GROUP CRITICAL ILLNESS INSURANCE POLICY
NON-PARTICIPATING

FIRST OCCURRENCE SPECIFIED ILLNESS INSURANCE POLICY
WHICH MAY INCLUDE A CANCER CRITICAL ILLNESS BENEFIT IF SELECTED

This policy is a legal contract between the policyholder and the Company. The policyholder should read this 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 and any amendments and/or attachments issued; and
2. the policyholder’s signed application.

This policy may be changed in whole or in part. The approval must be in writing, signed by one 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.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida on the policy effective date.

THIS COVERAGE IS NOT A MEDICARE SUPPLEMENT POLICY.
If a person is eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the company.

Secretary
President

THIS IS A CRITICAL ILLNESS POLICY WHICH PROVIDES STATED BENEFITS FOR SPECIFIED SICKNESSES AND INJURIES OR OTHER BENEFITS THAT MAY BE ADDED. THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.

Important Cancellation Information – Please read the provision entitled “Termination of Coverage” Found On Pages 6-7.
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POLICY SPECIFICATIONS

POLICYHOLDER: NC FLEX

POLICY NUMBER: 83126

POLICY EFFECTIVE DATE: JANUARY 1, 2016

POLICY ANNIVERSARY DATE: JANUARY 1, 2017 and the first day of January each calendar year thereafter.

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

ELIGIBLE CLASS(ES): All active employees working 20 or more hours per week in a permanent, probationary or time-limited position.

ELIGIBILITY WAITING PERIOD: None

BASIC BENEFIT AMOUNT:
- $15,000 for Insured employee or member
- $15,000 for Insured Spouse
- $15,000 for Insured Child(ren)

GUARANTEED ISSUE LIMIT: $15,000

OPTIONAL BENEFITS:
- Second Event Initial Critical Illness Benefit
- Cancer Critical Illness Benefit – Same as Basic Benefit Amount
- Second Event Cancer Critical Illness Benefit

INITIAL RATE:

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<tr>
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RATE GUARANTEE DATE: 01/01/2020
POLICY SPECIFICATIONS (Continued)

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. All premiums must be sent to us on or before the premium due date. The premium must be paid in United States dollars.

COST OF COVERAGE:
The insured employee 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 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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Location (City and State)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
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POLICYHOLDER PROVISIONS

RATE GUARANTEE

A change in premium rate will not take effect before the Rate Guarantee Date but in no case will premiums be changed during the first 48 months of coverage. After the first 48 months of coverage, we can change premium rates for reasons which affect the risk assumed, including those reasons shown below:

1. a change occurs in this plan design; or
2. a division, subsidiary, or affiliated company is added or deleted; or
3. the number of insured employees or members changes by 10% or more; or
4. a new law or a change in any existing law is enacted which applies to this plan; or
5. less than 10% of those eligible for coverage are participating.

After the first 48 months of coverage, we will change premium rates no more than once every 6 months based on at least 12 months of experience.

We will notify the policyholder in writing at least 45 days before a premium rate is changed. 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 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; and
   b. who are insured; and
   c. whose coverage changes; and
   d. whose coverage ends; and
2. any information that may be required to manage a claim; and
3. any other information that may be reasonably required.

Policyholder records that have a bearing, in our opinion, on this policy will be available for review by us at any reasonable time.
INCONTESTABILITY
After 2 years from the effective date of this policy, no misstatement of the policyholder, made in any applications, can be used to void this policy.

CANCELING POLICY
This policy can be canceled:
1. by us; or
2. by the policyholder.

We may cancel or offer to modify this policy, with at least 45 days written notice to the policyholder, if:
1. less than 10% of those eligible for coverage are participating; or
2. this policy has been in effect more than 12 months; or
3. the policyholder does not promptly provide us with information that is reasonably required; or
4. the policyholder fails to perform any of its obligations that relate to this policy; or
5. fewer than 10% employees or members are insured; or
6. the policyholder fails to pay any premium within the 31 day grace period.

