COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

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(800) 325-4368
A Stock Company

GROUP SPECIFIED DISEASE INSURANCE

THIS IS A LIMITED BENEFIT SPECIFIED DISEASE CERTIFICATE. THIS CERTIFICATE EXPLAINS THE BENEFITS FOR CANCER AND CANCER SCREENING PROCEDURES PROVIDED UNDER THE GROUP SPECIFIED DISEASE INSURANCE POLICY. BENEFITS PROVIDED ARE INTENDED ONLY TO SUPPLEMENT INSURANCE ALREADY IN FORCE AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE.

CERTIFICATE OF COVERAGE

The policy is not a policy of Workers' Compensation Insurance. The policyholder does not become a subscriber to the Workers' Compensation system by purchasing the policy, and, if the policyholder is a non-subscriber, the policyholder loses those benefits which would otherwise accrue under the Workers' Compensation laws. The policyholder must comply with the Workers' Compensation law as it pertains to non-subscribers and the required notifications that must be filed and posted.

Please Read This Certificate Carefully

This is your certificate of coverage as long as you are insured under the policy. You will want to read it carefully and keep it in a safe place.

In this certificate, the words *you* or *your* refer to the named insured shown on the Certificate Schedule who is a member of an eligible class as described in the Policy, who holds a certificate of coverage and for whom premiums are remitted. The words *covered person* refer to any person covered under the policy as described on the Certificate Schedule. The words *we*, *us*, *our* or *company* refer to Colonial Life & Accident Insurance Company. *Policy* means the Group Specified Disease Insurance contract owned by the policyholder and available for review by you. If the terms of your certificate of coverage and the policy differ, the policy will govern.

The policy and this certificate may be changed in whole or in part or cancelled as stated in the policy. Such an action may be taken without the consent of or notice to any covered person. Only an authorized officer at our home office can approve a change. The approval must be in writing and endorsed on or attached to the policy. No other person, including an agent, may change the policy or certificate or waive any of its provisions. Premiums are subject to periodic changes.

The male pronoun includes the female whenever used.

The 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 any amendments.

Secretary

President and Chief Executive Officer

The policy is a limited policy. Please read this certificate carefully.
THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.
If you are eligible for Medicare, review the Guide To Health Insurance for People with Medicare available from the company.

CERTIFICATE GUIDE

SECTION I FACE PAGE

SECTION II CERTIFICATE SCHEDULE

SECTION III GENERAL DEFINITIONS

SECTION IV ELIGIBILITY AND EFFECTIVE DATE

SECTION V CANCER SCREENING BENEFITS

SECTION VI ELIGIBILITY FOR CANCER BENEFITS

SECTION VII CANCER BENEFITS

SECTION VIII PRE-EXISTING CONDITION LIMITATION

SECTION IX TERMINATION OF INSURANCE

SECTION X PREMIUMS

SECTION XI GENERAL PROVISIONS

SECTION XII HOW TO FILE A CLAIM/CLAIM PROVISIONS

SECTION III GENERAL DEFINITIONS

Additional definitions may be contained in other certificate benefit provisions or any endorsement or rider.

Bone Marrow Stem Cell Transplant
A *bone marrow stem cell transplant* is the harvesting, storage and reinfusion of bone marrow stem cells from a matched donor or the covered person performed under general anesthesia or intravenous (IV) sedation.

Calendar Year
Calendar Year means the period beginning on the effective date of coverage shown on the Certificate Schedule and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

Cancer
Cancer means a disease which is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells. Pre-malignant conditions or conditions with malignant potential are not to be construed as cancer for purposes of this certificate. Cancer must be diagnosed by a pathological diagnosis or a clinical diagnosis.

Certificate
The *Certificate*, including the Certificate Schedule, amendments, riders and supplements, if any, is a written statement prepared by us to set forth a summary of:
- benefits to which the covered person is entitled;
- to whom the benefits are payable; and
- limitations or requirements that may apply.

Confined or Confinement
Confined or Confinement means the assignment to a bed as a resident inpatient in a hospital on the advice of a physician or confinement in an observation unit within a hospital for a period of no less than 20 continuous hours on the advice of a physician.

Date of Diagnosis
The *date of diagnosis* is the day the tissue specimen, blood samples and/or titer(s) are taken upon which the first diagnosis of cancer is based.

Doctor or Physician
A *Doctor or Physician* means a person who:
- is licensed by the state to practice a healing art; and
- performs services for a covered person which are allowed by his license.

For purposes of this definition, Doctor or Physician does not include any covered person or anyone related to any covered person by blood or marriage, a business or professional partner of any covered person, or any person who has a financial affiliation or a business interest with any covered person.

Hospice
Hospice means an organization that provides care for the terminally ill that:
- is licensed by a governmental agency;
- is accredited by the Joint Commission on Accreditation of Hospitals; or
- is qualified to receive benefit payments from Medicare or Medicaid.

The organization must have on its staff at least one doctor and one registered nurse and must keep complete medical records for each patient.

Hospital
A *Hospital* means a place that:
- is an institution licensed as a hospital and operated pursuant to law on a full-time basis;
- provides overnight care of injured and sick people;
- is supervised by a physician;
- has full-time nurses on duty or on call supervised by a registered nurse; and
- has at its locations or uses on a pre-arranged basis: X-ray equipment, a laboratory and an operating room where surgical operations take place.

