Loyal American Life Insurance Company®

Administrative Office: 5508 Parkcrest Drive, P.O. Box 559004, Austin, TX 78755-9004
Toll Free: 1-800-663-6752

CERTIFICATE OF CANCER EXPENSE INSURANCE
This certificate offers Limited Benefit Supplemental Heath Insurance Coverage.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If any proposed Insured Person is eligible for Medicare, such person should review the "Guide to Health Insurance for People with Medicare" available from the Company.

PART A INSURING CLAUSE

Loyal American Life Insurance Company (hereinafter referred to as We, Us or Our) agrees with the Named Insured (herein referred to as You, or Your) to cover each Insured Person identified in the issued Certificate of Cancer Insurance and any associated riders (hereinafter, "Certificate") for any covered loss described in the Certificate in return for payment of premiums and subject to the provisions, limitations and exclusions that follow. This certificate is executed as of the Certificate Effective Date and from which anniversary dates are measured. This Certificate takes effect at 12:01 A.M. Standard Time on the Certificate Effective Date at the address of the Certificate holder.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE ENROLLMENT FORM

The issuance of this Certificate is based upon Your answers to the questions on the enrollment form. A copy of the enrollment form is attached to this Certificate. If Your answers are materially incorrect or untrue, We may have the right to deny benefits or rescind this Certificate, subject to the Time Limit on Certain Defenses provision. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, please contact Us at this address 5508 Parkcrest Drive, P.O. Box 559004, Austin, Texas 78755-9004.

NOTICE OF 30-DAY RIGHT TO EXAMINE POLICY

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

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THIS IS A LIMITED BENEFIT CERTIFICATE — READ IT CAREFULLY.
NO BENEFITS WILL BE PROVIDED DURING THE FIRST YEAR IMMEDIATELY FOLLOWING THE EFFECTIVE DATE OF COVERAGE FOR ANY CLAIMS RESULTING FROM PRE-EXISTING CONDITIONS

This Certificate is governed by the laws of the state in which this master group cancer expense policy was issued and delivered.

Signed for Us on the Certificate Effective Date.

Secretary

President

FOR PUBLIC RELEASE

-TABLE OF CONTENTS-

	page
Certificate Schedule	3
PART B Definitions	4-9
PART C Eligibility and Effective Date	9
PART D Dependent Provisions	10
PART E Benefits	10-14
PART F Exclusions and Limitations	14-15
PART G Premiums	15
PART H Termination Provisions	15-16
PART I How to File a Claim	16
PART J Time of Payment of Claims	16-17
PART K Payment of Claims	17
PART L Assignability	17
PART M General Information	17-18

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GROUP CANCER EXPENSE CERTIFICATE OF INSURANCE CERTIFICATE SCHEDULE

POLICYHOLDER: [ABC, Inc.]

CERTIFICATE HOLDER [John Doe]

CERTIFICATE NUMBER: [LGC0012345]

TYPE: [FAMILY]

PRIMARY INSURED: [John Doe]

CERTIFICATE EFFECTIVE DATE: [March 1, 2007]

STATE OF ISSUE: [TEXAS]

PRIMARY INSURED'S AGE AT ISSUE: [32]

Coverage	Maximum Benefit Amount	Annual Premium
Base Policy	Base Policy Benefits	$[XXX]
Optional Benefit Riders		
Annual Cancer Screening Benefit Rider	[$25, $50, $75, $100, $125] Per Calendar Year	$[XXX]
First Occurrence Benefit Rider	[$500, $1,000, $1,500, $2,000, $2,500, $3,000, $3,500, $4,000, $4,500, $5,000, $5,500, $6,000, $6,500, $7,000, $7,500, $8,000, $8,500, $9,000, $9,500, $10,000] Lifetime Maximum	$[XXX]
Surgical Benefits Rider	[$500, $1,000, $1,500, $2,000, $2,500, $3,000, $3,500, $4,000, $4,500, $5,000, $5,500, $6,000, $6,500, $7,000, $7,500, $8,000, $8,500, $9,000, $9,500, $10,000] Per Schedule	$[XXX]
Daily Hospital Confinement Benefit Rider	[$100, $150, $200, $250, $300, $350, $400, $450, $500, $550, $600] Per Day	$[XXX]
Annual Radiation Treatment, Chemotherapy, Immunotherapy and Experimental Treatment Benefit Rider	[$2,500, $5,000, $7,500, $10,000, $12,500, $15,000, $17,500, $20,000] Per Calendar Year	$[XXX]
Daily Radiation Treatment, Chemotherapy, Immunotherapy and Experimental Treatment Benefit Rider	[$200, $300, $400, $500, $600, $700, $800, $900, $1,000] Per Day	$[XXX]
First Occurrence Building Benefit Rider	$100, $200, $300, $400, $500, $600] Per Year	$[XXX]
Hospital Intensive Care Unit Benefit Rider	[$100, $150, $200, $250 $300, $350 $400, $450, $500, $550, $600, $650, $700, $750, $800, $850, $900, $950, $1,000] Per Day	$[XXX]
Specified Disease Benefit Rider **Initial Hospitalization Benefit** **Hospital Confinement Benefit**	 $ 1,500 Per Calendar Year $ 300 per Day for 1st 30 days $ 600 per Day for 31 or more days of continuous confinement	$[XXX]
Premium Mode: [Payroll-Monthly]	**Total Annual Premium Amount:** **Total Modal Premium Amount:**	$ $

