AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

We agree to pay the benefits set out in this policy subject to its provisions, exclusions and limitations. This policy is a legal contract between you and us, American Heritage Life Insurance Company.

CONSIDERATION

Your policy is issued to you in consideration of statements made in your application and the payment of the premium shown on the Policy Specifications page. Your policy is effective from 12:01 a.m. Standard Time in the state where you reside on the effective date. It expires at 12:01 a.m. on the last day of the grace period unless you pay the next renewal premium.

NOTICE OF 10 DAY RIGHT TO EXAMINE POLICY

You may, within 10 days after receipt of this policy, return it to us or to our agent. You will receive a refund of all premiums paid and your policy will be void from the effective date. If you return this policy, please note on it in writing: This policy is returned for rescission and refund of premium.

IMPORTANT NOTICE

Please read the copy of the application attached to this policy. Carefully check the application and write to us in Jacksonville, Florida, within 10 days, if any information shown on it is not correct and complete. The application is a part of the policy and the policy was issued on the basis that the information shown on the application is correct and complete.

GUARANTEED RENEWABLE FOR LIFE, SUBJECT TO OUR RIGHT TO CHANGE PREMIUMS BY CLASS

Your policy will remain in effect when renewal premiums are paid as they are due or during the grace period. Renewal premiums will be at the premium rates in effect on the renewal date.

Once this policy has been issued, we cannot place any restrictive riders on it or cancel or refuse to renew your policy if you maintain it continuously in force. We can change the premium rates on premiums becoming due after the first premium. However, we can only change the rate on this policy by making the rate change for all such policies in a class. If we do change rates on all like policies in your class, we will mail you a notice of this change. Notice will be mailed at least 45 days prior to such change. It will be mailed to your address as shown on our records. No change in premiums is effective unless this notice is mailed.

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

Signed for AMERICAN HERITAGE LIFE INSURANCE COMPANY at its Home Office on the effective date.

Secretary

President

THIS IS A LIMITED BENEFIT CANCER AND SPECIFIED DISEASE POLICY.
IT ONLY PROVIDES BENEFITS FOR LOSS DUE TO CANCER AND SPECIFIED DISEASES AS DEFINED OR OTHER BENEFITS THAT MAY BE ADDED BY RIDER.
IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.

NON-PARTICIPATING
CANCER AND SPECIFIED DISEASE INDEMNITY POLICY

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DEFINITIONS

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 any ambulatory surgical center that is part of a hospital.

Bone marrow transplant means a procedure to replace bone marrow destroyed by treatment with high doses of anti-cancer drugs or radiation. A transplant may be autologous (the person's own marrow saved before treatment), allogeneic (marrow donated by someone else) or syngeneic (marrow donated by an identical twin).

Cancer 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.

Chemotherapeutic drug means a drug which directly modifies or destroys cancerous tissue. Drugs that are supportive or protective of, necessary for use with, or used in conjunction with, drugs that directly modify or destroy cancerous tissue but which do not themselves directly modify or destroy cancerous tissue are not chemotherapeutic drugs.

Chemotherapist means one who is licensed to administer chemotherapy or immunotherapy and who is certified by either the American Board of Internal Medicine, Radiology, or Hematology.

Class means any group of persons insured individually under this policy who have a common bond, such as age, sex, occupation, premium payment method, or geographical area.

Common carrier means only the following: commercial airlines; or passenger trains; or intercity buslines. It does not include taxis; intracity buslines; or private charter planes.

Confined or confinement means admitted to and confined as an inpatient in an institution for which a room and board charge is made by the institution. It does not include confinement for an observation room or confinement for a non-covered cancer or specified disease.

Continuous Confinement means 1 continuous confinement or 2 or more confinements not separated by more than 30 days. If there are more than 30 days between confinements, they are considered separate confinements.

Coverage anniversary means the same day and month each year as the effective date of the policy for each succeeding year the policy remains in force.

Coverage year means a consecutive 12 month period during which the policy is in force. The first coverage year begins on the effective date of the policy and ends after 12 consecutive months of coverage. Dependents added later will have the same coverage year as the insured.

Covered person means any of the following:

1. the insured; or
2. any eligible family member named in the application and not excluded from coverage by a signed waiver; or
3. any eligible family member added to this policy by endorsement after the effective date; or
4. 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.