Notwithstanding the above, a hospital is not:
- a nursing home;
- an extended care facility;
- a skilled nursing facility;
- a rest home or home for the aged;
- a rehabilitation center;
- a place for alcoholics or drug addicts; or
- an assisted living facility.

Alcoholism and drug addiction are not covered by this certificate.

Hospital Intensive Care Unit
A *Hospital Intensive Care Unit* means a place which:
- is a specifically designated area of the hospital that is restricted to patients who are critically ill or injured and who require intensive, comprehensive observation and care;
- is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement;
- is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- is under close observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24 hour basis; and
- has a physician assigned to the intensive care unit on a full-time basis.

A hospital intensive care unit that meets the definition above may include hospital units with the following names:
- Intensive Care Unit
- Coronary Care Unit
- Neonatal Intensive Care Unit
- Pulmonary Care Unit
- Burn Unit
- Transplant Unit

A hospital intensive care unit is not any of the following stepdown units:
- a progressive care unit;
- an intermediate care unit;
- a private monitored room;
- a sub-acute intensive care unit;
- an observation unit; or
- any facility not meeting the definition of a hospital intensive care unit as defined in this certificate.

Oral Chemotherapy
Oral Chemotherapy means chemotherapy taken by mouth.

Outpatient Surgical Center
An *Outpatient Surgical Center* is a place that:
- is equipped for outpatient surgical procedures administered by qualified physicians;
- provides anesthesia (other than local) by a licensed anesthesiologist or Certified Registered Nurse Anesthetist; and
- has written agreements with local hospitals to accept patients immediately who develop complications.

Pathologist
A *pathologist* means a doctor who is licensed to practice medicine and who is also licensed and certified to practice pathologic anatomy by the American Board of Pathology. A pathologist also means an osteopathic pathologist who is certified by the Osteopathic Board of Pathology.

Peripheral Stem Cell Transplant
A *peripheral stem cell transplant* is the harvesting, storage and subsequent reinfusion of peripheral stem cells taken from the covered person or a matched donor.

Pre-existing Condition
Pre-existing Condition means a sickness or physical condition for which any covered person was treated, had medical testing, received medical advice or had taken medication within 12 months before the effective date of coverage shown on the Certificate Schedule and which is not excluded by name or specific description in the policy or this certificate.

Skilled Nursing Care Facility
A *Skilled Nursing Care Facility* is a place where the covered person goes to recover from an illness and that:
- is a legally operated facility that can be a wing or part of a hospital;
- operates 24 hours a day and will accept inpatients on an overnight basis;
- is supervised by a doctor;
- has a 24-hour a day nursing staff which is supervised by a registered nurse; and
- keeps written daily records for each patient.

Notwithstanding the above, a skilled nursing care facility is not:
- a rest home or a home for the aged;
- a place that provides mostly custodial care; or
- a place for alcoholics or drug addicts.

Skin Cancer
Skin cancer means:
- melanoma of Clark's Level I or II (Breslow less than .75mm);
- basal cell carcinoma; or
- squamous cell carcinoma of the skin.

Supportive or Protective Care Drugs and Colony Stimulating Factors
Supportive or Protective Care Drugs and Colony Stimulating Factors are:
- bone marrow growth factors;
- radiation and chemotherapy protectants; and
- medications that promote bone growth.

Topical Chemotherapy
Topical Chemotherapy means a chemotherapy drug placed directly onto the skin.

U.S. Government Hospital
U.S. Government Hospital means a hospital that is funded by the U.S. Government primarily for military enlisted personnel and their families and military veterans.

SECTION IV - ELIGIBILITY AND EFFECTIVE DATE

Effective Dates of Coverage
Your coverage under the policy will start at 12:01 a.m. Eastern Standard Time on the effective date of coverage shown on your Certificate Schedule, except as provided in the Delayed Effective Date of Coverage provision.

Delayed Effective Date of Coverage
The effective date of your coverage will be delayed if you are not a member of an eligible class on the effective date shown on the Certificate Schedule. The coverage will be effective on the date that you return to status as a member of an eligible class. If this is family coverage, coverage on your spouse and/or dependent children will be effective on the date that you return to status as a member of an eligible class.

Who is Covered By This Certificate
If this is named insured coverage as shown on the Certificate Schedule, we insure you, the named insured.

If this is family coverage as shown on the Certificate Schedule, we insure you, your spouse and your dependent children.

Spouse means the person married to you on the day we issue your certificate.

Dependent children means your:
- natural children;
- step-children;
- grandchildren who are your dependents for federal income tax purposes;
- adopted children;
- children whom you are required to insure under a medical support order issued under section 14.061, Family code, or enforceable by a court in this state;
- children in your custody under a temporary court order that grants you conservatorship of the children.

Such children must be:
- unmarried;
- chiefly dependent on you or your spouse for support; and
- younger than age 26.

If this is family coverage as shown on the Certificate Schedule coverage on newborn children begins from the moment of birth and coverage for adopted children begins with the date of placement into the named insured's custody for adoption.

