TERMINATION

Insurance being continued will terminate on the first of the following dates that apply:

1. The date this policy terminates or is amended to terminate the type of insurance being continued.
2. The end of the last period for which premiums for such coverage has been made. This applies if any required premium is not made to the policyholder within 31 days of the due date.
3. The date the person becomes covered under any other group cancer policy, whether as an insured or otherwise. (This will not apply if such other policy contains any exclusion or limitation with respect to any pre-existing condition the person may have.)
4. The date the person becomes entitled to benefits under Medicare. (This will not apply if the qualifying event involves retired employees or members of policyholders under Chapter 11 Bankruptcy and his or her dependents.)
5. The date ending 18 months from the date of the qualifying event for persons who qualify due to termination of employment or reduction in hours worked. However, if a second qualifying event occurs within this 18 month period, the period of coverage for any affected dependent may be extended up to 36 months from the date of the first qualifying event. For all other qualifying events, insurance will terminate on the date ending 36 months from the date of the qualifying event, except as provided below:
   a. If a person is totally disabled for Social Security purposes any time during the first 60 days of continuation coverage, the 18 month period may be extended to 29 months. In order for this additional 11 months of insurance to be effective, the covered person must provide the policyholder or plan administrator with a copy of the notice of the determination. The notice must be provided:
      1. within 60 days of the Social Security determination of total disability; and
      2. within the initial 18 months of continuation coverage.
   b. If an insured employee or member has a qualifying event (termination or reduction in hours worked) and he or she had become entitled to Medicare before the date of this qualifying event, then any other qualified beneficiary (the spouse and/or children) will be entitled to a period of continuation that is the greater of:
      1. 36 months from the date the insured employee or member first became entitled to Medicare; or
      2. 18 months from the insured employee's or member's termination or reduction in hours.
   c. For a qualifying event involving retired employees or members of policyholders under Chapter 11 Bankruptcy and his or her dependents, the maximum period of continuation coverage is:
      1. the lifetime of the retiree; or
      2. the lifetime of the surviving spouse of a retiree who dies before the bankruptcy; or
      3. 36 months after the date of death of the retiree, when such date is after the bankruptcy.
6. With respect to a person entitled to a 29 month period of continuation coverage due to disability of a qualified beneficiary, the date of a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled. However, insurance will not terminate until the last day of the month that next follows the completion of a 30 day period beginning on the date of such final determination.

PORTABILITY PRIVILEGE

We will provide portability coverage, subject to these provisions.

Such coverage will not be available for a covered person, unless:

1. coverage under this policy terminates under the General Provision entitled "Termination of Coverage"; and
2. we receive a written request and payment of the first premiums for the portability coverage not later than 30 days after such termination; and
3. a request is made for that purpose.

No portability coverage will be provided for any person, if his or her insurance under this policy terminated due to his or her failure to make required premium payments.

PORTABILITY COVERAGE

The benefits, terms and conditions of the portability coverage will be the same as those provided under this policy when the insurance terminated. Portability coverage may include any eligible dependents who were covered under this policy. Any change made to this policy after a person is insured under the portability privilege will not apply to that covered person unless it is required by law.

Portability coverage will be effective on the day after insurance under this policy terminates.

PORTABILITY PREMIUMS

Premiums for portability coverage are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The portability premium rate is the rate in effect under this policy for active employees who have the same coverage. The premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least 31 days before the change is to take effect.

GRACE PERIOD

The grace period, as defined in this policy, will apply to each certificate holder of portability coverage as if such covered person is the policyholder.

TERMINATION OF INSURANCE

Insurance under this portability privilege will automatically end on the earliest of the following dates:

1. the date the person again becomes eligible for insurance under this policy; or
2. the last day for which premiums have been paid, if the covered person fails to pay premiums when due, subject to the grace period; or
3. with respect to insurance for dependents:
   a. the date the employee's or member's insurance terminates; or
   b. the date the dependent ceases to be an eligible dependent, as defined.

A dependent child whose portability coverage terminates when he or she reaches the age limit may apply for portability coverage in his or her own name, if he or she is otherwise eligible.

