

LOYAL AMERICAN LIFE INSURANCE COMPANY®
P.O. Box 559004, Austin, Texas 78755-9004

OUTLINE OF COVERAGE for CANCER EXPENSE POLICY FORM L-6040-TX

THE POLICY DESCRIBED IN THIS OUTLINE OF COVERAGE PROVIDES SUPPLEMENTAL COVERAGE AND IS DESIGNED TO SUPPLEMENT EXISTING INSURANCE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

If you are eligible for Medicare, please review the "Guide to Health Insurance for People with Medicare" which is available from the Company.

- I. **Read Your Policy Carefully.** This outline of coverage provides a very brief description of some of the important features of the policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and the Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**
- II. **Cancer Insurance Coverage** - The policy is designed to provide a benefit when an Insured Person is diagnosed with Cancer, is hospitalized or incurs certain medical expenses as a direct result of Cancer. It does not provide coverage for basic hospital, basic medical-surgical, or major medical coverage.
- III. **Benefits** - We will pay the benefits as described in the policy for the treatment of an Insured Person's Cancer, and if such optional rider is also issued, for the treatment of a listed Specified Disease provided he or she is covered under this Policy and/or rider and this Policy and/or rider remains in force. Payment will be made in accordance with all applicable Policy and/or rider provisions. Benefits are payable for a positive diagnosis that begins more than 30 days after the Effective Date. The positive diagnosis must be for Cancer as defined in this Policy, or for a Specified Disease as defined in the optional rider.

All benefits are subject to terms and conditions of this Policy and/or Specified Disease rider. If Cancer or a listed Specified Disease is diagnosed while You or any Insured Person is confined in the Hospital, benefits will begin on the day of admission or 10 days prior to the date of diagnosis if this is more favorable to You. Admission to the Hospital must begin more than 30 days after the Effective Date of coverage. If a positive diagnosis is made for Cancer or a listed Specified Disease within 12 months after a Tentative Diagnosis, benefits will be paid from the date of the Tentative Diagnosis if the Tentative Diagnosis is made more than 30 days after the Effective Date of coverage.

Description of Benefits:

Positive Diagnosis Benefit - We will pay the Actual Charge not to exceed \$300 per Calendar Year for one test that confirms the positive diagnosis of Cancer in an Insured Person. This benefit is not payable for multiple diagnoses of the same Cancer or for Cancer that metastasizes or for recurrence of the same Cancer.

National Cancer Institute Designated Comprehensive Cancer Treatment Center Evaluation / Consultation Benefit - If an Insured Person receives a positive diagnosis of Internal Cancer and seeks an evaluation or consultation at a National Cancer Institute designated Comprehensive Cancer Treatment Center for the purpose of obtaining a treatment option opinion, We will pay the Actual Charge not to exceed a lifetime maximum of \$750. If the Comprehensive Cancer Treatment Center is located more than 30 miles from the Insured Person's place of residence, We will also pay the transportation and lodging expenses incurred not to exceed a lifetime maximum of \$350. This benefit is not payable on the same day a Second or Third Surgical Opinion Benefit is payable. This benefit is payable in lieu of the Non-Local Transportation and Lodging Expense Benefits of the policy. This benefit is payable one time during the lifetime of the Insured Person.

Second and Third Surgical Opinion Expense Benefit – If surgery is recommended for the removal of Cancer, We will pay the Actual Charge for a written second surgical opinion concerning the Cancer surgery. If the second surgical opinion is in conflict with that of the Physician originally recommending the surgery, We will pay the Actual Charge for a written third surgical opinion. The Physician providing the second or third surgical opinion cannot be associated with the Physician who originally recommended the surgery. This benefit is not payable for the same day the National Cancer Institute Evaluation/Consulting Benefit is payable.

Outpatient Hospital or Ambulatory Surgical Center Expense Benefit - We will pay the Actual Charge, not to exceed \$350 per day, made by an Ambulatory Surgical Center or Outpatient department of a Hospital for the use of its facilities during the performance of a surgical procedure covered under the policy.

