Sample Policy – CriticalGuard Critical Illness

For illustrative purposes only. Actual benefits and provisions may vary by state and other factors. These are **not** the state-specific provisions. Applicants will be presented with a state and plan-specific policy upon issue.

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Golden Rule Insurance Company
[7440 Woodland Drive
Indianapolis, IN 46278-1719]
For Inquiries: [(800) 657-8205]

In this Policy, You or Your will refer to the Primary Insured named on page 3, and We, Our, or Us will refer to Golden Rule Insurance Company, a stock company.

CRITICAL ILLNESS POLICY
CANCER, CRITICAL CONDITIONS, and HEART AND STROKE BENEFITS
Section 1
AGREEMENT AND CONSIDERATION

We will pay benefits as set forth in this Policy. This Policy is issued in exchange for and on the basis of statements made on Your application and payment of the first premium. It takes effect on the applicable Effective Date shown on the Schedule of Benefits. It will remain in force until the first premium due date, and for such further periods for which payment is received by Us when due, subject to the renewal provision below. All periods will begin and end at 12:01 A.M., Standard Time, where You live.

GUARANTEED RENEWABLE SUBJECT TO LISTED CONDITIONS

You may keep this Policy, subject to the Policy's Termination provisions, as long as premiums are paid when they are due. However, We may refuse renewal if there is fraud or a material misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Policy benefits.

From time to time, We may change the rate table used for this Policy form. On each premium's due date, the premium will be based on the rate table in effect in the state where the Policy was issued. The type and level of benefits and the age of the Covered Person on the Policy Effective Date are the factors which may be used in determining Your premium rate. Your premium rate may also be adjusted based on a new requirement under state or federal law or when a change in any existing state or federal requirement becomes effective which applies to this Policy.

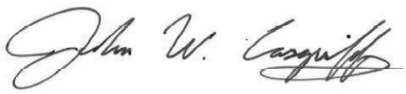
At least 31 days written notice of any plan to take an action or make a change permitted by this clause will be mailed to You at Your last address as shown in Our records. We will make no change in Your premium solely because of claims made under this Policy or a change in a Covered Person's health. While this Policy is in force, We will not restrict coverage already in force.

[10-30]-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY

Please read this Policy. If You are not satisfied, You may return the Policy to Us within [10-30] days after You received it. Any premium paid will be refunded, less claims paid. This Policy will then be void from its start.

Check the attached application. If it is not complete or has an error, please let Us know. An intentional misrepresentation of a material fact or a fraudulent misstatement in the application may cause Your Policy to be voided, or a claim to be reduced or denied.

This Policy is signed for Us as of the Effective Date as shown on the Schedule of Benefits.



[ ]
President

NOTICE TO BUYER: THIS POLICY PROVIDES LIMITED BENEFITS. This Policy provides benefits ONLY for the First Diagnosis of a Cancer Benefit Qualifying Event, the First Diagnosis of a Critical Condition Benefit Qualifying Event, or the First Diagnosis of a Heart and Stroke Benefit Qualifying Event while coverage is in force under this Policy, subject to the Waiting Period, lifetime maximum amount, and Preexisting Condition limitation stated herein. This coverage is supplemental and should not be considered a substitute for comprehensive health insurance coverage.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

THIS IS A LUMP SUM INDEMNITY POLICY THAT PAYS BENEFITS FOR THE FIRST DIAGNOSIS OF A CANCER BENEFIT QUALIFYING EVENT, THE FIRST DIAGNOSIS OF A CRITICAL CONDITION BENEFIT QUALIFYING EVENT, OR THE FIRST DIAGNOSIS OF A HEART AND STROKE BENEFIT QUALIFYING EVENT AS IDENTIFIED IN THIS POLICY. PLEASE READ IT CAREFULLY.

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Important Notice

This Policy is a legal contract between You and Us.
The terms of this Policy are binding on both You and Us.

READ YOUR POLICY CAREFULLY.

Section 2

SCHEDULE OF BENEFITS

Policy Number: [999-999-999]
Primary Insured: [John Doe]
[Spouse: Jane. B. Doe]
[Dependent child: Susie M. Doe]
[Dependent child: Mark S. Doe]
[Dependent child: Janet R. Doe]
[Dependent child: Sam M. Doe]
Initial Modal Premium: [$XXXX.XX]

Premium Mode: [*Payable Monthly, Quarterly, Semi-annually, Annually]
Effective Date: [xx/xx/xx]

[See rider-amendment(s) attached to Policy]

BENEFITS:

Waiting Period, per Covered Person, from the Effective Date of coverage .....[30-90] days
(First Diagnosis must be made after the applicable Waiting Period to be eligible for benefits.)

CANCER BENEFIT:
(If a Covered Person's First Diagnosis of a Cancer Benefit Qualifying Event occurs during a Covered Person's Pregnancy, We will pay an additional 50% of that paid benefit. The additional Pregnancy benefit is not subject to the Cancer Benefit Lifetime Maximum Amount.)

CANCER BENEFIT LIFETIME MAXIMUM AMOUNT
(Once the Cancer Benefit Lifetime Maximum Amount is exhausted by a Covered Person, no further benefits will be paid under this Policy for a Cancer Benefit Qualifying Event for that Covered Person.)

Per Covered Person..... [$5,000 - $200,000]

CANCER BENEFIT QUALIFYING EVENTS	**FIRST DIAGNOSIS BENEFIT**
Life-threatening Cancer.....	100% of Cancer Benefit Lifetime Maximum Amount
Cancer In Situ ..... *(Limited to one benefit payable, per Covered Person, per lifetime)*	25% of Cancer Benefit Lifetime Maximum Amount
Benign Brain Tumor..... *(Limited to one benefit payable, per Covered Person, per lifetime)*	25% of Cancer Benefit Lifetime Maximum Amount
Skin Cancer..... *(Limited to one benefit payable, per Covered Person, per lifetime)*	$500

CRITICAL CONDITION BENEFIT:
(If a Covered Person's First Diagnosis of a Critical Condition Benefit Qualifying Event occurs during a Covered Person's Pregnancy, We will pay an additional 50% of that paid benefit. The additional Pregnancy benefit is not subject to the Critical Condition Benefit Lifetime Maximum Amount.)