Day means a 24-hour period.

DEFINITIONS (Continued)

Disabled means you are:
1. unable to work; and
2. not working at any job for pay or benefits; and
3. under the care of a physician for the treatment of a covered cancer.

Domestic partner means the insured's same-sex or opposite-sex partner who is eligible for coverage provided that:
1. both the insured and his or her same-sex or opposite-sex partner must be considered as domestic partners according to the law of their state of residence; or
2. if their state of residence has no domestic partnership laws, they must satisfy the following:
   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 insured 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.

Effective date means the effective date shown on the POLICY SPECIFICATIONS page. This date is assigned by the Home Office. The effective date is not the date the insured signed the application for coverage.

Extended care facility means a licensed nursing facility under the direction of a physician which provides continuous skilled nursing services 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, as defined, his or her spouse or domestic partner and eligible children.

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

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.

No claim for payment under this policy for treatment, care or services in a licensed hospital, which is accredited by the Joint Commission on the Accreditation of Rehabilitative Services, shall be denied because such hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for treatment of physical disability.

Individual coverage means coverage that includes only the insured, as defined.

Insured means the person accepted for coverage by us who has completed and signed the application and whose name appears on the POLICY SPECIFICATIONS page.

Issue day means the same day of the month as the effective date of the policy.

Non-local means a round trip of more than 70 miles from the covered person's home to the nearest treatment facility.

Nurse means any one of the following who is not a member of the covered person's immediate family:
1. a licensed practical nurse (L.P.N.); or
2. a licensed vocational nurse (L.V.N.); or
3. a graduate registered nurse (R.N.).

DEFINITIONS (Continued)

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

Owner means the insured, unless another owner is shown on the application. The owner has all rights under this policy. While the insured is living, the owner can be changed by written notice to us.

Pathologist means a legally licensed Doctor of Medicine or Doctor of Osteopathic Medicine certified by the American Board of Pathology to practice Pathological Anatomy.

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 state he or she practices in.

We will not recognize the insured, his or her spouse or domestic partner, children, parents, or siblings as a physician for a claim.

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 during the covered person's life or at the time of death or autopsy. 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 during the covered person's life or at the time of death or autopsy.

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 does not include routine breast cancer follow-up care.

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.

Renewal date means the date to which premiums are paid and on which the next premium is due (renewal premium).

Specified disease means only one of the following:
1. Addison's Disease
2. Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
3. Brucellosis
4. Diphtheria
5. Encephalitis
6. Hansen's Disease
7. Hepatitis (Chronic B or Chronic C with liver failure or hepatoma)
8. Legionnaires' Disease (confirmation by culture or sputum)
9. Lyme Disease
10. Multiple Sclerosis
11. Muscular Dystrophy
12. Myasthenia Gravis
13. Primary Biliary Cirrhosis
14. Rabies
15. Reye's Syndrome
16. Rocky Mountain Spotted Fever
17. Sickle Cell Anemia
18. Systemic Lupus Erythematosus
19. Tetanus
20. Thalassemia
21. Tuberculosis
22. Tularemia
23. 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 covered person after treatment to help the bone marrow recover and continue producing healthy blood cells.

DEFINITIONS (Continued)

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

Unable to work means:
1. during the first 365 days of disability, you are unable to work at the occupation you were performing when disability began.
2. after the first 365 days of disability, you are unable to work at any gainful occupation for which you are suited by education, training or experience.

We, us and our means American Heritage Life Insurance Company.

You, your and yours means the insured under this policy.

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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.

OTHER EXCLUSIONS AND LIMITATIONS

We do not pay for:
1. any loss except for losses due directly from cancer or a specified disease.
2. 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.

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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 PRE-EXISTING CONDITION LIMITATION and OTHER EXCLUSIONS AND LIMITATIONS provisions, and all other provisions contained in this policy.

If cancer or a specified disease is diagnosed while hospital confined, benefits begin on the day of admission or 10 days prior to the date of diagnosis if this is more favorable. This does not apply if confinement is for a non-covered condition and cancer or a specified disease is treated which would normally be treated on an outpatient basis.

If positive diagnosis is made for cancer or a specified disease within 12 months after a tentative diagnosis, benefits are paid from the date of tentative diagnosis if the tentative diagnosis is made on or after the effective date, subject to the PRE-EXISTING CONDITION LIMITATION provision.

