Cigna Supplemental Solutions®
Insured by Loyal American Life Insurance Company

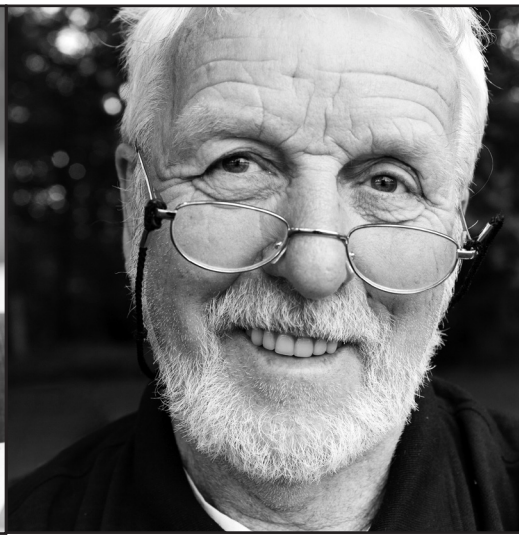
Flexible Choice

CANCER *and/or* HEART and STROKE INSURANCE

Customer Booklet for KANSAS

- OUTLINE(S) OF COVERAGE
- IMPORTANT NOTICE TO PERSONS ON MEDICARE
- REPLACEMENT NOTICE





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Cigna®

Loyal American
Life Insurance Company®
PO Box 5700, Scranton, PA 18505
Toll free: 866-459-4272

OUTLINE OF COVERAGE FOR
LUMP SUM CANCER INSURANCE POLICY
FORM LY-LSC-BA-KS

THE POLICY PROVIDES LIMITED BENEFITS.

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE
If an Insured Person is eligible for Medicare, please review the "*Guide to Health Insurance for People with Medicare*" which is available from the Company.

1. ***READ YOUR POLICY CAREFULLY!*** This Outline of Coverage provides a very brief description of the important features of Your policy. This is not the insurance policy and only the actual provisions of the policy will control the rights and obligations of the parties to it. The policy itself sets forth, in detail, those rights and obligations applicable to both You and LOYAL AMERICAN LIFE INSURANCE COMPANY. It is very important, therefore, that You READ YOUR POLICY CAREFULLY.

2. ***SPECIFIED DISEASE COVERAGE*** is designed to provide, to persons insured, restricted coverage providing benefits ONLY when certain losses occur as a result of specified diseases. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

3. ***CANCELLATION*** You may cancel this policy at any time by written notice delivered or mailed to us. Your cancellation will be effective upon receipt of your notice or on such later date as may be specified in such notice. In the event of Cancellation or death, we will promptly return the unearned portion of any premium paid by you. We will determine the amount of the refund, if any, by prorating the last modal premium paid from the date of the Cancellation until the next modal premium due date. Cancellation will be without prejudice to any claim originating prior to the effective date of Cancellation.

4. ***BENEFITS PROVIDED BY THE POLICY***

CANCER DIAGNOSIS BENEFIT Subject to the Reduction Schedule and Benefit Payment Conditions listed below, if an Insured Person receives a Diagnosis of Cancer from a Physician, We will pay You the Cancer Diagnosis Benefit Amount shown on the Policy Schedule Page or policy endorsement. This benefit is payable once per Insured Person per lifetime.

BENEFIT PAYMENT CONDITIONS Payment of the Cancer Diagnosis Benefit shall be subject to the following conditions:

a. Diagnosis must be made within the United States;
b. the Date of Diagnosis shall occur while the Insured Person is covered by the policy; and
c. payment shall be precluded by any general or specific exclusion, limitation, or reduction set forth in or attached to the policy (including, without limitation, the exclusion for any Pre-Existing Condition) or any failure by the Insured Person to meet any condition precedent.

REDUCTION SCHEDULE For any Cancer Diagnosed within the first thirty (30) days after the Policy Effective Date, the Cancer Diagnosis Benefit Amount shall be reduced. The reduced Benefit Amount for Cancer will be 10% of the Cancer Diagnosis Benefit Amount shown on the Policy Schedule Page or policy endorsement.

In the event an Insured Person is Diagnosed with Cancer within the first thirty (30) days following their Policy Effective Date and the reduced Benefit Amount for Cancer is paid, no other benefits shall be payable and coverage for that Insured Person under the policy will terminate.

5. EXCLUSIONS AND LIMITATIONS

In addition to any benefit-specific conditions, limitations, or exclusions, no benefits will be payable under the policy for:

a. any disease, Sickness, or incapacity other than Cancer as defined; this is so even though such disease, Sickness, or incapacity may have been complicated, affected (directly or indirectly), or caused by Cancer;
b. loss that begins prior to the Policy Effective Date;
c. Diagnosis received outside the United States or its territories, unless otherwise specified in the policy; or
d. any illness specifically excluded from the definition of Cancer or Carcinoma in Situ.

PRE-EXISTING CONDITION(S) The benefits of the policy will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Policy Effective Date for each Insured Person.

6. TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED

GUARANTEED RENEWABLE FOR LIFE The policy is guaranteed renewable for life. You may keep the coverage in force during Your lifetime by paying the premiums on time. We cannot cancel or refuse to renew the policy for any reason other than nonpayment of premium. At no time while You continue the policy in force may We place any restrictive Riders on it without Your permission.

7. OPTIONAL BENEFIT RIDERS *(additional premiums required)* - A checkmark in any of the boxes below indicates that You have selected the following optional coverage(s):

☐ **ACCIDENT FIXED INDEMNITY BENEFIT RIDER (Form #LY-LSAI-RD)**

ACCIDENT INJURY BENEFITS

BURN BENEFIT We will pay the Burn Benefit Amounts shown on the Benefit Schedule if any Insured Person suffers burns in a Covered Accident which require medical Treatment. The burns must be treated by a Physician within seventy-two (72) hours after the Covered Accident.

SKIN GRAFTS BENEFIT We will pay the Skin Graft Benefit Amount shown on the Benefit Schedule if any Insured Person receives one (1) or more skin grafts as the result of a Covered Injury suffered in a Covered Accident.

This benefit is only payable if a Burn Benefit is also payable.

COMA BENEFIT We will pay the Coma Benefit Amount shown on the Benefit Schedule if any Insured Person is Diagnosed and receives Treatment for a Coma as the result of a Covered Injury suffered in a Covered Accident. The Coma must:

a. be Diagnosed by a Physician within thirty (30) days after the Covered Accident; and
b. persist for at least seven (7) consecutive days.

This benefit is limited to one (1) Coma Benefit Amount per Insured Person per lifetime.

CONCUSSION (BRAIN) BENEFIT We will pay the Concussion (Brain) Benefit Amount shown on the Benefit Schedule if any Insured Person suffers a significant blow to the head in a Covered Accident which results in unconsciousness. The concussion must be Diagnosed by a Physician within seventy-two (72) hours after the Covered Accident using any type of medical imaging procedure such as an X-ray, CT (computerized tomography) scan, or MRI (magnetic resonance imaging).

This benefit is limited to one (1) Concussion Benefit Amount per Insured Person per Covered Accident.

DISLOCATION/SEPARATED JOINT BENEFIT We will pay the Dislocation/Separated Joint Benefit Amount shown on the Benefit Schedule if any Insured Person suffers a Dislocation as a result of a Covered Injury suffered in a Covered Accident. A Dislocation must:

a. be Diagnosed by a Physician within fourteen (14) days after the Covered Accident;
b. require correction with anesthesia by a Physician; and
c. be corrected by a Physician within ninety (90) days after the Covered Accident.

If an Insured Person suffers more than one (1) Dislocation in a Covered Accident, We will pay for multiple Dislocations. However, We will pay no more than 150% of the Dislocation/Separated Joint Benefit Amount for the separated joint involved which has the highest Dislocation/Separated Joint Benefit Amount.

If the Dislocation does not require anesthesia by a Physician, We will pay 25% of the Dislocation/Separated Joint Benefit Amount shown for the separated joint involved.