FOR PUBLIC RELEASE

PART B DEFINITIONS

When We use the following words, this is what We mean:

"Actual Charge" means the amount actually paid by or on behalf of the Insured Person and accepted by a provider for services provided. The amount the Insured Person is legally required to pay the provider for the covered services would be considered the Actual Charge. The negotiated fee, if any, between a managed care organization including but not limited to a preferred provider organization or Medicare would be considered the Actual Charge.

"Age" means Age last birthday of an Insured Person.

"Ambulatory Surgical Center" means a facility, within the United States, primarily licensed to provide elective or Outpatient surgical care and discharges each patient within the same working day. An Outpatient surgical unit of a Hospital also meets this criteria.

"Applicant" means the person first named as applicant in the Enrollment Form for a Certificate of Cancer Expense Insurance under this group policy.

"Audiologist" means anyone, other than an Immediate Family Member, who is licensed and certified to provide therapy to the hearing impaired.

"Calendar Year" means a period of 12 consecutive months starting on January 1 and ending on December 31 of the same year.

"Cancer" means a disease manifested by the presence of a malignant tumor that is characterized by the uncontrolled growth and spread of malignant cells that invade tissue, blood or the lymphatic system. This includes leukemia, Hodgkin's Disease, lymphoma, carcinoma, sarcoma or malignant tumor. Cancer also means Cancer In Situ, a malignant tumor that is confined to the site of origin, the cells of which have not invaded surrounding tissue. Cancer does not include other conditions which may be considered precancerous, including but not limited to, leukoplakia, actinic keratosis, carcinoid, hyperplasia, polycythemia, nonmalignant melanoma, moles or similar disease or lesions.

Such Cancer must be positively diagnosed by a Physician certified by the American Board of Pathology or the Osteopathic Board of Pathology to practice Pathologic Anatomy; and such diagnosis is on the basis of microscopic examination of fixed tissue or preparations from the blood system (either during life or post mortem). The diagnosis of Cancer must be based solely on the criteria of malignancy established by the American Board of Pathology. Clinical diagnosis of Cancer will be accepted as evidence that Cancer exists in a an Insured Person when a pathological diagnosis cannot be made, provided such medical evidence substantially documents the diagnosis of Cancer and the Insured Person receives treatment for Cancer.

"Cancer Treatment Center" means a Chemotherapy Treatment Center or Radiation Treatment Center.

"Certificate Anniversary" means the same day and month as the Certificate Effective Date shown in the Certificate Schedule for each year the Certificate remains in force.

"Certificate Effective Date" means the day on which coverage under the Certificate begins and is shown on the Certificate Schedule.

"Charity Hospital" means a Hospital which, in the absence of insurance, does not normally make a charge for its services.

"Chemotherapy" means a drug that: (a) it modifies, destroys, slows the growth, or prevents the spread or recurrence of Cancer cells; and (b) it is approved by the United States Food and Drug Administration to treat Cancer in humans.

"Chemotherapist" means a person who is licensed to administer Chemotherapy or Immunotherapy drugs in the State where such drugs are administered to the Insured Person.

FOR PUBLIC RELEASE

“Chemotherapy Treatment Center” means a Clinic or Outpatient section of a Hospital specializing in the treatment of Cancer with Chemotherapy or Immunotherapy on an Outpatient basis. It must be licensed by the State in which it operates.

“Clinic” means a place operating under the applicable state law or licensing requirements where specialized medical treatment is given.

“Colony Stimulating Factor” means substances that stimulate the production of blood cells or platelets. They must be approved by the United States Food and Drug Administration for use in human Cancer patients being treated with Radiation Treatment, Chemotherapy, or Immunotherapyany. Colony Stimulating Factors include, but are not limited to, granulocyte colony stimulating factors and granulocyte-macrophage colony stimulating factors, erythropoietin, epoetin alfa, darbepoetin, filgrastim, pegfilgrastim and sargramostin.

“Common Carrier” means only the following: commercial airline, passenger train, or bus line between cities. It does not include: taxis, city bus lines, or private charter airplanes.

