Employee Benefit Amounts

INITIAL CRITICAL ILLNESS BENEFITS	LOW OPTION	HIGH OPTION
Heart Attack (100%)	$10,000	$20,000
Stroke (100%)	$10,000	$20,000
Coronary Artery By-Pass Surgery (25%)	$2,500	$5,000
Major Organ Transplant (100%)	$10,000	$20,000
End Stage Renal Failure (100%)	$10,000	$20,000
Waiver of Premium (employee only)	Yes	Yes
CANCER CRITICAL ILLNESS BENEFITS		
Invasive Cancer (100%)	$10,000	$20,000
Carcinoma in Situ (25%)	$2,500	$5,000
SUPPLEMENTAL CRITICAL ILLNESS BENEFITS II		
Advanced Alzheimer's Disease (25%)	$2,500	$5,000
Advanced Parkinson's Disease (25%)	$2,500	$5,000
Benign Brain Tumor (100%)	$10,000	$20,000
Coma (100%)	$10,000	$20,000
Complete Blindness (100%)	$10,000	$20,000
Complete Loss of Hearing (100%)	$10,000	$20,000
Paralysis (100%)	$10,000	$20,000
CRITICAL ILLNESS ADDITIONAL BENEFITS		
Second Event Initial Critical Illness Benefit	Yes	Yes
Wellness Benefit (per year)	$50	$100
ADDITIONAL RIDERS		
Rates Include Waiver of Pre-existing Condition Limitation	Yes	Yes
Continuation of Insurance Coverage to Age 70	Yes	Yes

Covered dependents are eligible for 50% of employee benefit amount.

Premiums – Monthly

$10,000 Base (Low) $20,000 Base (High), Supplemental Critical Illness II, Cancer, with 2nd Event for CI, and $50 (Low) $100 (High) Wellness, COIC Rider

$10,000 – non-tobacco

Issue Age	EE, EE & CH	EE & SP, Family
18-29	$ 5.10	$ 8.27
30-39	$ 8.98	$ 14.09
40-49	$ 16.35	$ 25.14
50-59	$ 28.84	$ 43.89
60-63	$ 46.72	$ 70.71
64+	$ 61.24	$92.48

$10,000 – tobacco

Issue Age	EE, EE & CH	EE & SP, Family
18-29	$ 7.42	$ 11.75
30-39	$ 13.86	$ 21.41
40-49	$ 28.74	$ 43.73
50-59	$ 48.48	$ 73.34
60-63	$ 79.79	$ 120.32
64+	$ 105.66	$ 159.12

$20,000 – non-tobacco

Issue Age	EE, EE & CH	EE & SP, Family
18-29	$ 13.22	$ 22.59
30-39	$ 20.99	$ 34.24
40-49	$ 35.74	$ 56.36
50-59	$ 60.73	$ 93.84
60-63	$ 96.47	$ 147.46
64+	$ 125.50	$ 191.01

$20,000 – tobacco

Issue Age	EE, EE & CH	EE & SP, Family
18-29	$ 17.88	$ 29.57
30-39	$ 30.73	$ 48.86
40-49	$ 60.50	$ 93.51
50-59	$ 99.97	$ 152.72
60-63	$ 162.60	$246.66
64+	$ 214.33	$ 324.26

(rates include a waiver of Pre-Existing Condition Clause)

EE=Employee; EE + SP = Employee + Spouse; EE + CH = Employee + Child(ren); and F = Family

Benefit Conditions when Pre-Existing Conditions Clause is Waived {WITH CANCER}

Benefits are not payable for any critical illness diagnosed prior to the effective date. Benefits are subject to limitations and exclusions. All critical illnesses must meet the definitions and dates of diagnoses stated in the policy and be diagnosed by a physician while coverage is in effect. Cancer critical illness benefits are payable for a diagnosis of a new or a recurrence of cancer, as long as you are diagnosed after the effective date of coverage, and have been free of any symptoms and treatment of cancer for 12 consecutive months immediately preceding the effective date of coverage, or any 12 consecutive months. The date of diagnosis for each illness must be separated by 90 days. Emergency situations while you are outside the U.S. will be considered when you return to the U.S.

Plan design and rates indicate which of the following optional items are applicable to the proposed plan. Below information includes all possible policy provisions and options available in the proposed situs state.

INITIAL CRITICAL ILLNESS BENEFIT

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

1. The date of diagnosis for the critical illness is while the covered person is insured; 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 policy.

A covered person can receive benefits for the different critical illnesses and any optional critical illness benefits selected if the dates of diagnosis for each critical illness are separated by at least 90 days.

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

Benefits are provided for the covered illnesses shown. The policy does not pay for any condition or loss not described below.

The benefit amount payable for each illness is the percentage shown below multiplied by the basic benefit amount. Spouse and children are eligible for 50% of the insured employee benefit amount.