After the effective date, if any members of your family are to be added to this certificate, including a new spouse or dependent child, you must:
- notify us in writing within 31 days that you wish to add a person to your coverage;
- meet evidence of insurability requirements satisfactory to us; and
- pay any additional premium.

SECTION V - CANCER SCREENING BENEFITS

$75 Cancer Screening/Wellness Benefit
We will pay this benefit if any covered person has one of the following cancer screening tests performed while his coverage is in force. This benefit is payable once per calendar year for each covered person.

Cancer screening test is defined as:
- Biopsy of skin lesion;
- Bone marrow aspiration/biopsy;
- Breast ultrasound;
- CA 15-3 (blood test for breast cancer);
- CA125 (blood test for ovarian cancer);
- CEA (blood test for colon cancer);
- Chest X-ray;
- Colonoscopy;
- Flexible sigmoidoscopy;
- Hemoccult stool analysis;
- Mammography;
- Pap smear;
- PSA (blood test for prostate cancer);
- Serum Protein Electrophoresis (blood test for myeloma);
- Thermography;
- ThinPrep Pap test;
- Virtual Colonoscopy.

SECTION VI - ELIGIBILITY FOR CANCER BENEFITS

Eligibility for Cancer Benefits
We will pay benefits for the treatment of cancer if:
- the first date of diagnosis is while coverage under this certificate is in force;
- the covered person receives treatment for cancer while coverage under this certificate is in force;
- the covered person receives treatment for cancer within the United States; and
- the cancer or treatment is not excluded by name or specific description in this certificate or the policy.

We will pay the amount listed in the benefit provisions of this certificate.

If cancer is not pathologically or clinically diagnosed until after any covered person dies, we will only pay benefits for cancer treatment performed during the 45 day period before his death.

Cancer must be diagnosed in one of two ways:

1. Pathological Diagnosis
A *pathological diagnosis* of cancer is 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 established by the American Board of Pathology.

2. Clinical Diagnosis
A *clinical diagnosis* of cancer is based on the study of symptoms. We will pay benefits for a clinical diagnosis only if:
- a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening; and
- there is medical evidence to support the diagnosis; and
- a doctor is treating the covered person for cancer.

SECTION VII - CANCER BENEFITS

Ambulance
$100 per trip
We will pay this benefit for each trip any covered person makes if a professional ambulance service transports him to or from a hospital where he is confined as an inpatient for the treatment of cancer. He must incur charges for a professional ambulance service to receive this benefit. We will pay for no more than two one-way trips each time he is confined as an inpatient for the treatment of cancer.

Anesthesia
25% of the amount of the Surgery benefit paid
We will pay this benefit if any covered person incurs charges for and receives general anesthesia administered by an anesthesiologist or a Certified Registered Nurse Anesthetist during a surgical procedure that is performed for the treatment of cancer and for which a benefit is payable under this certificate.

$50 per procedure
We will pay this benefit if any covered person incurs charges for and receives local anesthesia during a surgical procedure performed for the treatment of cancer and for which a benefit is payable under this certificate.

If any covered person has more than one surgical procedure performed at the same time, we will pay only one Anesthesia benefit. We will pay the Anesthesia benefit for the surgical procedure performed that has the highest dollar value.

Antinausea Medication
$50 a day up to a maximum of $200 per calendar year
We will pay this benefit for each day any covered person incurs charges for and receives antinausea medication administered in a doctor's office, clinic or hospital or has a prescription filled for antinausea medication as a result of radiation or chemotherapy treatments up to the calendar year maximum.

We will pay only one Antinausea Medication benefit per day regardless of the number of antinausea medications the covered person receives on the same day.

Benefits for radiation and/or chemotherapy prescribed by the covered person's doctor are only available under the Radiation/Chemotherapy benefit. Benefits for supportive or protective care drugs and colony stimulating factors are only available under the Supportive or Protective Care Drugs and Colony Stimulating Factors benefit.

Attending Physician
$50 per day up to a maximum of 180 days per calendar year
We will pay this benefit if any covered person incurs charges for and uses the services of an attending physician while confined to a hospital for the treatment of cancer. An *attending physician* is a doctor, other than the covered person's surgeon, who performs services for him while confined to a hospital.

Blood, Plasma, Platelets and Immunoglobulins
$225 per day, up to a maximum of $7,500 per calendar year
We will pay this benefit for each day any covered person incurs charges for and receives a transfusion of blood/plasma/platelets/immunoglobulins during the treatment of cancer, up to the calendar year maximum.

Bone Marrow Stem Cell Transplant
$10,000 per lifetime
We will pay this benefit if any covered person incurs charges for and receives a bone marrow stem cell transplant for the treatment of cancer.

We will pay this benefit only once per lifetime for each covered person.

Benefits for peripheral stem cell transplants are only available under the Peripheral Stem Cell Transplant benefit.

Experimental Treatment
$300 per day up to $10,000 lifetime maximum
We will pay this benefit for each day that any covered person incurs charges for and receives hospital, medical or surgical care in connection with experimental treatment of internal (not skin) cancer, up to the lifetime maximum. These treatments must be prescribed by a physician and must be received in an experimental cancer treatment program. Treatment must be received in the United States.

