COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

1200 Colonial Life Boulevard, P. O. Box 1365
Columbia, South Carolina 29202
(800) 325-4368
A Stock Company

GROUP SPECIFIED DISEASE INSURANCE
THIS IS A LIMITED BENEFIT SPECIFIED DISEASE POLICY. THIS POLICY PROVIDES BENEFITS FOR CANCER AND CANCER SCREENING PROCEDURES. 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.

Master Policy

This is not a policy of Workers' Compensation Insurance. The policyholder does not become a subscriber to the Workers' Compensation system by purchasing this 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 Policy Carefully

This policy is a legal contract between you and us. To understand the coverage, you must read this policy as a whole.

In this policy, the words *you* or *your* refer to the policyholder shown on the Policy Rate Schedule. The words *named insured* refer to those persons who are members of an eligible class as described in the Policy, who hold a certificate of coverage and for whom premiums are remitted. The words *covered person* refer to any person covered under this policy as described on the Certificate Schedule. The words *we*, *us*, *our* or *company* refer to Colonial Life & Accident Insurance Company. The male pronoun includes the female whenever used.

This 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

This is a limited policy. Please read it carefully.
THE POLICY IS CANCELLABLE AT THE OPTION OF THE COMPANY. PLEASE READ THE TERMINATION PROVISION.

This Is Not Medicare Supplement Coverage.

POLICY GUIDE

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
POLICY RATE SCHEDULE

Policyholder **Highland ISD**
Policyholder Address **500 Turtle Cove Blvd**
Ste 200
Rockwall, TX 75087-5383

Group Policy Number **G0047685**

Effective Date of This Policy **September 01, 2019**

Initial Premium Due Date **September 01, 2019**

1. Description of Eligible Classes - See Master Application

2. Benefits: **See applicable provisions of the policy**

3. Pre-Existing Condition Limitation Period
Refer to Certificate Schedule for individual pre-existing condition limitation periods.

4. Initial Monthly Rates

	Level 4 with additional benefits	
	Named Insured	**Family**
	$23.90	**$39.70**
Riders		
Initial Diagnosis of Cancer Rider	**$1.05**	**$1.75**

5. Rate Guarantee Period: A change in premium rate will not take effect before 24 month(s) after the policy effective date.

SECTION III - GENERAL DEFINITIONS

Additional definitions may be contained in other policy 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 policy. 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 policy.

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 policy.

Master Application
Master Application means the document signed by the policyholder that contains the answers to our questions and is the policyholder's representations, which we accepted in good faith as being true, complete and correct. The master application is the basis upon which we issued the policy.

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 this policy or the 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

Policy Effective Date
Coverage under this policy begins at 12:01 a.m. Eastern Standard Time on the effective date shown on the Policy Rate Schedule.

Effective Dates of Covered Persons' Coverage
The covered person's coverage will start at 12:01 a.m. Eastern Standard Time on the effective date of coverage shown on the named insured's Certificate Schedule, except as provided in the Delayed Effective Date of Coverage provision.

Who is Eligible
To be eligible to apply for coverage, an individual must:
- be a member of an eligible class as defined on the Master Application; and
- satisfy the policyholder eligibility waiting period shown on the Master Application, if applicable; and
- meet evidence of insurability requirements as described on the Master Application, if any.

Delayed Effective Date of Coverage
The effective date of coverage will be delayed if the named insured is 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 the named insured returns to status as a member of an eligible class. If this is family coverage, coverage on the spouse and/or dependent children will be effective on the date that the named insured returns to status as a member of an eligible class.

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

If this is family coverage as shown on the Certificate Schedule, we insure the named insured, his spouse and his dependent children.

Spouse means the person married to the named insured on the day we issue his certificate.

Dependent children means the named insured's:
- natural children;
- step-children;
- grandchildren who are the named insured's dependents for federal income tax purposes;
- adopted children;
- children whom the named insured is 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 the named insured's custody under a temporary court order that grants him conservatorship of the children.