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

If the premiums are not received during the grace period, this policy will terminate automatically at the end of the grace period. This policy provides no coverage during the grace period unless premiums are paid in full prior to the end of the grace period. All premiums due must be paid to us for the full period this policy is in force.

The policyholder may cancel this policy by 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. If the policyholder cancels the policy for any reason, we will provide a refund of the pro rata portion of the unused collected premium to the beginning of the next monthly billing cycle.

ENTIRE CONTRACT
The contract consists of the following items:
1. the group policy; and
2. any amendments and endorsements; and
3. the applications and other written statements of the policyholder; and
4. any individual applications, enrollments, evidence of insurability or other statements of the insured employee or member.

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.

CONTRACT CHANGES
This policy may be changed in whole or in part. No changes to this policy will be valid unless approved and 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.
GENERAL PROVISIONS

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 that employee or member provided he or she is actively employed on that date.

If the employee or member is not actively employed on that date due to disability, injury, sickness, 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 employee’s or member’s 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 request for change.

For any change in coverage that is not subject to evidence of insurability, the change in coverage is effective on the date we receive such request for change.

Any decrease in coverage will take effect on the first day of the calendar month that next follows the date the employee or member applies for the decrease, but will not affect a payable claim that occurs prior to the effective date of the decrease.

CERTIFICATES OF INSURANCE

We will furnish to the policyholder a certificate of insurance for delivery to each insured employee or member. 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, the provisions of this policy govern.

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. at a re-enrollment period at any time.
2. The insured employee or member may increase coverage at the next enrollment period.
3. The insured employee or member may decrease coverage at the next enrollment period.
4. The insured employee or member may discontinue coverage at the next enrollment period.
GENERAL PROVISIONS (continued)

ELIGIBILITY OF DEPENDENTS

Eligible dependents are the insured employee’s or member’s:
1. legal spouse; and
2. children.

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

A child born to the insured employee or member or his or her spouse will be eligible for coverage. A foster child will be
eligible for coverage from the moment of placement in the foster home. This coverage begins at the moment of birth or the
moment of placement of such child and benefits will be the same as provided for any other child insured under this policy.
This includes coverage for any congenital defects and anomalies. No additional premium will be required for newborns
added if the insured employee or member already has children or family coverage in force at the time the newborn or
foster child is added.

If the insured employee or member does not already have children or family coverage in force, newborn children are
automatically covered from the moment of birth for a period of 31 days. Foster children are automatically covered from the
moment of placement in the foster home for a period of 31 days. If the insured employee or member desires uninterrupted
coverage for a newborn or foster child, he or she must notify the policyholder within 31 days of that child’s birth or
placement. Upon notice to us, we will change the coverage to include the additional child and provide notification of the
additional premium due. If the insured employee or member does not notify the policyholder within 31 days of the birth or
placement of the child, the temporary automatic coverage ends.

If the insured employee or member marries and desires coverage for his or her spouse, he or she must notify the
policyholder of the marriage within 31 days of the marriage. Upon notice to us, we will change the coverage to include the
insured employee’s or member’s spouse and provide notification of the additional premium due.

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 insured
   employee or member has been entered within 31 days after the date of birth.
2. If adoption proceedings have been instituted by the insured employee or member 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 insured employee or member has custody of the child pursuant to decree of the
court and required premiums are paid.

If the insured employee or member does not already have children or family coverage in force, adopted children or
children pending adoption are automatically covered as described above for a period of 31 days. If the insured employee
or member desires uninterrupted coverage for an adopted child or child pending adoption, he or she must notify the
policyholder within 31 days of the moment of placement. Upon notice to us, we will change the coverage to include the
additional adopted child or child pending adoption and provide notification of the additional premium due.