CRITICAL CONDITION BENEFIT LIFETIME MAXIMUM AMOUNT

(Once the Critical Condition Benefit Lifetime Maximum Amount is exhausted by a Covered Person, no further benefits will be paid under this Policy for a Critical Condition Benefit Qualifying Event for that Covered Person.)

Per Covered Person	[$5,000 - $200,000]

CRITICAL CONDITION BENEFIT QUALIFYING EVENTS	**FIRST DIAGNOSIS BENEFIT**
Advanced Alzheimer's Disease	100% of Critical Condition Benefit Lifetime Maximum Amount
Amyotrophic Lateral Sclerosis (ALS)	100% of Critical Condition Benefit Lifetime Maximum Amount
Coma *(Lasting for a period of at least 7 consecutive days)*	100% of Critical Condition Benefit Lifetime Maximum Amount
End Stage Renal Failure	100% of Critical Condition Benefit Lifetime Maximum Amount
Loss of Independent Living *(Limited to one benefit payable, per Covered Person, per lifetime)* *(Payable for the permanent inability to perform two or more of the six Activities of Daily Living for a period of at least 90 consecutive days)*	50% of Critical Condition Benefit Lifetime Maximum Amount
Major Organ Transplant	100% of Critical Condition Benefit Lifetime Maximum Amount

HEART AND STROKE BENEFIT:
(If a Covered Person's First Diagnosis of a Heart and Stroke Benefit Qualifying Event occurs during a Covered Person's Pregnancy, We will pay an additional 50% of that paid benefit. The additional Pregnancy benefit is not subject to the Heart and Stroke Benefit Lifetime Maximum Amount.)

HEART AND STROKE BENEFIT LIFETIME MAXIMUM AMOUNT
(Once the Heart and Stroke Benefit Lifetime Maximum Amount is exhausted by a Covered Person, no further benefits will be paid under this Policy for a Heart and Stroke Benefit Qualifying Event for that Covered Person.)

Per Covered Person	[$5,000 - $200,000]

HEART AND STROKE BENEFIT QUALIFYING EVENTS	**FIRST DIAGNOSIS BENEFIT**
Heart Attack	100% of Heart and Stroke Benefit Lifetime Maximum Amount
Stroke	100% of Heart and Stroke Benefit Lifetime Maximum Amount
Heart Illness *(Limited to one benefit payable, per Covered Person, per lifetime)*	25% of Heart and Stroke Benefit Lifetime Maximum Amount

COVID BENEFIT

COVID Benefit ..... *(Limited to one benefit payable, per Covered Person, per lifetime)*	$10,000 for Intensive Care Unit confinement

[WELLNESS RIDER:

Benefit amount	[$50-$100] per Covered Person, per exam
Limited to	1 exam, per Covered Person, per Calendar Year]

[OUTPATIENT PRESCRIPTION DRUG RIDER (dispensed at a licensed pharmacy):

Generic Prescription Drug.....	[$10-$50]per prescription fill
Brand Name Prescription Drug.....	[$25-$100] per prescription fill
Limited to	$600 per Covered Person, per Calendar Year]

Section 3

GENERAL DEFINITIONS

Whenever used in this Policy, the following words are defined as follows:

Activities of Daily Living means certain basic daily tasks necessary to maintain a Covered Person's health and safety. Activities of Daily Living refer to the activities described below:

A. **Bathing** means washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.

B. **Continence** means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

C. **Dressing** means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

D. **Eating** means feeding oneself by getting food into the body from a receptable (such as a plate, cup or table), feeding tube or intravenously.

E. **Toileting** means getting to and from the toilet, transferring on and off the toilet and performing associated personal hygiene.

F. **Transfer and Mobility** means the ability to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, wheelchair, cane, crutches, walker or other equipment.

Beneficiary means the person(s) or entity named by You in the application, or later changed as described in the Change of Beneficiary provision, to receive benefits payable under this Policy in the event of Your death.

Calendar Year means a twelve month period which begins at 12:00 a.m. on January 1 of any year and ends at 11:59 p.m. on December 31 of that year.

Cancer Benefit Qualifying Event includes the diseases or conditions listed below for which positive First Diagnosis is made by a Legally Qualified Physician based on diagnostic criteria generally accepted by the medical profession:

A. **Benign Brain Tumor** means a non-malignant mass present within the substance of the brain tissue resulting in permanent deficit to the neurological system.

   Benign Brain Tumor does not include cysts, granulomas, meningiomas, malformations of the intracranial arteries or veins and tumors of the cranial nerves, pituitary or spinal cord, unless documented by a Legally Qualified Physician as causing damage to surrounding neurological tissue; nor any non-malignant mass originally Diagnosed prior to the Effective Date of this Policy.

B. **Cancer In Situ** means a Diagnosis of cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue, except as specifically excluded below. As used herein, stage 0 disease and early prostate cancer requiring medical treatment shall be considered Cancer In Situ.

   Cancer In Situ does not include:

   1. Premalignant lesions, tumors or polyps;
   2. Benign tumors or polyps;
   3. Skin Cancer; or
   4. Any cancer originally Diagnosed prior to the Effective Date of this Policy or the metastasis of any such cancer.

C. **Life-threatening Cancer** means only those types of cancer manifested by the presence of a malignant neoplasm characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Life-threatening Cancer also includes but is not limited to leukemia, Hodgkin's disease, myeloproliferative and myelodysplastic blood disorders, and invasive melanoma in the dermis or deeper.