TERMINATION OF THE POLICY

If this policy terminates, insured employees or members and their covered dependents will be eligible to exercise the portability privilege on the termination date of this policy. Portability coverage may continue beyond the termination date of this policy, subject to the timely payment of premiums. Benefits for portability coverage will be determined as if the policy had remained in full force and effect.

LIMITATIONS / EXCEPTIONS

1. PRE-EXISTING CONDITION LIMITATION

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

2. OTHER LIMITATIONS AND EXCEPTIONS

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

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BENEFIT 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 diagnosis is made 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 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.

All claims are to be paid within 30 days from the date that proper notice and proof of claim are received by us.

SCHEDULE OF BENEFITS

We pay the following benefits for the necessary services and products for a covered cancer or a 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, benefits K., W. and X., 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, we pay the amount shown on page 3A per day for each day.

B. 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).

C. Private Duty Nursing Services. While a covered person is an inpatient receiving treatment, we pay 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 the attending physician and must be provided by a nurse.

D. Extended Care Facility. We pay the amount shown on page 3A per day for each day a covered person is confined in an extended care facility. 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.

E. At Home Nursing. While a covered person is receiving treatment, we pay 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. This benefit is limited to the number of days of the previous continuous hospital confinement.

F. Hospice Care. When a covered person is:
1. determined by a physician to be terminally ill; and
2. expected to live 6 months or less;

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

a. Freestanding Hospice Care Center. We pay 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. Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or

b. Hospice Care Team. We pay 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: (1) the covered person has been diagnosed as terminally ill; and (2) the attending physician has approved such services. We do not pay for: (a) food services or meals other than dietary counseling; or (b) services related to well-baby care; or (c) services provided by volunteers; or (d) support for the family after the death of the covered person.

BENEFIT INFORMATION (Continued)

G. Radiation/Chemotherapy for Cancer. We pay the actual cost, up to the amount stated below for radiation therapy and chemotherapy received by a covered person.

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 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: (a) any other chemical substance which may be administered with or in conjunction with radiation/chemotherapy; or (b) 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; or (c) any devices or supplies including intravenous solutions and needles related to these treatments.

H. Blood, Plasma and Platelets. We pay the actual cost, up to the limit stated below, when a covered person receives:
1. blood, plasma and platelets (including transfusions and administration charges); and
2. processing and procurement costs; and
3. cross-matching.

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. We also do not pay for immunoglobulins.

I. Hematological Drugs. We pay the actual cost up to the amount shown on page 3A for drugs intended to boost cell lines such as white blood cell counts, red blood cell counts and platelets. This benefit is paid only when the Radiation/Chemotherapy for Cancer benefit (benefit G.) is paid.

J. Medical Imaging. We pay the actual cost once per calendar year, up to the amount shown on page 3A if a covered person receives an initial diagnosis or follow-up evaluation based upon one of the following medical imaging exams: CT scan; Magnetic Resonance Imaging (MRI) scan; bone scan; thyroid scan; Multiple Gated Acquisition (MUGA) scan; Positron Emission Tomography (PET) scan; transrectal ultrasound; or abdominal ultrasound. This benefit is limited to 1 payment per calendar year per covered person.

K. Surgery. 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 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 a specified disease and that surgery results in a diagnosis of cancer or a specified disease; or
3. that is the first surgery performed subsequent to a diagnosis of cancer or a specified disease that is performed for the purpose of verifying the complete removal of the cancer or specified disease.

If any surgical procedure 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.

L. Anesthesia. We pay 25% of the amount paid for the Surgery benefit (benefit K.) for anesthesia received by an anesthetist.

BENEFIT INFORMATION (Continued)

M. 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:

1. A transplant which is other than non-autologous.
2 A transplant which is non-autologous for the treatment of cancer or a 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.

N. Ambulatory Surgical Center. We pay the amount shown on page 3A for the use of an ambulatory surgical center for a surgical procedure covered under the Surgery Benefit (benefit K.) that is performed at an ambulatory surgical center.