If a covered person dies while confined 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.

If this policy is a converted policy (see CONVERSION PRIVILEGE provision), any maximum benefit amounts or payable time frames already met under the original policy and/or any rider(s) attached to such are transferred to this converted policy and/or rider(s) attached. All benefits payable under this converted policy and/or rider(s) are reduced by the benefits paid under the original policy and/or rider(s).

BENEFIT INFORMATION

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.

A. Continuous Hospital Confinement. We pay the amount shown on page 3A per day when a covered person is confined in a hospital.

B. Government or Charity Hospital. We pay the amount shown on page 3A per day 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 policy, except for the Waiver of Premium benefit.

C. Private Duty Nursing Services. We pay the amount shown on page 3A 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. The nurse cannot be employed by the hospital where the covered person is confined.

D. Extended Care Facility. We pay the amount shown on page 3A 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 confinement in the hospital.

E. At Home Nursing. We pay the amount shown on page 3A 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 confinement in the hospital.

BENEFIT INFORMATION (Continued)

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 the amount shown on page 3A 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 the amount shown on page 3A per day for each additional day of confinement in a licensed freestanding hospice care center.

2. **Hospice Care Team.**
   a. We pay the amount shown on page 3A 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 the amount shown on page 3A per visit, 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 the amount shown on page 3A, 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 the amount shown on page 3A per coverage year, and limited to the lifetime maximum as shown on page 3A. 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 this policy;
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 shown on page 3A.

H. Blood, Plasma and Platelets. We pay the actual cost, up to the amount shown on page 3A, 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 on page 3A per 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 shown on page 3A.

I. Hematological Drugs. We pay the amount shown on page 3A 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. This benefit is payable only once per covered person per coverage year.

J. Medical Imaging. We pay the amount shown on page 3A 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 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 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 BENEFIT INFORMATION section.

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

M. Bone Marrow Transplant. We pay the amount shown on page 3A 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 the amount shown on page 3A 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 the amount shown on page 3A per day when a covered person undergoes surgery performed in an ambulatory surgical center, provided a benefit is paid under the Surgery benefit.

P. Second Opinion. We pay the amount shown on page 3A 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.

Q. Inpatient Drugs and Medicine. We pay the amount shown on page 3A for each day charges are made by the hospital for drugs and medicine while the covered person is confined in the hospital. This benefit does not pay for drugs and/or medicine covered under the Radiation/Chemotherapy for Cancer benefit or the Anti-Nausea benefit.

R. Physician's Attendance. We pay the amount shown on page 3A 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 confinement. A visit means personal attendance by the physician.

S. Ambulance. We pay the amount shown on page 3A (depending on whether ground or air) for each day a covered person is transferred by a licensed ambulance service or hospital owned ambulance to or from a hospital.

T. 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.

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.

U. Outpatient Lodging. We pay the amount shown on page 3A for each day a covered person receives radiation or chemotherapy on an outpatient basis, provided a benefit is paid under the Radiation/Chemotherapy for Cancer benefit, the specific treatment is authorized by the attending physician and the treatment cannot be obtained locally. This 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 maximum amount shown on page 3A per coverage year. Outpatient treatment must be received at a treatment facility more than 100 miles from the covered person's home.

V. 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 amount shown on page 3A 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 confinement in a hospital; 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 confinement in a hospital. 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.

W. Physical or Speech Therapy. We pay the amount shown on page 3A for each day a covered person undergoes physical or speech therapy for restoration of normal body function.

X. New or Experimental Treatment. We pay the actual cost, up to the amount shown on page 3A, when a covered person receives new or experimental treatment for cancer or a 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.

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 shown on page 3A.

This benefit is limited to the amount shown on page 3A per coverage year. This benefit does not pay if benefits are payable for treatment covered under any other benefit in this BENEFIT INFORMATION section.

Y. Prosthesis. We pay the amount shown on page 3A when a covered person is prescribed a prosthetic device as a direct result of surgery and which require surgical implantation. This benefit is payable only once per covered person per amputation.

Z. Hair Prosthesis. We pay the amount shown on page 3A every 2 years for a wig or hairpiece if the covered person experiences hair loss.

AA. Nonsurgical External Breast Prosthesis. We pay the amount shown on page 3A for the initial, nonsurgical breast prosthesis following a covered mastectomy or partial mastectomy that is paid for under the policy.

