Allstate BENEFITS

Group Voluntary Cancer (Kansas)

Benefit Amounts

HOSPITAL AND RELATED BENEFITS	2 UNITS	3 UNITS
Continuous Hospital Confinement (daily)	$200	$300
Government or Charity Hospital (daily)	$200	$300
Private Duty Nursing Services (daily)	$200	$300
Extended Care Facility (daily)	$200	$300
At Home Nursing (daily)	$200	$300
Freestanding Hospice Care Center (daily)	1. $200	1. $300
Hospice Care Team (per visit)	2. $200	2. $300
RADIATION, CHEMOTHERAPY & RELATED BENEFITS	**4 UNITS**	**6 UNITS**
Radiation/Chemotherapy for Cancer (every 12 months)	$10,000	$15,000
Blood, Plasma, and Platelets (every 12 months)	$10,000	$15,000
Hematological Drugs (yearly)	$200	$300
Medical Imaging (yearly)	$500	$750
SURGERY AND RELATED BENEFITS	**2 UNITS**	**3 UNITS**
Surgery (inpatient)	$3,000	$4,500
Surgery (outpatient)	$4,500	$6,750
Anesthesia (% of Surgery)	25%	25%
Ambulatory Surgical Center (daily)	$500	$750
Second Opinion	$400	$600
Bone Marrow or Stem Cell Transplant 1. Autologous 2. Non-autologous 3. Non-autologous for leukemia	1. $1,000 2. $2,500 3. $5,000	1. $1,500 2. $3,750 3. $7,500
MISCELLANEOUS BENEFITS	**1 UNIT**	**1 UNIT**
Inpatient Drugs and Medicine (daily)	$25	$25
Physician's Attendance (daily)	$50	$50
Ambulance (per confinement)	$100	$100
Non-Local Transportation (per trip or mile)	Coach Fare or $0.40	Coach Fare or $0.40
Outpatient Lodging (daily)	$50	$50
Family Member Lodging (Daily) and Transportation (per trip or mile)	$50 Coach Fare or $0.40	$50 Coach Fare or $0.40
Physical or Speech Therapy (daily)	$50	$50
New or Experimental Treatment (every 12 months)	$5,000	$5,000
Prosthesis	$2,000	$2,000
Hair Prosthesis (every 2 years)	$25	$25
Nonsurgical External Breast Prosthesis	$50	$50
Anti-Nausea Benefit (yearly)	$200	$200
Waiver of Premium (primary insured only)	Yes	Yes
ADDITIONAL BENEFITS	**2 UNITS**	**5 UNITS**
Cancer Initial Diagnosis	$2,000	$5,000
	4 UNITS	**4 UNITS**
Wellness (yearly)	$100	$100

In addition to cancer, the policy also covers: Muscular Dystrophy, Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Poliomyelitis, Multiple Sclerosis, Encephalitis, Rabies, Tetanus, Tuberculosis, Osteomyelitis, Diphtheria, Scarlet Fever, Cerebrospinal Meningitis (bacterial), Brucellosis, Sickle Cell Anemia, Thallasemia, Rocky Mountain Spotted Fever, Legionnaire's Disease (confirmation by culture or sputum), Addison's Disease, Hansen's Disease, Tularemia, Hepatitis (Chronic B or Chronic C with liver failure or Hepatoma), Typhoid Fever, Myasthenia Gravis, Reye's Syndrome, Primary Sclerosing Cholangitis (Walter Payton's Liver Disease), Lyme Disease, Systemic Lupus Erythematosus, Cystic Fibrosis, Primary Biliary Cirrhosis.

Plan design and rates indicate which of the following optional items are applicable to the proposed plan.

We pay the following benefits for the necessary services and products for a covered cancer or a specified disease. Treatment must be received in the United States or its territories.

HOSPITAL AND RELATED BENEFITS

A. Continuous Hospital Confinement - If a covered person is admitted to and confined as an inpatient in a hospital, we pay the amount shown per day for each day.

B. Government or Charity Hospital -
In lieu of all other benefits in the policy (except the Waiver of Premium benefit), we pay the amount shown per day for each day a covered person is confined to: 1.) a hospital operated by or for the U.S. Government (including the Veteran's Administration); or 2.) a hospital that does not charge for the services it provides (charity).

C. Private Duty Nursing Services - While a covered person is an inpatient receiving treatment, we pay the amount shown per day if such covered person requires the fulltime services of a private nurse. Full-time means at least 8 hours of attendance during a 24 hour period. These services must be required and authorized by the attending physician and must be provided by a nurse.