O. Second Opinion. If surgery or treatment is recommended by a physician and the covered person chooses to obtain the opinion of a second physician, we pay the amount shown on page 3A. This second opinion must be: rendered prior to surgery or treatment being performed; and obtained from a physician not in practice with the physician rendering the original recommendation.

P. Inpatient Drugs and Medicine. We pay the amount shown on page 3A for charges per day, made by the hospital for drugs and medicine while hospital confined, for each day of continuous hospital confinement. This benefit does not pay for drugs and/or medicine covered under the Radiation/Chemotherapy benefit (benefit G.) or the Anti-Nausea benefit (benefit AA.).

Q. Physician's Attendance. We pay the amount shown on page 3A per day for a visit by a physician while a covered person is receiving treatment during hospital confinement. 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.

R. Ambulance. We pay 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.

S. Non-Local Transportation. We pay the following benefit for transportation to receive 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.

T. Outpatient Lodging. We pay a daily lodging benefit when a covered person receives radiation or chemotherapy treatment (benefit G.) on an outpatient basis, provided the specific treatment is authorized by the attending physician and cannot be obtained locally. The benefit is for a single room in a motel, hotel, or other accommodations acceptable to us, for 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.

U. 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 they are confined in a non-local hospital for specialized treatment:

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 S.), when the family member lives in the same city or town as the covered person.

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

OPTIONAL BENEFIT(S)

Cancer Initial Diagnosis. We pay a one-time benefit when a covered person is diagnosed for the first time in their life 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.

A. Hospital Intensive Care Unit Confinement. We pay the amount shown on page 3 for each day of continuous hospital intensive care unit confinement, as defined, for any illness or accident. This benefit is limited 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.

Children born within 10 months of the effective date are not covered for any continuous hospital intensive care unit confinement that occurs or begins during the first 30 days of such child's life.

B. Step-Down Hospital Intensive Care Unit Confinement. We pay the amount shown on page 3 for each day of step-down hospital intensive care unit confinement, as defined, for any illness or accident. This benefit is limited 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 step-down hospital intensive care unit confinement if a covered person is admitted and confined in the following type of units: telemetry or surgical recovery rooms; post-anesthesia care units, progressive care units; intermediate care units; private monitored rooms; observation units located in emergency rooms or outpatient surgery units; beds, wards, or private or semi-private rooms with or without telemetry monitoring equipment; an emergency room; labor or delivery rooms; or other facilities that do not meet the standards for a step-down hospital intensive care unit.

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

Children born within 10 months of the effective date are not covered for any step-down hospital intensive care unit confinement that occurs or begins during the first 30 days of such child's life.

C. 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 R.) in the Schedule of Benefits.

DEFINITIONS

As used in this section, the terms listed below have the following meanings:

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.

Hospital Intensive Care Unit Confinement. Means one continuous confinement or two or more step-down 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.

Step-Down Hospital Intensive Care Unit. Means a specifically designated facility of the hospital that provides a level of medical care below the highest level of acute medical care provided in the hospital, but the level of medical care is above the level of care provided in a regular private or semi-private room or ward. The facility must be separate from other hospital areas, permanently equipped with telemetry equipment and under continual observation by nurses specially trained for that level of care.

OPTIONAL BENEFIT(S)

Wellness. We pay this benefit if a covered person has a wellness test performed. We pay the amount shown on page 3 per calendar year per covered person for any one of the wellness 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 wellness tests. The eligible wellness tests are:

1. Biopsy for skin cancer; and
2. Blood test for triglycerides; and
3. Bone Marrow Testing; and
4. CA15-3 (cancer antigen 15-3-blood test for breast cancer); and
5. CA125 (cancer antigen 125 – blood test for ovarian cancer); and
6. CEA (carcinoembryonic antigen – blood test for colon cancer); and
7. Chest X-ray; and
8. Colonoscopy; and
9. Doppler screening for carotids; and
10. Doppler screening for peripheral vascular disease; and
11. Echocardiogram; and
12. EKG (Electrocardiogram); and
13. Flexible sigmoidoscopy; and
14. Hemocult stool analysis; and
15. HPV (Human Papillomavirus) Vaccination; and
16. Lipid panel (total cholesterol count); and
17. Mammography, including Breast Ultrasound; and
18. Pap Smear, including ThinPrep Pap Test; and
19. PSA (prostate specific antigen – blood test for prostate cancer); and
20. Serum Protein Electrophoresis (test for myeloma); and
21. Stress test on bike or treadmill; and
22. Thermography; and
23. Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms.