BB. Anti-Nausea Drugs. We pay the amount shown on page 3A per coverage year when the 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.

CC. National Cancer Institute (NCI) Evaluation/Consultation. We pay the amount shown on page 3A 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.

The reason for such evaluation or consultation at an NCI-sponsored cancer center must be to determine the appropriate treatment for a covered cancer. This benefit is payable only once per coverage year.

DD. Egg Harvesting and Storage.
1. **Extraction and Harvesting of Oocytes.** We pay the amount shown on page 3A one time when a covered person has oocytes extracted and harvested. This benefit is payable only once per covered person.
2. **Storage of Oocytes or Sperm.** We pay the amount shown on page 3A one time when a covered person has oocytes or sperm stored with a licensed reproductive tissue bank or similarly licensed facility. This benefit is payable only once per covered person.

Any such extraction, harvesting or storage must occur prior to radiation or chemotherapy treatment prescribed for the covered person.

EE. Waiver of Premium for Cancer. We will waive the premiums for this policy if, while covered under this policy, the insured:
1. becomes disabled due to cancer first diagnosed after the effective date of coverage; and
2. remains disabled for at least 90 consecutive days.

After the 90th day, we will waive the premiums due for the first 90 days and each consecutive day thereafter the insured is disabled, until the earliest of:
1. the date the insured is no longer disabled; or
2. 5 years from the first day of disability; or
3. the date coverage ends according to the TERMINATION OF INSURANCE provision.

This benefit is only available to the insured, as defined. It does not apply to any other covered person. The insured must provide sufficient proof of disability at least once every 6 months.

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SCHEDULE OF SURGICAL PROCEDURES PER UNIT OF SURGERY COVERAGE

SURGICAL PROCEDURE	PER UNIT OF SURGERY COVERAGE
BRAIN	
Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	$1,250.00
Craniectomy, trephination, bone flap craniotomy; for excision of meningioma, supratentorial	$1,500.00
Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion	$1,250.00
Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computerized axial tomography	$1,400.00
BREAST	
Biopsy of breast; needle core (separate procedure)	$25.00
Biopsy of breast; incisional	$150.00
Excision of malignant tumor, male or female, one or more lesions	$150.00
Mastectomy, partial	$150.00
Mastectomy, simple, complete	$300.00
Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle	$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)	$150.00
Gastrectomy, total; with esophagoenterostomy	$1,000.00
Colectomy, partial; with anastomosis	$800.00
Proctectomy; complete, combined abdominoperineal, with colostomy, one or two stages	$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)	$280.00
Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	$500.00
EXTERNAL GENITALIA	
FEMALE	
Vulvectomy, simple; partial	$400.00
Vulvectomy, simple; complete	$550.00
Vulvectomy, radical; partial	$800.00
Vulvectomy, radical; complete, with inguinofemoral, iliac, and pelvic lymphadenectomy	$1,000.00
MALE	
Biopsy of testis, needle (separate procedure)	$20.00
Orchiectomy, radical, for tumor, inguinal approach	$400.00

SCHEDULE OF SURGICAL PROCEDURES (Continued)
PER UNIT OF SURGERY COVERAGE

SURGICAL PROCEDURE	PER UNIT OF SURGERY COVERAGE
LIVER	
Biopsy of liver; percutaneous needle	$50.00
Biopsy of liver, wedge (separate procedure)	$400.00
Hepatectomy, resection of liver; partial lobectomy	$800.00
LUNG	
Bronchoscopy; with biopsy	$200.00
Biopsy, lung or mediastinum, percutaneous needle	$50.00
Removal of lung, total pneumonectomy	$1,000.00
MUSCULOSKELETAL	
Biopsy, bone, trocar or needle, superficial (e.g., ilium, sternum, spinous process, ribs)	$50.00
Excision of tumor, soft tissue of neck or thorax; deep, subfascial, intramuscular	$100.00
Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical	$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)	$800.00
Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy)	$800.00
Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	$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)	$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)	$15.00
Excision, malignant lesion, trunk, arms, or legs; lesion diameter 0.5 cm or less	$60.00
Excision, malignant lesion, trunk, arms, or legs; lesion diameter 2.1 to 3.0 cm	$120.00
Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less	$100.00
Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 2.1 to 3.0 cm	$250.00