BENEFIT DESCRIPTION

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: new electrocardiographic changes; and 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.

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.

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.

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.

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.

Waiver of Premium - We will waive your premiums for this coverage if, while covered under the policy, you become disabled due to a critical illness for which a benefit is paid; and remain 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 you are disabled, until the earliest of: the date you are no longer disabled; or 2 years from the first day of disability; or the date coverage terminates. This benefit is payable only for the disability of the insured employee/member. It does not apply to any other covered person. You must provide sufficient proof of disability at least once every 6 months.

OPTIONAL CANCER CRITICAL ILLNESS BENEFIT

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: early prostate cancer diagnosed as stages A, I or II or equivalent staging; and melanoma not invading the dermis. Carcinoma in situ does not include: other skin malignancies; or pre-malignant lesions (such as intraepithelial neoplasia); or benign tumors or polyps.

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: carcinoma in situ; or tumors in the presence of any human immuno-deficiency virus; or skin cancer other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic; or early prostate (stages A, I or II) cancer.

Diagnosis Requirements - A cancer critical illness must be diagnosed by a pathological or clinical method. 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. 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 consecutive months immediately preceding the effective date of coverage or any 12 consecutive months thereafter. For the purposes of this benefit, "treatment" does not include maintenance drug therapy or routine follow-up visits to verify if the cancer critical illness has returned.

OPTIONAL SUPPLEMENTAL CRITICAL ILLNESS BENEFIT

Advanced Alzheimer's Disease - A progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's disease that causes the covered person to be incapacitated as defined in the policy and unable to perform at least 3 of the activities of daily living: bathing, dressing, toileting, bladder and bowel continence, transferring or eating. The date of diagnosis for Advanced Alzheimer's Disease is the date a physician diagnoses the covered person as incapacitated due to Alzheimer's disease.

Benefit Limitation - We will not pay benefits for Advanced Alzheimer's Disease if the covered person was diagnosed with Alzheimer's disease, regardless of the covered person's symptoms or incapacities, prior to the effective date of coverage.

Advanced Parkinson's Disease - A brain disorder that is diagnosed by a psychiatrist or neurologist as Parkinson's disease that causes the covered person to be incapacitated as defined in the policy and unable to perform at least 3 of the activities of daily living: bathing, dressing, toileting, bladder and bowel continence, transferring or eating. The date of diagnosis for Advanced Parkinson's Disease is the date a physician diagnoses the covered person as incapacitated due to Parkinson's disease.

Benefit Limitation - Benefit Limitation. We will not pay benefits for Advanced Parkinson's Disease if the covered person was diagnosed with Parkinson's disease, regardless of the covered person's symptoms or incapacities, prior to the effective date of coverage.

Benign Brain Tumor - A non-cancerous brain tumor: confirmed by the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination; and resulting in persistent neurological deficits including but not limited to: loss of vision; loss of hearing; or balance disruption. Benign brain tumor does not include: tumors of the skull; or pituitary adenomas; or germanomas. The date of diagnosis for Benign Brain Tumor is the date a physician determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

Coma - A continuous profound state of unconsciousness lasting 14 or more consecutive days due to an underlying sickness or traumatic brain injury. It is associated with severe neurologic dysfunction and unresponsiveness prolonged nature requiring significant medical intervention and life support measures. Coma does not include a medically induced coma. The date of diagnosis for Coma is the first day of the period for which a physician confirms a coma has lasted for 14 consecutive days.

Complete Blindness - A clinically proven irreversible reduction of sight in both eyes certified by an ophthalmologist with: sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (snellen or E-chart Acuity); or visual field restriction to 20 degrees or less in both eyes. The date of diagnosis for Complete Blindness is the date an ophthalmologist makes an accurate certification of complete blindness

Complete Loss of Hearing - The total and irreversible loss of hearing in both ears. Complete Loss of Hearing does not include loss of hearing that can be corrected by the use of any hearing aid or device. The date of diagnosis for Complete Loss of Hearing is the date the audiologist makes an accurate certification of total and permanent hearing loss.

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.

Optional Occupational HIV - An accidental occupational exposure to HIV-contaminated body fluids due to a needle stick or splash from which the covered person is infected with HIV. The accidental exposure must occur during the normal course of duties of the occupation in which the covered person is regularly engaged and for which remuneration is earned. The covered person must have never previously tested HIV positive. The date of diagnosis for Occupational HIV is the date a physician determines the covered person is HIV positive as supported by the ELISA test, Western Blot test or another FDA approved test.

OPTIONAL SECOND EVENT INITIAL CRITICAL ILLNESS BENEFIT

Same Amount as Initial Critical Illness - We will pay this benefit if the covered person is diagnosed for a second time with an initial critical illness for which a benefit was previously paid under the Initial Critical Illness Benefit provision if:

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

A covered person can receive a Second Event Initial Critical Illness Benefit only once for each initial critical illness.