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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 SURGICAL PROCEDURES (Continued)
PER UNIT OF SURGERY COVERAGE

SURGICAL PROCEDURE	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 PROCEDURES (Continued)
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 tube, 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

CLAIM INFORMATION

NOTICE OF CLAIM

We encourage the insured employee or member 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 insured employee, the member or the beneficiary to us at 1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687, or to any authorized agent of ours, with the insured employee's or member's name and certificate number, is notice to us.

The claim form can be requested from us. If it is not received within 15 days of the request, written proof of the claim may be sent to us without waiting for the form.

FILING A CLAIM

The insured employee or member and the employer must complete their own sections of the claim form and then give it to the attending physician. The physician should complete his or her section of the form and send it directly to us.

PROOF OF CLAIM

If this policy provides for periodic payment of a continuing loss, written proof of loss must be given 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 insured employee or member is legally incapacitated.

COOPERATION OF BENEFICIARY

The beneficiary must reasonably cooperate during any investigation and/or adjudication of a claim. This includes the authorization for the release of medical records and other information.

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 claim, we pay all benefits then due under this policy. Benefits for any other loss covered by this policy are paid when we receive proper written proof. All claims are to be paid within 30 days from the date that proper notice and proof of claim are received by us.

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

If benefits are payable to the insured employee's or member's estate or a beneficiary who cannot execute a valid release, we can pay benefits up to $1,000, to someone related to the insured employee or member 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.

CLAIM INFORMATION (Continued)

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 insured employee or member must reimburse us in full. We will work with such insured employee or member to develop a reasonable method of repayment if he or she is financially unable to repay us in a lump sum.

We will not recover more money than the amount we overpaid.

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 insured employee's or member's right to ask for a review of his or her claim; and
4. the right to submit any additional information that might allow us to change our decision.

The insured employee or member may, upon written request, read any reports that are not confidential. For a fee, we will make copies of those reports.

APPEALS PROCEDURE

Prior to filing any lawsuit and within 60 days after denial of a claim, the insured employee or member 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 or member 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 or member must be working at least the minimum number of hours as described under Eligible Class(es) in each plan. The employee or member will be deemed to be in active employment on a day which is not the employer's scheduled work days only if he or she was actively employed on the preceding scheduled work day.

The employee's or member'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 or member to travel.

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment. Temporary and seasonal workers are excluded from coverage.

Actual Charge. Means the amount billed for a treatment or service before any insurance discounts, other insurance payment, reductions or discounts of any kind.

Actual Cost. Means the amount actually paid by or on behalf of the covered person and accepted by the provider as full payment for the particular goods or services provided.

Ambulatory Surgical Center. Means 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. Means 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. Means 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).

Calendar Year. Means a consecutive 12 month period beginning on January 1st of each year and ending on December 31st of the same year.

Cancer. Means a 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. Means only the following: commercial airlines; or passenger trains; or inter-city buslines. It does not include taxis; intra-city buslines; or private charter planes.

Continuous Hospital Confinement. Means 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.

Covered Person. Means any of the following:
1. any eligible family member (including the employee or member) named on 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. Means 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.