Life-threatening Cancer does not include:

1. Premalignant lesions, tumors or polyps;
2. Benign tumors or polyps;
3. Cancer In Situ;
4. Skin Cancer; or
5. Any cancer originally Diagnosed prior to the Effective Date of this Policy or the metastasis of any such cancer.

D. **Skin Cancer** means a type of disease for which malignant cancer cells are found in the outer layer of the skin and which has not been Diagnosed as a malignant melanoma in the dermis or deeper or skin malignancy that has become Life-threatening Cancer, as defined herein.

Skin Cancer does not include:

1. Premalignant lesions, tumors or polyps; or
2. Benign tumors or polyps.

Coronavirus Disease (COVID) means the human coronaviruses known to cause severe acute respiratory illness including COVID-19, SARS and MERS (including variant strains of COVID-19, SARS or MERS).

Covered Person means You, Your Spouse and each Eligible Child:

A. Named in the application; or

B. Whom We agree in writing to add as a Covered Person.

Critical Condition Benefit Qualifying Event includes the diseases, conditions or procedures listed below for which positive First Diagnosis is made by a Legally Qualified Physician based on diagnostic criteria generally accepted by the medical profession:

A. **Advanced Alzheimer's Disease** means a progressive degenerative disease of the brain. In order to meet the definition of Advanced Alzheimer's Disease, the Diagnosis must be supported by medical evidence that the Covered Person exhibits the loss of intellectual capacity resulting in impairment in mental and social functioning, such that the Covered Person requires permanent daily personal supervision and is unable to perform independently in three or more Activities of Daily Living.

No other dementing organic brain disorders or psychiatric illness shall meet the definition of Advanced Alzheimer's Disease, nor will they be considered a Critical Condition Benefit Qualifying Event. In order for Advanced Alzheimer's Disease to be considered a Critical Condition Benefit Qualifying Event under this Policy, the Legally Qualified Physician making the Diagnosis of Advanced Alzheimer's Disease must be a board-certified neurologist.

B. **Amyotrophic Lateral Sclerosis (ALS)** means a progressive neurodegenerative disease that affects nerve cells in the brain and spinal cord in which there are both upper and lower motor neuron signs. In order for ALS to be covered under this Policy:

1. The Legally Qualified Physician making the Diagnosis of ALS must be a board-certified neurologist; and
2. Clinical findings must have measurable limitations and be present for more than 30 days.

C. **Coma** means a continuous state of profound unconsciousness, lasting for a period of seven or more consecutive days, characterized by the absence of:

1. Spontaneous eye movement;
2. Response to painful stimuli; and
3. Vocalization.

The condition must require intubation for respiratory assistance.

Coma does not include deliberately induced Comas for medical reasons.

D. **End Stage Renal Failure** means end stage renal disease which results in an irreversible failure of both kidneys to function. When this happens, periodic and ongoing peritoneal dialysis, periodic and ongoing renal dialysis or kidney transplant is required in order to live. In order for End Stage Renal Failure to be considered a Critical Condition Benefit Qualifying Event under this Policy, the Diagnosis of End Stage Renal Failure must be made by a Legally Qualified Physician who is a board-certified nephrologist.

We may require medical records and appropriate test results showing that the Diagnosis of End Stage Renal Failure was based on, but not limited to, renal function studies (blood urea nitrogen and creatinine tests), and abnormal results on a renal scan.

E. **Loss of Independent Living** means a Covered Person who has been certified by a Legally Qualified Physician as being permanently unable to perform (without substantial assistance from another individual) at least two or more of the six Activities of Daily Living for a period of at least 90 consecutive days.

F. **Major Organ Transplant** means clinical evidence of Major Organ(s) failure which requires the malfunctioning Major Organ(s) or tissue of the Covered Person to be replaced with the Major Organ(s) or tissue from a suitable human donor under generally accepted medical procedures. In order for a Major Organ Transplant to be considered a Critical Condition Benefit Qualifying Event under this Policy, the Covered Person must be registered by the United Network of Organ Sharing (UNOS).

Dependent means Your lawful Spouse and/or Eligible Child.

Diagnosis or **Diagnosed** means the initial definitive establishment of a Qualifying Event through the use of clinical and/or laboratory findings. The Diagnosis must be made by a Legally Qualified Physician who is also a board-certified specialist where required under this Policy.

In the case of Coronary Bypass, the Diagnosis includes the Coronary Bypass surgical procedure.

In the case of Angioplasty, the Diagnosis includes the Angioplasty surgical procedure.

Effective Date means the date a Covered Person becomes insured under this Policy. The Effective Date is shown:

A. In the Schedule of Benefits of this Policy for initial Covered Persons; and
B. In the written notification from Us confirming the addition of a new Covered Person.

Eligible Child means Your or Your Spouse's child, if that child is less than 26 years of age.

As used in this definition, "child" means a:

A. Natural child;
B. Legally adopted child;
C. Child placed with You or Your Spouse for adoption; or
D. Child for whom legal guardianship has been awarded to You and Your Spouse.

First Diagnosis means a Diagnosis, as defined in this Policy, which occurs for the first time in the Covered Person's lifetime after the Waiting Period and while the Covered Person's coverage is in effect under this Policy.

Heart and Stroke Benefit Qualifying Event means the diseases, conditions or procedures listed below for which positive First Diagnosis is made by a Legally Qualified Physician based on diagnostic criteria generally accepted by the medical profession:

A. **Heart Attack** means irreversible damage and death of a portion of the myocardium or heart muscle caused by either:

   1. Coronary thrombosis (complete occlusion of a coronary artery); or
   2. Severe stenosis or narrowing of a coronary artery causing an occlusion of a coronary artery,

   which is first positively Diagnosed by a Legally Qualified Physician.

   We may require medical records and appropriate test results to show that the onset of such acute myocardial infarction is confirmed by:

   1. Significant abnormal electrocardiographic findings; and/or
   2. Clinical findings and cardiac blood enzyme abnormalities.