Such children must be:
- unmarried;
- chiefly dependent on the named insured or his 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 the named insured's family are to be added to the certificate, including a new spouse or dependent child, he must:
- notify us in writing within 31 days that he wishes to add a person to his coverage;
- meet evidence of insurability requirements satisfactory to us; and
- pay any additional premium.

SECTION V - CANCER SCREENING BENEFITS

$100 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 the certificate is in force;
- the covered person receives treatment for cancer while coverage under the 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 the certificate or the policy.

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

If cancer is not pathologically or clinically diagnosed until after the 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 policy.

$75 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 policy.

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 any 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
$300 per day, up to a maximum of $10,000 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
$300 per day for first 30 days of hospital confinement in a calendar year
$600 per day for hospital confinement after the first 30 days of hospital confinement in a calendar year
$600 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
$300 per day for first 30 days of hospital confinement in a calendar year
$600 per day for hospital confinement after the first 30 days of hospital confinement in a calendar year
$600 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
$750 a day up to a maximum of $2,250 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
$300 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
$300 a day up to a maximum of $10,000 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
$90 per surgical unit up to a maximum of $4,500 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 policy.

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
$200 per day up to $1,600 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.

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

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.

Surgery
$90 per surgical unit up to $4,500 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
The named insured, will not be required to continue to pay premiums to keep his coverage in force if:
- the first date of diagnosis is while his coverage is in force; and
- he becomes disabled because of cancer after the effective date of his coverage and remains disabled for longer than three continuous months (90 days).

A month is 30 days. *Disabled* means the named insured is:
- unable to work at any job for which he is 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 he does not have a job, we will not require him to pay premiums as long as he is kept at home because of his cancer and is under the care of a doctor. *At home* means in his house or yard. However, he can follow his doctor's orders even if it means leaving home. *Under the care of a doctor* means a doctor is caring for the named insured on a regular basis.

Before we waive the named insured's premiums, he must send us a written notice prepared by his doctor stating:
- the date he was diagnosed as having cancer;
- that he is disabled, as defined in this policy, because of cancer; and
- the date he became continuously disabled because of cancer.

We may also each month thereafter require a doctor's statement that he continues to be disabled as defined in the policy.

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

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

If we do not require him to pay premiums during a period of disability, and he becomes 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 he must be disabled again for three continuous months before we will waive his premiums.

He must send us written notice as soon as he is no longer disabled. We will assume he is no longer disabled if:
- he does not send us satisfactory proof of continued disability when we request it;
- he does not agree to have a physical examination by a doctor chosen by us; or
- he notifies us that he is no longer disabled.

He must pay all premiums to keep his coverage in force beginning with the first premium due after he is no longer disabled.

This benefit does not apply to the named insured's spouse or to his dependent children. We will waive premiums only if the named insured is disabled due to cancer. However, if this is family coverage we will waive premiums on all family members insured by this policy.

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 policy, 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 policy.

Termination of This Contract
This policy can be cancelled:
- by you; or
- by us.

Except for nonpayment of the required premium or the failure to meet continued underwriting standards, we may not cancel the policy prior to the first anniversary date of the effective date of the policy as specified on the Policy Rate Schedule.

After the first anniversary date, we may cancel this policy for any reason. If the premium is not paid when it is due or during the grace period, this policy will terminate automatically at the end of the grace period. You must pay all premium due for the full period each certificate is in force.

If we cancel this policy for reasons other than your failure to remit premium, a written notice will be delivered to you at least 31 days prior to the cancellation date.

You may terminate this policy by providing us a notice of intent to terminate the coverage. This policy will be terminated on the date we receive the notice or on the date of termination as stated in the notice. Coverage will end at 12:00 midnight Eastern Standard Time on the termination date. This policy can be cancelled on an earlier date if we both agree.

Termination of a Named Insured's Coverage
The coverage on a named insured will terminate on the earliest of the following dates:
- the date this policy is terminated by either you or us;
- the end of the grace period following the premium due date you fail to remit the required premium for the named insured;
- the date the named insured is no longer in an eligible class;
- the date the named insured's class is no longer included for insurance; or
- the date the next premium is due after the named insured asks us to end his coverage.

