

REQUIRED OUTLINE OF COVERAGE FOR GROUP CRITICAL ILLNESS POLICY GVCIP4CA

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS OR MINIMUM ESSENTIAL COVERAGE AS DEFINED IN FEDERAL LAW

Read Your Policy Carefully! This outline of coverage provides a brief description of some of the important features of the policy. This is not the insurance contract and only the actual policy provisions control. The policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

Specified Illness Coverage – Policies of this category are designed to provide the insured with limited or supplemental coverage. The policy is designed to provide coverage paying benefits only when certain losses occur as a result of a specified illness first diagnosed on or after the effective date. Benefits are subject to any exceptions set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

CRITICAL ILLNESS BENEFITS

Subject to the conditions, limitations and exclusions of the policy and any attached riders, we will pay a benefit when a covered person is diagnosed with a critical illness described in the policy or any attached rider if the date of diagnosis for the critical illness or the date of loss is while the covered person is insured under the policy and any attached riders; and the critical illness is not excluded by name or specific description.

A covered person can receive benefits for different critical illnesses or specified diseases described in the policy and any attached riders if the dates of diagnosis for each are separated by at least 30 days. Coverage for a covered person terminates when he or she has exhausted all available benefits under the policy and any attached riders.

Initial Critical Illness Benefits. A covered person can receive a benefit for each critical illness only once, unless the Reoccurrence of Critical Illness Benefits provision is included in the coverage. The benefit amount for each Initial Critical Illness is the percentage shown in the policy for that Initial Critical Illness multiplied by the Basic Benefit Amount shown on the Policy Specifications page applicable to the covered person.

OPTIONAL BENEFITS, IF APPLICABLE

Reoccurrence of Critical Illness Benefits. We will pay a benefit for a reoccurrence of a critical illness if a covered person is diagnosed for a second time with an initial critical illness for which a benefit was previously paid under the Initial Critical Illness Benefit provision if:

1. the second date of diagnosis is more than 12 months after the first date of diagnosis for the initial critical illness; and
2. the second date of diagnosis is while the covered person is insured under the policy.

The benefit amount is equal to the benefit amount previously paid for that initial critical illness. A covered person can receive a benefit for a reoccurrence of a critical illness only once for each initial critical illness.

Cancer Critical Illness Benefits. The benefit amount for each Cancer Critical Illness is the percentage shown in the policy for that Cancer Critical Illness multiplied by the Basic Benefit Amount shown on the Policy Specifications page applicable to the covered person.

OPTIONAL BENEFITS, IF APPLICABLE (Continued)

Reoccurrence of Cancer Critical Illness Benefits. We will pay a benefit for a reoccurrence of cancer critical illness if a covered person is diagnosed for a second time with a cancer critical illness for which a benefit was previously paid under the Cancer Critical Illness Benefits provision if:

1. the second date of diagnosis is more than 12 months after the first date of diagnosis for the cancer critical illness;
2. the covered person did not receive treatment during that 12 month period; and
3. the second date of diagnosis is while the covered person is insured under the policy.

The benefit amount is equal to the benefit amount previously paid for that cancer critical illness. A covered person can receive a reoccurrence of cancer critical illness only once for each cancer critical illness.

For purposes of this benefit, "treatment" does not include maintenance drug therapy or routine follow-up office visits to verify if the cancer critical illness has returned.

WAIVER OF PREMIUM

We will waive premiums for this coverage if, while covered under the policy, the primary insured:

1. becomes disabled due to a covered critical illness or specified disease for which a benefit is paid; 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 primary insured is disabled, until the earliest of:

1. the date the primary insured is no longer disabled;
2. 2 years from the first day of disability; or
3. the date coverage ends according to the Termination of Coverage provision.

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

EXCLUSIONS

We will not pay benefits for a critical illness that is, or is caused by, or contributed to by, or results from:

1. intentionally self-inflicted injury while sane or insane;
2. any loss to which a contributing cause was the covered person's commission of or attempt to commit a felony, or being engaged in an illegal occupation;
3. suicide while sane, or self-destruction while insane, or any attempt at either; or
4. any loss sustained or contracted in consequence of the covered person being intoxicated or under the influence of alcohol, a drug, or a narcotic, unless administered and taken as prescribed by a physician.

PREMIUMS

The premiums for this product per insured will vary depending upon the number of units of coverage chosen and the type of coverage selected.

AMERICAN HERITAGE LIFE INSURANCE COMPANY

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

A Stock Company

REQUIRED OUTLINE OF COVERAGE FOR GROUP CRITICAL ILLNESS POLICY RIDER

SUPPLEMENTAL CRITICAL ILLNESS RIDER FORM GCIP4SR2CA

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS OR MINIMUM ESSENTIAL COVERAGE AS DEFINED IN FEDERAL LAW

Read Your Policy Carefully! This outline of coverage provides a brief description of some of the important features of the rider attached to your coverage. This is not the insurance contract and only the actual policy provisions control. The policy and rider itself sets forth, in detail, the rights, and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

Specified Illness Coverage – Policies of this category are designed to provide the insured with limited or supplemental coverage. The policy is designed to provide coverage paying benefits only when certain losses occur as a result of a specified illness first diagnosed on or after the effective date. Benefits are subject to any exceptions set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

BENEFITS

We will pay a benefit when a covered person is diagnosed with a Supplemental Critical Illness described in the rider if the date of diagnosis is while the covered person is insured under the rider and the critical illness is not excluded by name or specific description.

The benefit amount for each Supplemental Critical Illness is the percentage shown below for that Supplemental Critical Illness multiplied by the Basic Benefit Amount for the Initial Critical Illness Benefit applicable to the covered person shown on the Policy Specifications page. This benefit is payable only once per covered person.

Supplemental Critical Illness	Percentage Of Basic Benefit Amount
Benign Brain Tumor	100%
Coma	100%
Complete Loss of Hearing	100%
Complete Loss of Sight	100%
Complete Loss of Speech	100%
Paralysis	100%

EXCLUSIONS

The Exclusions provision in the policy applies to the rider.

PREMIUMS

The premiums for this product per insured will vary depending upon the number of units of coverage chosen and the type of coverage selected.

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GROUP CRITICAL ILLNESS INSURANCE POLICY NON-PARTICIPATING

American Heritage Life Insurance Company (referred to as we, us, our, or the company) will provide benefits under this policy. We make this promise subject to all of the provisions of this policy and any attached riders.

The policyholder should read this group policy carefully and contact us promptly with any questions. This group policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA), and consists of:

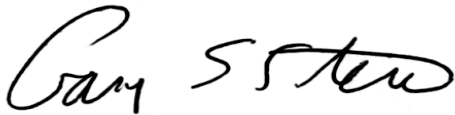
1. all policy provisions, any amendments, riders, and/or attachments issued; and
2. the policyholders' signed application.

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

This policy is not in lieu of and does not affect any requirement for coverage by workmen's compensation insurance.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida on the Policy Effective Date.

This policy is a legal contract between the policyholder and the company.



Secretary



President

This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law.

**THIS IS A GROUP CRITICAL ILLNESS POLICY WHICH ONLY PROVIDES
STATED BENEFITS FOR SPECIFIED CRITICAL ILLNESSES OR OTHER BENEFITS THAT MAY BE ADDED.**

THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.

Read Your Policy Carefully.

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POLICY SPECIFICATIONS

POLICYHOLDER: THE McCLATCHY COMPANY

POLICY NUMBER: G1494

POLICY EFFECTIVE DATE: January 1, 2018

POLICY ANNIVERSARY DATE: January 1, 2019 and the first day of January each calendar year thereafter.

GOVERNING JURISDICTION: the state of California and subject to the laws of that jurisdiction.

ELIGIBLE CLASS(ES): All active employees working at least 30 hours per week excluding those who are insured under any other critical illness policy issued by American Heritage Life Insurance Company.