   Heart Attack does not include cardiac arrest.

B. **Stroke** means any acute cerebrovascular incident producing neurological impairment and resulting in paralysis or other measurable objective neurological deficit persisting for at least 96 hours and expected to be permanent, except as specifically excluded below. In order for Stroke to be covered under this Policy, the Stroke must be positively Diagnosed by a Legally Qualified Physician based upon generally accepted diagnostic criteria.

   Stroke does not include:

   1. Head injury by an external force;
   2. Transient ischemic attack (TIA) (i.e., mini stroke); or
   3. Indications or symptoms related to chronic cerebrovascular insufficiency.

C. **Heart Illness** means an aneurysm or obstruction of an artery that is Diagnosed as being of sufficient severity to require surgical/invasive intervention, such as:

   1. Coronary Artery Bypass graft or other bypass;
   2. Angio jet clot busting;
   3. Laser/balloon Angioplasty;
   4. Arthrectomy;
   5. Stent implantation;
   6. Abdominal aortic aneurysm surgery; or
   7. Open heart surgery to replace or repair one or more heart valves.

Immediate Family means the parents, Spouse, children, or siblings of any Covered Person, or any person residing with a Covered Person.

Intensive Care Unit (ICU) means a Cardiac Care Unit, or other unit or area of a hospital that meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

Legally Qualified Physician means a person, other than the Covered Person, a member of the Covered Person's Immediate Family, or a business associate of the Covered Person, who is duly licensed and practicing medicine in the United States, and who is legally qualified to diagnose and treat Sickness and injuries. He or she must be providing services within the scope of his or her license, and must be a board-certified specialist where required under this Policy.

Major Organ means any of the following organs:

A. Heart;

B. Lung or lungs;

C. Liver;

D. Kidney;

E. Pancreas;

F. Intestine;

G. Vascular Composite Allografts (VCAs); or

H. Heart/lung combined.

Policy means this Policy issued and delivered to You. It includes the attached pages, the applications and/or enrollment form(s), and any amendments.

Preexisting Condition means:

A. Any Sickness, injury or condition for which medical advice, care or treatment was recommended or received within the [6-12] months immediately preceding the Covered Person's Effective Date;

B. Any Sickness, injury or condition for which any diagnostic procedure or screening was recommended to or received by the Covered Person within the [6-12] months immediately preceding the Covered Person's Effective Date that results in medical care or treatment after the Covered Person's Effective Date; or

C. Any Sickness, injury or symptom(s) that, in the opinion of a Legally Qualified Physician, manifested itself in a manner that would have caused an ordinarily prudent person to seek medical advice, Diagnosis, care, treatment, or further evaluation within the [6-12] months immediately preceding the Covered Person's Effective Date.

Pregnancy means the physical condition of being pregnant as confirmed by a Legally Qualified Physician.

Primary Insured means the Covered Person identified as such on the Schedule of Benefits.

Proof of Loss means information required by Us to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, medical bills or records.

Qualifying Event means any of the specific diseases, conditions or procedures as defined in this Policy and as shown on the Schedule of Benefits.

Residence means the physical location where You live. If You live in more than one location, and You file a United States income tax return, the physical address (not a P.O. Box) shown on Your United States income tax return as Your Residence will be deemed to be Your place of Residence. If You do not file a United States income tax return, the Residence where You spend the greatest amount of time will be deemed to be Your place of Residence.

Sickness means a disease, illness or other non-injury related condition of a Covered Person including conditions resulting from bug bites, stings or infestations by microorganisms.

Spouse means the person to whom You are legally married or Your domestic partner under [state] law.

Waiting Period means a period of time for which a Covered Person must wait, after the Effective Date of coverage, before benefits will be paid for a particular service or condition.

Section 4

PREMIUMS

PREMIUM PAYMENT: Each premium is to be paid by You and received by Us on or before its due date. A due date is the last day of the period for which the preceding premium was paid.

PREMIUM CHANGE: From time to time, We may change the rate table used for this Policy form. On each premium's due date, the premium will be based on the rate table in effect in the state where the Policy was issued. The type and level of benefits and the age of the Covered Person on the Policy Effective Date are the factors which may be used in determining Your premium rate. Your premium rate may also be adjusted based on a new requirement under state or federal law or when a change in any existing state or federal requirement becomes effective which applies to this Policy. At least 31 days written notice of any plan to take an action or make a change permitted by this clause will be delivered or mailed to You at Your last address as shown in Our records. We will make no change in Your premium solely because of claims made under this Policy or a change in a Covered Person's health.

GRACE PERIOD: After Your initial premium, You have until the 31st day following each premium due date to pay all premiums due. The Policy will remain in force during the grace period. We may pay benefits for a Qualifying Event during this 31 day grace period. Any such benefit payment is made in reliance on the receipt of the full premium due from You by the end of the grace period. This grace period does not apply if You request termination of this Policy.

However, if We pay benefits for any claims during the grace period, and the full premium is not received by the end of the grace period, We will require repayment of all benefits paid from You or any other person or organization that received payment on those claims. If repayment is due from another person or organization, You agree to assist and cooperate with Us in obtaining repayment. You are responsible for repaying Us if We are unsuccessful in recovering Our benefits from these other sources.

MISSTATEMENT OF RESIDENCE: Your premium will be based on Your place of Residence on the Policy Effective Date. If Your Residence is misstated on Your application for insurance under this Policy, or You fail to notify Us of a change of Residence, We will apply the correct premium amount beginning on the first premium due date You resided at that place of Residence. If the change results in lower premium, We will refund any excess premium. If the change results in a higher premium, You will owe Us the additional premium.

MISSTATEMENT OF AGE: If a Covered Person's age has been misstated in the application for insurance under this Policy, any future premiums will be adjusted and past premiums will be refunded or owed to Us based on the Covered Person's correct age. If a Covered Person's age has been misstated and We would not have issued coverage for that Covered Person, We will refund the premium paid minus any benefit amounts paid by Us, and coverage would be void from the Effective Date.