Termination of coverage will not affect any claim for cancer treatments that occurred while the named insured's coverage was in force.

When Coverage Ends on the Named Insured's Spouse and Dependent Children
If this is family coverage, coverage on the named insured's spouse will end on the earliest of the following dates:
- the date this policy terminates;
- the end of the grace period following the premium due date you fail to remit the required premium for the named insured's family coverage;
- the date the named insured's coverage terminates;
- the date the next premium is due after the named insured asks us to end his spouse's coverage;
- the date the named insured dies; or
- the date the next premium is due after the named insured divorces his spouse or his marriage is annulled.

If this is family coverage, coverage on the named insured's dependent children will end on the earliest of the following dates:
- the date this policy terminates;
- the end of the grace period following the premium due date you failed to remit the required premium for the named insured's family coverage;
- the date the named insured's coverage terminates;
- the date the next premium is due after the named insured asks us to end his dependent children's coverage; or
- the date the named insured dies.

Coverage will end on each child when he no longer qualifies as a dependent child as defined in this policy. It is the named insured's responsibility to notify us if any dependent child no longer qualifies as an eligible dependent. The named insured must notify us within 120 days after the child no longer qualifies as an eligible dependent, unless he is legally unable to do so. If this is family coverage and all of the dependent children no longer qualify as eligible dependents and we are not notified, 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 he was 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 the named insured or his 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 the named insured 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
A named insured may continue his coverage during absences for family or medical leave. If a named insured is on a family or medical leave of absence, coverage will continue under this policy as if the named insured were in active employment, if the following conditions are met:

- the premiums are paid in accordance with this policy's provisions; and
- you have approved the named insured's 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 the named insured's 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 the insured's family or medical leave of absence.

Leave of Absence - Other
If the named insured is 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, he 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 the named insured is temporarily absent from active employment for a period of time that has been agreed to in advance in writing by his employer. Normal vacation time is not considered a temporary layoff or leave of absence.

Conversion Privilege

If one of the following events occurs:

- the coverage of the named insured terminates because the named insured is no longer in an eligible class or the named insured's class is no longer eligible for coverage, or
- coverage of a spouse covered under a certificate issued under this policy terminates due to divorce, annulment or death of the named insured, 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 a certificate issued under this policy 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 the certificate issued under this policy 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 the 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 the 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 the 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 the certificate. Any waiting period under the converted policy is waived.

- If the named insured is eligible for a converted policy, any spouse or dependent children covered under the 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 the certificate may also be covered under the converted policy or they may remain covered under the certificate as the named insured and his 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 the death of the named insured, any dependent children covered under the 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 Policy Rate 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 the coverage will stay in force. If the premium is not paid before the grace period ends, the coverage provided by this policy will terminate at the end of the grace period.

Our Right to Change Premiums
We have the right to change the premium we charge. If we plan to make a change, we will send you a notice at least 60 days before we make it.

A change in premium rate will not take effect before the end of the rate guarantee period shown on the Policy Rate Schedule. However, we may change premium rates at any time for reasons which affect the risk assumed, including but not limited to, the reasons shown below:
- a change occurs in the plan design;
- a division, subsidiary, or affiliated company is added or deleted;
- a substantial change occurs in the participation level of the eligible class;
- the number of insureds changes by 25% or more; or
- a new law or a change in any existing law is enacted which applies to this plan.

Unpaid Premium
When a claim is paid under the coverage, any premium then due and unpaid may be deducted by us from the named insured’s claim payment.

SECTION XI - GENERAL PROVISIONS

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

Entire Contract: Changes
This policy is a legal contract between you and us. The policy is issued in consideration for the Master Application and payments called *premiums*. The initial rates for this policy are shown on the Policy Rate Schedule.

Whenever we use the word *policy*, we mean the entire contract. The entire contract consists of:

- the policy, including the Policy Rate Schedule;
- the attached copy of the Master Application; and
- any attached riders or endorsements.

Riders and endorsements add provisions to or change the terms of the policy.