If the insured employee or member already has children or family coverage in force, no additional premium will be
required for an adopted child or foster child at the time the adopted child or foster child is added.
GENERAL PROVISIONS (Continued)

COVERAGE FOR CHILDREN OF NONCUSTODIAL PARENTS

If the insured employee or member is a noncustodial parent and provides coverage for a child under this policy, we shall:
1. provide such information to the custodial parent as may be necessary for the child to obtain benefits;
2. permit the custodial parent or provider, with the custodial parent’s approval, to submit claims for losses without the noncustodial parent’s approval; and
3. make payments on claims submitted in accordance with paragraph 2 of this section directly to the custodial parent, the provider or the state Medicaid agency.

When the insured employee or member is required by a court or administrative order to provide critical illness coverage for a child and he or she is eligible for coverage that includes coverage for a child, we will:
1. permit the insured employee or member to enroll a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions; and
2. enroll the child upon application of the child’s other parent, the state agency administering the Medicaid program or the state agency administering 42 U.S.C. Sections 651 through 669, the child support enforcement program, even if the insured employee or member is enrolled but fails to make application for coverage for the child; and
3. not terminate or eliminate coverage of the child unless we are provided satisfactory written evidence that:
   a. the court or administrative order is no longer in effect; or
   b. the child is or will be enrolled in comparable coverage through another insurer that will take effect not later than the effective date of the termination of coverage under this policy.

We shall not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under the Medicaid program, and covered for health benefits from us, that are different from requirements applicable to an agent or assignee of any other individual so covered.

TERMINATION OF COVERAGE

The insured employee’s or member’s coverage under this policy ends on the earliest of:
1. the date this policy is canceled; or
2. the last day of the period for which any required premium payments were made; or
3. the last day the insured employee or member 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; or
4. the date the insured employee or member is no longer in an eligible class; or
5. the date the insured employee’s or member’s class is no longer eligible; or
6. the date the insured employee’s or member’s has received the maximum total percentage of the basic benefit amount for each critical illness; or
7. upon our discovery of fraud or material misrepresentation in the presentation of a claim under this policy.

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

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

Coverage for a child will end upon the insured employee’s or member’s death, or on the issue day of the month that follows when the child: (a) reaches age 26; or (b) otherwise does not meet the requirements of an eligible dependent.

Coverage does not end for an incapacitated dependent child who:
1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under this policy; and
3. is chiefly dependent upon the insured employee or member for support and maintenance.
GENERAL PROVISIONS (Continued)

TERMINATION OF COVERAGE (Continued)

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 within 31 days of 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 accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate and claims will not be paid. There may be no refund due if the insured employee or member has children or family coverage in force and there are other eligible dependents still insured under this policy.

Coverage may be eligible for continuation as outlined in the PORTABILITY PRIVILEGE provision.

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

If the insured employee or member 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 the insured employee or member ceased active employment or membership in the union or association.

If the insured employee’s or member’s coverage ends while on a Family and Medical Leave of Absence, the coverage will be reinstated when he or she returns to active status.

We will not:
1. apply a new pre-existing condition exclusion; or
2. require evidence of insurability.

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DISCRETIONARY AUTHORITY, IF GOVERNED BY ERISA

Act (ERISA), 29 U.S.C. 1001 et seq.:

We have the discretion and authority to construe disputed or seemingly inconsistent provisions of the policy and to make all decisions regarding eligibility and/or entitlement to coverage or benefits. Whenever we make reasonable determinations which are not arbitrary or capricious in the administration of the policy, such determinations shall be final and conclusive.

LEGAL ACTION

No legal action may be brought to obtain benefits under the 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 written proof of loss is required to have been furnished.

TIME LIMIT ON CERTAIN DEFENSES

After 2 years from the effective date of coverage, no misstatement of a covered person, made in writing, can be used to void coverage or deny 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. Complete proof must be supplied by us or the policyholder documenting any clerical errors.