BILLING/ADMINISTRATIVE FEE: Upon prior written notice, We may impose an administrative fee for credit card payments. This does not obligate Us to accept credit card payments. We may charge a [$20-$50] fee for any check or automatic payment deduction that is returned unpaid.

Section 5

DEPENDENT COVERAGE

DEPENDENT ELIGIBILITY: Your Dependents become eligible to apply for insurance on the later of:

A. The date You became insured under this Policy; or

B. The date of becoming Your Dependent.

EFFECTIVE DATES FOR INITIAL DEPENDENTS: The Effective Date for Your initial Dependents, if any, is shown on the Schedule of Benefits. Only Dependents included in the application for this Policy and approved by Us will be covered on Your Effective Date.

ADDING A NEWBORN CHILD: An Eligible Child born to You or Your Spouse will be covered from the time of birth until the 31st day after its birth unless You or Your Spouse advises Us not to add the newborn child to the Policy. The newborn child will be covered for a Qualifying Event from the time of its birth.

Additional premium may be required to continue coverage beyond the 31st day after the date of birth of the child. If required, the premium will be calculated from the child's date of birth. Coverage of the child will terminate on the 31st day after its birth, unless We have received both written notice of the child's birth and the required premium within 90 days of the child's birth.

ADDING AN ADOPTED CHILD: An Eligible Child legally placed for adoption with You or Your Spouse will be covered from the date of Placement until the 31st day after Placement unless the Placement is disrupted prior to legal adoption and the child is removed from Your or Your Spouse's custody.

Additional premium may be required to continue coverage beyond the 31st day following Placement of the child. If required, the premium will be calculated from the date of Placement for adoption. Coverage of the child will terminate on the 31st day following Placement, unless We have received both written notice of Your or Your Spouse's intent to adopt the child and any additional premium required for the addition of the child within 90 days of the date of Placement.

As used in the provision, **Placement** means the earlier of:

A. The date that You or Your Spouse assume physical custody of the child for the purpose of adoption; or

B. The date of entry of an order granting You or Your Spouse custody of the child for the purpose of adoption.

ADDING OTHER DEPENDENTS: If:

A. You apply in writing for insurance on a Dependent;

B. You pay the required premiums; and

C. We agree to insure the eligible Dependent,

then the Effective Date will be shown in the written notice to You that the Dependent is insured.

Section 6
CONTINUING ELIGIBILITY

FOR SPOUSE: Your Spouse will cease to be a Covered Person at the end of the premium period in which he or she ceases to be Your Dependent due to divorce.

We must receive notification within 90 days of the date Your Spouse ceases to be an eligible Dependent. If notice is received by Us more than 90 days from this date, any unearned premium will be credited only from the first day of the calendar month in which We receive the notice.

CONTINUATION: If Your Spouse ceases to be a Covered Person due to the fact that he or she no longer meets the definition of Dependent under the Policy, Your former Spouse will be eligible for continuation of coverage. We will continue Your former Spouse's coverage by issuing a separate new policy, if available, in Your former Spouse's state of residence. If applicable, the new policy and premium rates will be determined based on the residence of Your former Spouse. All other terms and conditions of the new policy, as applicable to Your former Spouse, will be the same as applicable to Your Spouse under this Policy, unless otherwise mandated by the state in which Your former Spouse resides. Any Waiting Period, exclusion and/or Preexisting Condition limitation, applicable indemnity amounts and maximum benefit limits will be satisfied under the new policy to the extent satisfied under this Policy at the time that the continuation of coverage is issued.

Notification Requirements: It is the responsibility of You or Your former Spouse to notify Us within 90 days of Your legal divorce. You must notify Us of the address at which the continuation of coverage should be issued.

Continuation of Coverage: We will issue the continuation of coverage within 30 days after the date We receive timely notice of Your legal divorce. Your former Spouse must pay the required premium within 31 days following notice from Us or the new policy will be void from its beginning.

FOR ELIGIBLE CHILD: An Eligible Child will cease to be a Covered Person at the end of the premium period in which he or she ceases to meet the definition of Eligible Child.

We must receive notification within 90 days of the date a Covered Person ceases to be an Eligible Child. If notice is received by Us more than 90 days from this date, any unearned premium will be credited only from the first day of the calendar month in which We receive the notice.

A Covered Person will not cease to be an Eligible Child solely because of age if the Eligible Child is:

A. Not capable of self-sustaining employment due to mental handicap or physical handicap that began before the age limit was reached; and

B. Mainly dependent on You for support.

Section 7

AMOUNT PAYABLE

AMOUNT PAYABLE: Subject to all terms, conditions, limitations, and exclusions in this Policy, We will pay the applicable First Diagnosis Benefit amount as specified on the Schedule of Benefits in this Policy which results from a First Diagnosis of a Qualifying Event incurred by a Covered Person while that person's coverage is in force under this Policy if:

A. First Diagnosis of a Qualifying Event occurs after a Waiting Period;

B. First Diagnosis of a Qualifying Event is made within the United States; and

C. Proof of Loss has been received by Us.

This Policy does not provide reimbursement for the expenses incurred but provides a lump sum payment of a specific amount for each applicable Qualifying Event as shown on the Schedule of Benefits.

The amount payable will be subject to:

A. Benefit maximums per Covered Person as shown on the Schedule of Benefits.

B. Calendar Year maximums per Covered Person as shown on the Schedule of Benefits.

C. Lifetime maximums per Covered Person as shown on the Schedule of Benefits.

D. Waiting Periods per Covered Person as shown on the Schedule of Benefits.

Section 8

BENEFITS

CANCER BENEFIT: Upon receipt of proof of the First Diagnosis of a Cancer Benefit Qualifying Event under this Policy, We will pay the applicable First Diagnosis Benefit, as shown on the Schedule of Benefits, subject to the Preexisting Condition limitation and the Waiting Period. The total amount payable per Covered Person for this benefit will not exceed the Cancer Benefit Lifetime Maximum Amount, as shown on the Schedule of Benefits.