If a Physician Diagnoses the Dislocation as an incomplete Dislocation, We will pay 25% of the Dislocation Benefit Amount shown for the separated joint involved. An incomplete Dislocation is a Dislocation in which the joint is not completely separated.

We will pay this benefit only for the first (1st) Dislocation of a joint per Covered Accident. Subsequent Dislocations of the same joint will not be covered.

If an Insured Person suffers a Dislocation and a Fracture in the same Covered Accident, We will pay for both. However, We will pay no more than 150% of the Dislocation/Separated Joint Benefit Amount for the bone or joint involved which has the highest Dislocation/Separated Joint Benefit Amount.

EMERGENCY DENTAL WORK BENEFIT We will pay the Emergency Dental Work Benefit Amount shown on the Benefit Schedule if any Insured Person requires a dental extraction and/or crown to their sound, natural teeth as the result of a Covered Injury suffered in a Covered Accident. Sound, natural teeth does not include false teeth such as dentures, bridges, veneers, partials, crowns, or implants. Treatment by a Physician or dentist must begin within seventy-two (72) hours after the Covered Accident.

This benefit is limited to one (1) payment per Insured Person per Covered Accident.

EYE INJURY BENEFIT We will pay the Eye Injury Benefit Amount shown on the Benefit Schedule if any Insured Person suffers an eye injury as the result of a Covered Accident. The eye injury must require surgery or the removal of a foreign object by a Physician within ninety (90) days after the Covered Accident. An examination with anesthesia will not be considered surgery.

This benefit is limited to one (1) payment per Insured Person per Covered Accident.

If an Insured Person suffers an eye injury and later loses sight of the eye as a result of the same Covered Accident, We will subtract the amount We paid under the Eye Injury Benefit from the Accidental Dismemberment Benefit.

FRACTURE (BROKEN BONE) BENEFIT We will pay the Fracture (Broken Bone) Benefit Amount shown on the Benefit Schedule if any Insured Person suffers a Fracture injury as a result of a Covered Accident. A Fracture must:

a. be Diagnosed by a Physician within fourteen (14) days after the Covered Accident; and
b. be corrected by a Physician within ninety (90) days after the Covered Accident.

If an Insured Person suffers more than one (1) Fracture in a Covered Accident, We will pay no more than the amount for the two (2) bones involved which have the highest Benefit Amounts.

If a Physician Diagnoses the Fracture as a Chip Fracture, We will pay 25% of the Benefit Amount shown for the bone involved.

If an Insured Person receives a Fracture and a Dislocation in the same Covered Accident, We will pay for both. However, We will pay no more than 150% of the Benefit Amount for the bone or joint involved which has the highest Benefit Amount.

LACERATION BENEFIT We will pay the Laceration Benefit Amount shown on the Benefit Schedule if any Insured Person suffers a Laceration injury as a result of a Covered Accident. The Laceration must be repaired by a Physician within seventy-two (72) hours after the Covered Accident.

The amount We pay will be based on the total length of all Lacerations received in any one (1) Covered Accident which require repair. If the Laceration is severe enough to require stitches but the Physician chooses to repair it another way, We will treat it as if it were repaired without stitches.

If an Insured Person suffers a Laceration on their finger or toe and later loses that finger or toe as a result of the same Covered Accident, We will subtract the amount We paid under the Laceration Benefit from the Accidental Dismemberment Benefit.

PARALYSIS BENEFIT We will pay the Paralysis Benefit Amount shown on the Benefit Schedule if any Insured Person suffers Paralysis as a result of a Covered Injury suffered in a Covered Accident. The duration of the Paralysis must be a minimum of thirty (30) days.

This benefit is limited to one (1) payment per Insured Person per lifetime.

SURGICAL PROCEDURES BENEFIT We will pay the Surgical Procedures Benefit Amount shown on the Benefit Schedule if any Insured Person requires a surgical procedure as a result of a Covered Injury suffered in a Covered Accident. The surgical procedure must be performed within one (1) year of the Covered Accident.

Two (2) or more surgical procedures performed through the same incision will be considered one (1) operation and benefits will be paid based upon the surgical procedure with the highest Surgical Procedures Benefit Amount.

A miscellaneous surgery means a surgical procedure that is not covered by any other specific Covered Injury benefit and requires general anesthesia. If more than one (1) miscellaneous surgical procedure is performed in a twenty-four (24) hour period, We will only pay one (1) miscellaneous surgery.

This benefit is limited to a maximum of two (2) miscellaneous surgeries per Insured Person per Calendar Year.

HOSPITAL AND SERVICES BENEFITS

ACCIDENT EMERGENCY TREATMENT BENEFIT We will pay the Accident Emergency Treatment Benefit Amount shown on the Benefit Schedule if any Insured Person suffers a Covered Injury as a result of a Covered Accident. For this benefit to be payable all the following must occur:

a. the Covered Injury is an Emergency; and
b. the Covered Injury requires examination and Treatment by a Physician in a Hospital Emergency Room, an Urgent Care Center, or Physician's office within seventy-two (72) hours after the Covered Accident.

This benefit is payable once per twenty-four (24) hour period and only once per Insured Person per Covered Accident.

If an Insured Person receives Treatment in an Urgent Care Center or Physician's office as a result of a Covered Injury suffered in a Covered Accident and subsequently requires Treatment in a Hospital or Emergency Room, We will only pay the highest Benefit Amount payable.

ACCIDENT FOLLOW-UP TREATMENT BENEFIT We will pay the Accident Follow-Up Treatment Benefit Amount shown on the Benefit Schedule per visit if any Insured Person needs additional Treatment of a Covered Injury suffered in a Covered Accident over and above Emergency Treatment administered in the first seventy-two (72) hours following the Covered Accident.

This benefit is limited to six (6) visits per Insured Person per Covered Accident.

Follow-up Treatment must begin within thirty (30) days of the Covered Accident and must conclude within six (6) months following the Covered Accident. Such treatments must be furnished by a Physician in a Physician's office or in a Hospital on an Outpatient basis.

AMBULANCE BENEFIT We will pay the Air Ambulance Benefit Amount shown on the Benefit Schedule when a licensed professional air ambulance company transports any Insured Person to or from a Hospital or between medical facilities where Treatment is received for a Covered Injury suffered in a Covered Accident.

The air ambulance transportation must be within seventy-two (72) hours after the Covered Accident.

The Air Ambulance Benefit is limited to one (1) payment per Insured Person per Covered Accident. We will pay a maximum of two (2) Air Ambulance Benefit Amounts per Insured Person per Calendar Year.

We will pay the Ground/Water Ambulance Benefit Amount shown on the Benefit Schedule when a licensed professional ground/water ambulance company transports any Insured Person to or from a Hospital or between medical facilities where Treatment is received for a Covered Injury suffered in a Covered Accident.

The ground/water ambulance transportation must be within ninety (90) days after the Covered Accident.

The Ground/Water Ambulance Benefit is limited to one (1) payment per Insured Person per Covered Accident. We will pay a maximum of two (2) Ground/Water Ambulance Benefit Amounts per Insured Person per Calendar Year. When an Insured Person is transported by two (2) separate ambulances for the same Covered Accident, We will pay the ground, water, or air ambulance benefit, whichever is greatest.

APPLIANCE BENEFIT We will pay the Appliance Benefit Amount shown on the Benefit Schedule if any Insured Person suffers a Covered Injury in a Covered Accident and a Physician prescribes the use of a medical appliance as an aid in personal locomotion or mobility. Crutches, leg braces, back braces, walkers, and wheelchairs are examples of medical appliances. The use of an appliance must begin within ninety (90) days after the Covered Accident.
This benefit is limited to one (1) payment per Insured Person per Covered Accident.

AT-HOME RECOVERY BENEFIT For each Day that an Insured Person was confined to a Hospital or Hospital Intensive Care Unit, We will pay three (3) days of the At-Home Recovery Benefit Amount shown on the Benefit Schedule. The at-home recovery must be received on the advice of a Physician and be the result of a Covered Injury suffered in a Covered Accident.

This benefit has a maximum of ninety (90) days per Insured Person per Covered Accident.