AGENCY

For purposes of this policy, the policyholder acts on its own behalf or as the insured employee’s or member’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:
4. the group policy; and
5. any amendments and endorsements; and
6. the applications and other written statements of the policyholder; and
4. any individual applications, enrollments, evidence of insurability or other statements made by a covered person.

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.

CONTRACT CHANGES

The policy may be changed in whole or in part. No changes to the policy will be valid unless approved and signed by one of our executive officers and endorsed on or attached to the policy. No other person, including an agent, may change this policy or waive any part of it.
PORTABILITY PRIVILEGE

We will provide portability coverage, subject to these provisions. Such coverage will not be available for an insured employee or member, unless:

1. coverage under the policy terminates under the TERMINATION OF COVERAGE provision; and
2. we receive a request and payment of the first premium for the portability coverage no later than 30 days after such termination; and
3. the request is made for that purpose.

No portability coverage will be provided for any person, if his or her insurance under the policy terminated due to his or her failure to make required premium payments.

PORTABILITY COVERAGE

The benefits, terms and conditions of the portability coverage will be the same as those provided under the policy when the insurance terminated, including credit for any limitations applied toward a pre-existing condition. Portability coverage may include any eligible dependents who were covered under the policy. Any change made to the policy after a person is insured under the portability privilege will not apply to that covered person unless it is required by law.

Portability coverage will be effective on the day after insurance under the policy terminates.

PORTABILITY PREMIUMS

Premiums for portability coverage are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The portability premium rate may differ from the premium rate in effect for insured employees or members and may change on any premium due date after the first 12 months of coverage. After the first 12 months of coverage, we have the right to change the rate table, but not more frequently than once in any 6 month period. Notice will be given at least 45 days before a change is to take effect.

GRACE PERIOD

The grace period, as defined, will apply to each certificate holder of portability coverage as if such insured employee or member is the policyholder.

TERMINATION OF INSURANCE

Insurance under this portability privilege ends on the earliest of:

1. The date the person again becomes eligible for insurance under the policy.
2. The last day for which premiums have been paid, if the insured employee or member fails to pay premiums when due, subject to the grace period.
3. With respect to insurance for dependents:
   a. the date the insured employee’s or member’s insurance terminates; or
   b. the date the dependent ceases to be an eligible dependent, as defined.

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

TERMINATION OF THE POLICY

If the policy terminates, the insured employee or member and his or her covered dependents will be eligible to exercise the portability privilege on the termination date of the policy. Portability coverage may continue beyond the termination date of the policy, subject to the timely payment of premiums. Benefits for portability coverage will be determined as if the policy had remained in full force and effect.
EXCLUSIONS

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

1. Active participation in a riot, insurrection or rebellion.
2. Intentionally self-inflicted injury or action.
3. Illegal activities or participation in an illegal occupation.
4. Suicide while sane, or self-destruction while insane, or any attempt at either.

(This space intentionally left blank.)
CRITICAL ILLNESS BENEFIT

GENERAL

Subject to the conditions, limitations and exclusions of this coverage, we will pay a benefit when a covered person is diagnosed with a critical illness described in this coverage if:

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

A covered person can receive a benefit for each critical illness only once, unless the Second Event Critical Illness Benefit for that critical illness is included in the coverage.

Coverage for a covered person terminates when the covered person is not eligible for any further benefits.

Each critical illness must be diagnosed by a physician in the United States. Claims for benefits not satisfying all the criteria for diagnosis may be subject to review by an independent physician consultant. Emergency situations that occur while the covered person is outside the United States may be reviewed and considered for approval by a United States physician on foreign soil or when the covered person returns to the United States.

We do not pay any benefit for any condition or loss not described below.

INITIAL CRITICAL ILLNESS BENEFIT

A. BENEFIT AMOUNT. The benefit amount for each initial critical illness is the percentage shown below for that initial critical illness multiplied by the basic benefit amount shown on page 3 of the certificate of insurance applicable to the covered person.