If a Covered Person is Diagnosed with a subsequent Qualifying Event while coverage is in effect under this Policy, no benefit will be payable if the subsequent Qualifying Event is resulting from, caused by, connected to, or associated with a prior Qualifying Event for which a benefit was paid under the Policy.

CRITICAL CONDITION BENEFIT: Upon receipt of proof of the First Diagnosis of a Critical Condition Benefit Qualifying Event under this Policy, We will pay the applicable First Diagnosis Benefit, as shown on the Schedule of Benefits, subject to the Preexisting Condition limitation and the Waiting Period. The total amount payable per Covered Person for this benefit will not exceed the Critical Condition Benefit Lifetime Maximum Amount, as shown on the Schedule of Benefits.

If a Covered Person is Diagnosed with a subsequent Qualifying Event while coverage is in effect under this Policy, no benefit will be payable if the subsequent Qualifying Event is resulting from, caused by, connected to, or associated with a prior Qualifying Event for which a benefit was paid under the Policy.

HEART AND STROKE BENEFIT: Upon receipt of proof of the First Diagnosis of a Heart and Stroke Benefit Qualifying Event under this Policy, We will pay the applicable First Diagnosis Benefit, as shown on the Schedule of Benefits, subject to the Preexisting Condition limitation and the Waiting Period. The total amount payable per Covered Person for this benefit will not exceed the Heart and Stroke Benefit Lifetime Maximum Amount, as shown on the Schedule of Benefits.

If a Covered Person is Diagnosed with a subsequent Qualifying Event while coverage is in effect under this Policy, no benefit will be payable if the subsequent Qualifying Event is resulting from, caused by, connected to, or associated with a prior Qualifying Event for which a benefit was paid under the Policy.

COVID BENEFIT: We will pay a lump sum benefit, as shown on the Schedule of Benefits, if a Covered Person is confined to the Intensive Care Unit with a concurrent positive Diagnosis for Coronavirus Disease (COVID), which includes a positive COVID test, subject to the Preexisting Condition limitation and the Waiting Period.

BENEFIT PAYMENT LIMITATION: In no event will We pay more than the Cancer Benefit Lifetime Maximum Amount, Critical Condition Benefit Lifetime Maximum Amount, Heart and Stroke Benefit Lifetime Maximum Amount, or COVID Benefit Lifetime Maximum Amount, as shown on the Schedule of Benefits, during a Covered Person's lifetime.

Section 9

GENERAL EXCLUSIONS AND LIMITATIONS

This is not major medical insurance.

We will not provide any benefits that are caused by, resulting from or in connection with:

A. Any care or benefits which are not specifically provided for in this Policy.

B. Any Diagnosis, as defined in this Policy, which is determined to be caused by any act of declared or undeclared war.

C. Any Diagnosis, as defined in this Policy, which is made by You or a member of Your Immediate Family or household.

D. Any Diagnosis, as defined in this Policy, which occurs prior to a Covered Person's Effective Date.

E. Any Diagnosis, as defined in this Policy, which is made outside the United States.

F. Any Diagnosis, as defined in this Policy, which occurs after the date on which coverage under this Policy has been terminated.

G. Any Diagnosis, as defined in this Policy, which occurs before satisfaction of the Covered Person's Waiting Period, as specified in the Schedule of Benefits.

H. Any Diagnosis, as defined in this Policy, while this Policy is not in force.

I. Intentionally self-inflicted bodily harm (whether the Covered Person is sane or insane).

J. Intentionally medically induced Critical Condition Benefit Qualifying Event, except in the case of Major Organ Transplant.

K. A Qualifying Event incurred as a result of the Covered Person being intoxicated, as defined by applicable state law in the state in which the Qualifying Event occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a Legally Qualified Physician or voluntary taking of any over the counter drug unless taken in accordance with the manufacturer's recommended dosage.

L. The Covered Person's commission or attempt to commit a felony, whether or not charged.

M. The Covered Person taking part in a riot.

N. A Covered Person's incarceration in a state or federal prison or other detention facility.

O. Participating, instructing, demonstrating, guiding, or accompanying others in any of the following:

1. Professional or semi-professional sports; intercollegiate sports (not including intramural sports);
2. Parachute jumping; hang-gliding; para-sailing; para-planing, skydiving; bungee jumping; parakiting;
3. Racing or speed testing any motorized vehicle or conveyance;
4. Racing or speed testing any non-motorized vehicle or conveyance (if the Covered Person is paid to participate or to instruct);
5. Scuba/skin diving (when diving 60 or more feet in depth);
6. Rodeo sports; horseback riding (if the Covered Person is paid to participate or to instruct);
7. Rock or mountain climbing (if the Covered Person is paid to participate or to instruct); or
8. Skiing (if the Covered Person is paid to participate or to instruct).

Benefits will not be payable for:

A. Any Cancer Benefit Qualifying Event, Critical Condition Benefit Qualifying Event, or Heart and Stroke Benefit Qualifying Event caused directly or indirectly by Acquired Immune Deficiency Syndrome (AIDS) or AIDS related condition.

B. Any condition that is not Diagnosed as a Cancer Benefit Qualifying Event, a Critical Condition Benefit Qualifying Event, a Heart and Stroke Benefit Qualifying Event, or a COVID Qualifying Event as defined in this Policy. This exclusion does not apply to the Outpatient Prescription Drug Rider or Wellness Rider, if attached to this Policy.