SCHEDULE OF SURGICAL PROCEDURES (Continued)
PER UNIT OF SURGERY COVERAGE

SURGICAL PROCEDURE	PER UNIT OF SURGERY COVERAGE
SKIN (Continued)	
Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 cm or less	$150.00
Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 2.1 to 3.0 cm	$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	$200.00
UTERUS	
Colposcopy (vaginoscopy); with biopsy(s) of the cervix and/or endocervical curettage	$60.00
Endometrial and/or endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)	$30.00
Dilation and curettage, diagnostic and/or therapeutic (non-obstetrical)	$150.00
Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)	$600.00
Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)	$1,000.00
Vaginal hysterectomy	$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	$100.00
Insertion of implantable venous access port, with or without subcutaneous reservoir	$400.00
Removal of implantable venous access port and/or subcutaneous reservoir	$150.00

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ELIGIBILITY

Eligible dependents are:
1. your spouse or domestic partner; and
2. your children and your domestic partner's children.

A child is a person under age 26 who is:
1. your or your domestic partner's natural or adopted son or daughter, stepson or stepdaughter; or
2. a foster child who is placed with you or your domestic partner by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.

If you marry and desire coverage for your spouse, you must notify us of the marriage within 31 days of the marriage. Upon notice to us, we will change the coverage to include your spouse and provide notification of any additional premium due.

If you enter into a domestic partnership and desire coverage for your domestic partner, you must notify us of the domestic partnership within 31 days of the date the domestic partnership was formed. Upon notice to us, we will change the coverage to include your domestic partner and provide notification of any additional premium due.

NEWBORN/ADOPTED CHILDREN

A child born to you or your spouse or domestic partner while family coverage is in force is a covered person with no additional premium due. A child born to other covered persons while family coverage is in force is a covered person up to 18 months with no additional premium due. A child born to a covered person while family coverage is not in force is covered from the moment of birth for a period of 30 days. Additional premium will be required to continue coverage beyond the 30 days after the birth of the child. If we receive notice of the newborn within 30 days from birth, we will not charge an additional premium for coverage of the newborn child for the 30 day notice period. If we do not receive notice within 30 days from birth, we will charge an additional premium from the date of birth. If we receive notice within 60 days of the birth of the child, we will not deny coverage of the child due to failure to notify us of the birth of the child. Coverage of the child will terminate on the 31st day after its birth, unless we have received written notice of the child's birth.

Coverage for adopted or foster children, or children in court-ordered temporary or other custody, begins from the moment of placement in your residence, with no additional premium due under family coverage. We exclude coverage for any pre-existing condition of a foster child. In the case of a newborn child, coverage begins from the moment of birth if a written agreement to adopt such child has been entered into by you prior to the birth or placement. If timely notice is given, we will not charge an additional premium for the notice period. If timely notice is not given, we will charge the applicable additional premium from the date of the birth for newborns or the date of placement in the residence for an adopted child. If family coverage is not in force, upon notification , we will convert the coverage to family coverage and send notice of the additional premium due for continuous coverage. We will not deny coverage for a child due to failure to notify us within the 60 day period of the birth of the child. An adopted child is covered from the moment of placement in the residence. However, coverage for such child will terminate in the event that the child is not ultimately placed in the residence of the insured.

TERMINATION OF INSURANCE

This policy terminates at the earlier of:
1. the due date of any unpaid premium, unless payment of all the unpaid premium is made during the grace period; or
2. the date requested by the insured to terminate coverage; or
3. the next renewal date after a request for termination; or
4. the insured's death except that, your spouse or domestic partner, if a covered person, becomes the new insured (and assumes all the rights held by the insured at death). Coverage will then continue until the new insured's death.

If your spouse is a covered person, the spouse's coverage ends upon valid decree of divorce.

If your domestic partner is a covered person, the 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: (a) reaches age 26; or (b) otherwise does not meet the requirements of an eligible dependent.

Coverage does not end for an incapacitated dependent 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 you for support and maintenance.

Coverage for an incapacitated dependent child continues as long as this policy remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished, in writing, to us when the child reaches the limiting age of eligibility. Thereafter, such proof must be furnished as often as may be required, but no more often than annually after the 2 year period following the child's attainment of the limiting age for eligibility.