<table>
<thead>
<tr>
<th>Initial Critical Illness</th>
<th>Percentage of Basic Benefit Amount</th>
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<tbody>
<tr>
<td>Heart Attack</td>
<td>100%</td>
</tr>
<tr>
<td>Stroke</td>
<td>100%</td>
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<tr>
<td>Coronary Artery By-Pass Surgery</td>
<td>25%</td>
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<tr>
<td>Major Organ Transplant</td>
<td>100%</td>
</tr>
<tr>
<td>Bone Marrow Transplant</td>
<td>100%</td>
</tr>
<tr>
<td>End Stage Renal Failure</td>
<td>100%</td>
</tr>
<tr>
<td>Paralysis</td>
<td>100%</td>
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</table>

B. BENEFIT DESCRIPTION. 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 an established (old) myocardial infarction.

   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.
B. BENEFITS DESCRIPTION. (Continued)

3. **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 diagnosis for Coronary Artery By-Pass Surgery is the date the actual coronary artery by-pass surgery occurs.

4. **Major Organ Transplant.** The surgical transplantation of a heart, lung, liver, pancreas, or kidney. The transplanted organ must come from a human donor.

   The date of diagnosis for Major Organ Transplant is the date the actual surgery occurs for the covered transplant.

5. **Bone Marrow Transplant.** The procedure to replace damaged or destroyed bone marrow with healthy bone marrow. Treatments may be any of the following:
   a. A transplant which is other than non-autologous.
   b. A transplant which is non-autologous for the treatment of cancer or specified disease other than leukemia.
   c. A transplant which is non-autologous for the treatment of leukemia.

   The date of diagnosis for Bone Marrow Transplant is the date the actual procedure occurs for the covered transplant.

6. **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.

7. **Paralysis.** The total and permanent loss of voluntary movement or motor function of 2 or more limbs.

   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.
SECOND EVENT INITIAL CRITICAL ILLNESS BENEFIT

We will pay a Second Event Initial Critical Illness Benefit 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:

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 the policy.

The benefit amount is equal to the benefit amount previously paid for that initial critical illness. A covered person can receive a Second Event Initial Critical Illness Benefit only once for each initial critical illness.
OPTIONAL BENEFITS

CANCER CRITICAL ILLNESS BENEFIT

A. BENEFIT AMOUNT. The benefit amount for each cancer critical illness is the percentage shown below for that cancer critical illness multiplied by the basic benefit amount shown on page 3 of the certificate of insurance applicable to the covered person.

<table>
<thead>
<tr>
<th>Cancer Critical Illness</th>
<th>Percentage of Basic Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carcinoma in situ</td>
<td>25%</td>
</tr>
<tr>
<td>Invasive Cancer</td>
<td>100%</td>
</tr>
</tbody>
</table>

B. BENEFIT DESCRIPTION. The cancer critical illnesses are:

1. **Carcinoma In Situ.** A cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue.

   Carcinoma in situ includes:
   a. early prostate cancer diagnosed as stages A, I or II or equivalent staging; and
   b. melanoma not invading the dermis.

   Carcinoma in situ does not include:
   a. other skin malignancies; or
   b. pre-malignant lesions (such as intraepithelial neoplasia); or
   c. benign 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 and Lymphoma.

   Invasive cancer does not include:
   a. carcinoma in situ; or
   b. tumors in the presence of any human immuno-deficiency virus; or
   c. skin cancer other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic; or
   d. early prostate (stages A, I or II) 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 of malignancy 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. a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening; and
   b. there is medical evidence to support the diagnosis.

Clinical diagnosis of cancer shall be accepted as evidence that cancer exists in a covered person when a pathological diagnosis cannot be made, provided the medical evidence substantially documents the diagnosis of cancer and the covered person received definitive treatment for cancer. If the requisite pathological clinical diagnosis can only be made postmortem, liability shall be assumed retroactively beginning with the date of the terminal admission to the hospital for not less than 45 days before the date of death.

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.