Experimental Treatment means:
- drugs or chemical substances that are pending approval by the United States Food and Drug Administration for use in the treatment of cancer; and
- surgery or therapy endorsed by either the National Cancer Institute or the American Cancer Society for experimental studies.

Payment of this benefit is in place of payment of any other benefit for the same covered treatments.

Hair/External Breast/Voice Box Prosthesis
$200 per calendar year
We will pay this benefit if any covered person incurs charges for and receives a hair prosthesis, external breast prosthesis or voice box prosthesis needed as a direct result of cancer.

Home Health Care Services
$300 per day
We will pay this benefit for up to the greater of:
- 30 days per calendar year; or
- twice the number of days any covered person was confined to a hospital during a calendar year for the treatment of cancer.

We will pay this benefit for each day any covered person incurs charges for and receives any of the following home health care services prescribed by his doctor for the treatment of cancer instead of confinement in a hospital, up to the calendar year maximum:

- professional nursing provided by a registered nurse;
- home health aide services provided under the supervision of a registered nurse or qualified therapist;
- physical therapy;
- occupational therapy;
- speech therapy and audiology;
- respiratory and inhalation therapy;
- nutrition counseling by a nutritionist or dietitian;
- medical social services;
- medical supplies;
- prosthesis and orthopedic appliances;
- rental or purchase of durable medical equipment; or
- administration of drugs or medicine.

Prior confinement in a hospital is not required. The service must be rendered by a home health agency as part of a plan of care established by the doctor and the home health agency.

A *home health agency* means an agency that is certified by the covered person's state government. Its main purpose is to arrange and provide nursing services, home health aide services, and other related services.

We will not pay the Home Health Care Services benefit for:

- services or supplies for personal comfort or convenience, including housekeeping services;
- child care; or
- food services or meals other than dietary counseling.

Hospice
$300 per day
We will pay this benefit for each day any covered person incurs charges for and:

- receives a visit from a representative of a hospice at home;
- uses the services of a hospital or a U.S. Government Hospital on an outpatient basis under the direction of a hospice;
- visits a hospice on an outpatient basis for treatment or services as the result of cancer; or
- is confined to a hospice facility.

We will only pay this benefit if a doctor determines that cancer treatments are no longer of benefit to the covered person and that he is expected to live for only six months or less.

We will not pay this benefit while any covered person is confined to a hospital, to a U.S. Government Hospital or to a skilled nursing care facility. This benefit will not be paid for days that the Home Health Care Services benefit is payable.

Hospital Confinement/Hospital Intensive Care Unit Confinement
$200 per day for first 30 days of hospital confinement in a calendar year
$400 per day for hospital confinement after the first 30 days of hospital confinement in a calendar year
$400 per day for hospital intensive care unit confinement
Maximum benefit of 180 days per calendar year for hospital confinement and hospital intensive care unit confinement combined.
We will pay the applicable benefit shown above for each day any covered person incurs charges for hospital confinement or hospital intensive care unit confinement for the treatment of cancer up to the 180-day maximum per calendar year. We will pay only one of the benefits shown above for the same day.

We will not pay this benefit if confined to a U.S. Government Hospital.

Hospital Confinement/Hospital Intensive Care Unit Confinement in a U.S. Government Hospital
$200 per day for first 30 days of hospital confinement in a calendar year
$400 per day for hospital confinement after the first 30 days of hospital confinement in a calendar year
$400 per day for hospital intensive care unit confinement
Maximum benefit of 180 days per calendar year for hospital confinement and hospital intensive care unit confinement combined.
We will pay the applicable benefit shown above for each day any covered person is confined in a U. S. Government hospital or a U. S. Government hospital intensive care unit for the treatment of cancer up to the 180-day maximum per calendar year. We will pay only one of the benefits shown above for the same day.

Lodging
$50 per day up to 70 days maximum per calendar year
We will pay this benefit for each day any covered person or any adult companion incurs charges for lodging required while the covered person is being treated for cancer more than 50 miles from his residence.

We will pay for up to 70 days per calendar year.

Outpatient Surgical Center
$500 a day up to a maximum of $1,500 per calendar year
We will pay this benefit for each day any covered person incurs charges for and has surgery at an outpatient surgical center for internal (not skin) cancer, up to the calendar year maximum. This does not include surgery received in the emergency room or while confined to the hospital.

We will only pay benefits for one outpatient surgery per day, even if the covered person has more than one surgical procedure performed.

Benefits for the surgical procedure and anesthesia are payable under the Surgery benefit and the Anesthesia benefit.

Peripheral Stem Cell Transplant
$5,000 per lifetime
We will pay this benefit if any covered person incurs charges for and receives a peripheral stem cell transplant for the treatment of cancer.

We will pay this benefit only once per lifetime for each covered person.

Benefits for bone marrow stem cell transplants are available only under the Bone Marrow Stem Cell Transplant benefit.

Private Full-Time Nursing
$200 per day
We will pay this benefit for each day any covered person incurs charges for and uses private full-time nursing services required and authorized by his doctor while he is confined to a hospital for the treatment of cancer. Private full-time nursing must be performed by a registered, a licensed practical or a licensed vocational nurse. *Private full-time nursing* means providing services only to the covered person for at least eight consecutive hours during any 24 hour period. Nursing services performed by family members or provided by the hospital are not covered.

