AMERICAN HERITAGE LIFE INSURANCE COMPANY

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

CANCER AND SPECIFIED DISEASE ADDITIONAL BENEFIT RIDER

Notice: To obtain information about this coverage, or for assistance in resolving complaints, you may contact the Company at 1-800-521-3535.

This rider is issued in consideration of the rider premium and the application for the rider. The benefits are paid in addition to the benefits of the policy, unless otherwise stated, subject to the PRE-EXISTING CONDITION LIMITATION and OTHER EXCLUSIONS AND LIMITATIONS provisions. The benefit is subject to all the terms, conditions, and provisions of the policy. All terms defined and used in the policy apply to this rider, unless otherwise provided in this rider.

DEFINITIONS

Rider date means the effective date of coverage under this rider. The rider date is the effective date of the policy, unless this rider is applied for at a later date. If this rider is applied for at a later date, the rider date is the effective date assigned by our Home Office.

Policy means the policy to which this rider is attached.

Unit means the benefits in this rider. The number of units of this rider is shown on page 3 of the policy. All benefit amounts are calculated according to the number of units purchased.

BENEFITS

We pay the following benefits for the treatment of a covered cancer or specified disease. Treatment must be received in the United States or its territories. No benefits are payable for the treatment of cancer or a specified disease except those expressly stated in this section.

Each benefit under this rider is only payable if the same benefit is payable under the policy.

A. Continuous Hospital Confinement. We pay $100 per day, per unit of coverage, when a covered person is confined in a hospital.

B. Government or Charity Hospital. We pay $100 per day, per unit of coverage, when a covered person is confined in a hospital that is operated by or for the U.S. Government (including the Veteran's Administration), or a hospital that does not charge for the services it provides (charity). This benefit is paid in lieu of all other benefits in this rider.

C. Private Duty Nursing Services. We pay $100 per day, per unit of coverage, when a covered person receives the full-time services of a private nurse while confined in a hospital receiving treatment. 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. The nurse cannot be employed by the hospital where the covered person is confined.

D. Extended Care Facility. We pay $100 per day, per unit of coverage, when 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 confinement in the hospital.

E. At Home Nursing. We pay $100 per day, per unit of coverage, when a covered person is receiving 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 confinement in the hospital.

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F. Hospice Care. We pay one of the following 2 benefits for hospice care when a covered person is determined by a physician to be terminally ill and expected to live 6 months or less:

1. **Freestanding Hospice Care Center.**
   a. We pay $1,000, per unit of coverage, for the first day a covered person is confined in a licensed freestanding hospice care center. This benefit is payable only once per covered person. 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 under the Continuous Hospital Confinement benefit.
   b. We also pay $100 per day, per unit of coverage, for each additional day of confinement in a licensed freestanding hospice care center.

2. **Hospice Care Team.**
   a. We pay $1,000, per unit of coverage, for the first time a covered person is visited by and receives home care services by a hospice care team. This benefit is payable only once per covered person. Home care services are hospice services provided in the patient's home. The covered person must be diagnosed by a physician as terminally ill and the attending physician must approve the services. We do not pay for: (i) food services or meals other than dietary counseling; or (ii) services related to well-baby care; or (iii) services provided by volunteers; or (iv) support for the family after the death of the covered person.
   b. We also pay $100 per visit, per unit of coverage, limited to 1 visit per day, for each additional visit by a hospice care team.

G. Radiation/Chemotherapy for Cancer. We pay the actual cost, up to $5,000, per unit of coverage, for only those individual items, within any of the following treatment techniques, that are directly for the modification or destruction of cancerous tissue:

1. teleradio therapy using either natural or artificially propagated radiation;
2. interstitial or intracavity application of radium or radioactive isotopes in sealed or non-sealed sources;
3. chemical substances, including hormonal therapy;
4. antigenic preparation or immunosuppressive techniques.

This benefit is limited to $5,000, per unit of coverage, per policy coverage year, and limited to a lifetime maximum of $25,000, per unit of coverage. This benefit is only payable after the limit per coverage year in the policy has been reached. We then pay the actual cost up to $5,000, per unit of coverage, in that coverage year. Hospital confinement is not necessary to receive this benefit. Treatment must be administered by a radiologist, chemotherapist, or oncologist.