D. Extended Care Facility - We pay the amount shown per day for each day a covered person is confined in an extended care facility. Confinement in the extended care facility must be at the direction of the attending physician and must begin within 14 days after a covered hospital confinement. This benefit is limited to the number of days of the previous continuous hospital confinement.

E. At Home Nursing - While a covered person is receiving treatment, we pay the amount shown per day for private nursing care and attendance by a nurse at home. At home nursing services must be required and authorized by the attending physician. This benefit is limited to the number of days of the previous continuous hospital confinement.

F. Hospice Care - When a covered person is: 1. determined by a physician to be terminally ill; and 2. expected to live 6 months or less; we pay one of the following two benefits for hospice care:
1. Freestanding Hospice Care Center. We pay the amount shown per day for confinement in a licensed freestanding hospice care center. The covered person must be diagnosed by a physician as terminally ill and the attending physician must approve the confinement. This benefit is payable only if a covered person is admitted to a freestanding hospice care center. Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or
2. Hospice Care Team. We pay the amount shown per visit, limited to one visit per day, for home care services by a hospice care team. Home care services are hospice services provided in the patient's home. This benefit is payable only if: the covered person has been diagnosed as terminally ill; and the attending physician has approved such services. We do not pay for: food services or meals other than dietary counseling; or services related to well-baby care; or services provided by volunteers; or support for the family after the death of the covered person.

RADIATION, CHEMOTHERAPY & RELATED BENEFITS

G. Radiation/Chemotherapy for Cancer - We pay the actual cost, up to the limit stated, for radiation therapy and chemotherapy received by a covered person. This benefit is limited to the amount shown per 12 month period beginning with the first day of benefit under this provision. Administration of radiation therapy or chemotherapy other than by medical personnel in a physician's office or hospital, including medications dispensed by a pump, will be limited to the costs of the drugs only, subject to the maximum amount payable per 12 month period explained above.

H. Blood, Plasma and Platelets - We pay the actual cost, up to the limit stated, for: 1. Blood, plasma and platelets (including transfusions and administration charges); and 2. Processing and procurement costs; and 3. Cross-matching. This benefit is limited to the amount shown per 12 month period beginning with the first day of benefit under this provision. We do not pay for blood replaced by donors. We do not pay for immunoglobulins.

I. Hematological Drugs - We pay the actual cost up to the amount shown for drugs intended to boost cell lines such as white blood cell

counts, red blood cell counts and platelets. This benefit is paid only when the Radiation/Chemotherapy benefit is paid.

J. Medical Imaging - We pay the actual cost once per calendar year, up to the amount shown, if a covered person receives an initial diagnosis or follow-up evaluation based upon one of the following medical imaging exams: CT scan; Magnetic Resonance Imaging (MRI) scan; bone scan; thyroid scan; Multiple Gated Acquisition (MUGA) scan; Positron Emission Tomography (PET) scan; transrectal ultrasound; or abdominal ultrasound. This benefit is limited to 1 payment per calendar year per covered person.

SURGERY AND RELATED BENEFITS

K. Surgery - We pay the actual charges, up to the amount listed in the Schedule of Surgical Procedures in the policy for the specific procedure per unit of coverage when surgery is performed on a covered person: 1. for the purpose of treating a diagnosed cancer or specified disease; or 2. for the purpose of diagnosing cancer or specified disease and that surgery results in a diagnosis of cancer or specified disease; or 3. that is the first surgery performed subsequent to a diagnosis of cancer or specified disease that is performed for the purpose of verifying the complete removal of the cancer or specified disease. Two or more procedures performed at the same time through one incision or entry point are considered one operation; we pay the amount for the procedure with the greatest benefit. Payment will never exceed the maximum per unit of coverage. Surgery performed on an outpatient basis is paid at 150% of the scheduled benefit. This benefit does not pay for surgeries covered by other benefits in this policy.

L. Anesthesia - We pay 25% of the amount paid for the Surgery Benefit (benefit K.) for anesthesia received.

M. Bone Marrow or Stem Cell Transplant - We pay the amounts shown for the following types of bone marrow or stem cell transplants performed on a covered person:

1. A transplant which is other than non-autologous.
2. A transplant which is non-autologous for the treatment of cancer or specified disease other than Leukemia.
3. A transplant which is non-autologous for the treatment of Leukemia.

This benefit is payable only once per covered person per calendar year.

N. Ambulatory Surgical Center - We pay for the use of an ambulatory surgical center, up to the amount shown for a surgical procedure covered under the Surgery Benefit (benefit K.) that is performed at an ambulatory surgical center.