Medical Imaging, Treatment Planning and Monitoring Expense Benefit - We will pay the Actual Charge not to exceed \$1,000 per Calendar Year, for laboratory tests, routine or diagnostic X-rays, scans or medical images and their interpretation when used in the planning or monitoring of external radiation, internal radiation, Chemotherapy or Immunotherapy treatments of Cancer.

Anti-Nausea Medication Expense Benefit - We will pay the Actual Charge for anti-nausea medication not to exceed \$150 per Calendar Month when an Insured Person is prescribed such medication as the result of Radiation Treatment, Chemotherapy or Immunotherapy treatments for Cancer.

Colony Stimulating Factor or Immunoglobulin Expense Benefit - We will pay the Actual Charge not to exceed \$1,000 per calendar month for Colony Stimulating Factor Drugs or Immunoglobulins prescribed by a Physician or Oncologist during an Insured Person's Cancer treatment regimen for which benefits are payable under the Radiation, Chemotherapy and Immunotherapy Benefit of the policy or any rider attached to it.

Outpatient Blood, Plasma and Platelets Expense Benefit - If, as the result of Cancer, an Insured Person requires blood, plasma, platelets or blood transfusions, on an Outpatient basis, We will pay the Actual Charge not to exceed \$300 per day including the costs of procurement, administration, processing and cross matching.

Inpatient Blood, Plasma and Platelets Expense Benefit - If, as the result of Cancer, an Insured Person requires blood, plasma, platelets or blood transfusions, on an Inpatient basis, We will pay the Actual Charge not to exceed \$300 per day including the costs of procurement, administration, processing and cross matching.

Bone Marrow Donor Expense Benefit - When an Insured Person receives bone marrow or stem cells from another live person for the purpose of a bone marrow or stem cell transplant in connection with the Insured Person's Internal Cancer treatment, We will pay the Daily Hospital Confinement Benefit amount shown on the Policy Schedule for each day the donor is confined in a Hospital for the harvesting of bone marrow or stem cells used in a covered bone marrow or stem cell transplant.

Bone Marrow or Stem Cell Transplant Expense Benefit - We will pay the Actual Charge not to exceed a lifetime maximum of \$15,000 for surgical and anesthesia procedures (including the harvesting and subsequent re-infusion of blood cells or peripheral stem cells) performed for a bone marrow transplant and/or a peripheral stem cell transplant for the treatment of an Insured Person's Internal Cancer. This benefit will be paid in lieu of the Surgical Expense Benefit and the Anesthesia Expense Benefit which may be described in a rider attached to the policy.

Inpatient Oxygen Expense Benefit – When an Insured Person is confined to a Hospital for the treatment of Cancer and requires oxygen that is prescribed and ordered by a Physician, We will pay the Actual Charge for the oxygen not to exceed \$300 per Hospital confinement.

Attending Physician Expense Benefit - We will pay the Actual Charge not to exceed \$ 40 per day for the professional services of a Physician or Oncologist rendered to an Insured Person while he or she is confined in a Hospital for the treatment of Cancer. This benefit is payable only if the Physician or Oncologist personally visits the Hospital room occupied by the Insured Person. The benefit amount stated is the maximum amount payable for each day of Hospital confinement regardless of the number of visits made by one or more Physicians or Oncologists.

Inpatient Private Duty Nursing Expense Benefit - We will pay the Actual Charge not to exceed \$150 per day for the full time service of a Nurse that is required and ordered by a Physician when an Insured Person is confined in a Hospital for the treatment of Cancer. The Nurse must provide services other than those normally provided by the Hospital. The Nurse may not be an employee of the Hospital or an Immediate Family Member of the Insured Person.

Outpatient Private Duty Nursing Expense Benefit – Following a period of Hospital confinement of an Insured Person for the treatment of Cancer, We will pay the Actual Charge not to exceed \$ 150 per day, limited to the same number of days of the prior Hospital confinement, for the full time service of a Nurse that is required and ordered by a Physician when an Insured Person is confined indoors at home as the result of Cancer. This benefit is not payable if the services of the Nurse are custodial in nature or to assist the Insured Person in the activities of daily living. This benefit is not payable when the Nurse is a member of the Insured Person's Immediate Family.