ATTENDING PHYSICIAN BENEFIT For each Day that an Insured Person is confined to a Hospital or Hospital Intensive Care Unit, We will pay the Attending Physician Benefit Amount shown on the Benefit Schedule for the services of an attending Physician, not to exceed 365 days per Insured person per Covered Accident. The Insured Person must become Confined within sixty (60) days for a Covered Injury suffered in a Covered Accident.

BLOOD, PLASMA, PLATELETS BENEFIT We will pay the Blood, Plasma, Platelets Benefit Amount shown on the Benefit Schedule if any Insured Person suffers a Covered Injury in a Covered Accident and requires the transfusion, administration, cross-matching, typing, and processing of blood, plasma, or platelets. The blood, plasma, or platelets must be administered within ninety (90) days after the Covered Accident.

This benefit is limited to one (1) payment per Insured Person per Covered Accident. We will not pay for immunoglobulins.

DIAGNOSTIC IMAGING BENEFIT We will pay the Diagnostic Imaging Benefit Amount shown on the Benefit Schedule for either an X-ray or a major diagnostic exam if any Insured Person requires one of the following in a Hospital, Urgent Care Center, Emergency Room, or a Physician's office.

a. an X-ray while receiving Emergency Treatment for a Covered Injury suffered in a Covered Accident; or
b. a major diagnostic exam, computerized tomography (CT) scan, computerized axial tomography (CAT), magnetic resonance imaging (MRI), positron emission tomography (PET), ultrasound, magnetic resonance angiography (MRA), electrocardiography (EKG), or electroencephalography (EEG)) while receiving Treatment for a Covered Injury suffered in a Covered Accident.

The X-ray benefit is limited to one (1) X-ray per Insured Person per Covered Accident and two (2) X-rays per Insured Person per Calendar Year. The X-ray benefit is not payable for major diagnostic exams.

The major diagnostic exam benefit is limited to one (1) major diagnostic exam per Insured Person per Covered Accident and two (2) major diagnostic exams per Insured Person per Calendar Year. Major diagnostic exams do not include X-rays.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

ACCIDENTAL DEATH BENEFIT If an Insured Person dies as a direct result of Covered Accident or a Covered Accident while riding as a passenger in, on, boarding, or alighting from a Common Carrier, We will pay the Accidental Death Benefit Amount shown on the Benefit Schedule if all of the following requirements are met:

a. Accidental Death occurs on or after the Insured Person's Rider Effective Date and while this Rider is in force;
b. We receive due proof of loss, satisfactory to Us, of the Insured Person's Accidental Death;
c. the proof shows that death resulted directly from a Covered Injury caused solely as a result of a Covered Accident and independent of disease, physical condition, bodily infirmity, or any other cause;
d. Accidental Death occurred within the first ninety (90) days after the Covered Accident, except in cases when, at the end of the ninety (90) Day period, an Insured Person is being kept clinically alive by an artificial life support system, the ninety (90) Day limit will be extended to 180 days; and
e. the benefit payment is not precluded by any general or specific exclusion, description, or any failure to meet any requirement stated in this Rider.

If We pay the Accidental Death – Common Carrier Benefit Amount, We will not pay the Accidental Death – Other Accidents Benefit Amount.

In the event that Accidental Death and Accidental Dismemberment result from the same Covered Accident, the total benefit payable will not exceed that of the Accidental Death Benefit Amount.

ACCIDENTAL DISMEMBERMENT BENEFIT If an Insured Person suffers an Accidental Dismemberment as a direct result of a Covered Accident, We will pay the Accidental Dismemberment Benefit Amount shown on the Benefit Schedule if all of the following requirements are met:

a. the Covered Accident and Accidental Dismemberment occur on or after the Insured Person's Rider Effective Date and while this Rider is in force;
b. Treatment for the Covered Injury is received within the United States;
c. the Accidental Dismemberment occurs within the first ninety (90) days after the Covered Accident; and
d. the benefit payment is not precluded by any general or specific exclusion, description, or any failure to meet any requirement stated in this Rider.

This benefit will be paid even if the severed body part is subsequently reattached. Only Accidental Dismemberments shown on the Benefit Schedule are eligible for payment under this Rider. Any dismemberment not listed on the Benefit Schedule is not eligible for payment under this Rider.

This benefit is limited to two (2) Benefit Amounts per Insured Person per lifetime. In the case of multiple dismemberments resulting from one (1) Covered Accident, only the highest single benefit will be paid per Insured Person. Loss of use does not constitute dismemberment except as stated for Loss of Sight of Eye injuries in the Rider.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: In addition to any benefit-specific conditions, limitations, or exclusions, no benefits will be payable for a Covered Injury which, directly or indirectly, in whole or in part, is caused by or results from any of the following:

a. an Insured Person's being intoxicated, as determined and defined by the laws and jurisdiction of the geographical area in which the injury or Illness or cause of injury or Illness was incurred, or under the influence of any narcotic unless administered under the advice of a Physician and taken as prescribed. The Insured Person's alcohol or narcotic impairment must be the cause or contributing cause of his or her injury or Sickness, irrespective of whether the injury or Sickness occurred while the Insured Person was driving a motor vehicle or engaged in any other activity;
b. flight in, boarding, or alighting from an aircraft or any craft designed to fly above the Earth's surface except as a fare-paying passenger on a regularly-scheduled commercial or charter airline;
c. elective or cosmetic surgery or complications of cosmetic surgery. This does not include reconstructive, cosmetic surgery: i) incidental to or following surgery for trauma, infection, or other disease of the involved part; or ii) due to congenital disease or anomaly of a covered dependent Child which has resulted in a functional defect;
d. dental treatment of the teeth, gums, or structures directly supporting the teeth including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints, and services for dental malocclusion for any condition are not covered, except if provided for or in connection with a Covered Injury to sound natural teeth and a continuous course of dental treatment is started within six (6) months of the Covered Injury. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support, and are functional in the arch;
e. commission of or attempt to commit an illegal activity or a felony;
f. participation in any high-risk activities such as bungee jumping, parachuting, skydiving, parasailing, hang-gliding, deep-sea scuba diving, parkour, free running, sail gliding, parakiting, bronc or bull riding, or any similar activity;
g. any motorized race or contest of speed, to include off-road vehicles that may not require a license;
h. any mental or nervous or emotional disorder, alcoholism, and drug addiction;
i. active-duty service in the military, naval, or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid during the Insured Person's time of active duty. Reserve or National Guard active-duty training is not excluded unless it extends beyond thirty-one (31) consecutive days;
j. suicide (while sane or insane), attempted suicide, or intentionally self-inflicted injury;
k. travel, activity, or Treatment outside the United States;
l. war or act of war (whether declared or undeclared);
m. commission of or active participation in a riot, insurrection, rebellion, or police action; or
n. voluntary self-administration of any narcotic, drug, poison, gas, or fumes unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage.

The following conditions, Treatments, and/or services are **not covered** under this Rider:

a. Care, services, or supplies received without charge or legal obligation to pay or while the Rider was not in force;
b. Treatment, services, and supplies for Experimental, Investigational, or Unproven purposes;
c. dental treatment of the teeth, gums, or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints, and services for dental malocclusion for any condition are not covered, except if provided for or in connection with a Covered Injury to sound natural teeth and a continuous course of dental treatment is started within six (6) months of the Covered Injury. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support, and are functional in the arch;

d. Treatment or services from a masseur, massage therapist or rolfer, massage therapy, and any type of holistic therapy which include but are not limited to meditation, aromatherapy, and relaxation therapy; or
e. repetitive or cumulative motions or stress traumas which include but are not limited to carpal tunnel syndrome, tennis elbow, and thoracic outlet syndrome.

☐ **CANCER RECURRENCE BENEFIT RIDER (Form #LY-CR-RD-KS)**

CANCELLATION You may cancel this Rider at any time by written notice delivered or mailed to us. Your cancellation will be effective upon receipt of your notice or on such later date as may be specified in such notice. In the event of Cancellation or death, we will promptly return the unearned portion of any premium paid by you. We will determine the amount of the refund, if any, by prorating the last modal premium paid from the date of the Cancellation until the next modal premium due date. Cancellation will be without prejudice to any claim originating prior to the effective date of Cancellation.