O. Second Opinion - If surgery or treatment is recommended by a physician and the covered person chooses to obtain the opinion of a second physician, we pay the amount shown. This second opinion must be: rendered prior to surgery or treatment being performed; and obtained from a physician not in practice with the physician rendering the original recommendation.

MICELLANEOUS BENEFITS

P. Inpatient Drugs and Medicine - We pay the amount shown per day, for charges made by the hospital for drugs and medicine while hospital confined, for each day of continuous hospital confinement. This benefit does not pay for drugs and/or medicine covered under the Radiation/Chemotherapy benefit (benefit G.) or the Anti-Nausea benefit (benefit AA.).

Q. Physician's Attendance - We pay the amount shown for a visit by a physician while a covered person is receiving treatment during hospital confinement. This benefit is limited to one visit by one physician per day of hospital confinement. A visit means personal attendance by the physician. Admission to the hospital as an inpatient is required.

R. Ambulance - We pay the amount shown per continuous hospital confinement for transportation by a licensed ambulance service or a hospital owned ambulance to or from a hospital in which the covered person is confined.

S. Non-Local Transportation - We pay the following benefit for transportation to receive treatment at a hospital (inpatient or outpatient); or radiation therapy center; or chemotherapy or oncology clinic; or any other specialized freestanding treatment center nearest to the covered person's home, provided the same or similar treatment cannot be obtained locally: 1.) actual cost of round trip coach fare on a common carrier; or 2.) the amount shown, up to 700 miles, for round trip personal vehicle transportation. We do not pay for: transportation for someone to accompany or visit the person receiving treatment; visits to a physician's office or clinic; or for services other than actual treatment. "Non-Local" means a round trip of more than 70 miles from the covered person's home to the nearest treatment facility.

T. Outpatient Lodging - We pay a daily lodging benefit when a covered person receives radiation or chemotherapy treatment (benefit G.) on an outpatient basis, provided the specific treatment is authorized by the attending physician and cannot be obtained locally. The benefit is for a single room in a motel, hotel, or other accommodations acceptable to us, for the amount shown per day during treatment. This benefit is limited to the amount shown per 12 month period beginning with the first day of benefit under this provision. Outpatient treatment must be received at a treatment facility more than 100 miles from the covered person's home.

U. Family Member Lodging and Transportation - We pay the following benefits for one adult member of the covered person's family to

be near the covered person, when a covered person is confined in a non-local hospital for specialized treatment:
1. Lodging - The actual cost of a single room in a motel, hotel, or other accommodations acceptable to us, up to the amount shown per day. This benefit is limited to 60 days for each period of continuous hospital confinement; and

2. Transportation - The actual cost of round trip coach fare on a common carrier or a personal vehicle allowance of the amount shown per mile, up to 700 miles per continuous hospital confinement. Mileage is measured from the visiting family member's home to the hospital where the covered person is confined. We do not pay the Family Member Transportation benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation benefit (benefit S.), when the family member lives in the same city or town as the covered person.

V. Physical or Speech Therapy - We pay the amount shown per day, for physical or speech therapy for restoration of normal body function.

W. New or Experimental Treatment - We pay actual charges, up to the amount shown, for new or experimental treatment for cancer or specified disease when: 1. the treatment is judged necessary by the attending physician; and 2. no other generally accepted treatment produces superior results in the opinion of the attending physician. This benefit is limited to the amount shown per 12 month period beginning with the first day of treatment under this provision. This benefit does not pay if benefits are payable for treatment covered under any other benefit in the policy.

X. Prosthesis and Reconstructive Breast Surgery - We pay the following benefits for Prosthesis and Breast Reconstruction.
1. Prosthesis. We pay actual charges up to the amount shown for prosthetic devices which are prescribed as a direct result of surgery for cancer or specified disease and which require surgical implantation. This benefit is limited to the amount shown per covered person, per amputation.
2. Reconstructive Breast Surgery. We pay actual charges up to the amount shown for reconstructive breast surgery following a mastectomy that is covered under this policy. This includes charges for the expense of reconstruction of the breast on which the mastectomy was performed; and surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses; and treatment of physical complications for all stages of the mastectomy, including lymph edemas; and at least 2 external postoperative prostheses. This benefit is limited to the amount shown per covered person.

Y. Hair Prosthesis - We pay the amount shown every 2 years for a wig or hairpiece if the covered person experiences hair loss.