Benefits will be paid for unrelated cancers diagnosed after the effective date of coverage.
OPTIONAL BENEFITS

CANCER CRITICAL ILLNESS BENEFIT (continued)

The “first diagnosis of cancer” includes a diagnosis of a recurrence 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 recurrence, the covered person is free of any symptoms and treatment of the cancer for the 12 months immediately preceding the effective date of coverage or any 12 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 recurrence rather than the palliation or suppression of a cancer that is still present.

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OPTIONAL BENEFITS

SECOND EVENT CANCER CRITICAL ILLNESS BENEFIT

We will pay a Second Event Cancer Critical Illness Benefit 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 BENEFIT provision if:

1. the second date of diagnosis is more than 12 months after the first date of diagnosis for the cancer critical illness; and
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.

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.

The benefit amount is equal to the benefit amount previously paid for that cancer critical illness. A covered person can receive a Second Event Cancer Critical Illness Benefit only once for each cancer critical illness.

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WAIVER OF PREMIUM BENEFIT

We will waive the insured employee’s or member’s premiums for this coverage if, while covered under the policy, the insured employee or member:
1. becomes disabled due to a critical illness 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 that the insured employee or member is disabled, until the earliest of:
1. the date he or she is no longer disabled; or
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 insured employee or member is:
1. unable to work; and
2. not working at any job for pay or benefits; and
3. under the care of a physician for the treatment of a covered critical illness. We will not require him or her to see or be under the care of a physician on a regular basis if it can be shown that they have reached their maximum point of recovery yet he or she is still disabled as defined. We may at our own expense, require the employee or member to have an examination to verify continuing disability.

“Unable to work” means:
1. During the first 365 days of disability, the insured employee or member is unable to work at the occupation he or she was performing when their disability began.
2. During the second 365 days of disability, the insured employee or member is unable to work at 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 insured employee or member. It does not apply to any other covered person. The insured employee or member must provide sufficient proof of disability at least once every 6 months, at our own expense.

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CLAIM INFORMATION

NOTICE OF CLAIM

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

CLAIM FORMS

Upon our receipt of a notice of claim, we will furnish to the covered person claim forms for filing proof of loss. If such forms are not furnished within 15 days after the covered person has given such notice, the covered person will be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within time given in the PROOF OF LOSS provision, written proof of the occurrence, the character and the extent of the loss for which claim is made.

If the form is not received within 15 days of the request, written proof of the claim may be sent to us without waiting for the form.

PROOF OF LOSS

Proof must be given to us within 180 days after each loss. If it is not possible to give us proof in the time required, we will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to us no later than 1 year from the time specified unless the insured employee or member is legally incapacitated.

PHYSICAL EXAMINATION AND AUTOPSY

We have the right, at our own expense, to have any 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. If an autopsy determines that the insured employee or member died as a result of one of the critical illnesses covered under this coverage, we will pay benefits due under the policy subject to the conditions described for each benefit and all other provisions of the policy.

FILING A CLAIM

The insured employee or member must complete all applicable sections of the claim form and then give it to their attending physician. The physician should complete his or her section statement of the form and send it directly to us.

PAYMENT OF CLAIMS

After receiving complete proof of loss, we will immediately pay all benefits then due under the policy. We will make payments to the insured employee or member unless such payments are assigned. Any amounts unpaid at the insured employee’s or member’s death may, at our option, be paid either to the named beneficiary or to the insured employee’s or member’s estate.

If benefits are payable to the insured employee’s or member’s estate or a beneficiary who cannot execute a valid release, we can pay benefits up to $3,000 to someone related to the insured employee or member or their beneficiary by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

CHANGE OF BENEFICIARY

The right to change a beneficiary is reserved for the insured employee or member. Consent of the beneficiary or beneficiaries shall not be required to assign benefits or to change a beneficiary or beneficiaries, or to make any other changes in the coverage.

 ASSIGNMENT

An assignment of the coverage under the policy is not binding on us, unless:
1. it is a request; and
2. it is received and recorded by us at our home office.