C. Loss resulting from any other disease, Sickness or incapacity, other than loss resulting from a Cancer Benefit Qualifying Event, a Critical Condition Benefit Qualifying Event, a Heart and Stroke Benefit Qualifying Event, or COVID Qualifying Event as defined in this Policy. This includes any other disease or incapacity which may have been complicated or directly or indirectly affected or caused by a Cancer Benefit Qualifying Event, a Critical Condition Benefit Qualifying Event, a Heart and Stroke Benefit Qualifying Event, or a COVID Qualifying Event, or as a result of treatment of a Cancer Benefit Qualifying Event, a Critical Condition Benefit Qualifying Event, a Heart and Stroke Benefit Qualifying Event, or a COVID Qualifying Event. This exclusion does not apply to the Outpatient Prescription Drug Rider or Wellness Rider, if attached to this Policy.

Section 10

PREEXISTING CONDITIONS LIMITATION

PREEXISTING CONDITIONS: We will not pay benefits under the Policy for a Cancer Benefit Qualifying Event, a Critical Condition Benefit Qualifying Event, or a Heart and Stroke Benefit Qualifying Event which manifests due to, results from, is caused or otherwise contributed to by, a Preexisting Condition, or complications resulting from a Preexisting Condition.

The Preexisting Condition limitation will not apply longer than [6-12] months after a Covered Person's applicable Effective Date under this Policy.

RESERVATION OF OTHER RIGHTS: This Preexisting Conditions Limitation section does not affect Our rights with respect to fraudulent misstatements made in an application.

These rights are set forth in the Rescissions and the Repayment for Fraud, Misrepresentation or False Information provisions in the General Provisions section of this Policy.

Section 11

TERMINATION

TERMINATION OF POLICY: All insurance will cease for You and any covered Dependents on termination of this Policy. This Policy will terminate on the earliest of:

A. The date the maximum benefit has been paid for the Cancer Benefit, Critical Condition Benefit, Heart and Stroke Benefit, and COVID Benefit and all attached Riders, if any;

B. Nonpayment of premiums when due, subject to the Grace Period provision in this Policy;

C. The date We receive a request from You to terminate this Policy, or any later date stated in Your request;

D. The date there is fraud or a material misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Policy benefits; or

E. The date of Your death, if this is a Primary Insured only Policy.

We will refund any premium paid and not earned due to Policy termination.

If this Policy is other than a Primary Insured only plan, it may be continued after Your death.

This Policy will be changed to a plan appropriate, as determined by Us, to the Covered Person(s) who continue(s) to be covered under it. Your Spouse or youngest Eligible Child will replace You as the Primary Insured. A proper adjustment will be made in the premium required for this Policy to be continued. We will also refund any premium paid and not earned due to Your death. The refund will be based on the number of full months that remain to the next premium due date.

TERMINATION OF COVERED PERSONS: All coverage will cease for a Covered Person on the date the Covered Person's eligibility for insurance under the Policy ceases due to any of the reasons stated in the Continuing Eligibility section in this Policy or as stated under this section of this Policy.

We will refund any premium paid and not earned due to termination of the Policy or termination of coverage for a Covered Person.

REINSTATEMENT: If any renewal premium is not paid within the time granted to You for payment, a subsequent acceptance of premium by Us or by an Authorized Agent to accept such premium, without requiring an application for reinstatement, will reinstate the Policy. However, if We or such Authorized Agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated:

A. Upon approval of such application by Us; or

B. Lacking such approval, upon the forty-fifth (45) day following the date of such conditional receipt unless We have previously notified You in writing of the disapproval of such application.

If We would not agree to insure You if You were applying initially for this Policy, We will not reinstate coverage.

Premium required and accepted for reinstatement may be applied to a period for which premium had not been paid. The period for which back premium may be required will not begin more than [30-60] days before the date of reinstatement.

The reinstated coverage provides benefits only for the First Diagnosis of a Cancer Benefit Qualifying Event, the Critical Condition Benefit Qualifying Event or the First Diagnosis of a Heart and Stroke Benefit Qualifying Event occurring after the effective date of the reinstatement, subject to the Waiting Period.

The Rescissions provision will apply to statements made on the reinstatement application, based on the date of reinstatement.

Changes may be made in Your Policy in connection with the reinstatement. These changes will be sent to You for You to attach to Your Policy. In all other respects, You and We will have the same rights as before Your Policy lapsed.

As used in this provision, an **Authorized Agent** means a person explicitly designated by Us to accept Your application and premium for reinstatement. An Authorized Agent shall not include an insured's insurance agent/broker or any other independent insurance agent/broker.

Section 12

CLAIMS

CLAIM FORMS: We will furnish claim forms after We receive notice of a claim. If Our usual claim forms are not furnished within 15 days, You or Your covered Dependent may file a claim without them. The claim must contain written Proof of Loss.

NOTICE OF CLAIM: We must receive notice of claim within 30 days after the First Diagnosis of a Qualifying Event or as soon as reasonably possible.

PROOF OF LOSS: You or Your covered Dependent must give Us written Proof of Loss within 90 days after the First Diagnosis of a Qualifying Event or as soon as reasonably possible. Proof of Loss furnished more than one year after the date written Proof of Loss is required to be submitted will not be accepted, unless You or Your covered Dependent had no legal capacity in that year.

COOPERATION PROVISION: Each Covered Person, or other person acting on his or her behalf, must cooperate fully with Us to assist Us in determining Our rights and obligations under the Policy and, as often as may be reasonably necessary:

A. Sign, date and deliver to Us authorizations to obtain any medical or other information, records or documents We deem relevant from any person or entity.

B. Obtain and furnish to Us, or Our representatives, any medical or other information, records or documents We deem relevant.

C. Answer, under oath or otherwise, any questions We deem relevant, which We or Our representatives may ask.

D. Furnish any other information, aid or assistance that We may require, including without limitation, assistance in communicating with any person or entity (including requesting any person or entity to promptly provide to Us, or Our representative, any information, records or documents requested by Us).