“Convalescent Care Facility” means an institution that:

(a) is legally operated to provide care and treatment to sick and injured persons at their expense;
(b) is primarily engaged in providing skilled care under the supervision of a Physician during a period of convalescence for sickness or injury;
(c) provides 24-hour nursing services by or under the supervision of Registered Nurses on duty or call; and
(d) maintains a medical record of each patient.

Convalescent Care Facility **does not mean** a home or facility that is used primarily for rest; or provides care and treatment for drug addicts, alcoholics or the mentally ill; or primarily provides custodial or educational care**.**

“Date of Diagnosis” means the later of:

(a) the day the tissue specimen is taken;
(b) the day the definitive diagnostic test is performed that confirms a positive diagnosis when preformed by a Pathologist; or
(c) the day the Positive Diagnosis of Cancer, or one of the listed Specified Diseases if such optional rider is issued, is pronounced when a clinical diagnosis is made.

“Dependent” means any of the following persons:

1. The Eligible Member’s lawful spouse; and
2. any unmarried child, stepchild or adopted child of the Eligible Member who has not attained the age of 25, and is:
    (a) under 25 years of age on the date of enrollment; or
    (b) born after the date of enrollment and any applicable additional premium is paid before the 32nd day after the child's birth; or
    (c) adopted by the Eligible Member or who becomes the Eligible Member’s stepchild before that child’s 25th birthday; and
3. A child for whom the Eligible Member is required to provide insurance under a medical support order or an order enforceable by a court; and
4. Any unmarried child of the Eligible Member’s child, if such child is younger than 25 years of age and is dependent on the Eligible Member for federal income tax purposes at the time of enrollment for coverage of the child.

If the Eligible Member is a party in a suit in which the adoption of the child is sought by the Eligible Member, that child will be deemed to be “adopted”. Also, if the Eligible Member becomes a legal guardian of a foster child, that child will be treated as an adopted child so long as: the Eligible Member continues as the child’s legal guardian; the child is living with the Eligible Member and is dependent upon the Eligible Member for support; and all other requirements of the certificate are met.

“Divorce/Divorced” means annulment or the dissolution of marriage.

FOR PUBLIC RELEASE

"Effective Date" means the date an individual Insured Person's coverage begins under this Certificate and is the latest of: (1) the Certificate Effective Date as shown on the Certificate Schedule page; or (2) the date shown on the endorsement or amendment adding the Insured Person to coverage under this Certificate.

"Eligible Member(s)" mean persons who satisfy the eligibility requirements of this group policy as described in PART C – Member Eligibility and Effective Date or PART D – Dependent Provisions.

"Eligible Family Member" means a person for whom the Eligible Member furnishes satisfactory Evidence of Insurability who is either the Eligible Member's spouse or a dependent child.

"Enrollment Form" means that document, signed by an Eligible Member, containing the member's answers to Our questions and the member's representations, which We accepted in good faith as being true, complete and correct, to the best of the member's knowledge and belief. The Enrollment Form is the basis upon which We issued this Certificate of Cancer Expense Insurance and it is attached to and made a part of this Certificate.

"Evidence of Insurability" means a statement of a proposed Insured's medical history which We will use to determine if he or she is approved for coverage. Evidence of Insurability will be provided at the Eligible Member's expense.

"Experimental Treatment" means chemotherapy, or immunotherapy drugs not yet approved by the United States Food and Drug Administration for the treatment of Cancer which are the subject of ongoing clinical studies sponsored and funded by the National Cancer Institute to determine their toxicity, safety, efficacy or their efficacy compared to standard means of treatment. Treatment must be received in the United States or its territories and administered by an Oncologist as defined in this Policy and any issued Certificate. The Oncologist must certify, to the best of his or her knowledge and belief, that no other treatment having United States Food and Drug Administration approval is superior to the proposed Experimental Treatment.

"Government Hospital" means a hospital operated by or for an agency of the United States Government.

"Home Health Care" means the care and treatment of an Insured Person at his or her place of residence. Home Health Care is provided only if hospitalization or confinement in a Convalescent Care Facility would otherwise have been required. A plan establishing the necessary Home Health Care Services must be approved in writing by the attending Physician. Home Health Care Services must be provided by an agency that meets the qualifications set out below.

"Home Health Care Agency" means entity licensed to provide Home Health Care Services under applicable state law, or, in the absence of such state law, an entity that meets the following requirements:

(a) it must be primarily engaged in providing Home Health Care Services;
(b) its policies must be established by a group of professional personnel, including at least one Physician and one Registered Nurse;
(c) supervision of Home Health Care Services must be performed by a Physician or Registered Nurse;
(d) it must maintain clinical records on all patients;
(e) it must have a full time administrator.

