American Heritage Life Insurance Company

A Cancer and Specified Disease Insurance Illustration

Name:	Test Tester
Age:	30
Application Signature State:	Florida
Case Name:	
Agent Name:	2A0K0 ENROLLMENT ALLIANCE
Policy:	CP12 Cancer (CP12)
Type of Coverage:	Individual
Benefits:	
Hospital Confinement	2 units
Radiation/Chemotherapy Benefits	2 units
Surgery and Related Benefits	2 units
Miscellaneous Benefits	1 unit
Optional/Additional Riders:	
Cancer Initial Diagnosis Level Benefit Rider	9 units
Fixed Wellness Benefit Rider	3 units
Premium Payment Mode:	Weekly
Premium by Benefits:	
Hospital Confinement	$0.71
Radiation/Chemotherapy Benefits	$2.63
Surgery and Related Benefits	$0.90
Miscellaneous Benefits	$0.29
Cancer Initial Diagnosis Level Benefit Rider	$2.59
Fixed Wellness Benefit Rider	$0.49
Total Modal Premium:	$7.61

April 9, 2017

Allstate Benefits is the marketing name for American Heritage Life Insurance Company, a subsidiary of the Allstate Corporation, Home Office: Northbrook, Illinois. All products are underwritten by American Heritage Life Insurance Company. Home Office: Jacksonville, Florida. This illustration highlights some features of the policy and riders, but is not the insurance contract. Only the actual policy and rider provisions control. The policy and riders set forth, in detail, the rights and obligations of both the insured and the insurance company. ©2017 Allstate Insurance Company.

In addition to cancer, the policy also covers Addison's Disease, Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Brucellosis, Diphtheria, Encephalitis, Hansen's Disease, Hepatitis (Chronic B or Chronic C with liver failure or hepatoma), Legionnaire's Disease (confirmation by culture or sputum), Lyme Disease, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Primary Biliary Cirrhosis, Rabies, Reye's Syndrome, Rocky Mountain Spotted Fever, Sickle Cell Anemia, Systemic Lupus Erythematosus, Tetanus, Thalassemia, Tuberculosis, Tularemia, Typhoid Fever.

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.

Continuous Hospital Confinement. We pay the amount shown per day when a covered person is confined in a hospital. — $200/day

Government or Charity Hospital. We pay the amount shown per day when a covered person is confined in a hospital 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). Paid in lieu of all other benefits in the policy except the Waiver of Premium benefit. — $200/day

Private Duty Nursing Services. We pay the amount shown per day 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. — $200/day

Extended Care Facility. We pay the amount shown per day 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 hospital confinement. — $200/day

At Home Nursing. We pay the amount shown per day 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 hospital confinement. — $200/day

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 the amount shown for the first day a covered person is confined in a licensed freestanding hospice care center. 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. — $2,000

b. We also pay the amount shown per day for each additional day of confinement in a licensed freestanding hospice care center. — $200/day

2. Hospice Care Team.

a. We pay the amount shown for the first time a covered person is visited by and receives home care services by a hospice care team. 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: 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. — $2,000

b. We also pay the amount shown per visit, limited to 1 visit per day, for each additional visit by a hospice care team. — $200/day

Benefit	Amount
Radiation/Chemotherapy for Cancer. We pay the actual cost, up to the amount shown, for radiation therapy and chemotherapy received by a covered person. This benefit is limited to the amount shown per coverage year, subject to the lifetime maximum amount shown. If actual cost is not obtainable as proof of loss, we will pay 50% of the billed amount for this benefit, up to the maximum amount shown.	Up to $10,000/year; Lifetime Max $50,000
Blood, Plasma and Platelets. We pay the actual cost, up to the amount shown, 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 the amount shown per coverage year. We do not pay for blood replaced by donors. We 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 maximum amount shown.	Up to $10,000/year
Hematological Drugs. We pay the amount shown 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 is paid. Payable only once per covered person per coverage year.	$200/year
Medical Imaging. We pay the amount shown 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. Payable only once per covered person per coverage year.	$500/year
Surgery. We pay the amount listed in the Schedule of Surgical Procedures in the policy, 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 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. 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 the policy.	Up to $3,000 Depends on Surgery
Anesthesia. We pay 25% of the amount paid for the Surgery benefit for anesthesia received by an anesthetist.	25% of Surgery
Bone Marrow or Stem Cell Transplant. We pay the amount shown when a covered person receives a bone marrow transplant. Payable only once per covered person per coverage year.	$7,000/year
Stem Cell Transplant. We pay the amount shown when a covered person receives a stem cell transplant. Payable only once per covered person per coverage year.	$7,000/year
Ambulatory Surgical Center. We pay the amount shown per day when a covered person undergoes surgery performed at an ambulatory surgical center, provided a benefit is paid under the Surgery benefit.	$500/day
Second Opinion. We pay the amount shown when a covered person is recommended by a physician to have surgery or treatment and the covered person chooses to obtain the 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. Payable only once per covered person per coverage year.	$200