Prosthesis/Artificial Limb
$2,000 per device or artificial limb up to a $4,000 lifetime maximum
We will pay this benefit if any covered person incurs charges for a surgically implanted prosthetic device or artificial limb needed as a direct result of cancer surgery, up to the lifetime maximum. We will pay any appropriate surgery or reconstructive surgery benefit as described in those benefit provision(s) for the surgical procedure required for the implant.

We will pay for no more than one of the same type of device per site.

Radiation/Chemotherapy
$225 a day up to a maximum of $7,500 per calendar year
We will pay this benefit for each day any covered person incurs charges for and receives one or more of the following treatments for the purpose of the destruction of malignant cells during the treatment of internal (not skin) cancer up to the calendar year maximum:

- teleradiotherapy, using either natural or artificially propagated radiation;
- interstitial or intracavitary application of radium or radioisotopes in sealed or non-sealed sources; or
- chemical substances that have a cancercidal effect (chemotherapy).

Benefits for oral chemotherapy, topical chemotherapy and chemotherapy injected by the covered person or anyone other than personnel in a doctor's office, clinic or hospital will be limited to the day the covered person has the prescription filled. Benefits for chemotherapy delivered by a pump will be limited to the day the pump is initially filled or is refilled.

We will pay only one Radiation/Chemotherapy benefit per day regardless of the number of radioactive and chemotherapy treatments the covered person receives on the same day.

Radiation and chemotherapy treatments must be approved for the treatment of cancer by the United States Food and Drug Administration.

We will not pay for office visits, laboratory tests, diagnostic X-rays, treatment planning, simulation, treatment devices, dosimetry, radiation physics, teletherapy or other procedures related to these treatments.

Benefits for supportive or protective care drugs and colony stimulating factors prescribed by the covered person's doctor are only available under the Supportive or Protective Care Drugs and Colony Stimulating Factors benefit. Benefits for antinausea medication prescribed by a doctor solely to prevent nausea will only be available under the Antinausea Medication benefit.

Reconstructive Surgery
$60 per surgical unit up to a maximum of $3,000 per procedure, including general anesthesia
We will pay this benefit if a covered person incurs charges for a reconstructive surgery that:

- requires an incision;
- is performed by a doctor for treatment of cancer; and
- is due to internal (not skin) cancer.

We will pay for no more than two surgeries per site.

We will use the most current Physicians' Relative Value table and the Current Procedural Terminology (CPT) Code provided by the covered person's doctor to determine the surgical unit value assigned to each surgery.

How to calculate the benefit:

Dollar amount per unit	x	Surgical Unit Value	=	Surgery Benefit Amount (up to the maximum per procedure)

If the Reconstructive Surgery benefit calculated above is less than the maximum benefit amount allowed for this benefit, then we will also pay up to 25% of the Reconstructive Surgery benefit amount if a covered person incurs charges for and has general anesthesia administered during surgery.

In no event will the amount paid for this benefit exceed the lesser of:
(1) the surgical unit value multiplied by the dollar amount per unit shown above plus 25% for general anesthesia; or
(2) the maximum amount per procedure shown above.

If a covered person has more than one reconstructive surgical procedure performed at the same time and through the same incision, we will pay only one Reconstructive Surgery benefit. We will pay the benefit that has the highest dollar value. If a covered person has more than one reconstructive surgical procedure performed at the same time but through different incisions, we will pay for each one.

For the purposes of this provision, reconstructive surgery includes, but is not limited to, surgical procedures performed following a mastectomy on one breast or both breasts to reestablish symmetry between the two breasts, augmentation mammoplasty, reduction mammoplasty and mastopexy.

We will not pay this benefit for skin cancer.

Second Medical Opinion
$300 per malignant condition
We will pay this benefit if any covered person incurs charges for and obtains a second medical opinion from another doctor on recommended surgery or treatment following the positive diagnosis of internal (not skin) cancer. The covered person is not required to obtain a second medical opinion in order to receive the surgical or other benefits under this certificate.

We will pay this benefit only once for each cancerous condition. This benefit is not payable for skin cancer treatment or reconstructive surgery.

Skilled Nursing Care Facility
$300 per day
We will pay this benefit for each day any covered person incurs charges for and is confined to a skilled nursing care facility during the treatment of cancer.

Confinement must begin within 14 days after the covered person is released from a hospital. We will pay this benefit for no more than the number of days for which we paid the Hospital Confinement/Hospital Intensive Care Unit Confinement benefit or the Hospital Confinement/ Hospital Intensive Care Unit Confinement in a U. S. Government Hospital benefit for his most recent confinement.

Supportive or Protective Care Drugs and Colony Stimulating Factors
$150 per day up to $1,200 calendar year maximum
We will pay this benefit for each day that any covered person incurs charges for and receives supportive or protective care drugs and/or colony stimulating factors for the treatment of cancer, up to the calendar year maximum.

Benefits for supportive or protective care drugs and/or colony stimulating factors will only be payable for the day the covered person has the prescription filled.

