American Heritage Life Insurance Company

A Cancer and Specified Disease Insurance Illustration

Name:	Sample Employee
Age:	40
Application Signature State:	Washington
Case Name:	
Agent Name:	9LBA1 LOSEE STEVE
Policy:	GVCP2 Group Voluntary Cancer (GVCP2)
Type of Coverage:	Employee Only
Plan Type:	Type 3
Benefits:	
Hospital Confinement	1 unit
Radiation/Chemotherapy Benefits	4 units
Surgery and Related Benefits	2 units
Miscellaneous Benefits	1 unit
Optional/Additional Benefits:	
Cancer Screening Benefit	1 unit
Cancer Initial Diagnosis Benefit	2 units
Premium Payment Mode:	Monthly
Premium by Benefits:	
Hospital Confinement	$0.88
Radiation/Chemotherapy Benefits	$6.64
Surgery and Related Benefits	$2.68
Miscellaneous Benefits	$0.60
Cancer Screening Benefit	$0.50
Cancer Initial Diagnosis Benefit	$1.28
Total Modal Premium:	$12.58

February 22, 2017

In addition to cancer, this policy also covers Muscular Dystrophy, Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Poliomyelitis, Multiple Sclerosis, Encephalitis, Rabies, Tetanus, Tuberculosis, Osteomyelitis, Diphtheria, Scarlet Fever, Cerebrospinal Meningitis (bacterial), Brucellosis, Sickle Cell Anemia, Thallasemia, Rocky Mountain Spotted Fever, Legionnaire's Disease (confirmation by culture or sputum), Addison's Disease, Hansen's Disease, Tularemia, Hepatitis (Chronic B or Chronic C with liver failure or Hepatoma), Typhoid Fever, Myasthenia Gravis, Reye's Syndrome, Primary Sclerosing Cholangitis (Walter Payton's Liver Disease), Lyme Disease, Systemic Lupus Erythematosus, Cystic Fibrosis, Primary Biliary Cirrhosis.

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.

BENEFITS	Maximum Benefit Payable
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 per day for each day. The maximum number of days payable is 70 days for each period of continuous hospital confinement.	$100/Day; Maximum 70 Days
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 per day. 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 (except the Waiver of Premium Benefit). This benefit continues as long as the covered person is continuously hospital confined.	$100/Day
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 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.	$100/Day
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 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.	$100/Day
E. Extended Care Facility. We pay actual charges up to the amount shown 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.	$100/Day
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 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.	$100/Day

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 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	$100/Day
2. *Hospice Care Team.* We pay actual charges up to the amount shown per visit, limited to one 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.	$100/Day
H. Radiation/Chemotherapy. We pay actual charges, up to the limit stated, 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 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.	Maximum $10,000 per 12 Months
I. Blood, Plasma and Platelets. We pay actual charges, up to the limit stated, 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 per 12 month period beginning with the first day of benefit under this provision. We do not pay for blood replaced by donors.	Maximum $10,000 per 12 Months
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 in the policy for the specific procedure 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 policy.	Maximum $3,000; Depends on Surgery
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.	25% of Surgery

L. Bone Marrow or Stem Cell Transplant. We pay actual charges up to the amounts shown 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. $1,000/Year
2. A transplant which is non-autologous for the treatment of cancer or specified disease other than Leukemia. $2,500/Year
3. A transplant which is non-autologous for the treatment of Leukemia. $5,000/Year

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

M. Ambulatory Surgical Center. We pay the actual charges for the use of an ambulatory surgical center, up to the amount shown for a surgical procedure covered under the Surgery Benefit (benefit J.) that is performed at an ambulatory surgical center. $500/Day

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. 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. $400

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 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). $25/Day

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 while admitted to the hospital as an inpatient up to the amount shown 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. $50/Day

Q. Ambulance. We pay actual charges up to the amount shown 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. $100/Confinement

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, up to 700 miles, for round trip personal vehicle transportation. 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. "Non-Local" means a round trip of more than 70 miles from the covered person's home to the nearest treatment facility. Mileage is measured from the covered person's home to the hospital where the covered person is confined. Coach Fare or $0.40/Mile