"Home Health Care Services" means:

(a) part-time or intermittent home nursing care provided by or under the supervision of a Registered Nurse;
(b) part-time or intermittent home health aide services that consists primarily of caring for the patient; and
(c) medical supplies and equipment suitable for home use.

Home Health Care Services **does NOT mean:** (a) services or supplies not included in the Home Health Care plan; (b) services of a person who is an Immediate Family Member; (c) custodial care; (d) services or supplies for personal comfort or convenience; (e) food service or meals; or (f) transportation services.

"**Hormonal Therapy"** means a drug that adds, blocks, or removes hormones to slow, stop the growth of or prevent the recurrence of Cancer cells. It must be approved by the United States Food and Drug Administration to treat Cancer in humans.

FOR PUBLIC RELEASE

"Hospice Center" means a facility that provides short periods of confinement for terminally ill patients. A Hospice Center must operate a program of hospice care that meets the standards set forth by the National Hospice Organization. It must also be directed by a Physician, supervised by a Registered Nurse, and licensed or certified by the state in which it is located.

"Hospice Team" means a team of professionals including a Physician and a Nurse. It may also include a social worker, clergyman, clinical psychologist, physical therapist, or counselor. It must exist primarily to administer a hospice care program meeting the standards of the National Hospice Organization in the patient's home. Care must be available 24 hours a day, seven days a week.

"Hospital" means an institution that:

(a) operates as a Hospital pursuant to law;
(b) operates primarily for the reception, care and treatment of sick or injured persons as Inpatients;
(c) provides 24-hour nursing service by Registered Nurses on duty or on call;
(d) has a staff of one or more Physicians available at all times;
(e) provides organized facilities for diagnosis, treatment and surgery either on its premises or in facilities available to it on a pre-arranged basis.

Hospital **does NOT include** the following: (a) convalescent homes or convalescent, rest or nursing facilities; (b) facilities primarily affording custodial, educational or rehabilitative care; or (c) facilities for the aged, drug addicts or alcoholics.

"Immediate Family Member" means the Eligible Member and the Eligible Member's spouse or the parent, child, brother or sister of the Eligible Member or the Eligible Member's spouse.

"Immunoglobulin" means a protein naturally made by plasma cells in response to an antigen (foreign substance). The protein helps destroy the antigen. For the purposes of this Policy or any issued Certificate, the protein may be either natural or recombinant but it must be approved by the United States Food and Drug Administration for use in treating Cancer in humans.

"Immunotherapy" means a drug including a biological response modifier, biological therapy or biotherapy that meets the following criteria: (1) it stimulates or restores the ability of the immune system to modify, destroy or aid in the prevention of the spread of Cancer cells and (2) it is approved by the United States Food and Drug Administration to treat Cancer in humans. Immunotherapy **does NOT include** Immunoglobulin.

"Incapacitated Child" means a Dependent child who becomes incapable of self-support because of physical impairment or mental retardation while an Insured Person and before attaining Age 25 and who is primarily dependent on the Eligible Member or the Eligible Member's spouse for support and maintenance and is unmarried.

"Inpatient" means the Insured Person who is confined in a Hospital using and being charged for daily room and board.

"Insured Person" means the Eligible Member and the Eligible Member's Eligible Family Members whose coverage under this Certificate has become effective and such coverage has not been terminated.

If the Type of Coverage shown on the Certificate Schedule is **Individual**, the Eligible Member's Newborn Child or the Eligible Member's Newly Adopted Child will become an Insured Person for a period of 31 days commencing with the moment of birth or adoption. Thereafter the Newly Adopted Child or Newborn Child will be considered a Dependent child who is an Eligible Family Member and insurance will continue past the 31 days only if the Eligible Member gives Us written notice of the birth or adoption within the 31 day period and pays the additional premium required.

If the Type of Coverage shown on the Certificate Schedule is **Single Parent** or **Family**, the Eligible Member's Newborn Child or the Eligible Member's Newly Adopted Child will become an Insured Person commencing with the moment of birth or adoption. Thereafter the Newborn Child or Newly Adopted Child will be considered a Dependent child who is an Eligible Family Member.

FOR PUBLIC RELEASE

“Internal Cancer” means Cancer that is not Skin Cancer.

“Local or Locally” means within 30 miles, one way, of the Insured Person’s usual place of residence.

“Named Insured” means the person accepted for coverage by Us who has completed and signed the Enrollment Form. This is the person whose name appears on the Certificate Schedule as “Named Insured.”

“Newborn Child” means any child born to the Eligible Member or the Eligible Member’s insured Spouse after the Certificate Effective Date.