GLOSSARY (Continued)

Domestic Partner. Means the employee's or member's same-sex or opposite-sex partner who is eligible for coverage providing that:

1. both the employee or member and the employee's or member's same-sex or opposite sex partner must be considered as domestic partners according to the law of employee's or member's state of residence; or
2. if the employee's or member's state of residence has no domestic partnership laws, but the policyholder seeks to provide insurance benefits to domestic partners, the employee or member must satisfy the definition of domestic partner as defined by the policyholder; or
3. if the employee's or member's state of residence has no domestic partnership law and the policyholder has no domestic partnership definition, but the policyholder seeks to provide insurance benefits to domestic partners, then both the employee and member and the employee's or member's same-sex or opposite sex partner must:
   a. have resided together in the same permanent residence; and
   b. be at least 18 years of age; and
   c. intend to remain each other's sole domestic partner indefinitely; and
   d. be emotionally committed to one another and share joint responsibilities for the common welfare and financial obligations of one another; or the domestic partner must be chiefly dependent upon the employee or member for care and financial assistance; and
   e. not be legally married to or the legal domestic partner of anyone else; and
   f. not be related by blood closer than would prohibit marriage under applicable state law.

If requested by us, satisfactory proof must be submitted that supports the domestic partner's eligibility for coverage.

Employee. Means a person who is: (a) a citizen or resident of the United States or one of its territories; and (b) in active employment with the employer or is a member in good standing in the labor union, association or other entity named as the policyholder.

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

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

Extended Care Facility. Means 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.

Family Coverage. Means coverage that includes the insured employee or member as defined, his or her spouse or domestic partner and eligible children.

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

Grace Period. Means a period of 31 days following the premium due date during which premium payment may be made.

Hospital. Means 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.

GLOSSARY (Continued)

Individual and Child(ren) Coverage. Means coverage that includes only the insured employee or member, as defined and eligible children.

Individual and Spouse Coverage. Means coverage that includes only the insured employee or member, as defined, and his or her eligible spouse or domestic partner.

Individual Coverage. Means coverage that includes only the insured employee or member, as defined.

Initial Enrollment Period. Means one of the following periods during which the employee or member may first apply in writing for coverage under this policy:
1. if the employee or member is eligible for coverage on the policy effective date, a period before the policy effective date as set by us and the policyholder; or
2. if the employee or member 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 Employee or Member. Means the employee or member 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. Means 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 or member's regular occupation; and
2. cannot be reasonably omitted or modified, except that if the employee or member is required to work on average in excess of 40 hours per week, we will consider such person able to perform that requirement if he or she is working or has the capacity to work 40 hours per week.

Member. Means a member in good standing in an labor union, association or other entity named as the policyholder and who is: (a) a citizen or resident of the United States; and (b) is (1) engaged in , or (2) able to engage in and currently seeking, active employment.

Non-Autologous Bone Marrow Transplant. Means an allogeneic or syngeneic graft of living bone marrow from one human being to another.

Nurse. Means 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. a licensed practical nurse (L.P.N.); or
2. a registered nurse (R.N.).

Oncologist. Means a legally licensed Doctor of Medicine or Doctor of Osteopathic Medicine certified to practice in the field of Oncology.

Pathologist. Means a legally licensed Doctor of Medicine or Doctor of Osteopathic 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 insured employee or member, his or her spouse, children, parents, or siblings as a physician for a claim.

GLOSSARY (Continued)

Policyholder. Means the legal entity to whom this policy is issued.

Positive Diagnosis (of cancer). Means 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). Means a diagnosis by a qualified physician based on generally accepted diagnostic procedures and criteria.

Pre-Existing Condition. Means a disease or physical condition for which:

1. symptoms existed within the 12 month period prior to the effective date of coverage; or
2. medical advice or treatment was recommended or received from a member of the medical profession within the 12 month period prior to the effective date of coverage.

A pre-existing condition can exist even though a diagnosis has not yet been made.

Radiologist. Means a person who is licensed to administer X-ray therapy, radium therapy, or radio-active isotopes therapy and is certified by the American Board of Radiology.

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

Stem Cell Transplant. Means 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, Leave of Absence or Family and Medical Leave of Absence. Means the employee or member is absent from active employment for a period of time that has been agreed to in advance in writing by the current employer.

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

Tentative Diagnosis. Means a diagnosis based upon dated medical records which indicate a diagnosis of a probable or possible cancer or specified disease.

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

AMERICAN HERITAGE LIFE INSURANCE COMPANY

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A Stock Company

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OTHER OPTIONAL BENEFITS
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