Home Health Care Expense Benefit - We will pay benefits for the following covered charges when an Insured Person requires Home Health Care for the treatment of Cancer.

1. Home Health Care Visits - We will pay the Actual Charge for Home Health Care Visits not to exceed \$ 75 for each day on which one or more such visits occur. We will not pay this benefit for more than 60 days in any Calendar Year.
2. Medicine and Supplies - We will pay the Actual Charge not to exceed \$ 450 in any Calendar Year for drugs, medicine, and medical supplies provided by or on behalf of a Home Health Care Agency.
3. Services of a Nutritionist - We will pay the Actual Charge not to exceed a lifetime maximum of \$ 300 for the services of a nutritionist to set up programs for special dietary needs.

Convalescent Care Facility Expense Benefit - We will pay the Actual Charge not to exceed \$ 100 per day for an Insured Person's confinement in a Convalescent Care Facility. The maximum number of days for which this benefit is payable will be the number of days in the last Period of Hospital Confinement that immediately preceded admission to the Convalescent Care Facility. The Convalescent Care Facility confinement must:

1. be due to Cancer;
2. begin within 14 days after the Insured Person has been discharged from a Hospital for the treatment of Cancer; and
3. be authorized by a Physician as being medically necessary for the treatment of Cancer.

Hospice Care Expense Benefit – When an Insured Person, as a result of Cancer, requires Hospice Care, We will pay the Actual Charge for Hospice Care not to exceed \$ 100 per day. This benefit is payable whether confinement is required in a Hospice Center or services are provided in the Insured Person's home by a Hospice Team. Eligibility for benefit payments will be based on the following conditions being met: (1) the Insured Person has been given a prognosis of being Terminally Ill with an estimated life expectancy of 6 months or less; and (2) We have received a written summary of such prognosis from the attending Physician. We will not pay this benefit while the Insured Person is confined to a Hospital or Convalescent Care Facility. The lifetime maximum benefit is 365 days of Hospice Care.

Non-Local Transportation Expense Benefit - We will pay the Actual Charge for Non-Local transportation not to exceed coach fare by on a Common Carrier for the Insured Person and one adult companion's travel to a Hospital, Radiation Therapy Treatment Center, Chemotherapy Treatment Center, Oncology Clinic or any other specialized treatment center where the Insured Person receives treatment for Cancer. This benefit is payable only if the treatment is not available Locally but is available Non-Locally. The adult companion may include the live donor of bone marrow or stem cells used in a bone marrow or stem cell transplant for the Insured Person. At the option of the Insured Person, We will pay a single private vehicle mileage allowance of 50 cents per mile for Non-Local transportation in lieu of the common carrier coach fare.

Lodging Expense Benefit - When an Insured Person receives treatment for Cancer at a Non-Local Hospital, Radiation Therapy Treatment Center, Chemotherapy Treatment Center, Oncology Clinic or any other specialized treatment center, We will pay the Actual Charge not to exceed \$ 75 per day for a room in a motel, hotel or other appropriate lodging facility (other than a private residence). The room must be occupied by the Insured Person or an adult companion, which may include the live donor of bone marrow or stem cells used in a bone marrow or stem cell transplant for the Insured Person. This benefit is not payable for lodging expense incurred more than 24 hours before the treatment, nor for lodging expense incurred more than 24 hours following treatment. This benefit is limited to 100 days per Calendar Year.

Ambulance Expense Benefit - We will pay the Actual Charge for ambulance service if an Insured Person is transported to a Hospital where he or she is admitted as an Inpatient for the treatment of Cancer. The ambulance service must be provided by a licensed professional ambulance company or an ambulance owned by the Hospital.

Prosthesis Expense Benefit:

(a) Surgically Implanted Breast Prosthesis – If, as the result of breast removal due to Cancer, the attending Physician prescribes a breast prosthesis to restore normal body contour, We will pay the Actual Charge for the prosthesis and its implantation. This benefit does not include coverage for breast reconstruction surgery which may be covered under the Surgical Schedule within the Surgical and Anesthesia Benefits Rider, if such rider is issued as part of the policy.

