Allstate BENEFITS

Benefits and Amounts

HOSPITAL AND RELATED BENEFITS	OPTION 1	OPTION 2	OPTION 3
Continuous Hospital Confinement (daily)	$100	$200	$300
Government or Charity Hospital (daily)	$100	$200	$300
Private Duty Nursing Services (daily)	$100	$200	$300
Extended Care Facility (daily)	$100	$200	$300
At Home Nursing (daily)	$100	$200	$300
Freestanding Hospice Care Center (daily) or	$100	$200	$300
Hospice Care Team (per visit)	$100	$200	$300
RADIATION, CHEMOTHERAPY, AND RELATED BENEFITS			
Radiation/Chemotherapy for Cancer (every 12 months)	$7,500	$10,000	$20,000
Blood, Plasma, and Platelets (every 12 months)	$7,500	$10,000	$20,000
Hematological Drugs (yearly)	$150	$200	$400
Medical Imaging (yearly)	$375	$500	$1,000
SURGERY AND RELATED BENEFITS			
Surgery (maximum, depending on surgery)	$1,500	$3,000	$4,500
Anesthesia (% of Surgery Benefit)	25%	25%	25%
Ambulatory Surgical Center (daily)	$250	$500	$750
Second Opinion	$200	$400	$600
Bone Marrow or Stem Cell Transplant - Autologous*	$500	$1,000	$1,500
Non-autologous*	$1,250	$2,500	$3,750
Non-autologous for Leukemia*	$2,500	$5,000	$7,500
MISCELLANEOUS BENEFITS			
Inpatient Drugs and Medicine (daily)	$25	$25	$25
Physician's Attendance (daily)	$50	$50	$50
Ambulance (per confinement)	$100	$100	$100
Non-Local Transportation (per trip or mile)	Coach Fare or $0.40/Mile	Coach Fare or $0.40/Mile	Coach Fare or $0.40/Mile
Outpatient Lodging (daily, $2,000 max/12 months)	$50	$50	$50
Family Member Lodging (daily) and	$50	$50	$50
Transportation (per trip or mile)	Coach Fare or $0.40/Mile	Coach Fare or $0.40/Mile	Coach Fare or $0.40/Mile
Physical or Speech Therapy (daily)	$50	$50	$50
New or Experimental Treatment (every 12 months)	$5,000	$5,000	$5,000
Prosthesis (per amputation)	$2,000	$2,000	$2,000
Hair Prosthesis (every 2 years)	$25	$25	$25
Nonsurgical External Breast Prosthesis	$50	$50	$50
Anti-Nausea Benefit (yearly)	$200	$200	$200
Waiver of Premium (primary insured only)	Yes	Yes	Yes
OPTIONAL BENEFITS			
Cancer Initial Diagnosis (one-time benefit)	$1,000	$2,000	$3,000
Intensive Care - Intensive Care Confinement (daily)	$200	$300	$400
Step-Down Confinement (daily)	$100	$150	$200
Air/Surface Ambulance	Actual Charges	Actual Charges	Actual Charges
Wellness (yearly)	$50	$50	$100

* Yearly

premiums

PLAN DESIGN	EE	EE + SP	EE + CH	F
Option 1 - Monthly 1 Unit Hospital Benefits, 3 Units Radiation & Chemotherapy Benefits, 1 Unit Surgery Benefits, 1 Unit Miscellaneous Benefits, 2 Units Wellness Benefit, 2 Units Intensive Care Benefits, 1 Unit Cancer Initial Diagnosis.	$15.92	$24.85	$22.51	$31.42
Option 2 - Monthly 2 Units Hospital Benefits, 4 Units Radiation & Chemotherapy Benefits, 2 Units Surgery Benefits, 1 Unit Miscellaneous Benefits, 2 Units Wellness Benefit, 3 Units Intensive Care Benefits, 2 Units Cancer Initial Diagnosis.	$23.39	$36.42	$33.42	$46.43
Option 3 - Monthly 3 Units Hospital Benefits, 8 Units Radiation & Chemotherapy Benefits, 3 Units Surgery Benefits, 1 Unit Miscellaneous Benefits, 4 Units Wellness Benefit, 4 Units Intensive Care Benefits, 3 Units Cancer Initial Diagnosis.	$40.60	$63.00	$57.74	$80.13

In addition to cancer, benefits (unless noted specifically for cancer) are also payable for: 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, Thalassemia, Rocky Mountain Spotted Fever, Legionnaires' 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.

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

Rates reflect 310 eligible employees for coverage. These rates are not for use with a group that has 1,000 or more eligible employees.
SQ V.09.27.2018 Proposal Creation Date: 10/3/2018
This Quote Expires on 10/3/2019
Eligible Lives: 310

MyBenefits an Account Original Effective Date on or before 1/1/2018.