We will only pay one benefit per day regardless of the number of supportive or protective care drugs and/or colony stimulating factors the covered person receives on the same day.

Benefits for radiation and/or chemotherapy will only be available under the Radiation/Chemotherapy benefit. Benefits for antinausea medication prescribed by a doctor solely to prevent nausea will only be available under the Antinausea Medication benefit.

These drugs/substances must be approved for the treatment of cancer by the United States Food and Drug Administration.

Surgery
$60 per surgical unit up to $3,000 per procedure
We will pay this benefit if any covered person incurs charges for a surgical procedure performed by a doctor for treatment of cancer up to the maximum benefit amount.

The maximum benefit amount is the lesser of:
(1) the surgical unit value multiplied by the dollar amount per unit shown above; or
(2) the maximum amount per procedure shown above.

We will use the most current Physicians' Relative Value table and the Current Procedural Terminology (CPT) Code provided by the covered person's doctor to determine the surgical unit value assigned to each surgery.

How to calculate the benefit:

Dollar amount per unit	x	Surgical Unit Value	=	Benefit Amount (up to the maximum per procedure)

If any covered person has more than one surgical procedure performed at the same time and through the same incision, we will pay only one Surgical Procedure benefit. We will pay the benefit that has the highest dollar value. If any covered person has more than one surgical procedure performed at the same time but through different incisions, we will pay for each one.

Transportation
$0.40 per mile up to 700 miles per round trip
We will pay this benefit if:
- any covered person travels on his doctor's advice to another city for diagnosis or treatment of his cancer;
- the destination is more than 50 miles one way from the city where he lives; and
- he is receiving treatment for internal (not skin) cancer.

We will pay this benefit when charges are incurred for travel to and from his destination for either:
- commercial travel (plane, train or bus); or
- non-commercial travel (use of a personal car).

We will measure the mileage for the most direct route from the city where he lives to the city in which he receives treatment.

Transportation for Companion
$0.40 per mile up to 700 miles per round trip
We will pay this benefit for one companion to accompany any covered person to another city where he is receiving treatment for cancer if:
- his doctor advises treatment or diagnosis of his cancer in another city;
- the destination is more than 50 miles one way from the city where he lives; and
- he is receiving treatment for internal (not skin) cancer.

If any covered person and his companion travel together in a personal car, we will only pay the Transportation benefit or the Transportation for Companion benefit but not both.

We will pay this benefit when charges are incurred for travel to and from any covered person's destination for either:
- commercial travel (plane, train or bus); or
- non-commercial travel (use of personal car).

We will measure the mileage for the most direct route from the city where any covered person lives to the city in which he receives treatment.

Waiver of Premium
You, the named insured, will not be required to continue to pay premiums to keep your coverage in force if:
- the first date of diagnosis is while your coverage is in force; and
- you become disabled because of cancer after the effective date of your coverage and remain disabled for longer than three continuous months (90 days).

A month is 30 days. *Disabled* means you, the named insured, are:
- unable to work at any job for which you are qualified by reason of education, training or experience;
- not, in fact, working at any job for pay or benefits; and
- under the care of a doctor for the treatment of cancer.

If you do not have a job, we will not require you to pay premiums as long as you are kept at home because of your cancer and are under the care of a doctor. *At home* means in your house or yard. However, you can follow your doctor's orders even if it means leaving home. *Under the care of a doctor* means a doctor is caring for you on a regular basis.

Before we waive your premium, you must send us a written notice prepared by your doctor stating:
- the date you were diagnosed as having cancer;
- that you are disabled, as defined in this certificate, because of cancer; and
- the date you became continuously disabled because of cancer.

We may also each month thereafter require a doctor's statement that you continue to be disabled as defined in the certificate.

After it has been determined that you have been disabled for longer than three continuous months (90 days), we will not require you to pay premiums for the length of time you continue to be disabled because of cancer.

We can require that you be examined by a doctor, chosen by us, to verify that you are disabled. This will be done at our expense.

If we do not require you to pay premiums during a period of disability, and you become disabled again within 30 days because of cancer, we will treat this disability as the same disability. If more than 30 days have passed between the periods of disability, we will treat this disability as a new disability and you must be disabled again for three continuous months before we will waive your premiums.

You must send us written notice as soon as you are no longer disabled. We will assume you are no longer disabled if:
- you do not send us satisfactory proof of continued disability when we request it;
- you do not agree to have a physical examination by a doctor chosen by us; or
- you notify us that you are no longer disabled.

You must pay all premiums to keep your coverage in force beginning with the first premium due after you are no longer disabled.

This benefit does not apply to your spouse or to your dependent children. We will waive premiums only if you are disabled due to cancer. However, if this is family coverage, we will waive premiums on all family members insured by this certificate.

SECTION VIII - PRE-EXISTING CONDITION LIMITATION

We will not cover cancer that meets the requirements of the Eligibility for Cancer Benefits provision but is a preexisting condition as defined in this certificate, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule. No benefits will be payable for any cancer for which the requirements of the Eligibility for Cancer Benefits provision are not met.

SECTION IX - TERMINATION OF INSURANCE

The words "terminate" and "cancel," and any forms thereof, are used interchangeably in this certificate.