(b) Non-Surgically Implanted Prosthesis – If an Insured Person sustains an amputation, as the result of treatment for Cancer, and an artificial limb or other non-surgically implanted prosthetic device is required and prescribed by a Physician to restore normal body function, We will pay the Actual Charge not to exceed a lifetime maximum of \$ 2,000 per such amputation. The cost for the replacement of a prosthetic device is not covered. Hairpieces or wigs are not covered under this benefit.

Hairpiece Expense Benefit – If an Insured Person suffers hair loss due to Cancer treatments, We will pay the Actual Charge not to exceed a lifetime maximum of \$150 for the purchase of a wig or hairpiece.

Rental or Purchase of Medical Equipment Expense Benefit – If, as the result of Cancer, the attending Physician prescribes covered medical equipment designed for home use, We will pay the lesser of the Actual Charge for the rental or purchase of such medical equipment not to exceed \$1,500 per Calendar Year. Covered medical equipment includes wheel chair, oxygen equipment, respirator, braces, crutches or hospital bed.

Physical, Speech, Audio Therapy and Psychotherapy Expense Benefit - We will pay the Actual Charge not to exceed \$ 25 per therapy session for:

1. Physical therapy treatments given by a licensed Physical Therapist, or
2. Speech therapy given by a licensed Speech Pathologist/Therapist; or
3. Audio therapy given by a licensed Audiologist; or
4. Psychotherapy given by a licensed Psychologist.

These therapy sessions may be given at an institute of physical medicine and rehabilitation, a Hospital, or the Insured Person's home. These treatments must be given on an Outpatient basis, unless the primary purpose of a Hospital confinement is for treatment of Cancer other than with physical, speech or audio therapy or psychotherapy. Benefits under this section may not exceed \$1,000 per Calendar Year.

Waiver of Premium Benefit - We will waive the premiums starting on the first premium due date following a 60 day period of Total Disability of the Named Insured due to Cancer. The Named Insured must: (1) be receiving treatment for such Cancer for which benefits are payable under this Policy; and (2) remain disabled for 60 consecutive days. We will waive premiums for as long as the Named Insured remains Totally Disabled. Premiums will be waived in accordance with the mode of payment in effect when treatment began.

Totally Disabled means the Named Insured is: (1) unable to work at any job for which he or she is qualified by education, training or experience; and (2) under the care of a Physician for the treatment of internal Cancer.

If the Named Insured is retired or Age 65 and over at the time he or she becomes Totally Disabled, the definition of Total Disability will mean the inability to perform two (2) or more of the ADL's (Activities of Daily Living) listed below without the assistance of another person. ADL's are defined as activities used in measuring levels of personal functioning capacity. Normally, these activities are performed without assistance, allowing personal independence in everyday living. The ADL's are:

1. Transferring - moving between the bed and a chair or the bed and a wheelchair;
2. Dressing - putting on and taking off all necessary items of clothing;
3. Toileting - getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene;
4. Eating - all major tasks of getting food into the body;
5. Bathing - getting into or out of the tub or shower and otherwise washing the parts of the body.

We may ask for and use an independent consultant to determine whether the Named Insured can perform an ADL when this benefit is in force.

IV. Exclusions and Limitations - No benefits will be paid for:

1. any loss due to any disease or illness other than Cancer;
2. care and treatment received outside the territorial limits of the United States;
3. treatment by any program engaged in research that does not meet the criteria for Experimental Treatment as defined;
4. treatment that has not been approved by a Physician as being medically necessary; or
5. losses or medical expenses incurred prior to the Effective Date of an Insured Person's coverage regardless of the Date of Positive Diagnosis.

Pre-Existing Condition(s) Limitation - "Pre-existing Condition" means Cancer, or a listed Specified Disease if that optional rider is issued, which was diagnosed by a Physician or for which medical consultation, advice or treatment was recommended by or received from or sought from a Physician within five years prior to the effective date of coverage for each Insured Person.

For Insured Persons who were under age 65 on the effective date of coverage, the benefits of this policy will not be payable during the first 24 months that coverage is in force with respect to an Insured Person for a loss caused by a Pre-Existing Condition disclosed or not disclosed on the application. This 24-month period is measured from the effective date of coverage for each Insured Person.