Subject to the Benefit Payment Conditions listed below, a Cancer Recurrence Benefit is payable each time an Insured Person receives a Diagnosis for the recurrence of Cancer. However, for the Cancer Recurrence Benefit to be payable:
a. the Cancer Diagnosis Benefit Amount under the policy to which the Rider is attached shall have been previously paid for the Insured Person; and
b. the Insured Person shall not have received any Advice or Treatment for at least twenty-four (24) consecutive months prior to the Date of Diagnosis for the recurrence of Cancer.

The amount payable for the recurrence of Cancer is equal to the percentage times the Cancer Recurrence Benefit Amount shown on the Policy Schedule Page or policy endorsement. The percentage of the Cancer Recurrence Benefit Amount payable is shown in chart below.

Time Period without Advice or Treatment	% of Cancer Recurrence Benefit Amount Payable	Maximum Percentage of the Cancer Recurrence Benefit Amount
Less than 24 months	0%	100%
24 months or more but less than 5 years	25%	
5 years or more but less than 10 years	75%	
10 years or more	100%	

If an Insured Person receives benefits payable for the recurrence of Cancer that is less than 100% of the Cancer Recurrence Benefit Amount payable and later receives a Diagnosis for a different recurrence of Cancer, We will pay the specified percentage in the chart above, less any prior amounts paid or payable under this benefit. However, for the Cancer Recurrence Benefit to be payable such Diagnosis of Cancer must be separated by at least twenty-four (24) consecutive months from an Insured Person's last Date of Diagnosis for Cancer under the Rider.

After payment of the maximum percentage of the Cancer Recurrence Benefit Amount for an Insured Person shown in the chart above, coverage for that Insured Person under the Rider will terminate.

BENEFIT PAYMENT CONDITIONS Payment of the Cancer Recurrence Benefit shall be subject to the following conditions:
a. Diagnosis must be made within the United States;
b. the Date of Diagnosis shall occur while the Insured Person is covered by the Rider; and
c. payment shall be precluded by any general or specific exclusion, limitation or reduction set forth in the Rider or attached to the policy or any failure by the Insured Person to meet any condition precedent.

EXCLUSIONS AND LIMITATIONS The Rider is subject to the following Exclusions and Limitations, in addition to those outlined in the policy.

In addition to any benefit-specific conditions, limitations, or exclusions, no benefits will be payable under the Rider for:

a. any disease, Sickness, or incapacity other than Cancer as defined; this is so even though such disease, Sickness, or incapacity may have been complicated, affected (directly or indirectly), or caused by Cancer;
b. loss that begins prior to the Rider Effective Date;
c. Diagnosis received outside the United States or its territories, unless otherwise specified in the Rider; or
d. any Illness specifically excluded from the definition of Cancer or Carcinoma in Situ.

CONTINUITY OF COVERAGE If this Rider replaced another specified disease policy or rider, or is issued in addition to existing specified disease coverage, the issuing company shall give credit for the expired portion of any waiting period, elimination period, probationary period, pre-existing condition limitation or exclusion provision or conditions for any similar provision.

If coverage is provided for two (2) or more individuals, such coverage will be determined separately for each Insured Person.

☐ **LUMP SUM CANCER BENEFIT BUILDER RIDER (Form #LY-CBB-RD.v2-KS)**

CANCELLATION You may cancel this Rider at any time by written notice delivered or mailed to us. Your cancellation will be effective upon receipt of your notice or on such later date as may be specified in such notice. In the event of Cancellation or death, we will promptly return the unearned portion of any premium paid by you. We will determine the amount of the refund, if any, by prorating the last modal premium paid from the date of the Cancellation until the next modal premium due date. Cancellation will be without prejudice to any claim originating prior to the effective date of Cancellation.

This Rider, beginning with the Rider Effective Date, increases the policy Benefit Amount annually by the amount shown on the Policy Schedule Page.

This benefit will be paid under the same terms as the policy to which this Rider is attached. For the benefit to be payable:

a. the Date of Diagnosis must occur after the Rider Waiting Period has expired;
b. the Date of Diagnosis must occur while the Insured Person is covered by this Rider; and
c. the Rider premiums must continue to be paid for the accrued benefit to remain in force.

The annual benefit will increase each year for all Insured Person(s) until the thirty-fifth (35^{th}) Rider anniversary. After the thirty-fifth (35^{th}) year, no additional amounts will be accrued.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR This Rider is subject to the Exclusions and Limitations outlined in the policy. In addition to any benefit-specific conditions, limitations, or exclusions, no benefits will be payable under this Rider for:

a. loss that begins prior to the Rider Effective Date; or
b. Cancer Diagnosed during the Waiting Period.

WAITING PERIOD: This Rider has a thirty (30) Day Waiting Period. No benefits will be paid for Cancer that is Diagnosed during the Waiting Period. If an Insured Person is Diagnosed with Cancer during the Waiting Period, We will terminate the Insured Person's coverage under this Rider and refund the applicable portion of premium paid for that Insured Person's coverage.

PRE-EXISTING CONDITION(S): The benefits of this Rider will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Rider Effective Date for each Insured Person.

CONTINUITY OF COVERAGE If this Rider replaced another specified disease policy or rider, or is issued in addition to existing specified disease coverage, the issuing company shall give credit for the expired portion of any waiting period, elimination period, probationary period, pre-existing condition limitation or exclusion provision or conditions for any similar provision.

If coverage is provided for two (2) or more individuals, such coverage will be determined separately for each Insured Person.

☐ **RADIATION AND CHEMOTHERAPY BENEFIT RIDER (Form #LY-RC-RD.v2-KS)**

CANCELLATION You may cancel this Rider at any time by written notice delivered or mailed to us. Your cancellation will be effective upon receipt of your notice or on such later date as may be specified in such notice. In the event of Cancellation or death, we will promptly return the unearned portion of any premium paid by you. We will determine the amount of the refund, if any, by prorating the last modal premium paid from the date of the Cancellation until the next modal premium due date. Cancellation will be without prejudice to any claim originating prior to the effective date of Cancellation.

We will pay the benefits described below for the care and treatment of an Insured Person. The Benefit amounts are shown on the Rider Benefit Schedule. The Cancer Recurrence Benefit Rider must be purchased with this Rider.

The benefits listed below are not payable for:

a. Skin Cancer;
b. Cancer or Carcinoma in Situ Diagnosed prior to the Rider Effective Date; or
c. the care and treatment of an Insured Person who is Diagnosed with Cancer prior to the Waiting Period ending.

IMMUNOTHERAPY BENEFIT We will pay the Immunotherapy Benefit Amount shown on the Benefit Schedule for each Calendar Month an Insured Person incurs a charge for and receives Physician-prescribed Immunotherapy for the treatment of Cancer.

This benefit is payable only once per Calendar Month and is limited to the Calendar Month in which the charge for Immunotherapy is incurred.

This benefit is limited to a maximum of five (5) Calendar Months per Calendar Year per Insured Person.

INJECTED CHEMOTHERAPY BENEFIT We will pay the Injected Chemotherapy Benefit Amount shown on the Benefit Schedule for each Calendar Week in which an Insured Person incurs a charge for and receives Physician-prescribed Injected Chemotherapy for the treatment of Cancer.

There is no limit to the number of Calendar Weeks in which an Insured Person can receive the Injected Chemotherapy Benefit during the care and treatment of Cancer.

NON-HORMONAL ORAL CHEMOTHERAPY BENEFIT We will pay the Non-Hormonal Oral Chemotherapy Benefit Amount shown on the Benefit Schedule for each Calendar Month in which an Insured Person incurs a charge for and receives Physician-prescribed Non-Hormonal Oral Chemotherapy for the treatment of Cancer.

This benefit is payable only once per Calendar Month per Insured Person even if more than one (1) drug is prescribed within the Calendar Month and is limited to the Calendar Month in which the charge for Non-Hormonal Oral Chemotherapy is incurred.