Termination of a Named Insured's Coverage
Your coverage under this certificate will terminate on the earliest of the following dates:
- the date the policy terminates;
- the end of the grace period following the premium due date we fail to receive the required premium for you;
- the date you are no longer in an eligible class;
- the date your class is no longer included for insurance; or
- on the date the next premium is due after you ask us to end your coverage.

Termination of coverage will not affect any claim for cancer treatments that occurred while your coverage was in force.

When Coverage Ends on Your Spouse and Dependent Children
If this is family coverage, coverage on your spouse will end on the earliest of the following dates:
- the date the policy terminates;
- the end of the grace period following the premium due date we failed to receive the required premium for your family coverage;
- the date your coverage terminates;
- the date the next premium is due after you ask us to end your spouse's coverage;
- the date you die; or
- the date the next premium is due after you divorce your spouse or your marriage is annulled.

If this is family coverage, coverage on your dependent children will end on the earliest of the following dates:
- the date the policy terminates;
- the end of the grace period following the premium due date we fail to receive the required premium for your family coverage;
- the date your coverage terminates;
- the date the next premium is due after you ask us to end your dependent children's coverage; or
- the date you die.

Coverage will end on each child when he no longer qualifies as a dependent child as defined in this certificate. It is your responsibility to notify us if any dependent child no longer qualifies as an eligible dependent. You must notify us within 120 days after the child no longer qualifies as an eligible dependent, unless you are legally unable to do so. If this is family coverage and all of your dependent children no longer qualify as eligible dependents and you do not notify us, the extent of our liability will be to refund premium for the time period for which they did not qualify up to a maximum of 120 days, unless you were legally unable to notify us. Coverage will not end on a dependent child who reaches age 26 if that child is and continues to be incapable of self-sustaining employment by reason of mental or physical incapacity and is chiefly dependent on you or your spouse for support. However, we must continue to receive the premiums for family coverage to keep the coverage in force.

We can ask that proof of the child's incapacity and dependency be furnished to us by you within 120 days of the child's attainment of the limiting age and, subsequently, at reasonable intervals during the two years following the child's attainment of the limiting age. We cannot require proof more than once per year in the time more than two years after the child's attainment of the limiting age.

COBRA Continuation of Coverage
The coverage may be continued in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). It is the responsibility of the policyholder to comply with COBRA.

Leave of Absence Under the Family and Medical Leave Act
You may continue your coverage during absences for family or medical leave. If you are on a family or medical leave of absence, coverage will continue under this certificate as if you were in active employment, if the following conditions are met:
- the premiums are paid in accordance with the policy's provisions; and
- the policyholder has approved your leave in writing.

Coverage will be continued for up to the greater of:
- the leave period required by the federal Family and Medical Leave Act of 1993, and any amendments; or
- the leave period required by applicable state law.

If coverage is not continued during a family or medical leave of absence, upon your return to active employment:
- no new pre-existing condition limitation period will be applied; and
- no new evidence of insurability will be required to reinstate the coverage which was in effect before the leave began.

The satisfaction of the pre-existing condition limitation period, if applicable, will continue during your family or medical leave of absence.

Leave of Absence - Other
If you are on a temporary layoff or leave of absence other than for family or medical leave and premium is paid in accordance with the policy's provisions, you will be covered through the premium due date immediately following the date the temporary layoff or leave of absence begins.

If premium is remitted beyond the premium due date referenced above, our only liability will be to return the premium.

Temporary layoff or leave of absence means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your employer. Normal vacation time is not considered a temporary layoff or leave of absence.

Conversion Privilege

If one of the following events occurs:
- your coverage terminates because you are no longer in an eligible class or your class is no longer eligible for coverage, or
- coverage of your spouse under this certificate terminates due to divorce, annulment or your death, or
- coverage of a covered dependent child terminates due to the child becoming married or reaching age 26, or
- coverage of a covered person who has received benefits for the treatment of cancer under this certificate terminates for any reason,

then such covered person may be eligible to obtain a policy of insurance (called the converted policy), without evidence of insurability. Obtaining that policy is subject to the following conditions:

- Such covered person's coverage under this certificate must have been in effect for 12 months from the effective date shown on the Certificate Schedule. Provided, however, that if such covered person has received benefits for the treatment of cancer under this certificate, he may obtain a converted policy regardless of the length of time covered under the certificate.
- Application for the converted policy must be made to us within 31 days after the coverage terminates. The effective date of the converted policy will be the date on which coverage under this certificate terminates.
- The converted policy will be the individual cancer policy designated by us at the time of conversion, which may contain different benefits and limitations and exclusions from the coverage provided under this certificate.
- The premium for the converted policy will be at the rate for that policy for the class of risk at such covered person's age as of the date of the application for the converted policy.
- Any Pre-existing Conditions Limitation and Incontestability provisions under the converted policy are waived to the extent that the time periods in such provisions have been met under this certificate. Any waiting period under the converted policy is waived.
- If you are eligible for a converted policy, any spouse or dependent children covered under this certificate may also be covered under the converted policy. If a spouse is eligible for a converted policy due to divorce or annulment, any dependent children covered under this certificate may also be covered under the converted policy or they may remain covered under this certificate as you and your former spouse may elect. They may not be covered under both the certificate and the converted policy. If a spouse is eligible for a converted policy due to your death, any dependent children covered under this certificate may also be covered under the converted policy.