If any Covered Person, or other person acting on his or her behalf, fails to provide any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by Us unless and until the item or information requested is received or the requested action is taken, subject to the terms and conditions of the Policy.

In addition, failure on the part of any Covered Person, or other person acting on his or her behalf, to provide any of the items or information requested or to take any action requested may result in the denial of claims of all Covered Persons.

TIME OF PAYMENT OF CLAIMS: Benefits will be paid as soon as We receive proper Proof of Loss.

PAYMENT OF CLAIMS: Except as set forth in this provision, all benefits are payable to You. Any accrued benefits unpaid at Your death or Your Dependent's death may, at Our option, be paid either to the Beneficiary or to the estate. If any benefit is payable to Your or Your Dependent's estate, or to a Beneficiary who is a minor or is otherwise not competent to give valid release, We may pay up to $1,000 to any relative who, in Our opinion, is entitled to it.

Any payment made by Us in good faith under this provision shall fully discharge Our obligation to the extent of the payment. We reserve the right to deduct any overpayment made under this Policy from any future benefits under this Policy.

OVERPAYMENT REIMBURSEMENT: We have the right to recover any overpayment We make due to claim processing error, including overpayment due to fraud. Such notice will state the nature of the error and the amount of the overpayment to be fully reimbursed to Us.

PHYSICAL EXAMINATION AND AUTOPSY: We shall have the right and opportunity to examine a Covered Person while a claim is pending or while a dispute over the claim is pending. These examinations are made at Our expense and as often as We may reasonably require.

LEGAL ACTIONS: No suit may be brought by You on a claim sooner than 60 days after the required Proof of Loss is given. No suit may be brought more than three years after the date Proof of Loss is required.

No action at law or in equity may be brought against Us under the Policy for any reason unless the Covered Person first completes all steps in the complaint/grievance procedures made available to resolve disputes in Your state under the Policy. After completing that complaint/grievance procedures process, if You want to bring legal action against Us on that dispute, You must do so within three years of the date We notified You of the final decision on Your complaint/grievance.

Section 13

GENERAL PROVISIONS

ENTIRE CONTRACT: The entire contract between You and Us consists of this Policy, the application, and any Riders or amendments. No change in this Policy will be valid unless it is signed by one of Our officers.

All statements contained in the application will, in the absence of fraud, be deemed representations and not warranties. No statement made by an applicant for insurance will be used to void the insurance or reduce the benefits, unless contained in a written application that is signed by the applicant.

No agent may:

A. Change this Policy;

B. Waive any of the provisions of this Policy;

C. Extend the time for payment of premiums; or

D. Waive any of Our rights or requirements.

NON-WAIVER: If We or You fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the Policy, that will not be considered a waiver of any rights under this Policy. A past failure to strictly enforce this Policy will not be a waiver of any rights in the future, even in the same situation or set of facts.

TIME LIMIT ON CERTAIN DEFENSES: Subject to the Rescissions provision below, a material misstatement intentionally made in any application for this Policy may be used to void this Policy or to deny a claim. This action

may be taken in the first two years, with no lapse, of a person's coverage. After the two-year period, this action may be taken only for a fraudulent misstatement.

RESCISSIONS: No misrepresentation of material fact made regarding a Covered Person during the application process that relates to insurability will be used to void/rescind the insurance coverage or deny a claim unless:

A. The misrepresented fact is contained in a written application, including amendments, signed by a Covered Person;

B. A copy of the application, and any amendments, has been furnished to the Covered Person(s), or to their Beneficiary; and

C. The misrepresentation of fact was intentionally made and material to Our determination to issue coverage to any Covered Person.

A Covered Person's coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud.

CONFORMITY WITH STATE LAWS: This Policy will be interpreted by the laws of the state in which it is delivered. Any part of this Policy in conflict with the laws of the state in which it is delivered is changed to conform to the minimum requirements of that state's law.

REPAYMENT FOR FRAUD, MISREPRESENTATION OR FALSE INFORMATION: During the first two years a Covered Person is insured under the Policy, if a Covered Person commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any Covered Person under this Policy or in filing a claim for Policy benefits, We have the right to demand that Covered Person pay back to Us all benefits that We paid during the time the Covered Person was insured under the Policy.

CHANGE OF BENEFICIARY: You have the right to change the Beneficiary by giving Us notice, in writing, of such change. The consent of the Beneficiary or Beneficiaries shall not be requisite to surrender or assignment of this Policy or to any change or Beneficiary or Beneficiaries, or to any other changes in this Policy.

CONDITIONS PRIOR TO LEGAL ACTION: On occasion, We may have a disagreement related to coverage, benefits, premiums, or other provisions under this Policy. Litigation is an expensive and time-consuming way to resolve these disagreements and should be the last resort in a resolution process. Therefore, with a view to avoiding litigation, You must give written notice to Us of Your intent to sue Us as a condition prior to bringing any legal action. Your notice must:

A. Identify the coverage, benefit, premium, or other disagreement;

B. Refer to the specific Policy provision(s) at issue; and

C. Include all relevant facts and information that support Your position.

Unless prohibited by law, You agree that You waive any action for statutory or common law extra-contractual or punitive damages that You may have if the specified contractual claims are paid, or the issues giving rise to the disagreement are resolved or corrected, within 30 days after We receive Your notice of intention to sue Us.

NON-CONTRACTUAL BENEFITS: We may make arrangements to offer Covered Persons with additional health information resources. In addition, We may arrange for third party service providers to provide discounted goods and services to Covered Persons. This is not an insurance benefit.

While We may make arrangements to offer these resources, goods, services, and/or third party service provider discounts, the third party service providers are liable to Covered Persons for providing such resources, goods, services, and/or discounts. We are not responsible for such resources, goods, services, and/or discounts nor are We liable for the failure of providing such resources, goods, services, and/or discounts. Further, We are not liable to Covered Persons for the negligent provision of such resources, goods, services and/or discounts by third party service providers.