ELIGIBILITY WAITING PERIOD: 30 Days

EFFECTIVE DATES:

CERTIFICATE: The First Of The Month

CHANGE IN COVERAGE: The First Of The Month

TERMINATIONS: The End Of The Month

REINSTATEMENT IF REHIRED: Within 30 Days

INITIAL CRITICAL ILLNESS BENEFITS

PLAN I BASIC BENEFIT AMOUNT:

Primary Insured	Amount selected by the primary insured	GUARANTEED ISSUE LIMIT: \$10,000
Covered Spouse	50% of the primary insured's Basic Benefit Amount	\$ 5,000
Covered Child(ren)	50% of the primary insured's Basic Benefit Amount	\$ 5,000

ADDITIONAL BENEFITS:

Reoccurrence of Critical Illness Benefits
Cancer Critical Illness Benefits
Reoccurrence of Cancer Critical Illness Benefits

RIDERS:

Supplemental Critical Illness Rider

PLAN II BASIC BENEFIT AMOUNT:

Primary Insured	Amount selected by the primary insured	GUARANTEED ISSUE LIMIT: \$20,000
Covered Spouse	50% of the primary insured's Basic Benefit Amount	\$10,000
Covered Child(ren)	50% of the primary insured's Basic Benefit Amount	\$10,000

ADDITIONAL BENEFITS:

Reoccurrence of Critical Illness Benefits
Cancer Critical Illness Benefits
Reoccurrence of Cancer Critical Illness Benefits

RIDERS:

Supplemental Critical Illness Rider

POLICY SPECIFICATIONS (Continued)

MONTHLY RATES:

PLAN I

Monthly rate per employee:

Premium Rates	Attained Age	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
Non-Tobacco	18-24	\$1.14	\$1.72	\$1.14	\$1.72
	25-29	\$1.56	\$2.33	\$1.56	\$2.33
	30-34	\$2.28	\$3.41	\$2.28	\$3.41
	35-39	\$3.65	\$5.49	\$3.65	\$5.49
	40-44	\$5.28	\$7.91	\$5.28	\$7.91
	45-49	\$7.47	\$11.22	\$7.47	\$11.22
	50-54	\$10.49	\$15.72	\$10.49	\$15.72
	55-59	\$13.95	\$20.91	\$13.95	\$20.91
	60-64	\$20.08	\$30.13	\$20.08	\$30.13
	65-69	\$28.53	\$42.79	\$28.53	\$42.79
	70-74	\$40.30	\$60.46	\$40.30	\$60.46
	75-79	\$52.79	\$79.18	\$52.79	\$79.18
	80+	\$66.30	\$99.43	\$66.30	\$99.43
Tobacco	18-24	\$1.38	\$2.07	\$1.38	\$2.07
	25-29	\$1.83	\$2.72	\$1.83	\$2.72
	30-34	\$3.05	\$4.58	\$3.05	\$4.58
	35-39	\$5.09	\$7.64	\$5.09	\$7.64
	40-44	\$7.53	\$11.30	\$7.53	\$11.30
	45-49	\$11.54	\$17.28	\$11.54	\$17.28
	50-54	\$17.03	\$25.54	\$17.03	\$25.54
	55-59	\$23.34	\$35.01	\$23.34	\$35.01
	60-64	\$33.93	\$50.89	\$33.93	\$50.89
	65-69	\$48.49	\$72.73	\$48.49	\$72.73
	70-74	\$67.08	\$100.62	\$67.08	\$100.62
	75-79	\$83.99	\$125.99	\$83.99	\$125.99
	80+	\$104.29	\$156.41	\$104.29	\$156.41

POLICY SPECIFICATIONS (Continued)

MONTHLY RATES:

PLAN II

Monthly rate per employee:

Premium Rates	Attained Age	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
Non-Tobacco	18-24	\$2.31	\$3.43	\$2.31	\$3.43
	25-29	\$3.12	\$4.65	\$3.12	\$4.65
	30-34	\$4.56	\$6.84	\$4.56	\$6.84
	35-39	\$7.33	\$10.96	\$7.33	\$10.96
	40-44	\$10.55	\$15.81	\$10.55	\$15.81
	45-49	\$14.96	\$22.43	\$14.96	\$22.43
	50-54	\$20.97	\$31.44	\$20.97	\$31.44
	55-59	\$27.90	\$41.84	\$27.90	\$41.84
	60-64	\$40.19	\$60.25	\$40.19	\$60.25
	65-69	\$57.07	\$85.58	\$57.07	\$85.58
	70-74	\$80.62	\$120.91	\$80.62	\$120.91
	75-79	\$105.58	\$158.37	\$105.58	\$158.37
	80+	\$132.58	\$198.86	\$132.58	\$198.86
Tobacco	18-24	\$2.77	\$4.13	\$2.77	\$4.13
	25-29	\$3.65	\$5.46	\$3.65	\$5.46
	30-34	\$6.12	\$9.17	\$6.12	\$9.17
	35-39	\$10.21	\$15.29	\$10.21	\$15.29
	40-44	\$15.06	\$22.58	\$15.06	\$22.58
	45-49	\$23.05	\$34.59	\$23.05	\$34.59
	50-54	\$34.04	\$51.06	\$34.04	\$51.06
	55-59	\$46.68	\$70.02	\$46.68	\$70.02
	60-64	\$67.85	\$101.76	\$67.85	\$101.76
	65-69	\$96.98	\$145.46	\$96.98	\$145.46
	70-74	\$134.16	\$201.24	\$134.16	\$201.24
	75-79	\$167.99	\$251.96	\$167.99	\$251.96
	80+	\$208.56	\$312.84	\$208.56	\$312.84

POLICY SPECIFICATIONS (Continued)

RATE GUARANTEE DATE:

January 1, 2019

PREMIUM DUE:

The initial date agreed to between American Heritage Life Insurance Company and the Policyholder and each specified date thereafter.

The policyholder must send all premiums on or before the premium due date to us. The premium must be paid in United States dollars.

COST OF COVERAGE:

The primary insured pays the cost of coverage.

DIVISIONS, SUBSIDIARIES, OR AFFILIATED COMPANIES:

These are the policyholder's divisions, subsidiaries, or affiliates listed below. The policyholder may act for and on behalf of any and all of these entities in all matters that pertain to this policy. Every act done by, agreement made with, or notice given to the policyholder will be binding on them.

Name

None

Location (City and State)

(This space intentionally left blank.)

POLICYHOLDER PROVISIONS

RATE GUARANTEE

A change in premium rate will not take effect before the Rate Guarantee Date except for reasons which affect the risk assumed, including those reasons shown below:

1. a change occurs in this plan design;
2. a division, subsidiary, or affiliated company is added or deleted;
3. the number of insured employees or members changes by 25% or more;
4. a new law or a change in any existing law is enacted which applies to this plan; or
5. less than 25% of those eligible for coverage are participating.

We will notify the policyholder in writing at least 30 days before a premium rate is changed. We will also notify the producer and administrator, if any, in writing, at least 45 days prior to any rate change. A change may take effect on an earlier date when both we and the policyholder agree in writing.

PREMIUM INCREASES OR DECREASES

Premium increases or decreases may take effect at any time, subject to the Rate Guarantee provision. If they take effect during a policy month, they are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

INFORMATION REQUIRED FROM THE POLICYHOLDER

The policyholder must provide us with the following on a regular basis:

1. information about employees or members:
 - a. who are eligible to become insured;
 - b. who are requesting a coverage change;
 - c. whose coverage ends;
2. any information that may be required to manage a claim; and
3. any information that may be required to determine the amount of premium due.

Policyholder records on this policy will be available for review by us at any reasonable time.

CANCELING POLICY

This policy can be canceled:

1. by us; or
2. by the policyholder.

We may cancel or modify this policy, with at least 31 days written notice to the policyholder and at least 45 days written notice to the producer or administrator, if any, if:

1. less than 25% of those eligible for coverage are participating;
2. this policy has been in effect longer than 12 months;
3. the policyholder does not provide us with information as stated in the INFORMATION REQUIRED FROM THE POLICYHOLDER provision;
4. fewer than 5 employees or members are insured; or
5. the policyholder fails to pay any premium due by the end of the grace period.

When both we and the policyholder agree, in writing, this policy may be modified on an earlier date.

If this policy is canceled or modified and there are non-employee certificateholders or certificateholders of more than 1 employer covered, written notice will also be delivered to each affected certificateholder or affected employer, at least 30 days prior to the effective date of the action.