HORMONAL ORAL CHEMOTHERAPY BENEFIT We will pay the Hormonal Oral Chemotherapy Benefit Amount shown on the Benefit Schedule for each Calendar Month in which an Insured Person incurs a charge for and receives Physician-prescribed Hormonal Oral Chemotherapy for the treatment of Cancer.

This benefit is payable only once per Calendar Month per Insured Person even if more than one (1) drug is prescribed within the Calendar Month and is limited to the Calendar Month in which the charge for Hormonal Oral Chemotherapy is incurred.

This benefit is limited to a maximum of thirty-six (36) months per Insured Person per lifetime.

ANTI-NAUSEA DRUG BENEFIT We will pay the Anti-Nausea Drug Benefit Amount shown on the Benefit Schedule for each Calendar Month in which an Insured Person incurs a charge for a Physician-prescribed Anti-Nausea Drug during the treatment of Cancer. The Insured Person must be receiving Chemotherapy or Radiation Therapy to qualify for this benefit.

This benefit is only payable once per Calendar Month per Insured Person even if more than one (1) drug is prescribed within the Calendar Month and is limited to a maximum of ten (10) months per Insured Person per Calendar Year.

Medical marijuana will not be covered as an Anti-Nausea Drug.

RADIATION BENEFIT We will pay the Radiation Benefit Amount shown on the Benefit Schedule for each Calendar Week an Insured Person incurs a charge for and receives Radiation Therapy for the treatment of Cancer.

There is no limit to the number of Calendar Weeks an Insured Person can receive the Radiation Benefit during the care and treatment of Cancer.

EXPERIMENTAL TREATMENT FOR CANCER BENEFIT We will pay the Experimental Treatment for Cancer Benefit Amount shown on the Benefit Schedule for each Day an Insured Person incurs a charge for and receives hospital, medical, or surgical care in connection with an Experimental Treatment for Cancer within the United States.

This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, Immunotherapy, colony-stimulating factors, and therapeutic devices or other procedures related to these Experimental Treatments.

This benefit is limited to a maximum of thirty (30) days per Insured Person per Calendar Year.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR This Rider is subject to the Exclusions and Limitations outlined in the policy. In addition to any benefit-specific conditions, limitations, or exclusions, no benefits will be payable under this Rider for:

a. loss that begins prior to the Rider Effective Date;
b. any disease, Sickness, or incapacity other than Cancer as defined; this is so even though such disease, Sickness, or incapacity may have been complicated, affected (directly or indirectly), or caused by Cancer;
c. loss that begins prior to the expiration of the Waiting Period;

d. Diagnosis received outside the United States or its territories, unless otherwise specified in this Rider; or
e. any illness specifically excluded from the definition of Cancer or Carcinoma in Situ.

WAITING PERIOD: This Rider has a thirty (30) Day Waiting Period. Waiting Period means the first thirty (30) days following an Insured Person's Rider Effective Date. No benefits will be paid for Cancer that is Diagnosed during the Waiting Period. If an Insured Person is Diagnosed with Cancer during the Waiting Period, We will terminate the Insured Person's coverage under this Rider and refund the applicable portion of premium paid for that Insured Person's coverage.

PRE-EXISTING CONDITION(S): The benefits of this Rider will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Rider Effective Date for each Insured Person.

CONTINUITY OF COVERAGE If this Rider replaced another specified disease policy or rider, or is issued in addition to existing specified disease coverage, the issuing company shall give credit for the expired portion of any waiting period, elimination period, probationary period, pre-existing condition limitation or exclusion provision or conditions for any similar provision.

If coverage is provided for two (2) or more individuals, such coverage will be determined separately for each Insured Person.

☐ **SPECIFIED DISEASE BENEFIT RIDER (Form #LY-LSD2-RD.v2-KS)**

CANCELLATION You may cancel this Rider at any time by written notice delivered or mailed to us. Your cancellation will be effective upon receipt of your notice or on such later date as may be specified in such notice. In the event of Cancellation or death, we will promptly return the unearned portion of any premium paid by you. We will determine the amount of the refund, if any, by prorating the last modal premium paid from the date of the Cancellation until the next modal premium due date. Cancellation will be without prejudice to any claim originating prior to the effective date of Cancellation.

SPECIFIED DISEASE BENEFIT We will pay You the Specified Disease Benefit Amount, shown on the Policy Schedule Page, if an Insured Person receives a Diagnosis or procedure from a Physician for one (1) of the Specified Diseases shown in the chart below and subject to the following conditions:
a. Diagnosis must be made within the United States; and
b. the Date of Diagnosis or Procedure shall occur while the Insured Person is covered by this Rider.

MODERATE ALZHEIMER'S DEMENTIA/SEVERE ALZHEIMER'S DEMENTIA To qualify for coverage under this Rider, You must be Diagnosed by either a board-certified neurologist or a psychiatrist with **either** Moderate Alzheimer's Dementia **or** Severe Alzheimer's Dementia. A qualifying Diagnosis must include:
a. a score on the MMSE of less than 18 for Moderate Alzheimer's Dementia or less than 11 for Severe Alzheimer's Dementia; and
b. the conclusion that You are permanently unable to perform three (3) or more Activities of Daily Living.

The benefit provided by this Rider for a Diagnosis of Alzheimer's Dementia (whether Diagnosed as Moderate or Severe) is a one-time payment equal to 50% of the Alzheimer's Dementia Amount noted on the Policy Schedule Page, with no further payout for any other Specified Disease nor for the worsening of Your Alzheimer's Dementia.

Specified Diseases	Benefit Paid One Time
Alzheimer's Dementia (Moderate or Severe)	50%
Amyotrophic Lateral Sclerosis (ALS)	100%
Blindness	100%
Coma	100%
End Stage Renal Failure	100%
Loss of Hearing	100%
Loss of Speech	100%
Major Organ Transplant	100%
Multiple Sclerosis (MS)	100%
Paralysis	100%
Severe Burns	100%

Each Insured Person is limited to one (1) Specified Disease Benefit Amount under the terms of this Rider. After payment of the Specified Disease Benefit Amount shown on the Policy Schedule Page for an Insured Person, We will not pay any additional benefits for any additional Specified Diseases covered by this Rider for the same Insured Person.

If the Date of Diagnosis of two (2) or more Specified Diseases is the same Day, We will pay only one (1) Specified Disease Benefit Amount. We will pay the larger of the Specified Disease benefits Diagnosed on the same Day.

No benefits are payable for conditions other than the Specified Diseases defined in this Rider. Payment of the Specified Disease Benefit is subject to all terms and conditions of this Rider and the policy to which it is attached.

EXCLUSIONS AND LIMITATIONS: This Rider does not cover any Sickness, illness, incapacity, or procedure other than the Specified Diseases defined above.

EXCLUSIONS– WHAT WE WILL NOT PAY FOR This Rider is subject to the Exclusions and Limitations outlined in the policy. In addition to any benefit-specific conditions, limitations, or exclusions, no benefits will be payable under this Rider for:

a. intentionally self-inflicted injury, suicide, or any attempt while sane or insane;
b. loss that begins prior to the effective date of coverage; or
c. voluntary self-administration of any narcotic, drug, poison, gas, or fumes unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage.

PRE-EXISTING CONDITION(S) The benefits of the Rider will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Rider Effective Date for each Insured Person.

CONTINUITY OF COVERAGE If this Rider replaced another specified disease policy or rider, or is issued in addition to existing specified disease coverage, the issuing company shall give credit for the expired portion of any waiting period, elimination period, probationary period, pre-existing condition limitation or exclusion provision or conditions for any similar provision.

If coverage is provided for two (2) or more individuals, such coverage will be determined separately for each Insured Person.

☐ **LUMP SUM HEART AND STROKE RIDER (Form #LY-LSH-RD-KS)**

CANCELLATION You may cancel this Rider at any time by written notice delivered or mailed to us. Your cancellation will be effective upon receipt of your notice or on such later date as may be specified in such notice. In the event of Cancellation or death, we will promptly return the unearned portion of any premium paid by you. We will determine the amount of the refund, if any, by prorating the last modal premium paid from the date of the Cancellation until the next modal premium due date. Cancellation will be without prejudice to any claim originating prior to the effective date of Cancellation.