For Insured Persons who were age 65 or older on the effective date of coverage, the benefits of this policy will not be payable during the first 6 months that coverage is in force with respect to an Insured Person for a loss caused by a Pre-Existing Condition disclosed or not disclosed on the application. This 6-month period is measured from the effective date of coverage for each Insured Person.

V. Guaranteed Renewable - Except for fraud or material misrepresentation, you will have the right to renew the Policy for your lifetime, as long as premiums are paid on time. The Policy will terminate on the last day of the period for which premium is paid unless continued in force during a Grace Period. We reserve the right to change premiums. On any premium due date after the first Policy Anniversary, We may change the premium rates for the policy only if We also change the rates for all other policies issued in the same rating class. We must give 60 days advance written notice of any premium change. No change in the premiums will be made because of the number of claims you file nor because of a change in your health.

VI. Optional Benefit Riders - A checkmark in any of the boxes below indicates that You have selected the following optional coverage(s):

ANNUAL CANCER SCREENING BENEFIT RIDER L-6041

Basic Benefit - We will pay the Actual Charge, not to exceed the Maximum Benefit Amount per Calendar Year as shown on the Policy Schedule for the Annual Cancer Screening Benefit, per Insured Person for screening tests performed to determine whether Cancer exists in an Insured Person. Covered annual Cancer screening tests include but are not limited to the following:

Mammogram	Breast Ultrasound
Pap Smear	ThinPrep
Flexible Sigmoidoscopy	Biopsy
Hemocult Stool Specimen	Chest X-Ray
CEA (blood test for colon cancer)	Thermography
PSA (blood test for prostate cancer)	Colonoscopy
CA 125 (blood test for ovarian cancer)	Serum Protein Electrophoresis (blood test for myeloma)
CA 15-3 (blood test for breast cancer)	

Additional Benefit - We will pay the Actual Charge, not to exceed two times the Maximum Benefit Amount per Calendar Year as shown on the Policy Schedule for the Annual Cancer Screening Benefit, per Insured Person for one additional invasive diagnostic procedure required as the result of an abnormal cancer screening test for which benefits are payable under the Basic Benefit above. Invasive diagnostic procedure means a procedure requiring an excision or the insertion of an instrument in the body. This additional benefit is payable regardless of the results of the additional diagnostic procedure, however, the amount payable will be reduced dollar for dollar for any amount payable under the Positive Diagnosis Benefit contained within the base policy.

DAILY HOSPITAL CONFINEMENT BENEFIT RIDER L-6042

Confinements of 30 Days or Less - We will pay the Daily Hospital Confinement Benefit amount shown on the Policy Schedule for the Daily Hospital Confinement Benefit, for each of the first 30 days in each Period of Hospital Confinement during which an Insured Person is confined to a Hospital, including a Government or Charity Hospital, for the treatment of Cancer.

Confinements lasting longer than 30 Consecutive Days – If an Insured Person is continuously confined to a Hospital, including a Government or Charity Hospital, for longer than 30 consecutive days for the treatment of Cancer, We will pay two times the Daily Hospital Confinement Benefit amount shown on the Policy Schedule for the Daily Hospital Confinement Benefit. This benefit payment will begin on the 31st continuous day of such confinement and continue for each day of confinement until the Insured Person is discharged from the Hospital.

Benefits for an insured Dependent Child under Age 21 - Benefits payable under the Daily Hospital Confinement Expense Benefits will be double the Daily Hospital Confinement Benefit amount shown on the Policy Schedule for the Daily Hospital Confinement Benefit if the Insured Person so confined is a dependent child under the age of 21.

FIRST OCCURRENCE BENEFIT RIDER L-6043

If an Insured Person receives a positive diagnosis of Internal Cancer while insured, We will pay the First Occurrence Benefit amount shown on the Policy Schedule. If the Insured Person receiving the positive diagnosis of Internal Cancer is a child under the age of 21, We will pay one and one-half times the First Occurrence Benefit amount shown on the Policy Schedule. This benefit is payable one time only during the lifetime of each Insured Person, regardless of the number of positive diagnoses that an Insured Person may have of Internal Cancer.