If the premium is not paid during the grace period, this policy will terminate automatically on the due date of any unpaid premium. The policyholder is liable for the premium for coverage through the end of the grace period. The policyholder must pay us all premiums due for the full period this policy is in force.

The policyholder may cancel this policy by written notice delivered to us at least 31 days prior to the cancellation date. When both the policyholder and we agree, this policy can be canceled on an earlier date. If canceled, coverage will end at 12:00 midnight on the last day of coverage.

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

GENERAL PROVISIONS

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

1. The employee or member may apply for coverage during:
 - a. the initial enrollment period; or
 - b. a re-enrollment period, subject to evidence of insurability.
2. The primary insured may:
 - a. increase coverage at any time, subject to evidence of insurability;
 - b. decrease coverage at any time; or
 - c. discontinue coverage at any time.

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability is required if:

1. the employee or member:
 - a. voluntarily canceled coverage and is reapplying;
 - b. is applying for an amount of coverage over the Guaranteed Issue Limit;
 - c. is applying for the coverage, or an increase in the amount of coverage, at any time after his or her initial enrollment period;
2. an eligible spouse or domestic partner was not enrolled within 31 days of eligibility.

EFFECTIVE DATE OF COVERAGE

Coverage for each eligible employee or member will be effective at 12:01 a.m. on the effective date shown on page 3 of the certificate of insurance issued to him or her provided that he or she is actively employed on that date.

If the employee or member is not actively employed on that date due to a temporary layoff, leave of absence or Family and Medical Leave of Absence, coverage begins on the date he or she returns to active employment. This applies to initial coverage, as well as any increase in coverage that occurs after his or her initial coverage is effective.

For any change in coverage that is subject to evidence of insurability, the change in coverage is effective on the date we approve such change and in accordance with the Policy Specifications page.

For any change in coverage that is not subject to evidence of insurability, the change in coverage is effective when we receive such request for change and as stated on the Policy Specifications page.

Any decrease in coverage will take effect on the date the primary insured applies for the decrease, but will not affect a payable claim that occurs prior to the effective date of the decrease.

If an employee or member terminates employment and returns to work for the policyholder within the timeframe stated on the Policy Specifications page, this coverage may be reinstated without providing evidence of insurability.

CERTIFICATES OF INSURANCE

We will furnish to the policyholder a certificate of insurance for delivery to each primary insured that describes the terms of the coverage made available to the eligible employees or members of the policyholder and their eligible dependents. The certificate will provide a description of the insurance provided by this policy and will state:

1. the essential features of the insurance coverage; and
2. to whom benefits are payable.

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

GENERAL PROVISIONS (Continued)

ELIGIBILITY OF DEPENDENTS

Eligible dependents are the primary insured's:

1. spouse or domestic partner; and
2. child(ren) and spouse's or domestic partner's children.

If the primary insured marries and desires coverage for his or her spouse, the policyholder must be notified of the marriage within 31 days of the marriage. Upon notice to us, we will change the coverage to include the spouse and provide notification of any additional premium due.

If the primary insured enters into a domestic partnership and desires coverage for his or her domestic partner, the policyholder must be notified 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 the domestic partner and provide notification of the additional premium due.

A child born to the primary insured or his or her spouse or domestic partner, will be eligible for coverage. This coverage begins at the moment of birth of such child and benefits will be the same as provided for any other child insured under this policy. No additional premium will be required for newborns added.

An adopted child or child pending adoption will be covered as follows:

1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by the primary insured or his or her spouse or domestic partner has been entered within 31 days after the date of birth.
2. If adoption proceedings have been instituted by the primary insured or his or her spouse or domestic partner within 31 days after the date of birth and he or she has temporary custody, coverage is provided from the moment of birth.
3. Coverage shall begin from the moment of placement.

Coverage will be provided as long as the primary insured or his or her spouse or domestic partner has custody of the child pursuant to decree of the court.

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

If the primary insured ceases active employment or membership in the union or association because of a temporary layoff or leave of absence while coverage is in force, we will continue the coverage in accordance with the personnel practices of the policyholder, if premium payments continue and the policyholder approved the leave in writing. Coverage will be continued for 3 months following the date he or she ceased active employment or membership in the union or association.

If his or her coverage ends while on a Family and Medical Leave of Absence, the coverage may be reinstated when he or she returns to active status.

We will not require evidence of insurability.

GENERAL PROVISIONS (Continued)

TERMINATION OF COVERAGE

The coverage under this policy ends on the earliest of:

1. the date this policy is canceled;
2. the last day of the period for which any required premium payments were made;
3. the last day the primary insured is actively employed with the employer or a member in good standing in the labor union, association or other entity that is the policyholder, except as provided under the Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence provision;
4. the date the primary insured is no longer in an eligible class;
5. the date the primary insured's class is no longer eligible; or
6. our discovery of fraud or material misrepresentation in the presentation of a claim under this policy or any attached rider.

Coverage for a covered person terminates when he or she has exhausted all available benefits under this policy and any attached riders.

We will provide coverage for a payable claim that occurs while a covered person is covered under this policy.

The primary insured or other qualifying dependents have the responsibility to inform us of: (a) divorce; (b) legal separation; or (c) a child losing eligibility under this policy.

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

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

Coverage for a child will end on the issue day of the month that follows when the primary insured dies or the child: (a) reaches age 26; or (b) otherwise does not meet the requirements of an eligible dependent.

Coverage does not end at age 26 for an incapacitated dependent child who:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. is chiefly dependent upon the primary insured 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 child's attainment of the limiting age for eligibility.

If we receive premium for coverage extending beyond the date or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate and claims will not be paid.

Coverage may be eligible for continuation as outlined in the Continuation of Insurance Coverage provision.

GENERAL PROVISIONS (Continued)

LEGAL ACTION

No legal action may be brought to obtain benefits under this policy:

1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 3 years from the time proof of loss is required to have been furnished, or the period specified in state law, whichever is longer.

TIME LIMIT ON CERTAIN DEFENSES

After 2 years from the effective date of this policy, no misstatement of the policyholder or covered person, made in any application, can be used to void this policy. After 2 years from the effective date of any covered person's coverage, no misstatement of a covered person, made in writing, can be used to void coverage or deny a claim for loss incurred.

Any statements made by the policyholder or by a covered person, in the absence of fraud, are representations and not warranties. Only written statements signed by the policyholder or a covered person will be used in defense of a claim. A copy of any written statement, if applicable, will be furnished to the policyholder or the covered person or his or her personal representative, if any, if such written statement will be used in defense of a claim.

CLERICAL ERROR

Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force, nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Written proof must be supplied by the policyholder documenting any clerical errors.

AGENCY

For purposes of this policy, the policyholder acts on its own behalf or as the primary insured's agent. Under no circumstances will the policyholder be deemed the agent of American Heritage Life Insurance Company.

ENTIRE CONTRACT

The contract consists of the following items:

1. the group policy;
2. any amendments and endorsements;
3. the applications and other written statements of the policyholder; and
4. any individual applications, enrollments, evidence of insurability or other statements of the primary insured or a covered person.

CHANGE OF BENEFICIARY

Any change of beneficiary must be filed at our home office. It will not take effect unless so filed, but if so filed, will take effect on the date signed by the primary insured. This will be true whether or not the primary insured is living on the date it is filed. There will be no prejudice to us on account of any payment we make prior to its receipt by us at our home office.

The right to change a beneficiary is reserved to the primary insured. The consent of the beneficiary or beneficiaries will not be required to assign benefits or to change a beneficiary or beneficiaries, or to make any other changes, unless the designation of the beneficiary is irrevocable.

ASSIGNMENT

An assignment of benefit is not binding on us unless:

1. it is a written request; and
2. it is received by us at our home office.

An assignment will take effect when recorded at our home office. We are not responsible for the validity of any assignment.

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 this policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statute.

EXCLUSIONS

We will not pay benefits for a critical illness that is, or is caused by, or contributed to by, or results from:

5. intentionally self-inflicted injury while sane or insane;
6. any loss to which a contributing cause was the covered person's commission of or attempt to commit a felony, or being engaged in an illegal occupation;
7. suicide while sane, or self-destruction while insane, or any attempt at either; or
8. any loss sustained or contracted in consequence of the covered person being intoxicated or under the influence of alcohol, a drug, or a narcotic, unless administered and taken as prescribed by a physician.