We will pay the Heart and Stroke Diagnosis Benefit if an Insured Person receives a Diagnosis of any of the Qualifying Events shown in the chart below and subject to the definitions, terms, limitations, and exclusions set forth in the Rider and the following conditions:

a. the Diagnosis must be made within the United States;
b. the Date of Diagnosis is after the Waiting Period has expired;
c. the Date of Diagnosis shall occur while the Insured Person is covered by the Rider; and
d. payment shall be precluded by any general or specific exclusion, limitation, or reduction set forth in or attached to the Rider and the policy (including, without limitation, the exclusion for any Pre-Existing Condition) or any failure by the Insured Person to meet any condition precedent.

The amount payable for each Qualifying Event is equal to the percentage times the Heart and Stroke Diagnosis Benefit Amount shown on the Policy Schedule Page or policy endorsement. The percentage of the Heart and Stroke Diagnosis Benefit Amount payable for each Qualifying Event is shown beside the event in the chart below.

Qualifying Events	Percentage of Benefit Amount Payable for each Qualifying Event	Maximum Percentage of Benefit Amount Payable
Heart Attack	100%	100%
Heart Transplant	100%	
Stroke	100%	
Coronary Artery Bypass Surgery*	25%	
Aortic Surgery*	25%	
Heart Valve Replacement/Repair Surgery*	25%	
Angioplasty*	10%	
Stent*	10%	

*The Coronary Artery Bypass Surgery, Aortic Surgery, Heart Valve Replacement/Repair Surgery, Angioplasty, and Stent benefits are each payable only once in an Insured Person's lifetime.

If an Insured Person receives benefits payable for a Qualifying Event that is less than 100% of the Heart and Stroke Diagnosis Benefit Amount and later receives a Diagnosis for a different Qualifying Event, we will pay the specified percentage of the Qualifying Event in the chart above, less any prior amounts paid or payable under this benefit.

If the Date of Diagnosis of two (2) or more Qualifying Events is the same Day, We will pay only one (1) Heart and Stroke Diagnosis Benefit Amount. We will pay the larger of the Qualifying Event benefits Diagnosed on the same Day.

The Date of Diagnosis for two (2) or more surgical treatments performed at the same time and through a common incision or entry point are considered one (1) operation. We will pay the larger of the Qualifying Event benefits performed at the same time.

No benefits are payable for conditions other than the Qualifying Events defined in the Rider.

After payment of the maximum percentage of the Heart and Stroke Diagnosis Benefit Amount for an Insured Person shown in the chart above, coverage for that Insured Person under the Rider will terminate.

EXCLUSIONS AND LIMITATIONS The Rider is subject to the following Exclusions and Limitations, in addition to those outlined in the Policy.

No benefits will be payable under the Rider for:

a. any disease, Sickness, or incapacity other than Qualifying Events as defined; this is so even though such disease, Sickness, or incapacity may have been complicated, affected (directly or indirectly), or caused by a Qualifying Event;
b. loss that begins prior to the Rider Effective Date;
c. a Qualifying Event Diagnosed during the Waiting Period;
d. Diagnosis received outside the United States or its territories, unless otherwise specified in the Rider;
e. intentionally self-inflicted Injury, suicide, or any attempt while sane or insane;
f. voluntary self-administration of any narcotic, drug, poison, gas, or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage; and
g. any illness specifically excluded from the definition of Qualifying Events listed in the Rider.

WAITING PERIOD The Rider has a thirty (30) Day Waiting Period. Waiting Period means the first thirty (30) days following an Insured Person's Rider Effective Date. No benefits will be paid for a Qualifying Event that is Diagnosed during the Waiting Period. If an Insured Person is Diagnosed with a Qualifying Event during the Waiting Period, We will terminate the Insured Person's coverage under the Rider and refund the applicable portion of premium paid for that Insured Person's coverage.

PRE-EXISTING CONDITION(S) The benefits of the Rider will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Rider Effective Date for each Insured Person.

CONTINUITY OF COVERAGE If this Rider replaced another specified disease policy or rider, or is issued in addition to existing specified disease coverage, the issuing company shall give credit for the expired portion of any waiting period, elimination period, probationary period, pre-existing condition limitation or exclusion provision or conditions for any similar provision.

If coverage is provided for two (2) or more individuals, such coverage will be determined separately for each Insured Person.

☐ **RETURN OF PREMIUM RIDER (Form #LY-ROP-D)**

In the event You die while this rider is in force, a Return of Premium Benefit may be payable to your named beneficiary or estate. If this rider is added to the policy after the policy was issued, only the premium paid for the policy on or after the Rider Effective Date will be returned. The Return of Premium Benefit is Original Premium less Claims Paid.

The benefit provided by this rider is payable only once during the entire time that the policy and this rider is in force.

If a payable claim is incurred on a date when the Return of Premium Benefit would otherwise be payable, regardless of whether it has been reported or adjudicated, We will:

a. pay the claim if it is payable upon the terms of the policy or Rider and then reduce the Return of Premium Benefit by the sum of all Claims Paid; or
b. pay the Return of Premium Benefit and then reduce the claim by the amount of the Return of Premium Benefit; or
c. pay the Return of Premium Benefit if the claim is not payable upon the terms of the policy or Rider.

☐ **WELLNESS BENEFIT RIDER (Form #LY-WL-RD) (only available through Worksite)**

We will pay the benefit shown on the Policy Schedule Page, if an Insured Person undergoes or receives Health Screening Tests, as set forth below, while coverage under this Rider is in force. Benefits are subject to the Rider Benefit Waiting Period.

For the benefit to be payable:

a. the testing must be rendered by a Physician or a licensed health care professional under the supervision of a Physician; and
b. the date of the health screening test is after the Rider Waiting Period has expired.

Only one (1) benefit will be paid per Insured Person per Rider year. A Rider year is a full twelve (12) month period from the Rider Effective Date.

Health Screening Tests:

- Mammography;
- Pap smear for women over Age 18;
- Flexible sigmoidoscopy;
- Hemoccult stool specimen;
- Colonoscopy;
- Prostate specific antigen (for prostate cancer);
- Stress test on a bicycle or treadmill;
- Fasting blood glucose test;
- Blood test for triglycerides;
- Serum cholesterol test to determine levels of HDL and LDL;
- Bone marrow testing;
- Breast ultrasound;
- CA 15-3 (blood test for breast cancer);
- CA125 (blood test for ovarian cancer);
- CEA (blood test for colon cancer);
- Chest X-ray;
- Serum protein electrophoresis (blood test for myeloma); and
- Thermography

This Rider does not cover any health screening tests other than the Health Screening Tests defined above.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR This Rider is subject to the Exclusions and Limitations outlined in the policy. In addition to any benefit-specific conditions, limitations, or exclusions, no benefits will be payable under this Rider for loss that begins prior to the effective date of coverage.

WAITING PERIOD: This Rider has a thirty (30) Day Waiting Period.

8. ***YOUR TOTAL ANNUAL PREMIUM*** **(at time of application)**

Lump Sum Cancer Policy	$_____
Accident Fixed Indemnity Benefit Rider	$_____
Cancer Recurrence Benefit Rider	$_____
Lump Sum Cancer Benefit Builder Rider	$_____
Radiation & Chemotherapy Benefit Rider	$_____
Specified Disease Benefit Rider	$_____
Lump Sum Heart and Stroke Rider	$_____
Return of Premium Rider	$_____
Wellness Benefit Rider	$_____
TOTAL	**$**_____

_____

Agent's name (print)

_____

Agent's signature Date

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Loyal American
Life Insurance Company®
PO Box 5700, Scranton, PA 18505
Toll free: 866-459-4272

OUTLINE OF COVERAGE FOR
LUMP SUM HEART AND STROKE INSURANCE POLICY
FORM LY-LSH-BA-KS

THE POLICY PROVIDES LIMITED BENEFITS.

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE
If an Insured Person is eligible for Medicare, please review the "*Guide to Health Insurance for People with Medicare*" which is available from the Company.