Unless specified elsewhere in this policy, we do not pay for any or all of the following:

1. treatment planning, consultation, or management;
2. the design and construction of treatment devices;
3. medications or drugs, other than chemotherapeutic drugs;
4. medications or drugs covered elsewhere in the policy or this rider;
5. emergency or treatment room charges;
6. supplies or devices related to treatment;
7. X-rays, scans, and their interpretations;
8. drugs, charges or expenses that do not directly modify or destroy cancerous tissue, even though they may be supportive or protective of, necessary for use with, or used in conjunction with, drugs, charges or expenses that directly modify or destroy cancerous tissue.

If actual cost is not obtainable as proof of loss, we will pay 50% of the billed amount for this benefit, up to the applicable maximum of $5,000, per unit of coverage.

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H. Blood, Plasma and Platelets. We pay the actual cost, up to $5,000, per unit of coverage, when a covered person receives:
1. blood, plasma and platelets (including transfusions and administration charges); and
2. processing and procurement charges; and
3. cross-matching.

This benefit is limited to $5,000, per unit of coverage, per policy coverage year. This benefit is only payable after the limit per coverage year in the policy has been reached. We then pay the actual cost up to $5,000, per unit of coverage, in that coverage year. We do not pay for blood replaced by donors. We also do not pay for immunoglobulins.

If actual cost is not obtainable as proof of loss, we will pay 50% of the billed amount for this benefit, up to the applicable maximum of $5,000, per unit of coverage.

I. Hematological Drugs. We pay $100, per unit of coverage, when a covered person receives 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 in the policy is paid. This benefit is payable only once per covered person per coverage year.

J. Medical Imaging. We pay $250, per unit of coverage, when 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 payable only once per covered person per coverage year.

K. Surgery. We pay the amount listed in the Schedule of Surgical Procedures in the policy for the specific procedure, per unit of coverage, 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 an amount based upon the amount shown in the Schedule of Surgical Procedures for the most comparable surgery. 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 BENEFITS section.

L. Anesthesia. We pay 25% of the amount paid for the Surgery benefit in this rider for anesthesia received by an anesthetist.

M. Bone Marrow Transplant. We pay $3,500, per unit of coverage, when a covered person receives a bone marrow transplant. This benefit is payable only once per covered person per coverage year.

N. Stem Cell Transplant. We pay $3,500, per unit of coverage, when a covered person receives a stem cell transplant. This benefit is payable only once per covered person per coverage year.

O. Ambulatory Surgical Center. We pay $250 per day, per unit of coverage, when a covered person undergoes surgery performed in an ambulatory surgical center, provided a benefit is paid under the Surgery benefit in the policy.

P. Second Opinion. We pay $100, per unit of coverage, when a covered person is recommended by a physician to have surgery or treatment, and the covered person chooses to obtain the second opinion of a second physician. 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. This benefit is payable only once per covered person per coverage year.

EXCLUSIONS AND LIMITATIONS

The PRE-EXISTING CONDITION LIMITATION and OTHER EXCLUSIONS AND LIMITATIONS provisions of the policy apply to this rider.

TERMINATION

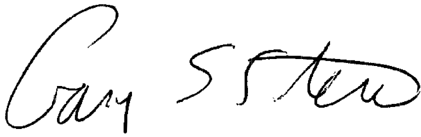
This rider terminates at the earliest of:

1. the end of the grace period for the payment of the premium for the policy or this rider unless all of the unpaid premium is made during the grace period; or
2. the date the policy terminates; or
3. the date requested by the insured to terminate coverage; or
4. the next renewal date after a request for termination.

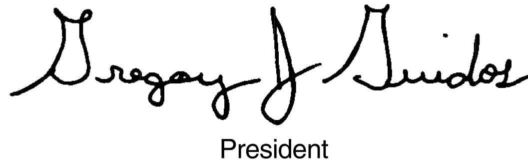
RENEWABILITY

The GUARANTEED RENEWABLE provision of the policy applies to this rider.

Signed for AMERICAN HERITAGE LIFE INSURANCE COMPANY at its Home Office.



Secretary



President