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CRITICAL ILLNESS BENEFITS

GENERAL

Subject to the conditions, limitations and exclusions of this policy and any attached riders, we will pay a benefit when a covered person is diagnosed with a critical illness described in this policy or any attached rider if:

1. the date of diagnosis for the critical illness or the date of loss is while the covered person is insured under this policy and any attached riders; and
2. the critical illness is not excluded by name or specific description.

A covered person can receive benefits for different critical illnesses or specified diseases described in this policy and any attached riders if the dates of diagnosis for each critical illness are separated by at least 30 days.

Each critical illness must be diagnosed by a physician qualified to make such diagnosis. Claims for benefits not satisfying all the criteria for diagnosis may be subject to review by an independent physician consultant.

We do not pay any benefit for any condition or loss not described in this policy or any attached rider.

INITIAL CRITICAL ILLNESS BENEFITS

A covered person can receive a benefit for each critical illness only once, unless the Reoccurrence of Critical Illness Benefits provision is included in the coverage.

- A. BENEFIT AMOUNTS.** The benefit amount for each Initial Critical Illness is the percentage shown below for that Initial Critical Illness multiplied by the Basic Benefit Amount for the Initial Critical Illness Benefit shown on the Policy Specifications page applicable to the covered person.

Initial Critical Illness	Percentage of Basic Benefit Amount
Heart Attack	100%
Stroke	100%
Transient Ischemic Attack (TIA)	25%
End Stage Renal Failure	100%
Major Organ Transplant	100%
Coronary Artery By-Pass Surgery	25%

- B. BENEFIT DESCRIPTIONS.** The Initial Critical Illnesses are:

1. **Heart Attack.** The death of a portion of heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis must be based on both:
 - a. new electrocardiographic changes; and
 - b. elevation of cardiac enzymes or biochemical markers showing a pattern and to a level consistent with a diagnosis of heart attack.

Heart Attack does not include cardiac arrest. Cardiac arrest is covered under the Heart and Lung Supplemental Critical Illness Rider, if included in the coverage.

The date of diagnosis for Heart Attack is the date of death (infarction) of a portion of the heart muscle.

2. **Stroke.** The death of a portion of the brain producing neurological sequelae including infarction of brain tissue, hemorrhage and embolization from an extra-cranial source. There must be evidence of permanent neurological deficit.

Stroke does not include: transient ischemic attacks (TIA's), head injury, chronic cerebrovascular insufficiency or reversible ischemic neurological deficits.

The date of diagnosis for Stroke is the date the stroke occurred based on documented neurological deficits and neuroimaging studies.

CRITICAL ILLNESS BENEFITS (Continued)

B. BENEFIT DESCRIPTIONS. (Continued)

3. **Transient Ischemic Attack (TIA).** An episode of stroke-like symptoms related to central nervous system ischemia in which there are no residual neurologic complications or sequelae.

Transient ischemic attack does not include: stroke, head injury or peripheral neurologic disorders.

The date of diagnosis for Transient Ischemic Attack (TIA) is the date the attack occurred based on documented neurological deficits and neuroimaging studies.

4. **End Stage Renal Failure.** The irreversible failure of both kidneys to perform their essential functions, with the covered person undergoing peritoneal dialysis or hemodialysis.

End stage renal failure does not include renal failure caused by a traumatic event, including surgical traumas.

The date of diagnosis for End Stage Renal Failure is the date renal dialysis first begins due to the irreversible failure of both kidneys to perform their essential functions.

5. **Major Organ Transplant.** Being placed on the National Transplant List or the performance of a surgical transplantation of a major organ.

- a. **Candidate Benefit.** A covered person is placed on the National Transplant List as an active or an inactive candidate for a major organ transplant.

The Candidate Benefit is not payable if we have previously paid:

- i. the Candidate Benefit on the covered person, for any reason; or
- ii. the Surgery Benefit on the covered person for the same major organ.

- b. **Surgery Benefit.** A covered person undergoes a major organ transplant, performed by a physician.

The Surgery Benefit is not payable if we have previously paid the Candidate Benefit on the covered person for the same major organ. If we paid the Candidate Benefit for a covered person listed as a candidate for multiple major organ transplants, only the first one of those major organs transplanted will be considered the same major organ.

No benefit is payable for major organ transplants using mechanical or non-human organs.

Major Organ means the heart, lungs, liver, pancreas, or kidneys. Lungs and kidneys are each one major organ regardless of whether one or both lungs, or one or both kidneys, are transplanted.

Major organ transplant means the surgical transplant, by a physician, of a major organ. Each major organ transplanted is a major organ transplant eligible for the Surgery Benefit, even if multiple major organ transplants are performed in one surgical procedure.

National Transplant List means the database containing information on all people in the United States and Puerto Rico who are waiting for one or more major organ transplants, as mandated by the National Organ Transplant Act.

The date of loss for Major Organ Transplant is the date a covered person:

- a. is placed on the National Transplant List, as an active or an inactive candidate, for a major organ transplant; or
- b. undergoes the actual surgery for a major organ transplant.

6. **Coronary Artery By-Pass Surgery.** The surgical operation to correct narrowing or blockage of one or more coronary arteries with by-pass grafts on the advice of a cardiologist registered in the United States. Angiographic evidence to support the necessity for this surgery will be required.

Coronary Artery By-Pass Surgery does not include: abdominal aortic bypass; balloon angioplasty; laser embolectomy; atherectomy; stent placement; or other non-surgical procedures.

The date of loss for Coronary Artery By-Pass Surgery is the date the actual coronary artery by-pass surgery occurs.

ADDITIONAL BENEFITS

REOCCURRENCE OF CRITICAL ILLNESS BENEFITS

We will pay a benefit for a reoccurrence of a critical illness if a covered person is diagnosed for a second time with an initial critical illness for which a benefit was previously paid under the Initial Critical Illness Benefits provision if:

3. the second date of diagnosis is more than 12 months after the first date of diagnosis for the initial critical illness; and
4. the second date of diagnosis is while the covered person is insured under this policy.

The benefit amount is equal to the benefit amount previously paid for that initial critical illness. A covered person can receive a benefit for a reoccurrence of a critical illness only once for each initial critical illness.

Initial Critical Illness
Heart Attack
Stroke
Transient Ischemic Attack (TIA)
End Stage Renal Failure
Major Organ Transplant
Coronary Artery By-Pass Surgery

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ADDITIONAL BENEFITS

CANCER CRITICAL ILLNESS BENEFITS

- A. BENEFIT AMOUNTS.** The benefit amount for each Cancer Critical Illness is the percentage shown below for that Cancer Critical Illness multiplied by the Basic Benefit Amount for the Initial Critical Illness Benefit shown on the Policy Specifications page applicable to the covered person. The benefit payable varies as shown in the chart below depending on whether the diagnosis of cancer indicates that the cancer is still localized (in situ) or whether it has spread (invasive).

Cancer Critical Illness	Percentage of Basic Benefit Amount
Carcinoma In Situ (Non-Invasive Cancer)	25%
Invasive Cancer	100%

- B. BENEFIT DESCRIPTIONS.** The Cancer Critical Illnesses are:

- 1. Carcinoma In Situ (Non-Invasive Cancer).** A cancer wherein the tumor cells still lie within the tissue of origin without having spread to neighboring tissue. Carcinoma In Situ (Non-Invasive Cancer) includes melanoma in situ, and early prostate cancer diagnosed as stages A, I, or II, or equivalent staging. We rely on the physician's diagnosis to determine whether the cancer is in situ (non-invasive).

Conditions not covered under the Carcinoma In Situ (Non-Invasive Cancer) benefit:

- a. basal cell and squamous cell skin cancers;**
 - b. skin cancers;**
 - c. pre-cancerous lesions (such as intraepithelial neoplasia); or**
 - d. benign (non-cancerous) tumors or polyps.**
- 2. Invasive Cancer.** A malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Invasive Cancer includes Leukemia, Lymphoma, melanoma, and skin cancer that has become metastatic. We rely on the physician's diagnosis to determine whether the cancer is invasive.