“Newly Adopted Child” means a child who is: (a) adopted by the Eligible Member after the Certificate Effective Date; or (b) a child who has been placed with the Eligible Member after the Certificate Effective Date and for whom the application and approval procedures prescribed by law for adoption have been completed.

“Non-Local or Non-Locally” means more than 30 miles, one way, and less than 700 miles, one way, from the Insured Person’s usual place of residence.

“Nurse” means any one of the following who is not one of the Insured Person’s Immediate Family Members: a graduate Registered Nurse (R.N.); or a Licensed Practical Nurse (L.P.N.); or a Licensed Vocational Nurse (L.V.N.). With respect to the benefits provided under any issued Certificate, Nurse will not include an R.N., L.P.N., or L.V.N. who is employed by the Hospital where the Insured Person is confined.

“Oncologist” means a Physician certified to practice in the field of Oncology.

“Outpatient” means the Insured Person is not confined in a Hospital.

“Pathologist” means a Physician who has been certified by either the American Board of Pathology, the Osteopathic Board of Pathology, or the American Board of Dermatopathology to practice pathological anatomy.

“Period of Hospital Confinement” means the period of consecutive days that the Insured Person is confined as an Inpatient in a Hospital on the advice and recommendation of a Physician. It begins on the date the Insured Person is admitted to the Hospital as an Inpatient and ends on the Insured Person’s date of discharge, unless discharge is for the purpose of immediate readmission to another Hospital.

“Physician” means a practitioner of the healing arts, including a nurse practitioner, duly licensed, practicing in the United States and legally qualified to treat sickness or injuries. Such person must not be the Insured Person, an Insured Person’s Immediate Family Member or a business associate. He or she must be providing services within the scope of his or her license, and must be a board certified specialist where required by any issued Certificate. Practitioners of homeopathic, naturopathic and related medicines are not considered eligible Physicians.

“Pre-existing Condition(s)” 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 one year prior to the Effective Date of coverage for each Insured Person.

“Proposed Insured” means any person named in an Enrollment Form for insurance.

“Radiation Treatment” means x-ray therapy, gamma ray therapy, particle beam therapy, proton beam therapy, or intensity-modulated radiation therapy**,** brachytherapy, radioactive isotopes therapy, radioactive iodine, cobalt, palladium, cesium or iridium that is approved by the United States Food and Drug Administration for the treatment of Cancer in humans and is used to modify, destroy, slow the growth or prevent recurrence of Cancer cells. The treatments discussed above must not be used for diagnostic or planning purposes.

“Radiation Treatment Center” means a Clinic or outpatient section of a Hospital specializing in Radiation Treatment of Cancer on an Outpatient basis.

FOR PUBLIC RELEASE

“Radiation Therapist” means a Physician, Nurse or other medical personnel who are licensed to administer external or internal radiation. The medical professional must also be certified by the American Board of Radiology to administer therapeutic radiation.

“Rating Class” means a population segment classified by actuaries as having similar insurance risk characteristics, such as issue age, gender, underwriting classification, benefit category, issue state, and health status of the insured at the time the Certificate was purchased.

“Renewal Date” means the date any premium, after the first premium, for the Certificate is due.

“Skin Cancer” means basal cell carcinoma, basal cell epithelioma, squamous cell carcinoma, or melanoma of Clark’s Level I or II or Breslow level equal to or less than 1.5 mm.

“Substantially Similar Group Policy” means a policy of group Cancer Expense insurance issued to the Policyholder and insuring persons in the same Rating Class of Eligible Members as the group policy under which this Certificate was issued. Eligibility for initial coverage under the Substantially Similar Group Policy must be conditioned by the existence of an employer-employee relationship and persons insured must be issued a certificate of insurance. It does not mean an individual type of an insurance policy issued on a payroll or salary deduction basis or otherwise to an employee of the Policyholder, even if premiums for the policy are paid under a Section 125 Cafeteria Plan.

“Tentative Diagnosis” means a diagnosis by a qualified Physician, based on the Physician’s experience, training and expertise, when a Positive Diagnosis cannot be made due to medical reasons**.**

“Terminally Ill” means the Insured Person has a life expectancy of 6 months or less.

“Total Disability / Totally Disabled” means that, as a result of Cancer, the Eligible Member is:

(a) unable to perform all of the substantial or material duties of the Eligible Member’s regular occupation during the first two years beginning with the commencement of such disability;

(b) unable to engage in any employment or occupation for which the Eligible Member is or becomes qualified by reason of education, training or experience after the first two years beginning with the commencement of such disability; and

(c) under the care of a Physician.

If 60 days or less separate two periods of Total Disability for the same Cancer, the second will be a continuation of the first.

“We, Our, Us, or Company” means Loyal American Life Insurance Company.

PART C MEMBER ELIGIBILITY AND EFFECTIVE DATE

ELIGIBLE MEMBER: means a member of the Policyholder as described in the master Group Cancer Expense Policy.