No change in this policy shall be valid until approved in writing by one of our executive officers in our home office and attached hereto. No agent or anyone else has authority to change this policy or to waive any of its provisions. You must sign any change that modifies, limits or excludes coverage in order for it to be binding.

Furnishing Certificates
The company will provide a certificate to the named insured. If the terms of a certificate and this policy differ, this policy will govern. If dependents are included in the coverage, only one certificate will be issued for each family unit.

Incontestability
No statement made by any named insured relating to his insurability or the insurability of his 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 named insured making the statement, unless the statement was fraudulent.

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

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

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 this policy that, on the effective date, does not agree with state laws where the named insured lives will be amended to conform to the minimum requirements of those laws.

Information to Be Furnished By You
As the policyholder, you must keep a record of the named insureds and the particulars of the insurance on each. You should provide us at regular intervals, on forms acceptable to us, information relative to persons:

- who are eligible to apply; and
- whose coverage terminates pursuant to the "Termination of a Named Insured's Coverage" provision.

You should also provide us with any other information about the coverage that may be reasonably required, such as named insureds on leave of absence, including named insureds who are on leave under the Family and Medical Leave Act.

We have the right to inspect your books which may have a bearing on the insurance provided by this policy. We may inspect these at any time while this policy is in force and within one year after the termination of this policy.

In the absence of fraud, all statements made in any application are considered representations and not warranties. No representation by the policyholder in applying for insurance under this policy will make it void unless the representation is contained in the Master Application.

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. The claim form along with proof of loss should be sent to us at our home office.

If the named insured does not have a claim form, he 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 his name and certificate number as shown in the named insured's Certificate Schedule. It must also include proof of loss and how the loss occurred. The named insured should send the statement to us at our home office.
When we receive the statement describing the loss, we will send him claim forms within 15 days. If he does not receive claim forms, his written statement along with the proof of loss will be used to process his 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. The named insured should include his name and certificate number. If the named insured has a claim form, he can send it to us in place of the written notice of claim. If he is not able to give us written proof of loss within 90 days, it will not have a bearing on his 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 he is 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, the named insured 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
The named insured must give us written proof of loss within 90 days after the covered loss begins. If he is not able to give us written proof of loss within 90 days, it will not have a bearing on his 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 he is 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 your 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 the named insured 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 the named insured benefits at his death, we will pay them to his estate.

If benefits are payable to his estate, we can pay benefits up to $1,000 to someone related to him 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 the named insured's claim, we will pay any benefits due within 60 days.

Questions Concerning Any Covered Person's Claim
If the named insured has questions concerning any covered person's claim, he 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 policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
P.O. Box 1365, Columbia, South Carolina 29202
(800) 325-4368

GROUP INITIAL DIAGNOSIS OF CANCER RIDER

THIS IS A LIMITED RIDER - READ IT CAREFULLY.

All terms, explanations of terms, conditions and limitations stated in the policy will also apply to this rider unless we state otherwise in this rider.

In this rider, the words *you* or *your* refer to the policyholder shown on the Policy Rate Schedule. The words *named insured* refer to those persons who are members of an eligible class as described in the Policy, who hold an Initial Diagnosis of Cancer Rider Certificate and for whom you remit premium. The words *covered person* refer to any person covered under this rider as described on the Rider Certificate Schedule. The *words we, us, our* or *company* refer to Colonial Life & Accident Insurance Company. The male pronoun includes the female whenever used. If the terms of the rider certificate and the rider differ, the rider will govern.

Coverage Provided by This Rider
We will pay the benefit shown in the Rider Certificate Schedule when any covered person is diagnosed for the first time as having internal (not skin) cancer if:

- the first date of diagnosis is after the effective date on the Rider Certificate Schedule;
- the first date of diagnosis is while the Rider Certificate is in force; and
- the covered person furnishes us with written proof of cancer diagnosis.

We will not pay this benefit for skin cancer.

We will not pay this benefit for cancer that is a pre-existing condition if the diagnosis occurs during the pre-existing condition limitation period shown on the Rider Certificate Schedule.

This benefit is payable once per covered person.

Secretary