MyBenefits is our customers' online resource for claims submission and account information. Optimized for mobile devices, employees can quickly and securely file their claims and supporting documentation at home or on the go! MyBenefits provides registered account holders with anytime access to Frequently Asked Questions, a personalized message center, helpful resources and more. With our Fast File claims processing, employees submitting Wellness or Outpatient Physicians Treatment (OPT) benefit claims can receive their money in their bank account in as little as 48 hours (ACH required).

To register, access MyBenefits at https://www.allstatebenefits.com/mybenefits/User/Login/

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

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 full-time 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 AND 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 (benefit G.) 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 shown 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 the 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 the amount shown for the use of an ambulatory surgical center 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.

MISCELLANEOUS 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** - We pay actual charges up to the amount shown for prosthetic devices which are prescribed as a direct result of surgery and which require surgical implantation. This benefit is limited to the amount shown per covered person, per amputation.

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.

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 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; Hemoccult 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.

Intensive Care

A. Hospital Intensive Care Unit Confinement. We pay the amount shown for each day of hospital intensive care unit confinement for any illness or accident. This benefit is limited to 45 days for each period of such confinement. A day is a 24 hour period. If confinement is for only a portion of a day, then a pro-rata share of the daily benefit is paid.
B. Step-Down Hospital Intensive Care Unit Confinement. We pay the amount shown for each day of step-down hospital intensive care unit confinement for any illness or accident. This benefit is limited to 45 days for each period of such confinement. A day is a 24 hour period. If confinement is for only a portion of a day, then a pro-rata share of the daily benefit is paid.
C. Ambulance. We pay the actual charges for transportation of a covered person by licensed air or surface ambulance service to a hospital for admission to an intensive care unit for a covered confinement. We do not pay this benefit if an ambulance benefit is paid under the Ambulance benefit (benefit R.) in the policy.

Specifications

You decide who is eligible for your group (such as length of service and hours worked each week). Issue ages are 18 and over.

Family members eligible for coverage are the employee's spouse or domestic partner and eligible children. Coverage for children ends when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent. Spouse coverage ends upon valid decree of divorce or the employee's death. Domestic partner coverage ends when the domestic partnership ends or the employee's death.

Coverage under the policy ends when: the policy is canceled; the employee stops paying their premium; last day of active employment, except as provided under the Temporary Layoff, Leave of Absence, or Family and Medical Leave of Absence provision; or they are no longer eligible.

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. A Pre-Existing Condition can exist even though a diagnosis has not yet been made. 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.

The Radiation/Chemotherapy for Cancer benefit does not pay for: (a) any other chemical substance which may be administered with or in conjunction with radiation/chemotherapy; or (b) treatment planning consultation; management; or the design and construction of treatment devices; or basic radiation dosimetry calculation; or any type of laboratory test; X-ray or other imaging used for diagnosis or monitoring; or the diagnostic tests related to these treatments; or (c) any devices or supplies including intravenous solutions and needles related to these treatments.

Intensive Care Exceptions and Limitations

The Hospital Intensive Care Unit Confinement benefit does not pay for intensive care if a covered person is admitted because of an attempted suicide; or intentional self-inflicted injury; or intoxication or being under the influence of drugs not prescribed or recommended by a physician; or alcoholism or drug addiction. We do not pay for confinements in any care unit that does not qualify as a hospital intensive care unit. Progressive care units, sub-acute intensive care units, intermediate care units, and private rooms with monitoring, step down units and any other lesser care treatment units do not qualify as hospital intensive care units. We do not pay for step-down hospital intensive care unit confinement if a covered person is admitted and confined in the following type of units: telemetry or surgical recovery rooms; post-anesthesia care units, progressive care units; intermediate care units; private monitored rooms; observation units located in emergency rooms or outpatient surgery units; beds, wards, or private or semi-private rooms with or without telemetry monitoring equipment; an emergency room; labor or delivery rooms; or other facilities that do not meet the standards for a step-down hospital intensive care unit. We do not pay this benefit for continuous hospital intensive care unit confinements or continuous step-down hospital intensive care unit confinements that occur during a hospitalization that begins before the effective date of coverage. Children born within 10 months of the effective date are not covered for any continuous hospital intensive care unit confinement that occurs or begins during the first 30 days of such child's life.

This material is valid as long as information remains current. Group Voluntary Cancer benefits provided by policy form GVCP3, or state variations thereof. Cancer Initial Diagnosis Progressive Benefit (Progressive First Occurrence) Rider, if included, provided by GPCPR1, or state variations thereof.

Coverage is provided by Limited Benefit Supplemental Cancer and Specified Disease Insurance. The policy is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from Allstate Benefits.

This proposal highlights some features of the policy but is not the insurance contract. For complete details, contact your Allstate Benefits Agent. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company (Home Office, Jacksonville, FL). Details of the insurance, including exclusions, restrictions and other provisions are included in the policy issued.

The coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

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