Z. Nonsurgical External Breast Prosthesis - We pay the actual cost up to the amount shown for the initial, nonsurgical breast prosthesis following a covered mastectomy or partial mastectomy that is paid for under the policy. This benefit is not paid when the Prosthesis and Reconstructive Breast Surgery benefit (benefit X.) is paid.

AA. Anti-Nausea Benefit - We pay the actual cost, up to the amount shown per calendar year for anti-nausea medication prescribed for a covered person by a physician. We will not pay this benefit for medication administered while the covered person is an inpatient.

BB. Waiver of Premium - If, while this coverage is in force, the insured employee or member becomes disabled due to cancer first diagnosed after the effective date of coverage and remains disabled for 90 days, we pay premiums due after such 90 days for as long as the insured employee or member remains disabled.

OPTIONAL ADDITIONAL BENEFITS

Wellness - We pay this benefit if a covered person has a wellness test performed. We pay the amount shown per calendar year per covered person for any one of the wellness tests. Each covered person is covered for no more than the amount shown per calendar year. We pay this benefit regardless of the result of the test. There is no limit as to the number of years we pay for wellness tests. The eligible wellness tests are: Biopsy for skin cancer; Blood test for triglycerides; Bone marrow testing; CA15-3 (cancer antigen 15-3-blood test for breast cancer); CA125 (cancer antigen 125 - blood test for ovarian cancer); CEA (carcinoembryonic antigen - blood test for colon cancer); Chest X-ray; Colonoscopy; Doppler screening for carotids; Doppler screening for peripheral vascular disease; Echocardiogram; EKG (Electrocardiogram); Flexible sigmoidoscopy; Hemocult stool analysis; HPV (Human Papillomavirus) Vaccination; Lipid panel (total cholesterol count); Mammography, including Breast Ultrasound; Pap Smear, including ThinPrep Pap Test; PSA (prostate specific antigen - blood test for prostate cancer); Serum Protein Electrophoresis (test for myeloma); Stress test on bike or treadmill; Thermography; and Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms

Cancer Initial Diagnosis - We pay a one-time benefit of the amount shown when a covered person is diagnosed for the first time in their life as having cancer other than skin cancer. The first diagnosis must occur after the effective date of coverage for that covered person. The benefit is payable only once per covered person.

Terms of Coverage

Coverage is subject in every way to the terms of the policy that is issued to the policyholder. The group policy may at any time be amended or discontinued by agreement between us and the policyholder. Your consent is not required for this. Neither are we required to give you prior notice. Family coverage includes you, your spouse or domestic partner and eligible children. Individual and Child (ren) coverage includes you and eligible children. Individual and Spouse coverage includes you and your eligible spouse or domestic partner. Your coverage under the certificate ends on the earliest of the date the policy is canceled; or the last day of the period for which you made any required premium payments; or the last day you are in active employment or membership, except as provided under the "Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence" provision; or the date you are no longer in an eligible class; or the date your class is no longer eligible. If your spouse is a covered person, your spouse's coverage ends upon valid decree of divorce or your death. If your domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or your death. Coverage for your child will end on the issue day of the month that follows when the child reaches age 26 or otherwise does not meet the requirements of an eligible dependent.

Portability Privilege

If a covered person's coverage terminates for reasons other than non-payment of premium, such covered person will be eligible for portability coverage. This means the covered person may continue the same benefits he or she had under the group policy, subject to the conditions defined in the policy, as long as premiums are paid directly to American Heritage Life Insurance Company.

Pre-Existing Condition, Exceptions and Limitations

We do not pay any benefit due to or caused by a pre-existing condition during the 12 month period beginning on the date that person became a covered person. A Pre-Existing Condition is a disease or physical condition for which symptoms existed within the 12 month period prior to the effective date of coverage; or medical advice or treatment was recommended or received from a member of the medical profession within the 12 month period prior to the effective date of coverage. We do not pay for any loss except for losses due directly from cancer or a specified disease. We do not pay for any other conditions or diseases caused or aggravated by cancer or a specified disease. Diagnosis must be submitted to support each claim. For those benefits for which we pay actual charges up to a specified maximum amount (benefits K., W., and X.), if specific charges are not obtainable as proof of loss, we will pay 50% of the applicable maximum for the benefits payable.

This illustration highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy itself sets forth, in detail, the rights and obligations of both the insured and the insurance company.

This is Limited Benefit Cancer and Specified Disease coverage which only provides benefits for cancer and specified diseases as defined or other optional benefits described herein.

The policy is not a Medicare Supplement Policy. If eligible for Medicare, review the Medicare Supplement Buyer's Guide, available from American Heritage Life Insurance Company.