1. ***READ YOUR POLICY CAREFULLY!*** This Outline of Coverage provides a very brief description of the important features of Your policy. This is not the insurance policy and only the actual provisions of the policy will control the rights and obligations of the parties to it. The policy itself sets forth, in detail, those rights and obligations applicable to both You and LOYAL AMERICAN LIFE INSURANCE COMPANY. It is very important, therefore, that You READ YOUR POLICY CAREFULLY.

2. ***SPECIFIED DISEASE COVERAGE*** is designed to provide, to persons insured, restricted coverage providing benefits ONLY when certain losses occur as a result of specified diseases. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

3. ***CANCELLATION*** You may cancel this policy at any time by written notice delivered or mailed to us. Your cancellation will be effective upon receipt of your notice or on such later date as may be specified in such notice. In the event of Cancellation or death, we will promptly return the unearned portion of any premium paid by you. We will determine the amount of the refund, if any, by prorating the last modal premium paid from the date of the Cancellation until the next modal premium due date. Cancellation will be without prejudice to any claim originating prior to the effective date of Cancellation.

4. ***BENEFITS PROVIDED BY THE POLICY***

   HEART AND STROKE DIAGNOSIS BENEFIT We will pay the Heart and Stroke Diagnosis Benefit if an Insured Person receives a Diagnosis of any of the Qualifying Events shown in the chart below and subject to the definitions, terms, limitations, and exclusions set forth in the policy and the following conditions:
   a. the Diagnosis must be made within the United States;
   b. the Date of Diagnosis is after the Waiting Period has expired;
   c. the Date of Diagnosis shall occur while the Insured Person is covered by the policy; and
   d. payment shall be precluded by any general or specific exclusion, limitation, or reduction set forth in or attached to the policy (including, without limitation, the exclusion for any Pre-Existing Condition) or any failure by the Insured Person to meet any condition precedent.

   The amount payable for each Qualifying Event is equal to the percentage times the Heart and Stroke Diagnosis Benefit Amount shown on the Policy Schedule Page or policy endorsement. The percentage of the Heart and Stroke Diagnosis Benefit Amount payable for each Qualifying Event is shown beside the event in the chart below.

Qualifying Events	Percentage of Benefit Amount Payable for each Qualifying Event	Maximum Percentage of Benefit Amount Payable
Heart Attack	100%	100%
Heart Transplant	100%	
Stroke	100%	
Coronary Artery Bypass Surgery*	25%	
Aortic Surgery*	25%	
Heart Valve Replacement/Repair Surgery*	25%	
Angioplasty*	10%	
Stent*	10%	

*The Coronary Artery Bypass Surgery, Aortic Surgery, Heart Valve Replacement/Repair Surgery, Angioplasty, and Stent benefits are each payable only once in an Insured Person's lifetime.

If an Insured Person receives benefits payable for a Qualifying Event that is less than 100% of the Heart and Stroke Diagnosis Benefit Amount and later receives a Diagnosis for a different Qualifying Event, we will pay the specified percentage of the Qualifying Event in the chart above, less any prior amounts paid or payable under this benefit.

If the Date of Diagnosis of two (2) or more Qualifying Events is the same Day, We will pay only one (1) Heart and Stroke Diagnosis Benefit Amount. We will pay the larger of the Qualifying Event benefits Diagnosed on the same Day.

The Date of Diagnosis for two (2) or more surgical treatments performed at the same time and through a common incision or entry point are considered one (1) operation. We will pay the larger of the Qualifying Event benefits performed at the same time.

No benefits are payable for conditions other than the Qualifying Events defined in the policy.

5. ***EXCLUSIONS AND LIMITATIONS***

In addition to any benefit-specific conditions, limitations, or exclusions, no benefits will be payable under the policy for:

a. any disease, Sickness, or incapacity other than Qualifying Events as defined; this is so even though such disease, Sickness, or incapacity may have been complicated, affected (directly or indirectly), or caused by a Qualifying Event;
b. loss that begins prior to the Policy Effective Date;
c. a Qualifying Event Diagnosed during the Waiting Period;
d. Diagnosis received outside the United States or its territories, unless otherwise specified in the policy;
e. intentionally self-inflicted Injury, suicide or any attempt while sane or insane;
f. voluntary self-administration of any narcotic, drug, poison, gas, or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage; or
g. any illness specifically excluded from the definition of Qualifying Events listed in the policy.

WAITING PERIOD This policy has a thirty (30) Day Waiting Period. Waiting Period means the first thirty (30) days following an Insured Person's Policy Effective Date. No benefits will be paid for a Qualifying Event that is Diagnosed during the Waiting Period. If an Insured Person is Diagnosed with a Qualifying Event during the Waiting Period, We will terminate the Insured Person's coverage under this policy and refund the applicable portion of premium paid for that Insured Person's coverage.

PRE-EXISTING CONDITION(S) The benefits of this policy will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Policy Effective Date for each Insured Person.

6. TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED

GUARANTEED RENEWABLE FOR LIFE The policy is guaranteed renewable for life. You may keep the coverage in force during Your lifetime by paying the premiums on time. We cannot cancel or refuse to renew the policy for any reason other than nonpayment of premium. At no time while You continue the policy in force may We place any restrictive Riders on it without Your permission.

7. OPTIONAL BENEFIT RIDERS (additional premiums required) - A checkmark in any of the boxes below indicates that You have selected the following optional coverage(s):

☐ **ACCIDENT FIXED INDEMNITY BENEFIT RIDER (Form #LY-LSAI-RD)**

ACCIDENT INJURY BENEFITS

BURN BENEFIT We will pay the Burn Benefit Amounts shown on the Benefit Schedule if any Insured Person suffers burns in a Covered Accident which require medical Treatment. The burns must be treated by a Physician within seventy-two (72) hours after the Covered Accident.

SKIN GRAFTS BENEFIT We will pay the Skin Graft Benefit Amount shown on the Benefit Schedule if any Insured Person receives one (1) or more skin grafts as the result of a Covered Injury suffered in a Covered Accident.

This benefit is only payable if a Burn Benefit is also payable.

COMA BENEFIT We will pay the Coma Benefit Amount shown on the Benefit Schedule if any Insured Person is Diagnosed and receives Treatment for a Coma as the result of a Covered Injury suffered in a Covered Accident. The Coma must:

a. be Diagnosed by a Physician within thirty (30) days after the Covered Accident; and
b. persist for at least seven (7) consecutive days.

This benefit is limited to one (1) Coma Benefit Amount per Insured Person per lifetime.

CONCUSSION (BRAIN) BENEFIT We will pay the Concussion (Brain) Benefit Amount shown on the Benefit Schedule if any Insured Person suffers a significant blow to the head in a Covered Accident which results in unconsciousness. The concussion must be Diagnosed by a Physician within seventy-two (72) hours after the Covered Accident using any type of medical imaging procedure such as an X-ray, CT (computerized tomography) scan, or MRI (magnetic resonance imaging).

This benefit is limited to one (1) Concussion Benefit Amount per Insured Person per Covered Accident.

DISLOCATION/SEPARATED JOINT BENEFIT We will pay the Dislocation/Separated Joint Benefit Amount shown on the Benefit Schedule if any Insured Person suffers a Dislocation as a result of a Covered Injury suffered in a Covered Accident. A Dislocation must:

a. be Diagnosed by a Physician within fourteen (14) days after the Covered Accident;
b. require correction with anesthesia by a Physician; and
c. be corrected by a Physician within ninety (90) days after the Covered Accident.

If an Insured Person suffers more than one (1) Dislocation in a Covered Accident, We will pay for multiple Dislocations. However, We will pay no more than 150% of the Dislocation/Separated Joint Benefit Amount for the separated joint involved which has the highest Dislocation/Separated Joint Benefit Amount.

If the Dislocation does not require anesthesia by a Physician, We will pay 25% of the Dislocation/Separated Joint Benefit Amount shown for the separated joint involved.

If a Physician Diagnoses the Dislocation as an incomplete Dislocation, We will pay 25% of the Dislocation Benefit Amount shown for the separated joint involved. An incomplete Dislocation is a Dislocation in which the joint is not completely separated.