EFFECTIVE DATE: This Certificate begins on the Certificate Effective Date shown on the Certificate Schedule page at 12:01 AM Standard Time at the address of the Certificate holder where this Certificate is delivered.

Coverage with respect to any Insured Person can never become effective until after the Eligible Member has submitted to Us the required written Enrollment Form along with any premium due, unless the Policyholder has payroll deduction facilities available and acceptable to Us. If such payroll deduction facilities are available and acceptable to Us, premium will be remitted per PART G – Premiums.

FOR PUBLIC RELEASE

PART D DEPENDENT PROVISIONS

TYPE OF COVERAGE: The Type of Coverage issued is as shown on the Certificate Schedule.

1. **Individual:** coverage means that only the primary insured, as named on the Certificate Schedule is covered.
2. **Single Parent:** coverage means that the primary insured and his or her eligible Dependent children are covered.
3. **Family:** coverage means that the primary insured, his or her spouse, and the eligible Dependent children of the primary insured or those of the spouse are covered.

ELIGIBLE DEPENDENTS: At the time of Certificate issue, only the spouse and eligible Dependants listed by name on an underwriting approved Enrollment Form and who were not excluded from coverage by an issued exclusionary endorsement are insured under this Certificate.

After the Certificate Effective Date, a spouse or eligible Dependents (other than newborn or adopted children who are temporarily covered under the "Newborn and Adopted Children" provision below) may be added to coverage by endorsement, subject to acceptance by Us of the written Enrollment Form and payment of any required premium. These persons, added as Insured Persons by endorsement, will be covered after the effective date of such endorsement.

NEWBORN AND ADOPTED CHILDREN: Any child of the primary insured or a covered spouse born or adopted, or a child who has been placed with the primary insured and for whom the application and approval procedures prescribed by law for adoption have been completed, while coverage under this Certificate is in force will be immediately covered as an Insured Person from the moment of birth, adoption or placement for adoption for 31 days from the moment of birth, adoption or placement for adoption.

In order for coverage to continue beyond such date, We must receive written notice of the birth, adoption or placement for adoption of the newborn, adopted child or child placed for adoption; and any required additional premium. Please include the child's name, date of birth and sex with such notice. If the required notice is not received by Us during the 31 day period, a newborn or adopted child may be covered after this date only if the following conditions are met: (a) an insured member's written Enrollment Form for coverage is approved by Us; and (b) the payment of any required premium is made.

PART E BENEFITS

We will pay the benefits as described below 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 Certificate and/or rider and the Certificate and/or rider remains in force. Payment will be made in accordance with all applicable Certificate and/or rider provisions. Benefits are payable for a positive diagnosis that begins after the Certificate Effective Date. The positive diagnosis must be for Cancer as defined in this Certificate, or for a Specified Disease as defined in an attached rider.

All benefits are subject to terms and conditions of this Certificate and/or an attached Specified Disease rider. If Cancer or a listed Specified Disease is diagnosed while 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 the Eligible Member. Admission to the Hospital must begin after the Certificate 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 after the Certificate Effective Date of coverage.

FOR PUBLIC RELEASE

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 this Certificate. 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 this Certificate.

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 this Certificate or 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 Certificate 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.

FOR PUBLIC RELEASE

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 this Certificate.

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.

FOR PUBLIC RELEASE

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 Persons 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 this Certificate.
(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.

FOR PUBLIC RELEASE

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 the Certificate; 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.

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.

PART F 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 Certificate Effective Date of an Insured Person's coverage regardless of the Date of Positive Diagnosis.

Pre-Existing Condition(s) Limitation

Subject to the Group Cancer Expense Policy Replacement of Prior Carrier provision below, the benefits of this Certificate will not be payable during the first 12 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 Enrollment Form. This 12-month period is measured from the effective date of coverage for each Insured Person.

Group Cancer Expense Policy Replacement of Prior Carrier

If an Insured Person has a loss due to a Pre-Existing Condition and the Policyholder changed the prior group cancer expense insurance carrier to Loyal American Life Insurance Company, We may pay benefits if an Insured Person’s loss results from a Pre-Existing Condition if the primary insured was:

1. in active employment with the Policyholder and both the primary insured and the Insured Person are insured under the Loyal American Group Cancer Expense Policy on the Policy Effective Date; and
2. both the primary insured and the Insured Person were insured under the prior group cancer expense policy when it terminated.

The prior group cancer expense policy’s coverage must be under a Substantially Similar Group Policy to the Loyal American Group Cancer Expense Policy. The prior group policy must also have been in effect within 60 days of the Loyal American Policy’s Effective Date in order for this provision to apply.