Conditions not covered under the Invasive Cancer benefit:

- a. basal cell and squamous cell skin cancers;**
- b. skin cancers;**
- c. pre-cancerous lesions (such as intraepithelial neoplasia);**
- d. benign (non-cancerous) tumors or polyps; or**
- e. cancer that has not spread to adjacent tissue (carcinoma in situ/non-invasive cancer).**

- C. DIAGNOSIS REQUIREMENTS.** A Cancer Critical Illness must be diagnosed in one of two ways:

- 1. Pathological diagnosis** means identification of cancer based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a certified pathologist whose diagnosis is in keeping with the standards set by the American Board of Pathology.
- 2. Clinical diagnosis** means a clinical identification of cancer based on history, laboratory study, and symptoms. We will pay benefits for a clinical diagnosis only if:
 - a. the diagnosis is consistent with professional medical standards; and**
 - b. there is medical evidence to support the diagnosis.**

The date of diagnosis for Cancer Critical Illness is the day the tissue specimen, culture and/or titer(s) are taken on which the first diagnosis of cancer is based, or the date a clinical diagnosis is made.

The "first diagnosis of cancer" includes a diagnosis of a reoccurrence of a cancer that was previously diagnosed before the effective date of coverage if, after the previous diagnosis and before the date of diagnosis of the reoccurrence, the covered person is free of any symptoms and treatment of the cancer for the 12 consecutive months immediately preceding the effective date of coverage or any 12 consecutive months thereafter.

For purposes of this benefit, "treatment" does not include maintenance drug therapy or routine follow-up office visits to verify if the Cancer Critical Illness has returned.

"Maintenance drug therapy" means ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer due to primary treatment. It is meant to decrease the risk of cancer reoccurrence rather than the palliation or suppression of a cancer that is still present.

ADDITIONAL BENEFITS

REOCCURRENCE OF CANCER CRITICAL ILLNESS BENEFITS

We will pay a benefit for a reoccurrence of cancer critical illness if a covered person is diagnosed for a second time with a cancer critical illness for which a benefit was previously paid under the Cancer Critical Illness Benefits provision if:

1. the second date of diagnosis is more than 12 months after the first date of diagnosis for the cancer critical illness;
2. the covered person did not receive treatment during that 12 month period; and
3. the second date of diagnosis is while the covered person is insured under this policy.

The benefit amount is equal to the benefit amount previously paid for that cancer critical illness. A covered person can receive a benefit for a reoccurrence of a cancer critical illness only once for each cancer critical illness.

Cancer Critical Illness
Carcinoma In Situ (Non-Invasive Cancer)
Invasive Cancer

For purposes of this benefit, "treatment" does not include maintenance drug therapy or routine follow-up office visits to verify if the cancer critical illness has returned.

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WAIVER OF PREMIUM BENEFIT

We will waive premiums for this coverage if, while covered under this policy and any attached riders, the primary insured:

1. becomes disabled due to a covered critical illness or specified disease for which a benefit is paid; 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 primary insured is disabled, until the earliest of:

1. the date the primary insured is no longer disabled;
2. 2 years from the first day of disability; or
3. the date coverage ends according to the Termination of Coverage provision.

"Disabled" means the primary insured is:

1. unable to work;
2. not working at any job for pay or benefits; and
3. under the care of a physician for the treatment of a covered critical illness or specified disease.

"Unable to work" means:

1. During the first 365 days of disability, the primary insured is unable to perform the material and substantial duties of the occupation he or she was performing when his or her disability began.
2. During the second 365 days of disability, the primary insured is unable to perform the material and substantial duties of any gainful occupation for which he or she is suited by education, training or experience.

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

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CONTINUATION OF INSURANCE COVERAGE

This section provides for automatic Continuation of Insurance Coverage, hereafter referred to as continuation coverage. It applies if a covered person suffers the loss of this group critical illness coverage due to one of the following events:

1. Termination of the primary insured's employment; or of a primary insured's eligibility due to reduction in his or her hours; or the date such primary insured is no longer in an eligible class; or the date such primary insured's class is no longer eligible. Insurance may be continued for any covered person.
2. The death of a primary insured. Insurance may be continued for any covered person.
3. Divorce or legal separation. Insurance may be continued for any covered person whose insurance would otherwise end.
4. The primary insured becoming eligible for Medicare. Insurance may be continued for any covered person who is not entitled to Medicare.
5. A child ceasing to be an eligible dependent as defined in this policy. Insurance may continue for that child.
6. The policyholder filing a Chapter 11 Bankruptcy petition. Insurance may be continued for any retired primary insured and his or her covered dependents. But this only applies if the insurance ends or is substantially reduced within 1 year before or after the filing of the bankruptcy.
7. Termination of the policy. (Benefits will be determined as if the policy had remained in full force and effect.)
8. Strike, layoff, leave of absence for personal reasons. Insurance may be continued for any covered person.
9. Military Service. The primary insured's leave of absence due to military service. Insurance may be continued for any covered person, except for the person who is in active military service.

Continuation coverage is not available for any person if coverage under the policy terminated due to his or her failure to make required premium payments.

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

COVERAGE CONTINUED

A person will not be denied continuation coverage solely because he or she is covered under another group critical illness plan, or eligible for Medicare on the date of the event that caused loss of coverage.

The continuation coverage may include any eligible dependents who were covered under the policy. The coverage being continued is subject to all terms and provisions of the policy that do not conflict with this section. The coverage will be the same as that provided under the policy for other persons in the same insurance class in which such person would have been if the loss of coverage had not occurred. The coverage will be subject to any changes to the policy affecting the benefits of such class. The continuation coverage will be effective on the day after the coverage under the policy terminates.

NOTIFICATION AND PAYMENT REQUIREMENTS

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

The policyholder has the responsibility of notifying the insurer of: (a) a covered person's death; (b) termination of the primary insured's employment or reduction in hours; or (c) the policyholder's bankruptcy. This notice must be made within 30 days of the event.

The insurer will notify the qualifying person of the right to continue within 14 days of the notice described above.

The qualifying person will be required to pay a premium for the continuation coverage to the insurer.

CONTINUATION OF INSURANCE COVERAGE (Continued)

PREMIUMS

Premiums are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The premium rate for the first 36 months of continuation coverage will not exceed 102% of the rate in effect under the policy covering a similarly situated class of primary insureds who have not elected continuation coverage. After the first 36 months, the premium rate may change for the class of persons covered under continuation coverage. Notice will be given at least 31 days before any change is to take effect.

GRACE PERIOD

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

TERMINATION OF INSURANCE

Insurance under continuation coverage will automatically end on the earliest of the following dates:

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

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

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CLAIM INFORMATION

NOTICE OF CLAIM

We encourage the primary insured to notify us of a claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of claim must be given to us within 20 days after the occurrence or commencement of any event or loss covered by this policy and any attached riders, or as soon as is reasonably possible. Notice must be given to us by, or on behalf of, the primary insured or the beneficiary at 1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687 to the attention of the Claims Department, or to any authorized agent of ours, with the primary insured's name and certificate number.

Upon receipt of a written notice of claim, we will furnish the primary insured with the claim form. If the form is not received from us within 15 days, written proof of claim may be sent to us without waiting for the form.

FILING A CLAIM

The primary insured must complete all applicable sections of the claim form and then give it to the covered person's attending physician. The physician should complete the attending physician's statement and send it directly to us.

PROOF OF LOSS

Written proof of loss must be furnished to us within 90 days of each critical illness or payable loss. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim as long as it can be shown that it was not reasonably possible to provide the proof at an earlier date, and the proof is provided as soon as was reasonably possible. In any event, the proof required must be given to us no later than one (1) year from the time specified, unless the primary insured is legally incapacitated.

Written proof of the eligibility of dependent child(ren) may be required at the time of claim.

PHYSICAL EXAMINATION AND AUTOPSY

We have the right, at our own expense, to have the covered person examined by a physician of our choosing, as often as may be reasonably required while a claim is pending. We may have an autopsy performed during the period of incontestability, where it is not forbidden by law.

TIME OF PAYMENT OF CLAIMS

Subject to due written proof of loss, all indemnities for loss for which this policy provides payment will be paid as they accrue and any balance remaining unpaid at termination of the period of liability will be paid immediately upon receipt of due written proof.