OPTIONAL SECOND EVENT INITIAL CANCER CRITICAL ILLNESS BENEFIT

Same Amount as Cancer Critical Illness - We will pay this benefit if the 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 the purposes of this benefit, "treatment" does not include maintenance drug therapy or routine follow-up visits to verify if the cancer critical illness has returned. A covered person can receive a Second Event Cancer Critical Illness Benefit only once for each cancer critical illness.

OPTIONAL INCREASING CRITICAL ILLNESS BENEFIT

Insured Employees - $250/Per Coverage Year* Insured Spouse - $125/Per Coverage Year* Each Insured Child - $125/Per Coverage Year*
We will increase the basic benefit amounts by the amount shown on each of the first 5 coverage year anniversaries. This increase will be the specified amount shown and will increase the basic benefit amount for each covered person. This increase only applies to the basic benefit amount. It does not apply to any other benefit included with the certificate. Each increase in the basic benefit amount will be automatically processed by us. *Coverage Years 2-5

OPTIONAL SECOND EVALUATION BENEFIT RIDER

Second Consultation - If surgery or treatment is recommended by a physician for a covered critical illness and the covered person chooses to obtain a consultation with a second physician, we pay $1,000. This consultation 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.

Non-Local Transportation - We pay the following benefit for transportation to receive treatment for a covered critical illness at a non-local hospital (inpatient or outpatient) or any other non-local specialized freestanding treatment center: (1) $500 for round trip airfare; or (2) $0.50 per mile, up to 1,000 miles, for round trip personal vehicle transportation. Mileage is measured from the covered person's home to the treatment facility. We do not pay for: transportation for someone to accompany or visit the person receiving treatment; visits to a physician's office or clinic;

or for services other than actual treatment. This benefit is limited to $5,000 per 12 month period beginning with the first day of benefit under this provision.

Outpatient Lodging - We pay a daily lodging benefit when a covered person receives treatment for a covered critical illness on an outpatient basis at a non-local treatment facility. The benefit is $100 per day during treatment for a single room in a motel, hotel, or other accommodations acceptable to us. This benefit is limited to $1,000 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 75 miles from the covered person's home.

Family Member Lodging and Transportation - We pay the following benefits for one adult member of the covered person's family to be near the covered person, when they are confined in a non-local hospital for specialized treatment for a covered critical illness:

1. Lodging - $100 per day for a single room in a motel, hotel, or other accommodations acceptable to us. This benefit is limited to $1,000 per 12 month period beginning with the first day of benefit under this provision; and
2. Transportation -$500 for round trip airfare or a personal vehicle allowance of $0.50 per mile, up to 1,000 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 personal vehicle allowance in the Family Member Transportation benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation benefit, when the family member lives in the same city or town as the covered person. This benefit is limited to $5,000 per 12 month period beginning with the first day of benefit under this provision.

Limitations and Exclusions: The policy pre-existing condition limitation and exclusions apply to this rider.

OPTIONAL WELLNESS BENEFIT

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

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; or the date the you have received the maximum total percentage of the basic benefit amount for each critical illness; or upon our discovery of fraud or material misrepresentation in the presentation of a claim. 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.

Optional Rider Continuation of Insurance Coverage to age 70

If your coverage terminates for reasons other than non-payment of premium, or if coverage of a spouse terminates due to divorce or your death, or if coverage of a child terminates due to the child reaching age 26, the covered person will be eligible for portability coverage. This means the covered person may continue the same benefits you 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. A dependent child whose Continuation Coverage terminates when he or she reaches the age limit may apply for Continuation Coverage in his or her own name, if he or she is otherwise eligible. Continuation Coverage will remain in effect for no longer than 36 months, or until you reach age 70, whichever occurs later.

Optional Pre-existing Condition Limitation

We do not pay benefits for a critical illness that is, or is caused by, contributed by or results from, a pre-existing condition when the date of diagnosis for the critical illness is within 12 months after the effective date of coverage. A Pre-Existing Condition is a sickness, injury or other condition, whether diagnosed or not, for which, during the 12 months just prior to the effective date of coverage, either: symptoms existed; or medical advice or treatment was recommended by or received from a physician or other member of the medical profession, acting within the scope of their license.

Exclusions

We will not pay benefits for a critical illness that is, or is caused by, contributed to by or results from: 1. War, declared or undeclared, during military service. 2. Participation in a riot, insurrection or rebellion. 3. Intentionally self-inflicted injury or action. 4. Illegal activities or committing or attempting to commit a felony. 5. Suicide while sane, or self-destruction while insane, or any attempt at either. 6. Substance abuse, to include abuse of alcohol, alcoholism, drug addiction or dependence upon any controlled substance.