FIRST OCCURRENCE BUILDING BENEFIT RIDER L-6044

While this rider is in effect, on the day following each Policy Anniversary, the First Occurrence Benefit amount shown on the Policy Schedule will be increased for each Insured Person by the First Occurrence Building Benefit amount shown on the Policy Schedule. The First Occurrence Building Benefit, if any accrued, will be paid under the same terms and conditions as the First Occurrence Benefit Rider.

This First Occurrence Building Benefit will cease to annually increase for an Insured Person on the day following the first Policy Anniversary after the Insured Person's 65th birthday or on the date of positive diagnosis of Internal Cancer, whichever occurs first. However, regardless of the age of the Insured Person on the Effective Date of this rider, this benefit shall accrue for a period of at least five years unless Internal Cancer is diagnosed prior to the fifth year of coverage. If the Coverage Type shown on the Policy Schedule is "Individual", no further premium will be billed for this rider after the payment of the First Occurrence benefit.

ANNUAL RADIATION, CHEMOTHERAPY, IMMUNOTHERAPY and EXPERIMENTAL TREATMENT BENEFIT RIDER L-6045

While this rider is in effect, We will pay the Actual Charge incurred in any one Calendar Year by an Insured Person for Radiation Treatment, Chemotherapy, Hormonal Therapy or Immunotherapy or Experimental Treatment not to exceed the Radiation Treatment, Chemotherapy, Immunotherapy or Experimental Treatment Benefit amount shown on the Policy Schedule for each Calendar Year. The Radiation Treatment, Chemotherapy, Hormonal Therapy, Immunotherapy or Experimental Treatment must be for the treatment of an Insured Person's Cancer. Treatments must be administered, or in the case of self-administered or oral chemotherapy or immunotherapy, prescribed by a Physician, Chemotherapist, Oncologist, Radiation Therapist or other licensed medical personnel as required by the applicable state law to administer the treatment. Treatment may be on an Inpatient or Outpatient basis. The Radiation Treatment, Chemotherapy, Immunotherapy and Experimental Treatment Benefit amount shown on the Policy Schedule is the maximum We will pay in any one Calendar Year for each Insured Person's Cancer treatments regardless of the number or types of treatments received.

DAILY RADIATION, CHEMOTHERAPY, IMMUNOTHERAPY and EXPERIMENTAL TREATMENT BENEFIT RIDER L-6046

While this rider is in effect, We will pay the Actual Charge incurred by an Insured Person, not to exceed the Radiation Treatment, Chemotherapy, Immunotherapy and Experimental Treatment Benefit amount shown on the Policy Schedule for each day an Insured Person receives one or more of the following Cancer treatments:

1. Chemotherapy (including Hormonal Therapy) or Immunotherapy injected by a Chemotherapist, an Oncologist, Physician or other legally qualified medical personnel in the office of an Oncologist or Physician, a Chemotherapy Treatment Center, a Hospital or Clinic;
2. Self-injected Chemotherapy or Immunotherapy drugs, limited to the maximum daily benefit amount per treatment.
3. Chemotherapy or Immunotherapy drugs dispensed by a pump or implant. This is limited to the maximum daily benefit amount for the initial prescription and an equal amount for each refill.
4. Oral Chemotherapy or Immunotherapy regardless of where administered. This is limited to the maximum daily benefit amount per prescription.
5. Radiation Treatment administered by a Radiation Therapist, an Oncologist, Physician or other legally qualified medical personnel in the office of an Oncologist or Physician, a Radiation Treatment Center, a Hospital or Clinic. Benefits payable for interstitial or intracavitary applications of Radiation Treatments are payable on the day of insertion only and not for each day the Radiation Treatment remains in the body.
6. Experimental Treatment

The Radiation Treatment, Chemotherapy, Immunotherapy Benefit amount shown on the Policy Schedule is the maximum We will pay on any day an Insured Person receives a Chemotherapy, Immunotherapy or Radiation Treatment, regardless of the type or number of different treatments the Insured Person may receive on the same day.