Our acceptance of premium after such date, age or event specified for termination will be considered as premium for only the remaining dependents who qualify as covered persons under this policy. When coverage on all eligible dependent children terminates, you must notify us, in writing, and elect whether to continue this policy as individual coverage or family coverage. After such notice, we will arrange for the payment of the appropriate premium due, including returning any unearned premium.

Termination of this policy by us is without prejudice to any continuous loss which commenced while this policy was in force. This does not apply if termination is due to non-payment of premiums.

CONVERSION PRIVILEGE

If coverage of a spouse or domestic partner covered under this policy terminates due to divorce or termination of domestic partnership, or if coverage of a covered child terminates due to no longer meeting the requirements of an eligible dependent, such covered person can obtain a policy of insurance (called the converted policy), without evidence of insurability. Obtaining that policy is subject to all of the following conditions:

1. Application for the converted policy must be made to us within 31 days after the coverage terminates. The effective date of the converted policy will be the date on which coverage under this policy terminates.
2. The converted policy premium is at the rate for the class of risk at the applicant's age for insurance provided as of the date of the conversion.
3. Any conditions excluded in this policy are excluded in the converted policy. No other pre-existing conditions are excluded. The PRE-EXISTING CONDITION LIMITATION and INCONTESTABILITY provisions are waived to the extent that such periods have already been met under this policy. Benefits payable to the applicant under the converted policy are reduced by benefits payable under this policy.
4. The converted policy will be a similar policy or a policy providing lesser benefits at the applicant's option.

When conversion is due to divorce or termination of domestic partnership, any dependent children covered under this policy may be covered under such new policy or under this policy, as you and your former spouse or domestic partner may elect. They may not be covered under both policies.

If either this policy or a new policy is in force on you or your former spouse or domestic partner, and either of you remarry or enter into a new domestic partnership, such new spouse or domestic partner may be covered under the appropriate policy. We must be advised of the remarriage or domestic partnership by the completion of a new application for such new spouse or domestic partner. This new application is subject to our approval.

You or your former spouse or domestic partner must pay the premiums appropriate to such new policy in order to have it issued and maintained in force.

GENERAL PROVISIONS

Entire Contract; Changes. This policy, with the application and attached papers, if any, is the entire contract between you and us. No change in this policy is effective until approved by an officer of ours. This approval must be attached to this policy. No agent may change this policy or waive any of its provisions.

Incontestability. After this policy is in force for a period of 2 years during the lifetime of the insured, it becomes incontestable as to the statements contained in the application.

No claim for loss incurred, commencing after 12 months from the effective date, is reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description, effective on the date of loss, existed prior to the effective date.

Grace Period. We grant a grace period of 31 days for the payment of each premium falling due after the first premium. This provision means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the policy continues in force. In the case of termination due to non-payment of premiums, you will receive a 10 day advance written notice. Notice will be mailed to the insured's last known address. We will promptly return any unearned portion of the premium.

Reinstatement. If the renewal premium is not paid before the grace period ends, the policy lapses. Later acceptance of the premium by us or by an agent authorized by us to accept payment, without requiring an application for reinstatement, reinstates the policy.

If we or our agent requires an application for reinstatement, you will be given a conditional receipt for the premium tendered. If the application is approved, the policy will be reinstated as of the approval date. Lacking approval, the policy will be reinstated on the 45th day after the date of the conditional receipt unless we have previously notified you in writing of our disapproval of the application.

The reinstated policy covers only loss due to cancer or specified disease incurred after the date of reinstatement. In all other respects, you and we have the same rights as provided under the policy immediately before the due date of the defaulted premium subject to any provisions attached to the reinstated policy.

Any premium accepted in connection with a reinstatement will be applied to a period for which premiums have not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

A policy cancelled by you cannot be reinstated.

Notice of Claim. 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 you or the beneficiary to us at 1776 American Heritage Life Drive, Jacksonville, Florida 32224 or to any authorized agent of ours, with the insured's name and policy number, is notice to us.

Claim Forms. When we receive notice of claim, we will send you forms for filing proof of loss. If these forms are not sent to you within 15 days, you will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the PROOFS OF LOSS provision.

Proofs of Loss. Written proof of loss must be furnished 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 is reasonably possible. In any event, the proof required must be given to us no later than 1 year from the time specified unless you are legally incapacitated.