In order to receive benefits the Insured Person must satisfy the Pre-Existing Condition(s) provision under either:

1. the Loyal American Group Cancer Expense Policy; or
2. the prior group cancer expense policy, if benefits would have been paid had that policy remained in force.

FOR PUBLIC RELEASE

If such Insured Person does not satisfy either item # 1 or # 2 above, We will not pay any benefits for a loss resulting from Pre-Existing Condition(s). If the Insured Person satisfies either item # 1 or # 2 above, We will determine Our benefit payments according to Our Policy provisions.

PART G PREMIUMS

Coverage is in consideration of and subject to payment of the first premium. An insured member's first premium and premium payment mode is shown in the Certificate Schedule. Subsequent premiums are due and payable on the premium due date. We reserve the right to change the premium rates by Class on any premium due date after the first policy anniversary. We must give advanced written notice to the Policyholder of any premium change.

If payroll deduction facilities are available to an insured member, the premium will be deducted from such person's pay and remitted to the Us. If there are no payroll deduction facilities available to an insured member, premiums must be remitted directly to Us.

GRACE PERIOD: We grant a grace period of 31 days for each premium payment due after the first premium payment. Coverage remains in force during the grace period unless an insured member or the Policyholder has given Us written notice of the insured member's cancellation. There is no grace period if We have been given such a cancellation notice.

PART H TERMINATION PROVISIONS

Termination of coverage will not affect any claim for a covered loss that occurred while coverage was in force.

GROUP POLICY: Either the Policyholder or We may terminate this group policy by giving an advance written 30-day notice to the other party.

TERMINATION OF AN INSURED MEMBER'S COVERAGE: Coverage for an insured member will terminate on the date premiums are not received when due, subject to the GRACE PERIOD provision; or on the date the group policy terminates.

TERMINATION OF DEPENDENT COVERAGE: Coverage for a Dependent will terminate on the date the insured member's coverage terminates, except when coverage continues with the insured member's Spouse as the new insured member. Coverage for Dependent persons may also terminate as explained in the following paragraphs.

Coverage for each Dependent child will terminate on the renewal date following the earlier of: (a) his or her attainment of the limiting age as stated in Part D Dependent Provisions; or (b) marriage. It is the Certificate holder's obligation to notify Us if and when either of these events occur.

Our acceptance of premium after such termination date will be considered as premium only for the remaining persons who qualify for coverage. Our liability will be limited to a refund of any subsequent overpayment. If a Certificate holder's premium needs to be changed due to the termination of Dependent coverage, he or she should notify Us and We will adjust it accordingly.

If a Dependent child reaches the termination date stated above and continues to be both: (a) incapable of self-sustaining employment by reason of mental incapacity or physical handicap; and (b) remains dependent upon the Certificate holder for support and maintenance; and (c) the Certificate holder notifies Us about this, coverage for such child will continue while the Certificate is in force and so long as such incapacity continues and the applicable premium is paid. Satisfactory proof must be submitted to Us within 31 days of such termination date. We may request this proof periodically at Our discretion following a child's attainment of the limiting age.

CONTINUATION OF COVERAGE: If an insured member is no longer affiliated with Policyholder, We agree thereafter to renew the previously issued Certificate coverage for each term as long as such insured member continues to pay the required premium when due and the group policy remains in force. The insured member must notify Us of the change in status within 31 days of such change. Direct premium payments will begin following the end of the period for which premium has been paid.

If an insured member dies while his or her Spouse is an Insured Person under this Certificate, We agree thereafter to renew the coverage for each term, with such Spouse as the new insured member, as long as such Spouse lives and pays the required premium before the end of the grace period and the group policy remains in force. Direct premium payments will begin following the end of the period for which premium has been paid.

DIVORCE: If an insured member divorces his/her Spouse, and his/her Spouse is named as an Insured Person on the Enrollment Form for this coverage, or was made an Insured Person pursuant to Certificate endorsement procedures, the insured member must provide Us with an actual, written notice of said divorce. Coverage for a Spouse or ex-spouse, if an Insured Person, will terminate 30 days following the date We receive actual, written notice from the insured member or his/her insured Spouse of a divorce between the insured member and his/her insured Spouse, regardless of the date of the divorce decree. An insured member may not add a new Spouse as an Insured Person under any issued Certificate until his/her covered ex-spouse has been terminated from the insured member's coverage pursuant to these procedures.

PART I HOW TO FILE A CLAIM

NOTICE OF CLAIM: Written notice of claim must be given to Us within 30 days after any loss covered by this Certificate, while it was in force, occurs or starts. If notice is not given within that time, it must be given as soon as reasonably possible. Notice must be received by Us at our Administrative Office in Austin, Texas. It should include the insured member's name and Certificate number.