SECTION X - PREMIUMS

When and Where to Pay Premiums
The premiums for this coverage must be paid to us at our home office when they are due.

The premium due dates are based on:
- the effective date of the coverage shown on the Certificate Schedule; and
- the premium frequency.

The *premium frequency* is how often the premiums are paid.

Grace Period (If Premiums Are Not Paid When Due)
After the first premium, if the premium is not paid when due, it can be paid during the next 31 days. These 31 days are called the *grace period*. During the grace period this coverage will stay in force. If the premium is not paid before the grace period ends, the coverage provided by this certificate will terminate at the end of the grace period.

Our Right to Change Premiums
We have the right to change the premium we charge.

Unpaid Premium
When a claim is paid under this coverage, any premium then due and unpaid may be deducted by us from your claim payment.

SECTION XI - GENERAL PROVISIONS

Coverage Provided by The Policy
We insure a covered person for loss according to the provisions of the policy.

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

When making a benefit determination under the policy, we have discretionary authority to determine the covered person's eligibility for the benefits and to interpret the terms and provisions of the policy, subject to the rights to bring action as provided in the Legal Action provision.

Incontestability
No statement made by you relating to your insurability or the insurability of your dependents shall be used to contest the validity of the insurance after the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made and unless the statement is contained in a written instrument signed by the policyholder or you, unless the statement was fraudulent.

Contest means that we question the validity of coverage under the policy through a letter to the policyholder or you. This contest is effective on the date we mail the letter and refund premiums.

All statements made by the policyholder or you shall be deemed representations and not warranties. No written statement made by the policyholder or you shall be used in any contest unless a copy of the statement is furnished to the policyholder or you.

Error in Age
If any covered person's age was stated incorrectly during the application process and if, based on his correct age, we would not have covered him, then we will cancel his coverage as of the effective date of the certificate and refund the premiums paid.

State Laws
Any provision of the policy that, on the effective date, does not agree with state laws where you live will be amended to conform to the minimum requirements of those laws.

SECTION XII - HOW TO FILE A CLAIM/CLAIM PROVISIONS

How to File a Claim
A claim form must be completed within 90 days after the covered loss begins or as soon as it is reasonably possible. Send the claim form along with proof of loss to us at our home office.

If you do not have a claim form, you must give us a written statement describing the loss within 90 days after the covered loss begins or as soon as it is reasonably possible. The statement should include your name and certificate number as shown in the Certificate Schedule. It must also include proof of loss and how the loss occurred. You should send the statement to us at our home office. When we receive the statement describing the loss, we will send you claim forms within 15 days. If you do not receive claim forms, your written statement along with the proof of loss will be used to process the claim.

Notice of Claim
Written notice of claim must be sent to us within 90 days after the covered loss begins or as soon as it is reasonably possible. Written notice should be sent along with proof of loss to our home office. You should include your name and certificate number. If you have a claim form, you can send it to us in place of the written notice of claim. If you are not able to give us written proof of loss within 90 days, it will not have a bearing on the claim if proof is given to us as soon as it is reasonably possible. In any event, proof must be given no later than one year from the time stated unless you are legally unable to do so.

Claim Form
When we receive a written notice of a claim, we will send claim forms for filing proof of loss. If these forms are not received within 15 days after giving such notice, you may meet the proof of loss requirement by giving us a written statement of the nature and extent of the loss within the time stated in the Proof of Loss section.

Proof of Loss
You must give us written proof of loss within 90 days after the covered loss begins. If you are not able to give us written proof of loss within 90 days, it will not have a bearing on this claim if proof is given to us as soon as it is reasonably possible. In any event, proof must be given no later than one year from the time stated unless you are legally unable to do so.

Written proof of loss must include a pathology report and one or more of the following: a doctor's bill, a hospital bill or other proof of charges. If a pathological diagnosis cannot be made, then written proof of loss must include written medical evidence from the covered person's doctor to support the diagnosis and treatment of cancer.

In case of death, written proof of loss must include a certified death certificate.

Payment of Claim
Benefits will be paid to you unless we receive a written authorization to pay them elsewhere, such as to a hospital or a doctor's office. This is called *assignment*.

If we still owe you benefits at your death, we will pay them to your estate.

If benefits are payable to your estate, we can pay benefits up to $1,000 to someone related to you by blood or marriage who we feel is fairly entitled to them. If we do this, we will have no responsibility for this payment because we made it in good faith.

Time of Payment of Claim
After we receive written proof of loss and process your claim, we will pay any benefits due within 60 days.

Questions Concerning Any Covered Person's Claim
If you have questions concerning any covered person's claim, you can call us at our home office. We are open Monday through Friday from 8:30 a.m. until 5:00 p.m. Eastern Standard Time.

Physical Examinations and Autopsy
We can require that any covered person be examined by a physician of our choice at our expense as often as it is reasonably necessary while his claim is pending and require an autopsy in case of death where it is not forbidden by law.

Legal Action
No action at law or in equity shall be brought to recover on this certificate prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this certificate. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.