HOSPITAL INTENSIVE CARE UNIT BENEFIT RIDER L-6047

Subject to all the terms, provisions, conditions, definitions, exclusions, limitations and reductions contained in the rider and the base policy, for covered Intensive Care Unit or Step Down Unit confinements which occur during a Period of Confinement that begins after the Insured Person's Effective Date of coverage We will pay the benefits described in A., B., or C., below. During each Period of Confinement, We will pay benefits for a maximum of 45 days under A., B., or C.

A. Intensive Care Unit Benefit - We will pay the Daily Hospital Intensive Care Unit Benefit amount shown on the Policy Schedule for each day an Insured Person is confined in an Intensive Care Unit as the result of Sickness or Injury, subject to the following: (1) Intensive Care Unit Benefits will begin on the first day of such confinement. (2) However, We will not pay benefits for any more than 45 days during any one Period of Hospital Intensive Care Unit Confinement.

B. Double Intensive Care Unit Benefit - The Daily Hospital Intensive Care Unit Benefit payable for any one Period of Confinement that is the result of Cancer or as the result of a Travel Related Injury will be double the Hospital Intensive Care Unit Benefit shown on the Policy Schedule. The double benefit for a Travel Related Injury is payable only for the initial Intensive Care Unit confinement that commences within 24 hours of the accident causing the Travel Related Injury. Double benefits are not payable for successive periods of Intensive Care Unit confinement, even when part of the same Period of Confinement.

C. Step Down Unit Benefit - We will pay one-half of the Daily Hospital Intensive Care Unit Benefit shown on the Policy Schedule for each day the Insured Person is confined in a Step Down Unit as the result of Sickness or Injury.

Additional Exclusions and Limitations - Coverage under the rider is subject to the applicable Exclusions and Limitations of the base policy to which it is attached. The following additional Exclusions, Reduction and Limitations also apply.

On the date an Insured Person attains Age 75, and continuing thereafter, his or her Daily Hospital Intensive Care Unit benefit will be reduced to an amount equal to one-half of the Daily Hospital Intensive Care Unit Benefit shown on the Policy Schedule.

The rider does not cover Intensive Care Unit or Step Down Unit confinements that are the result of (1) intentionally self-inflicted injury, or (2) the Insured Person being intoxicated or under the influence of alcohol, drugs or any narcotic, unless administered on and according to the advice of a Medical Practitioner.

SURGICAL BENEFITS RIDER L-6048

We will pay a Surgical Expense Benefit for a surgical procedure for the treatment of Cancer (except Skin Cancer) according to the Surgical Schedule shown in the rider. The surgery may be performed either as an inpatient of a Hospital or as an outpatient in a Hospital, Ambulatory Surgical Center, Physician's office or other free standing medical facility. The following rules apply to the Surgical Schedule shown in the rider:

1. Two or more surgical procedures performed at the same time and through the same incision will be deemed one surgery, the surgery with the highest Surgical Benefit.
2. The procedures listed in the Surgical Schedule are selected examples from a complete surgical schedule used by Us. For any surgical procedure not listed in the Surgical Schedule, We will pay a benefit according to the complete schedule. However, in no event will the amount payable exceed the Maximum Benefit amount shown on the Policy Schedule. The complete Surgical Schedule is incorporated into the rider by reference and is available upon request.
3. One unit of coverage under this benefit provides a maximum benefit Amount of \$1,000. The amounts shown in the rider provide examples of benefits as they would be payable under the Surgical Schedule. The maximum Surgical Benefit amount for Your coverage under the rider will be shown on the Policy Schedule.
4. We will not pay more than the Actual Charge for any surgical procedure.

Anesthesia Expense Benefit - When a surgical procedure is performed that is a covered surgical expense and the Insured Person incurs charges for anesthesia, We will pay the Actual Charge for the anesthesia not to exceed an amount equal to 25% of the covered Surgical Expense Benefit for the operation performed. This includes the services of a professional anesthesiologist or of an anesthesiologist under supervision of a Physician for the purpose of administering anesthesia.