PAYMENT OF CLAIMS

After receiving all required written proof of claim, we will pay all benefits then due under this policy and any attached riders. We will make payment to the primary insured, unless such payments are assigned. Any amounts unpaid at the primary insured's death will be paid to the named beneficiary.

If there is no named beneficiary, or the named beneficiary does not survive the primary insured, we will pay any benefits due in the following order:

1. to the primary insured's living spouse or domestic partner; otherwise
2. to the covered person's living children, in equal shares; otherwise
3. to the covered person's living parents, in equal shares; otherwise
4. to the covered person's living siblings, in equal shares; otherwise
5. to the covered person's estate.

If benefits are payable to an individual who cannot execute a valid release, or to the primary insured's estate, we may pay benefits up to \$1,000, to someone related to the primary insured or his or her beneficiary by blood, law, or marriage whom we consider to be entitled to the benefits. We will be discharged from liability to the extent of any such payment made in good faith.

CLAIM INFORMATION (Continued)

OVERPAID CLAIM

We have the right to recover any overpayments due to:

1. fraud; or
2. any error we make in processing a claim.

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

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

CLAIM REVIEW

If a claim is denied, we will give written notice of:

1. the reason for denial;
2. the policy or rider provision that relates to the denial;
3. the primary insured's right to ask for a review of the denial; and
4. the primary insured's right to submit any additional information that might allow us to change our decision.

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GLOSSARY

(Glossary may contain terms that are not included in the coverage selected)

Accident means a sudden, unforeseen, and unexpected event which occurs without the covered person's intent.

Active employment or **actively employed** means the employee or member is working for his or her employer for earnings that are paid regularly and that he or she is performing the material and substantial acts of his or her regular occupation. For the purposes of this policy the employee or member:

1. must be working at least the minimum number of hours as described under Eligible Class(es); and
2. will be deemed to be in active employment on a day which is not the employer's scheduled work days only if he or she was actively employed on the preceding scheduled work day.

The employee or member's work site must be:

1. the employer's usual place of business;
2. an alternative work site at the direction of the employer; or
3. a location to which the job requires the employee or member to travel.

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

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

Child means a person under age 26 who is the primary insured's or his or her spouse's or domestic partner's natural or adopted son or daughter, stepson or stepdaughter, or a foster child who is placed with the primary insured or his or her spouse or domestic partner by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.

A child also includes an incapacitated dependent who:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. is chiefly dependent upon the insured employee or member for support and maintenance.

Coverage for an incapacitated dependent child is provided regardless of the age of the child as long as the insured employee's or member's coverage remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished, in writing, to us.

Covered person means any of the following:

1. any eligible family member (including the primary insured) named on the enrollment or evidence of insurability form and accepted for coverage by us;
2. any eligible family member added by endorsement after the effective date; or
3. a newborn or adopted child.

Critical illness means one of the critical illnesses described in the Critical Illness Benefits provision, any Additional Benefits, or any attached riders, for which a benefit may be paid.

Domestic partner means the primary insured's same-sex partner who is eligible for coverage provided that:

1. both the primary insured and his or her same-sex partner must be considered as domestic partners according to the law of the primary insured's state of residence; or
2. if the primary insured's state of residence has no domestic partnership law, he or she must satisfy the definition of domestic partner as defined by the policyholder.

For California residents, we comply with the statutory definition of a domestic partner.

GLOSSARY (Continued)

Eligibility waiting period means the continuous period of time that the employee or member must be in active employment in an eligible class before he or she is eligible to enroll or apply for coverage.

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

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

Evidence of insurability means a statement of the employee's or member's or a dependent's medical history which we will use to determine if he or she is approved for coverage.

Family Coverage means coverage that includes the primary insured, his or her eligible spouse or domestic partner, and his or her eligible child(ren).

Grace period means a period of 31 days for the payment of each premium falling due after the first premium.

Individual and Child(ren) Coverage means coverage that includes the primary insured and eligible children.

Initial enrollment period means one of the following periods during which the employee or member may first apply in writing for coverage under this policy:

1. if the employee or member is eligible for coverage on the policy effective date, a period before the policy effective date as set by us and the policyholder; or
2. if the employee or member becomes eligible for coverage after the policy effective date, the period ending 31 days after the date he or she is first eligible to apply for coverage.

Injury means accidental bodily harm or damage to a covered person.

Insured employee or member means the employee or member accepted for coverage by us who has completed and signed the enrollment form or evidence of insurability and whose name appears on the Certificate Specifications page.

Material and substantial acts means duties that:

1. are normally required for the performance of the primary insured's regular occupation; and
2. cannot be reasonably omitted or modified, unless the primary insured is required to work on average in excess of 40 hours per week, we will consider he or she is able to perform that requirement if he or she is working or has the capacity to work 40 hours per week.

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

Payable claim means a claim for which we are liable under the terms of this policy or any attached riders.

Physician means an individual who is licensed in the United States to practice medicine or treat illness in the state in which treatment is received. The physician cannot be the employee or member, a covered person or a member of the family by blood, marriage, law, or adoption.

GLOSSARY (Continued)

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

Primary insured means the insured employee or member covered under this policy, and for whom a certificate of insurance has been issued.

Re-enrollment period means a period of time as set by the policyholder and us during which the primary insured may apply, in writing, for coverage under this policy, or change existing coverage under this policy if he or she is currently enrolled.

Sickness means an illness or disease.

Spouse means a person to whom the employee or member is legally married. Spouse may also include the employee's or member's domestic partner if recognized under the law of the insured employee's or member's state of residence.

Symptoms means the subjective evidence of disease or physical disturbance observed by a physician or other member of the medical profession, acting within the scope of their license.

Temporary Layoff or Leave of Absence or Family and Medical Leave of Absence means the employee or member is absent from active employment for a period of time that has been agreed to in advance in writing by the policyholder.

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

Treatment means consultation, care, or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

Under the influence means a condition as determined by the laws of the state in which the loss occurred.

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

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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

**THIS IS A GROUP CRITICAL ILLNESS POLICY WHICH ONLY PROVIDES
STATED BENEFITS FOR SPECIFIED CRITICAL ILLNESSES OR OTHER BENEFITS THAT MAY BE ADDED.**

THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.

Read Your Policy Carefully.

AMERICAN HERITAGE LIFE INSURANCE COMPANY

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

SUPPLEMENTAL CRITICAL ILLNESS RIDER

Benefits are subject to all of the terms, conditions, and provisions of the policy and any attached riders. All terms defined and used in the policy apply to this rider unless otherwise provided in this rider.

DEFINITIONS

Benign brain tumor means a non-malignant tumor that is located in the cranial vault and limited to the brain, meninges, cranial nerves, or pituitary gland. The tumor must require surgery or radiation treatment or cause irreversible objective neurological deficits.

The date of diagnosis for Benign Brain Tumor is the date a physician determines a Benign Brain Tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

Benign brain tumor does not include: tumors of the skull; pituitary adenomas less than 10mm; or germinomas.

Coma means a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 7 days and for which period the Glasgow Coma score must be 4 or less. The date of diagnosis is the first day of the period for which a physician confirms a Coma has lasted for 7 or more consecutive days.

Coma does not include:

1. a medically-induced Coma;
2. a Coma which results directly from alcohol or drug use; or
3. a diagnosis of brain death.

Complete loss of hearing means the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

The date of diagnosis for Complete Loss of Hearing is the date the physician makes an accurate certification of total and permanent hearing loss.

Complete loss of sight means the total and irreversible loss of vision in both eyes, evidenced by:

1. the corrected visual acuity being 20/200 or less in both eyes; or
2. the field of vision being less than 20 degrees in both eyes.

The date of diagnosis for Complete Loss of Sight is the date a physician makes an accurate certification of total and permanent blindness.

Complete loss of speech means the total and irreversible loss of the ability to speak or communicate verbally without the assistance of a medical device. The diagnosis of Complete Loss of Speech must be made by a physician.

The date of diagnosis for Complete Loss of Speech is the date a physician makes accurate certification of total and permanent loss of speech.