We are not responsible for the validity of any assignment. An assignment is subject to any payment we make or other action we take before we record the assignment. An assignee may not change the owner or beneficiary.
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 insured employee or member must reimburse us in full. We will work with such insured employee or member 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.

UNPAID PREMIUM
Upon the payment of a claim under the policy, any unpaid premium may be deducted.

CLAIM REVIEW
If a claim is denied, we will give written notice of:
1. the reason for denial; and
2. the policy provision that relates to the denial; and
3. the right to ask for a review of the claim; and
4. any additional information that might allow us to change our decision.

The insured employee or member may, upon request, read any reports that are not confidential. For a small fee, we will make copies of those reports for his or her use.

APPEALS PROCEDURE
Prior to filing any lawsuit and within 60 days after denial of a claim, the insured employee or member or his or her beneficiary must appeal any denial of benefits under the policy by making a request for review of the denial. The insured employee or member or his or her beneficiary can contact us at 1-800-521-3535. They can also write us at American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687.
**Active employment or actively employed** means the employee or member is working for the employer for earnings that are paid regularly and that he or she is performing the material and substantial duties of his or her regular occupation. For the purposes of this policy:

1. the employee or member must be working at least the minimum number of hours as described under Eligible Class(es); and
2. the employee or member 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’s or member’s work site must be:

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

**Covered person** means any of the following:

1. any eligible family member (including the employee or member) as named in the enrollment form and acceptable for coverage by us; or
2. any eligible family member added by endorsement after the effective date; or
3. a newborn child or foster child.

**Critical Illness** means one of the critical illnesses described in the CRITICAL ILLNESS BENEFIT provision for which a benefit may be paid.

**Eligibility Waiting Period** means the continuous period of time that the employee or member must be in active employment in an eligible class before coverage goes into effect.

**Employee** means a person who is a citizen or resident of the United States or one of its territories in active employment with his or her employer.

**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 medical history or the employee’s or member’s dependent’s medical history which we will use to determine if he or she is approved for coverage. Evidence of insurability will be provided at such person’s expense.

**Family coverage** means coverage that includes the insured employee or member, as defined, his or her eligible spouse and children.
Foster Child means a minor (a) over whom a guardian has been appointed by the clerk of superior court of any county in North Carolina; or (b) the primary or sole custody of whom has been assigned by order of a court of competent jurisdiction. The term "placement" when used with reference to a foster child means the child is physically residing with the insured employee or member, and the insured employee or member has been appointed as guardian or custodian of the foster child. The insured employee or member has assumed the legal obligation for total or partial support of the foster child with the intent that the foster child reside with the insured employee or member on more than a temporary or short-term basis.

Grace Period means a period of 31 days following the premium due date during which premium payment may be made.

Individual Coverage means coverage that includes only the insured employee or member, as defined.

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 injury.

Insured employee or member means the employee or member accepted for coverage by us who has completed and signed the enrollment form and whose name appears on the certificate specifications page.

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

Material and substantial duties means duties that:
1. are normally required for the performance of the employee’s or member’s regular occupation; and
2. cannot be reasonably omitted or modified, except that if the employee or member is required to work on average in excess of 40 hours per week, we will consider him or her 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 one of 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 the policy.

Physician means:
1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person who is a legally qualified medical practitioner according to the laws and regulations of the state he or she practices in.

We will not recognize an employee or member, his or her spouse, children, parents, or siblings as a physician for a claim.

Policy means the policy of insurance issued by us to the policyholder.

Policy Date means the effective date of the policy.

Policyholder means the legal entity to whom the policy is issued.
Re-enrollment period means a period of time as set by the policyholder and us during which the employee or member may apply, in writing, for coverage under the policy, or change coverage under the policy if currently enrolled.

Sickness means an illness or disease.

Symptoms mean 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 insured employee or member is absent from active employment for a period of time that has been agreed to in advance in writing by the current employer. 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.