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 per day during treatment. This benefit is limited to the amount shown 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. $50/Day; $2,000Max. per 12 Months

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 per day. This benefit is limited to 60 days for each period of continuous hospital confinement; and — $50/Day
2. *Transportation* - The actual cost of round trip coach fare on a common carrier or a personal vehicle allowance of the amount shown 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. — Coach Fare or $0.40/Mile

U. Physical or Speech Therapy. We pay actual charges up to the amount shown per day, for physical or speech therapy for restoration of normal body function. — $50/Day

V. New or Experimental Treatment. We pay actual charges, up to the amount shown, 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 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 policy. — Maximum $5,000 per 12 Months

W. Prosthesis and Reconstructive Breast Surgery. We pay the following benefits for Prosthesis and Breast Reconstruction.

1. *Prosthesis.* We pay actual charges up to the amount shown for prosthetic devices which are prescribed as a direct result of surgery for cancer or specified disease and which require surgical implantation. This benefit is limited to the amount shown per covered person, per amputation. — $2,000 per Amputation
2. *Reconstructive Breast Surgery.* We pay actual charges up to the amount shown for reconstructive breast surgery following a mastectomy that is covered under this policy. This includes charges for all stages of one breast reconstruction on the non-diseased breast to make it equal in size with the diseased breast after definitive reconstructive surgery on the diseased breast has been performed. This benefit is limited to the amount shown. — $1,200

X. Comfort/Anti-Nausea Benefit. We pay the actual charges, up to the amount shown 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. — $200/Year

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.

OPTIONAL/ADDITIONAL BENEFITS	Maximum Benefit Payable
Cancer Initial Diagnosis Benefit. We pay a one-time benefit of the amount shown 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 payable only once per covered person.	$2,000
Cancer Screening Benefit. We pay this benefit if a covered person has a covered cancer screening test performed. We pay the amount shown per calendar year per covered person for any one of the cancer screening tests. We pay this benefit regardless of the result of the test. The eligible cancer screening tests are: Bone marrow testing; CA15-3 (cancer antigen 15-3-blood test for breast cancer); CA125 (cancer antigen 125 - blood test for ovarian cancer); CEA (carcinoembryonic antigen - blood test for colon cancer); Chest X-ray; Colonoscopy; Flexible sigmoidoscopy; Hemocult stool analysis; Mammography; Pap Smear; PSA (prostate specific antigen - blood test for prostate cancer); and Serum Protein Electrophoresis (test for myeloma).	$25/Year

TERMS OF COVERAGE

Coverage is subject in every way to the terms of the policy that is issued to the policyholder (employer). The group policy may at any time be amended or discontinued by agreement between us and the policyholder. Your consent is not required for this. Neither are we required to give you prior notice. Family Plan coverage may include you, your spouse or domestic partner and dependent children as defined in the policy. Your coverage under the policy ends on the earliest of the date the policy is canceled; or the last day of the period for which you made any required premium payments; or the last day you are in active employment; or the date you are no longer in an eligible class; or the date your class is no longer eligible. If your spouse is a covered person, your spouse's coverage ends upon valid decree of divorce or your death. If your domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or your death. Coverage for your child will end on the issue day of the month that follows when the child reaches age 26 or otherwise does not meet the requirements of an eligible dependent. The Cancer Initial Diagnosis Benefit terminates when a benefit is paid on all covered persons.

CONVERSION PRIVILEGE

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

PRE-EXISTING CONDITION, EXCEPTIONS AND LIMITATIONS

If a covered person has a pre-existing condition as defined, we do not pay benefits for such conditions under this policy during the 12 month period beginning on the date that person became a covered person. A Pre-Existing Condition is 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. 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. 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 amount shown for the benefits payable.

This brochure highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy itself sets forth, in detail, the rights and obligations of both the insured and the insurance company.

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.

The policy is not a Medicare Supplement Policy. If eligible for Medicare, review the Medicare Supplement Buyer's Guide, available from American Heritage Life Insurance Company.