Skin Cancer Surgery Expense Benefit - When there is a positive diagnosis of Skin Cancer of an Insured Person and a cutting surgical procedure is performed to remove the positively diagnosed Skin Cancer, We will pay the Actual Charge, not to exceed the amount shown below, for such surgical removal. This benefit is payable in lieu of any benefits for surgical expense and anesthesia expense which are not applicable to Skin Cancer.

Biopsy	\$ 125
Excision of lesion of skin	\$ 350
Excision of lesion of skin with flap or graft	\$ 750

SPECIFIED DISEASE BENEFIT RIDER L-6052

While coverage is in force, if an Insured Person is first diagnosed with one or more covered Specified Diseases and is hospitalized for the definitive treatment of any covered Specified Disease, We will pay benefits according to the provisions of the rider.

Covered Specified Diseases

Addison's Disease	Lyme Disease	Rocky Mountain Spotted Fever
Amyotrophic Lateral Sclerosis	Malaria	Sickle Cell Anemia
Botulism	Meningitis	Tay-Sachs Disease
Bovine Spongiform	Multiple Sclerosis	Tetanus
Encephalopathy		
Budd-Chiari Syndrome	Muscular Dystrophy	Toxic Epidermal Necrolysis
Cystic Fibrosis	Myasthenia Gravis	Tuberculosis
Diphtheria	Neimann-Pick Disease	Tularemia
Encephalitis	Osteomyelitis	Typhoid Fever
Epilepsy	Poliomyelitis	Undulant Fever
Hansen's Disease	Q Fever	West Nile Virus
Histoplasmosis	Rabies	Whipple's Disease
Legionnaire's Disease	Reye's Syndrome	Whooping Cough
Lupus Erythematosus	Rheumatic Fever	

Initial Hospitalization Benefit - We will pay the Initial Hospitalization Benefit amount shown on the Policy Schedule when an Insured Person is confined to a Hospital for 12 or more hours as a result of receiving treatment for a Specified Disease. This benefit is payable only once per period of confinement and once per Calendar Year for each Insured Person. A period of confinement is a Hospital confinement that starts while the rider is in force. If the confinement follows a previously covered confinement, it will be deemed a continuation of the first confinement unless it is the result of an entirely different Specified Disease, or unless the confinements are separated by 30 days or more.

Hospital Confinement Benefit - We will pay the Hospital Confinement Benefit amount shown on the Policy Schedule per day when an Insured Person is hospitalized during any continuous period of 30 days or less for the treatment of a covered Specified Disease. Benefits will double per day beginning with the 31st day of continuous confinement.

Exclusions - No benefits will be paid for:

1. loss due to any disease or illness other than those listed as covered Specified Diseases;
2. care and treatment received outside the territorial limits of the United States;
3. treatment that has not been approved by a Physician as being medically necessary; or
4. losses or medical expenses incurred prior to the Effective Date of an Insured Person's coverage regardless of the date of diagnosis.

VII. Premiums - The annual premiums for the coverages outlined above are:

Cancer Policy Only	\$ _____
Annual Cancer Screening Benefit Rider	\$ _____
Daily Hospital Confinement Benefit Rider	\$ _____
First Occurrence Benefit Rider	\$ _____
First Occurrence Building Benefit Rider	\$ _____
Annual Radiation, Chemotherapy, Immunotherapy and Experimental Treatment Benefit Rider	\$ _____
Daily Radiation, Chemotherapy, Immunotherapy and Experimental Treatment Benefit Rider	\$ _____
Hospital Intensive Care Unit Benefit Rider	\$ _____
Surgical Benefits Rider	\$ _____
Specified Disease Benefit Rider	\$ _____
TOTAL	\$ _____

The premium for the coverages outlined above for each _____ month period on the Effective Date is \$ _____, when premium payments are by:

- Payroll Deduction
- Share Withdrawal
- Electronic Funds Transfer
- Direct Bill (No Direct Bill Monthly)

NOTICE OF 30-DAY RIGHT TO EXAMINE POLICY

Within thirty (30) days from receipt of the Policy, You may return it for any reason. If returned, the Policy is void. Any premiums paid on the Policy will be refunded. The Policy may be returned to Us or to the agent who sold the Policy.