We, Us and Our mean American Heritage Life Insurance Company.

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THIS IS A CRITICAL ILLNESS POLICY WHICH PROVIDES STATED BENEFITS ONLY FOR SPECIFIED SICKNESSES AND INJURIES OR OTHER BENEFITS THAT MAY BE ADDED. THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.
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

GLBNAHL 8/11
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.
Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers’ care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law’s coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone’s rights or obligations under the act or the rights or obligations of the guaranty association.

(please turn to back of page)
COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

• they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
• the insurer was not authorized to do business in this state;
• their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

• 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 a variable contract sold by prospectus;
• any policy of reinsurance (unless an assumption certificate was issued);
• interest rate yields that exceed an average rate specified in the law;
• dividends;
• experience or other credits given in connection with the administration of a policy by a group contract holder;
• employers’ plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).
• unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.
• a policy or contract commonly known as Medicare Part C or Part D or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

(1) The act also limits the amount the association is obligated to pay out as follows: The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
(2) Except as provided in (3), (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.
(3) The guaranty association will pay a maximum of $500,000 with respect to basic hospital, medical and surgical insurance and major medical insurance.
(4) The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.
(5) The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.
NOTICE OF PROHIBITIONS

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY SUCH PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.
NOTICE OF NON-INSURED BENEFITS

FROM TIME TO TIME AMERICAN HERITAGE LIFE INSURANCE COMPANY OR ITS AGENTS OR BROKERS MAY OFFER OR PROVIDE CERTAIN PERSONS WHO APPLY FOR COVERAGE WITH THE COMPANY OR BECOME INSURED/ENROLLEES WITH THE COMPANY FOR GOODS OR SERVICES INCLUDING, BUT NOT LIMITED TO: IRS SECTION 125 CAFETERIA PLAN ADMINISTRATION, FLEXIBLE SPENDING ACCOUNT ADMINISTRATION, CONSOLIDATED BILLING AND PAYMENT, ENROLLMENT AND ENROLLMENT ADMINISTRATION, COBRA ADMINISTRATION, ALL FORMS, HANDBOOKS, DVDS ETC. RELATED TO THE ABOVE. IN ADDITION, THE COMPANY OR ITS AGENTS OR BROKERS MAY ARRANGE FOR THIRD PARTY SERVICE PROVIDERS TO PROVIDE THE SAME SERVICES AS OUTLINED ABOVE OR OTHER DISCOUNTED GOODS AND SERVICES (E.G. PHARMACEUTICALS, VISION, DENTAL) TO THOSE PERSONS WHO APPLY FOR COVERAGE WITH THE COMPANY OR WHO BECOME INSURED/ENROLLEES OF THE COMPANY. WHILE THE COMPANY OR ITS AGENTS OR BROKERS HAVE ARRANGED THESE GOODS, SERVICES AND/OR THIRD PARTY PROVIDER DISCOUNTS, THE THIRD PARTY SERVICE PROVIDERS ARE LIABLE TO THE APPLICANTS/INSURED/ENROLLEES FOR THE PROVISION OF SUCH GOODS AND/OR SERVICES, UNLESS OTHERWISE REQUIRED BY LAW. THE COMPANY OR ITS AGENTS OR BROKERS ARE NOT RESPONSIBLE FOR THE PROVISION OF SUCH GOODS AND/OR SERVICES NOR IS IT LIABLE FOR THE FAILURE OF THE PROVISION OF THE SAME, UNLESS OTHERWISE PROVIDED BY LAW. FURTHER, THE COMPANY OR ITS AGENTS OR BROKERS ARE NOT LIABLE TO THE APPLICANTS/INSURED/ENROLLEES FOR THE NEGLIGENT PROVISION OF SUCH GOODS AND/OR SERVICES BY THIRD PARTY SERVICE PROVIDERS, UNLESS OTHERWISE PROVIDED BY LAW.