Paralysis means the total and permanent loss of muscle function of 2 or more limbs as a result of disease or injury to the nerve supply of those limbs.

This does not include loss of muscle function that is limited to fingers or toes.

The date of diagnosis for Paralysis is the date a physician establishes the diagnosis of Paralysis based on clinical and/or laboratory findings as supported by medical records.

Policy means the policy to which this rider is attached.

DEFINITIONS (Continued)

Rider date means the effective date of coverage under this rider. The rider date is the policy date, 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.

BENEFIT INFORMATION

We will pay a benefit when a covered person is diagnosed with a Supplemental Critical Illness by a physician if:

1. the date of diagnosis is after the effective date of this rider;
2. the date of diagnosis is while this rider is in force; and
3. the illness is not excluded by name or specific description in the policy or any attached rider.

The benefit amount for each Supplemental Critical Illness is the percentage shown below for that Supplemental Critical Illness multiplied by the Basic Benefit Amount for the Initial Critical Illness Benefit applicable to the covered person on the Policy Specifications page. This benefit is payable only once per covered person.

Supplemental Critical Illness	Percentage Of Basic Benefit Amount
Benign Brain Tumor	100%
Coma	100%
Complete Loss of Hearing	100%
Complete Loss of Sight	100%
Complete Loss of Speech	100%
Paralysis	100%

LIMITATIONS AND EXCLUSIONS

The Exclusions provision in the policy applies to this rider.

TERMINATION

This rider terminates at the earliest of:

1. the date the policy is canceled;
2. the last day of the period for which any required premium payments were made;
3. the last day the primary insured is in active employment with his or her employer and/or a member in good standing in the labor union, association or other entity that is the policyholder, except as provided under the "Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence" provision;
4. the date the primary insured is no longer in an eligible class;
5. the date the primary insured's class is no longer eligible; or
6. the date of our discovery of fraud or material misrepresentation in the presentation of a claim under the policy or any attached rider.

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



Secretary



President



Important Privacy Policy Notice

At Allstate Benefits (“AB”), we value you as a customer. We also share your concerns about privacy. We are sending this notice to explain how we treat personal information (“customer information”) that is not public. This is information that we obtain from you or other sources when we provide you with products and services.

We want you to know that: we respect your privacy; and we protect your information.

- We do not sell customer information.
- We do not share your information with: persons; companies; or organizations outside of AB that would use that information to contact you about their products and services.
- We expect persons or organizations that provide services on our behalf to keep your information confidential. We also expect them to use your information only to provide the services we’ve asked them to perform.
- We communicate to our employees about the need to protect your information. We have established safeguards (these are physical, electronic and procedural) to protect this information.

Below are answers to questions that you might have about privacy. You may be wondering...

What do we do with your information?

AB does not sell your customer or medical information to anyone. We do not share it with companies or organizations outside of AB that would use that information to contact you about their own products and services. If this were to change, we would offer you the option to opt out of this type of information sharing. Also, we would obtain your consent before we share medical information for marketing purposes.

Your agent or broker may use your information to help you with your insurance needs. We may also communicate with you about products, features, and options in which you have expressed an interest. Without your consent, we may provide your information to persons or organizations in and out of AB. This would be done as permitted or required by law. We may do this to:

- Fulfill a transaction you have requested.
- Service your policy.
- Market our products to you.
- Investigate or handle claims.
- Detect or prevent fraud.
- Participate in insurance support organizations (Information from a report by an insurance support organization may be retained by that organization and distributed to other persons.).
- Comply with lawful requests from regulatory and law enforcement authorities.

These persons or organizations may include:

- Our affiliated companies.
- Companies that perform services, including marketing, on our behalf.
- Other financial institutions with which we have an agreement for the sale of financial products.
- Other insurance companies to perform their role in an insurance transaction involving you.
- Businesses that conduct actuarial or research studies.
- Persons requesting information pursuant to a subpoena or court order.
- Your agent or broker.
- An employer, if your premiums are payroll deducted.
- The creditor who sold you insurance, if your policy is credit insurance.

What kind of customer information do we have, and where did we get it?

Much of the information that we have about you comes from you. When you perform certain transactions, you may give us information such as your name, address, and Social Security number. These transactions include when you submit: an application for insurance; a request for insurance; a request for products and services we offer; or a request for an insurance quote. We may have contacted you by telephone or mail for additional information. We keep information about the types of services you purchase from us and our affiliates. Examples of this include premiums, fund values, and payment history. We may collect information from outside sources such as consumer reporting agencies and health care providers. The information we collect may include the following:

- Motor vehicle reports.
- Credit reports.
- Medical information.

How do we protect your customer information?

We expect any company with whom we share your information to use it only to provide the service we have asked them to perform. Information about you is also available within AB to those individuals who may need to use it to fulfill and service the needs of our customers. We communicate the need to protect your information to all employees and agents. We especially communicate this need to individuals who have access to it. Plus, we have established physical, electronic, and procedural safeguards to protect your information. Note that if your relationship with us ends, your information will remain protected. This protection will be provided according to our privacy practices outlined in this Important Notice.

How can you find out what information we have about you?

You may request to see, or obtain by mail, the information about you in our records. If you believe that our information is incomplete or inaccurate, you may request that we correct, add to, or delete from the disputed information. In order to fulfill your request, we may make arrangements to copy and disclose your information to you on our behalf. This may be done with an insurance support organization or a consumer reporting agency. You may also request a more complete description of the entities to which we disclose your information, or the conditions that might warrant such disclosures. Please send any of the requests listed above in writing to:

AB
 Policyholder Services (Privacy Section)
 1776 American Heritage Life Drive
 Jacksonville, FL 32224-6687

If you are an Internet user ...

Our website, www.allstateatwork.com, provides information about AB, our products, and the agencies and brokers that represent us. You may also perform certain transactions on the website. When accessing www.allstateatwork.com, please be sure to read the Privacy Statement that appears there. To learn more, the www.allstateatwork.com Privacy Statement provides information relating to your use of the website. This includes, for example:

- 1) our use of online collecting devices known as “cookies”;
- 2) how we collect information such as IP address (the number assigned to your computer when you use the Internet), browser and platform types, domain names, access times, referral data, and your activity while using our site;
- 3) who should use our website;
- 4) the security of information over the Internet;
- 5) links and co-branded sites.

We hope you have found this notice helpful. If you have any questions or would like more information, please don't hesitate to contact your agent or write us at:

AB
 Policyholder Services (Privacy Section)
 1776 American Heritage Life Drive
 Jacksonville, FL 32224-6687

This notice is being provided on behalf of the following companies:

American Heritage Life Insurance Company	Holiday Life Insurance Company
Bluegrass Life Insurance Company	Kentucky Home Mutual
Acme United Insurance Company	Keystone State Life
SMA Life Assurance Company	National Guardian Life



Benefits

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE APRIL 14, 2003

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of our Plan's customers' Protected Health Information, to provide those customers with notice of our legal duties and privacy practices with respect to Protected Health Information, and to send notification to affected customers if there is a breach of unsecured Protected Health Information. If your state provides privacy protections that are more stringent than those provided by HIPAA, we will maintain your Protected Health Information in accordance with the more stringent state standard.

This Notice applies to "Protected Health Information" associated with "Health Plans" issued by American Heritage Life Insurance Company.

This Notice describes how we may use and disclose Protected Health Information to perform claims handling, payment, general insurance operations, and for other purposes that are permitted or required by law. Use or disclosure of your Protected Health Information for the purposes described in this Notice may be made in writing, orally, or by electronic means.

We are required to abide by the terms of this Notice. However, we may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all of your Protected Health Information that we maintain, including any information we created or received prior to issuing the new notice. If we make a material revision to our Privacy Notice, copies will be sent to you if you are then currently insured under our Plan.

Protected Health Information means information about you that is created or received by us and during the administration of coverage under the Plan, which identifies you or for which there is a reasonable basis to believe the information can be used to identify you and that relates to:

- 1) the past, present or future physical or mental health condition of the individual; or
- 2) the provision of health care to the individual; or
- 3) the past, present or future payment for the provision of health care to the individual.