Benefit	Amount
Inpatient Drugs and Medicine. We pay the amount shown for each day charges are made by the hospital for drugs and medicine while the covered person is confined in a hospital. This benefit does not pay for drugs and/or medicine covered under the Radiation/Chemotherapy for Cancer benefit or the Anti-Nausea benefit.	$25/day
Physician's Attendance. We pay the amount shown for each day a physician visits a covered person while confined in a hospital. This benefit is limited to one visit by one physician per day of hospital confinement. A visit means personal attendance by the physician.	$50/day
Ambulance. We pay the amount shown for each day a covered person is transferred by a licensed ambulance service or hospital owned ambulance to or from a hospital.	$250 Ground $10,000 Air
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, 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.	Coach Fare or $0.50/mile
Outpatient Lodging. We pay the amount shown for each day a covered person receives radiation or chemotherapy 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 per day during treatment. This benefit is limited to the amount shown per coverage year. Outpatient treatment must be received at a treatment facility more than 100 miles from the covered person's home.	$100/day Max $2,000/year
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:	
1. *Lodging.* We pay the amount shown for each day of lodging in a single room in a motel, hotel, or other accommodations acceptable to us. This benefit is limited to 60 days for each period of continuous hospital confinement; and	$100/day
2. *Transportation.* We pay 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, when the family member lives in the same city or town as the covered person.	Coach Fare or $0.50/mile
Physical or Speech Therapy. We pay the amount shown for each day a covered person undergoes physical or speech therapy for restoration of normal body function.	$50/day
New or Experimental Treatment. We pay the actual cost, up to the amount shown, when a covered person receives 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 coverage year. This benefit does not pay if benefits are payable for treatment covered under any other benefit in the policy. If actual cost is not obtainable as proof of loss, we will pay 50% of the billed amount for this benefit, up to the maximum amount shown.	Up to $5,000/year

Benefit	Amount
Prosthesis. We pay the amount shown when a covered person is prescribed a prosthetic device as a direct result of surgery and which requires surgical implantation. This benefit is payable only once per covered person, per amputation.	$2,000/ amputation
Hair Prosthesis. We pay the amount shown every 2 years for a wig or hairpiece if the covered person experiences hair loss.	$50/2 years
Nonsurgical External Breast Prosthesis. We pay the amount shown for the initial, nonsurgical breast prosthesis following a covered mastectomy or partial mastectomy that is paid for under the policy.	$100/initial prosthesis
Anti-Nausea Drugs. We pay the amount shown per coverage year when a covered person is prescribed anti-nausea medication by a physician. We will not pay this benefit for medication administered while the covered person is confined in a hospital.	$200/year
National Cancer Institute (NCI) Evaluation/Consultation. We pay the amount shown per coverage year when a covered person receives an evaluation or consultation at an NCI-sponsored cancer center as a result of a previous diagnosis of cancer other than skin cancer.	$500/year
Egg Harvesting and Storage.	
1. *Extraction and Harvesting of Oocytes.* We pay the amount shown one time when a covered person has oocytes extracted and harvested. Payable only once per covered person.	$500
2. *Storage of Oocytes or Sperm.* We pay the amount shown one time when a covered person has oocytes or sperm stored with a licensed reproductive tissue bank or similarly licensed facility. Payable only once per covered person.	$175
Extraction, harvesting or storage must occur prior to radiation or chemotherapy treatment.	
Waiver of Premium for Cancer. If, while this coverage is in force, the insured becomes disabled due to cancer first diagnosed after the effective date of coverage and remains disabled for at least 90 consecutive days, we waive premiums for the policy until the earliest of: the date the insured is no longer disabled; or 5 years from the first day of disability; or the date coverage ends as explained in the Termination section.	

Cancer Initial Diagnosis Level Benefit Rider

We pay a one-time benefit of $4,500 when a covered person is diagnosed as having cancer (other than skin cancer) for the first time after the effective date of coverage for that covered person. Payable only once per covered person. This rider terminates when a benefit is paid on all covered persons.

The Pre-existing Condition Limitation and Other Exclusions and Limitations sections apply to this rider.

Fixed Wellness Benefit Rider

We pay $75 per day when a covered person has an eligible wellness benefit performed. Payable only once per day per covered person, limited to one day per calendar year, per covered person. The eligible wellness benefits are: Biopsy for skin cancer; Blood test for triglycerides; 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; Doppler screening for carotids; Doppler screening for peripheral vascular disease; Echocardiogram; EKG (Electrocardiogram); Flexible sigmoidoscopy; Hemocult stool analysis; HPV (Human Papillomavirus) Vaccination; Lipid panel (total cholesterol count); Mammography, including Breast Ultrasound; Pap Smear, including ThinPrep Pap Test; PSA (prostate specific antigen - blood test for prostate cancer); Serum Protein Electrophoresis (test for myeloma); Stress test on bike or treadmill; Thermography; and Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms.

Pre-existing Condition Limitation

We do not pay for any benefits due to, or caused by, a pre-existing condition 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: symptoms existed within the 12 month period prior to the effective date of coverage; or 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 does not include routine breast cancer follow-up care.

Other Exclusions and Limitations

We do not pay for any loss except for losses due directly from cancer or a specified disease. We do not pay for any disease or incapacity that has been caused, complicated, worsened or affected by cancer or a specified disease or as a result of cancer or specified disease treatment. Diagnosis must be submitted to support each claim.

Effective Date

The effective date of coverage will be the policy date assigned by the Home Office and shown on the policy specification page, not the application date.

Termination

Your coverage under the policy ends on the earliest of: the due date of any unpaid premium, subject to the grace period; or the date you requested to terminate coverage; or the next renewal date after a request for termination; or your death except that your spouse or domestic partner, if covered, becomes the new insured. If your spouse is a covered person, your spouse’s coverage ends upon final divorce. If your domestic partner is a covered person, your domestic partner’s coverage ends upon termination of the domestic partnership. 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 policy is a Limited Benefit Cancer and Specified Disease Insurance policy. 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.