Time of Payment of Claims. After receiving written proof of loss, we pay all benefits then due for this policy. Benefits for any other loss covered by this policy are paid as soon as we receive proper written proof.

GENERAL PROVISIONS (Continued)

Payment of Claims. All benefits becoming payable will be paid to you, or to your beneficiary in the event of your death. If no beneficiary is designated, benefits are payable to the insured's spouse or domestic partner, if living, otherwise to the estate of the insured. Any amounts unpaid at the insured's death may, at our option, be paid either to such beneficiary or to such estate. All other amounts are payable to the insured.

If benefits are payable to the insured's estate or a beneficiary who cannot execute a valid release, we can pay benefits up to an amount of $3,000 to someone related to the insured 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 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 it. An assignment may not change the owner or beneficiary.

Non-Participating. The policy is issued on a non-participating basis and does not share in surplus earnings of ours.

Physical Examinations and Autopsy. We, at our own expense, shall have the right and opportunity to examine the person of any covered person as often as it may reasonably require while a claim is pending, and to make a request to conduct an autopsy in case of death where it is not forbidden by law.

Legal Actions. No action, at law or in equity, shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of the applicable statute of limitations from the time written proof of loss is required to be given.

Change of Beneficiary. You can change the beneficiary at any time by giving us written notice. The consent of the beneficiary or beneficiaries is not required unless the designation of the beneficiary is irrevocable.

Misstatement of Age. If the age of the insured has been misstated, all amounts payable under this policy are as the premium paid would have purchased at the correct age. For any period that no coverage would have existed at the correct age, we are liable only for the refund of premiums paid for such period.

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

Conformity with State Statutes. Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which you reside on such date is hereby amended to conform to the minimum requirements of such statutes.

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AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

AMENDMENT

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

The policy to which this amendment is attached is amended as follows:

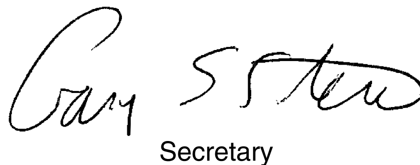
The third and fourth paragraphs of the ELIGIBILITY provision, in regards to coverage for spouses and domestic partnerships, are hereby deleted in their entirety and replaced with the following:

If you marry and desire coverage for your spouse, you must notify us of the marriage and complete the required application. Subject to approval by us, we will change the coverage to include your spouse and provide notification of any additional premium due.

If you enter into a domestic partnership and desire coverage for your domestic partner, you must notify us of the domestic partnership and complete the required application. Subject to approval by us, we will change the coverage to include your domestic partner and provide notification of any additional premium due.

This amendment will not change, alter, or amend the policy it is attached to except as stated.

This amendment become effective as of the issue date of the policy.



Secretary

CP12ELAMFL

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida 32224-6688

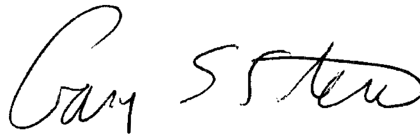
AMENDMENT

The following is added to the General Provisions of the policy/certificate to which it is attached:

> **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.

This Amendment does not change, alter, or amend the policy/certificate except as stated.

This Amendment becomes effective as of the policy/certificate date.



Secretary

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida 32224-6688

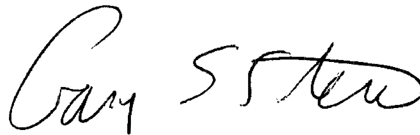
AMENDMENT

The following provision is added to the General Provisions of the policy to which this amendment is attached:

> **Receipt of Premiums.** You will be given credit for premiums under this policy at the time the premiums are actually received by us or our authorized agent. Financial institutions (such as banks and credit unions) and employers who send your premiums to us directly at your request, are not our agents, and premiums paid by those parties are not credited until actually received by us.

This Amendment does not change, alter or amend the policy except as stated above.

This Amendment becomes effective as of the policy date.



Secretary

AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

THIS IS A LIMITED BENEFIT CANCER AND SPECIFIED DISEASE POLICY.
IT ONLY PROVIDES BENEFITS FOR LOSS DUE TO CANCER AND SPECIFIED DISEASES AS DEFINED OR OTHER BENEFITS THAT MAY BE ADDED BY RIDER.
IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.

NON-PARTICIPATING

CANCER AND SPECIFIED DISEASE INDEMNITY POLICY