CLAIM FORMS: When We receive the notice of claim, We will send the claimant forms for filing proof of loss. If these forms are not sent to the claimant within 15 days, the claimant will be deemed to have met the proof of loss requirement by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof of loss must be given to Us within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one year from the time specified unless the claimant was legally incapacitated.

PART J TIME OF PAYMENT OF CLAIMS

All benefits payable under this Certificate for any loss, other than loss for which this Certificate provides any periodic payment, will be paid within thirty-five (35) days after receipt of due written proof of such loss in the form of clean claim.

Claims for benefits due under this Certificate are overdue if not paid within thirty-five (35) days after We receive a clean claim containing necessary medical information and other information essential for Us to administer Pre-existing Conditions and determine Actual Charges.

A **"clean claim"** means a claim We receive for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the insured in order to be processed and paid by Us. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. A clean claim does not include any of the following:

(a) A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim;
(b) Claims which are submitted fraudulently or that are based upon material misrepresentations;
(c) Claims that require information essential for Us to administer Pre-existing Conditions or determine Actual Charges; or
(d) Claims submitted by a provider more than thirty (30) days after the date of service. If the provider does not submit the claim on behalf of the insured, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the provider to the insured.

FOR PUBLIC RELEASE

Not later than thirty-five (35) days after the date We receive a claim, We shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider or the insured of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by Us shall be paid within twenty (20) days after receipt.

PART K PAYMENT OF CLAIMS

All benefits will be paid to the Certificate holder or to his or her estate.

PART L ASSIGNABILITY

Neither this Certificate nor any benefits payable are assignable.

PART M GENERAL INFORMATION

ENTIRE CONTRACT: This Certificate is a legal contract between the Certificate holder and Us. The entire contract with the Certificate holder consists of the Certificate, which includes the Enrollment Form, and any attached riders, endorsements or papers. No change in this Certificate will be effective until approved by one of Our officers. Such officer approval must be noted on or attached to the Certificate. No agent has any authority to change this Certificate or to waive any of its provisions. All statements in the Enrollment Form are deemed representations and not warranties.

INCONTESTABILITY: We will not contest the validity of this Certificate after it has been in force for two years from the Certificate Effective Date.

CLERICAL ERROR: Clerical error on the part of the Policyholder will not void coverage that would otherwise be in force or continue coverage that would otherwise have terminated.

CONFORMITY WITH STATE STATUTES: On the Certificate Effective Date, if any contract provision conflicts with the laws of the state of issue, it shall be deemed to conform to such law.

CERTIFICATE SCHEDULE: The Schedule and information it shows is a part of the Certificate as if it preceded the execution clause.

TIME LIMIT ON CERTAIN DEFENSES: After two years from the date a person becomes covered under this Certificate We cannot use misstatements, except fraudulent misstatements, in the Enrollment Form to void coverage or deny a claim for loss that happens after the two-year period.

No claim for loss incurred after one year from the date a person becomes covered under this Certificate shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description existed prior to the effective date of such person’s coverage.

The above provisions also apply to riders attached to this Certificate. In applying them, the word “rider” will be used for the word “Certificate”.

LEGAL ACTIONS: An Insured Person cannot bring any action at law or in equity to recover under this Certificate for at least 60 days after he or she has given Us written Proof of Loss. No such action shall be brought after three (3) years from the time written Proof of Loss is required to be given.

FOR PUBLIC RELEASE

REINSTATEMENT: If any renewal premium is not paid within the time allowed for payment and We accept a premium without requiring an application for reinstatement, Our acceptance of that payment shall reinstate coverage under this Certificate. If We require an application, the Certificate will be reinstated when We approve the application. If We do not approve the application, the Certificate will be reinstated on the 45th day after the date of the application unless We notify the applicant in writing of its disapproval.

After two years from the date We reinstate the Certificate, We cannot use misstatements in the reinstatement application to void coverage or deny a claim for loss that happens after the two-year period. In all other respects the Certificate holder and We have the same rights under the Certificate as the Certificate holder and We both had before it lapsed, unless special conditions are added to the Certificate in connection with the reinstatement. Any premium accepted in connection with this provision will be used for a period for which payment has not been made, but not to any period more than 60 days before the date of reinstatement.

MISSTATEMENT OF AGE: If the age of an Insured Person has been misstated, an adjustment in premiums, coverage, or both, will be made based on the Insured Person's true age. No misstatement of age will continue insurance otherwise validly terminated or terminate insurance otherwise validly in force.

PHYSICAL EXAMINATION AND AUTOPSY: We have the right to have an Insured Person examined when and as often as is reasonable during the handling of a claim and to do any autopsy where it is not forbidden by law. If We initiate the request, either or both will be done at Our expense.

FOR PUBLIC RELEASE