Uses and Disclosures of Protected Health Information With Your Written Authorization

Except as described in the next section of this Notice, we will not use or disclose your Protected Health Information for any purpose unless you have signed a form authorizing the use or disclosure. For example, most uses and disclosures of psychotherapy notes, uses and disclosures of Protected Health Information for marketing purposes, and disclosures that constitute a sale of Protected Health Information will be made only with your authorization. You have the right to revoke that authorization in writing at any

time, except to the extent that we have already taken action in reliance on the authorization; or the authorization was obtained as a condition of obtaining coverage, to the extent that other law allows the insurer to contest a claim under the policy or the policy itself.

Uses and Disclosures of Protected Health Information Without Your Written Authorization

For Payment. We may make use of and disclose your Protected Health Information without your written authorization as may be necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims or certify these services are covered under your Plan.

For Plan Administrative Operations. We may make use of and disclose your Protected Health Information without your written authorization as necessary for our Plan administrative operations. Plan administrative operations include our usual business activities, examples of which are management, licensing, peer review, quality improvement and assurance, enrollment, underwriting, reinsurance, compliance, auditing, rating, claims handling, complaint handling and other functions related to your Plan. We are prohibited from using or disclosing genetic information for underwriting purposes.

To Individuals Involved In Your Care. We may, without your written authorization, for the purposes of treatment, payment or Plan administrative operations, disclose the fact that you are covered under a Plan or that payment has been processed to a family member, other relative, your close personal friend or any other person you may identify. In these circumstances, we would not disclose any Protected Health Information which is not directly relevant to that person's involvement with your care or with payment for your care.

If you have designated a person to receive information regarding payment of the premium or pay premium via credit card, we may inform that person or credit card facility when your premium has not been paid or received by us.

We may also disclose limited Protected Health Information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

To Our Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations. Examples of these may include, but are not limited to our duly appointed insurance agents, financial auditors, reinsurers, legal services, enrollment and billing services, claim payment and medical management services. We may provide access to your Protected Health Information without your written authorization to one or more of these outside persons or organizations who assist us with payment or Plan administrative operations. We require these business associates to appropriately safeguard the privacy of your information.

To Plan Sponsors. If you are enrolled in a group health plan, we may share summary health information with your employer, union, or other employee organization that sponsors and maintains the group health plan, for purposes of obtaining premium bids; or modifying, amending, or terminating the group health plan; or enrollment and disenrollment information. Summary health information excludes genetic information.

For Other Products and Services. We may contact you without your written authorization to provide information regarding Plan upgrades or additional benefits that may be of interest to you. For example, we may use the fact that you currently are insured under a Plan for the purpose of communicating to you about changes to our Plan or products that could enhance or add value to existing coverage.

For Disclosure With Authorization. Unless otherwise excluded in this notice, we will not disclose any other Protected Health Information to any person or entity not specifically mentioned elsewhere in this Notice without your express written authorization.

For Other Uses and Disclosures. We are permitted or required by law to make some other uses and disclosures of your Protected Health Information without your authorization. We may release your Protected Health Information:

- if required by law to a government authorized health oversight agency or company conducting audits, investigations, or civil or criminal proceedings.
- if required to do so by a court or administrative ordered subpoena or discovery request. In most cases you will have notice of such a release.
- for public health activities, such as required reporting of disease, injury, birth and death and for required public health investigations.
- as required by law if we suspect child abuse or neglect or if we believe you to be a victim of abuse, neglect or domestic violence.
- to the Food and Drug Administration if necessary to report adverse events, product defects or to participate in product recalls.
- to law enforcement officials as required by law to report wounds, injuries or crimes.
- to coroners, medical examiners and/or funeral directors consistent with law.
- for a national security or intelligence activity or, if you are a member of the military, as required by the armed forces.
- to workers' compensation agencies or similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Your Rights

Right to Inspect and Copy Your Protected Health Information. You may have access to our records that contain your Protected Health Information in order to inspect and obtain copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from our Privacy Officer and submit the completed form to our Privacy Office. If you request copies, we may charge you copying and mailing costs. If you request a copy of your Protected Health Information in electronic form, we will provide it to you electronically only if the record is readily producible in electronic form.

Right to Amend Your Protected Health Information. You have the right to request that we amend your Protected Health Information maintained in our enrollment, payment, claims adjudication and case or medical management records, or other records we use to make decisions about you. If you desire to amend these records, please obtain an amendment request form from our Privacy Officer and submit the completed form to our Privacy Office. We will comply with your request unless special circumstances apply. If your physician or other health care provider created the information that you desire to amend, you should contact the provider to amend the information.

Right to an Accounting of the Disclosures of Your Protected Health Information. Upon request, you may obtain an accounting of certain disclosures of your Protected Health Information made by us on or after April 14, 2003, excluding disclosures made earlier than six years before the date of your request. If you request an accounting more than once during any 12 month period, we will charge you a reasonable fee for the subsequent accounting statements.

Right to Request Confidential Communications. We will accommodate your reasonable request to receive communications of your Protected Health Information from us by alternative means of communication or at alternative locations if the request clearly states that disclosure of that information could endanger you.

Right to Request Restrictions on Use and Disclosure of Your Protected Health Information. You have the right to request restrictions on some of our uses and disclosures of your Protected Health Information to family members and others involved in your care or payment for care; or some of our uses and disclosures used to carry out treatment, payment, or Plan administrative operations, by notifying us of your request for a restriction in writing mailed to the contact identified at the end of this Notice. Your request must describe in detail the restriction you are requesting. We are not required to agree to your restriction request but will attempt to accommodate your requests. We retain the right to terminate an agreed-to restriction. In the event of a termination of an agreed-to restriction by us, we will notify you of such termination, but the termination will only be effective for Protected Health Information we receive after we have notified you of the termination. You also have the right to terminate any agreed-to restriction by contacting us using the "Contact Information" provided at the end of this Notice.

Personal Representatives. You may exercise your rights through a personal representative who will be required to produce evidence of his or her authority to act on your behalf. Proof of authority may be made by a notarized power of attorney, a court order of appointment of the person as your legal guardian or conservator, or if you are the parent of a minor child. We reserve the right to deny access to your personal representative.

Right to Receive Paper Copy of this Notice. You may obtain a copy of this Notice. You may obtain a paper copy of this Notice even if you agreed to receive such notice electronically. Please contact us and we will mail it to you.

Complaints

If you believe your privacy rights have been violated, you can file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Plan, send it in writing to the "Contact Information" at the address listed at the end of this Notice. There will be no retaliation for filing a complaint.

You may obtain a copy of this Notice by writing to us at the contact address below.

Contact Information

If you have questions or need further assistance regarding this Notice, you may contact:

Allstate Benefits
Attn: HIPAA Privacy Officer
1776 American Heritage Life Drive
Jacksonville, Florida 32224

Or, you may telephone the Customer Care Center at 1-800-521-3535.

The California Department of Insurance should be contacted if discussions with us, our agent or other representative, or both have failed to satisfactorily resolve a consumer problem.

The address of the Department's Consumer Services Division is:

**300 S. Spring Street
Los Angeles, CA 90013**

**The phone number for callers inside the State of California is:
1-800-927-HELP**

**The phone number for callers outside the State of California is:
1-(213) 897-8921**

If you have questions or concerns regarding your insurance policy/certificate, please contact us, our agent or other representative.

**The address for American Heritage Life Insurance Company is:
1776 American Heritage Life Drive
Jacksonville, FL 32224**

**The phone number for customer service is:
1-800-521-3535**

The California Department of Insurance should be contacted only if discussions with us, our agent or other representative, or both have failed to satisfactorily resolve a consumer problem.

**The address and website of the Department's Consumer Services Division is:
300 S. Spring Street
Los Angeles, CA 90013
www.insurance.ca.gov**

**The phone number for callers inside the State of California is:
1-800-927-HELP**

**The phone number for callers outside the State of California is:
1-(213) 897-8921**

**NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION**

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

Persons Covered

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

Amounts of Coverage

The basic coverage protections provided by the Association are as follows:

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- **Life Insurance**
80% of death benefits but not to exceed \$300,000
80% of cash surrender or withdrawal values but not to exceed \$100,000
- **Annuities and Structured Settlement Annuities**
80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed \$250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is \$300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is \$546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O. Box 16860
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.