We will pay this benefit only for the first (1st) Dislocation of a joint per Covered Accident. Subsequent Dislocations of the same joint will not be covered.

If an Insured Person suffers a Dislocation and a Fracture in the same Covered Accident, We will pay for both. However, We will pay no more than 150% of the Dislocation/Separated Joint Benefit Amount for the bone or joint involved which has the highest Dislocation/Separated Joint Benefit Amount.

EMERGENCY DENTAL WORK BENEFIT We will pay the Emergency Dental Work Benefit Amount shown on the Benefit Schedule if any Insured Person requires a dental extraction and/or crown to their sound, natural teeth as the result of a Covered Injury suffered in a Covered Accident. Sound, natural teeth does not include false teeth such as dentures, bridges, veneers, partials, crowns, or implants. Treatment by a Physician or dentist must begin within seventy-two (72) hours after the Covered Accident.

This benefit is limited to one (1) payment per Insured Person per Covered Accident.

EYE INJURY BENEFIT We will pay the Eye Injury Benefit Amount shown on the Benefit Schedule if any Insured Person suffers an eye injury as the result of a Covered Accident. The eye injury must require surgery or the removal of a foreign object by a Physician within ninety (90) days after the Covered Accident. An examination with anesthesia will not be considered surgery.

This benefit is limited to one (1) payment per Insured Person per Covered Accident.

If an Insured Person suffers an eye injury and later loses sight of the eye as a result of the same Covered Accident, We will subtract the amount We paid under the Eye Injury Benefit from the Accidental Dismemberment Benefit.

FRACTURE (BROKEN BONE) BENEFIT We will pay the Fracture (Broken Bone) Benefit Amount shown on the Benefit Schedule if any Insured Person suffers a Fracture injury as a result of a Covered Accident. A Fracture must:

a. be Diagnosed by a Physician within fourteen (14) days after the Covered Accident; and
b. be corrected by a Physician within ninety (90) days after the Covered Accident.

If an Insured Person suffers more than one (1) Fracture in a Covered Accident, We will pay no more than the amount for the two (2) bones involved which have the highest Benefit Amounts.

If a Physician Diagnoses the Fracture as a Chip Fracture, We will pay 25% of the Benefit Amount shown for the bone involved.

If an Insured Person receives a Fracture and a Dislocation in the same Covered Accident, We will pay for both. However, We will pay no more than 150% of the Benefit Amount for the bone or joint involved which has the highest Benefit Amount.

LACERATION BENEFIT We will pay the Laceration Benefit Amount shown on the Benefit Schedule if any Insured Person suffers a Laceration injury as a result of a Covered Accident. The Laceration must be repaired by a Physician within seventy-two (72) hours after the Covered Accident.

The amount We pay will be based on the total length of all Lacerations received in any one (1) Covered Accident which require repair. If the Laceration is severe enough to require stitches but the Physician chooses to repair it another way, We will treat it as if it were repaired without stitches.

If an Insured Person suffers a Laceration on their finger or toe and later loses that finger or toe as a result of the same Covered Accident, We will subtract the amount We paid under the Laceration Benefit from the Accidental Dismemberment Benefit.

PARALYSIS BENEFIT We will pay the Paralysis Benefit Amount shown on the Benefit Schedule if any Insured Person suffers Paralysis as a result of a Covered Injury suffered in a Covered Accident. The duration of the Paralysis must be a minimum of thirty (30) days.

This benefit is limited to one (1) payment per Insured Person per lifetime.

SURGICAL PROCEDURES BENEFIT We will pay the Surgical Procedures Benefit Amount shown on the Benefit Schedule if any Insured Person requires a surgical procedure as a result of a Covered Injury suffered in a Covered Accident. The surgical procedure must be performed within one (1) year of the Covered Accident.

Two (2) or more surgical procedures performed through the same incision will be considered one (1) operation and benefits will be paid based upon the surgical procedure with the highest Surgical Procedures Benefit Amount.

A miscellaneous surgery means a surgical procedure that is not covered by any other specific Covered Injury benefit and requires general anesthesia. If more than one (1) miscellaneous surgical procedure is performed in a twenty-four (24) hour period, We will only pay one (1) miscellaneous surgery.

This benefit is limited to a maximum of two (2) miscellaneous surgeries per Insured Person per Calendar Year.

HOSPITAL AND SERVICES BENEFITS

ACCIDENT EMERGENCY TREATMENT BENEFIT We will pay the Accident Emergency Treatment Benefit Amount shown on the Benefit Schedule if any Insured Person suffers a Covered Injury as a result of a Covered Accident. For this benefit to be payable all the following must occur:

a. the Covered Injury is an Emergency; and
b. the Covered Injury requires examination and Treatment by a Physician in a Hospital Emergency Room, an Urgent Care Center, or Physician's office within seventy-two (72) hours after the Covered Accident.

This benefit is payable once per twenty-four (24) hour period and only once per Insured Person per Covered Accident.

If an Insured Person receives Treatment in an Urgent Care Center or Physician's office as a result of a Covered Injury suffered in a Covered Accident and subsequently requires Treatment in a Hospital or Emergency Room, We will only pay the highest Benefit Amount payable.

ACCIDENT FOLLOW-UP TREATMENT BENEFIT We will pay the Accident Follow-Up Treatment Benefit Amount shown on the Benefit Schedule per visit if any Insured Person needs additional Treatment of a Covered Injury suffered in a Covered Accident over and above Emergency Treatment administered in the first seventy-two (72) hours following the Covered Accident.

This benefit is limited to six (6) visits per Insured Person per Covered Accident.

Follow-up Treatment must begin within thirty (30) days of the Covered Accident and must conclude within six (6) months following the Covered Accident. Such treatments must be furnished by a Physician in a Physician's office or in a Hospital on an Outpatient basis.

AMBULANCE BENEFIT We will pay the Air Ambulance Benefit Amount shown on the Benefit Schedule when a licensed professional air ambulance company transports any Insured Person to or from a Hospital or between medical facilities where Treatment is received for a Covered Injury suffered in a Covered Accident.

The air ambulance transportation must be within seventy-two (72) hours after the Covered Accident.

The Air Ambulance Benefit is limited to one (1) payment per Insured Person per Covered Accident. We will pay a maximum of two (2) Air Ambulance Benefit Amounts per Insured Person per Calendar Year.

We will pay the Ground/Water Ambulance Benefit Amount shown on the Benefit Schedule when a licensed professional ground/water ambulance company transports any Insured Person to or from a Hospital or between medical facilities where Treatment is received for a Covered Injury suffered in a Covered Accident.

The ground/water ambulance transportation must be within ninety (90) days after the Covered Accident.

The Ground/Water Ambulance Benefit is limited to one (1) payment per Insured Person per Covered Accident. We will pay a maximum of two (2) Ground/Water Ambulance Benefit Amounts per Insured Person per Calendar Year. When an Insured Person is transported by two (2) separate ambulances for the same Covered Accident, We will pay the ground, water, or air ambulance benefit, whichever is greatest.

APPLIANCE BENEFIT We will pay the Appliance Benefit Amount shown on the Benefit Schedule if any Insured Person suffers a Covered Injury in a Covered Accident and a Physician prescribes the use of a medical appliance as an aid in personal locomotion or mobility. Crutches, leg braces, back braces, walkers, and wheelchairs are examples of medical appliances. The use of an appliance must begin within ninety (90) days after the Covered Accident.

This benefit is limited to one (1) payment per Insured Person per Covered Accident.

AT-HOME RECOVERY BENEFIT For each Day that an Insured Person was confined to a Hospital or Hospital Intensive Care Unit, We will pay three (3) days of the At-Home Recovery Benefit Amount shown on the Benefit Schedule. The at-home recovery must be received on the advice of a Physician and be the result of a Covered Injury suffered in a Covered Accident.

This benefit has a maximum of ninety (90) days per Insured Person per Covered Accident.

ATTENDING PHYSICIAN BENEFIT For each Day that an Insured Person is confined to a Hospital or Hospital Intensive Care Unit, We will pay the Attending Physician Benefit Amount shown on the Benefit Schedule for the services of an attending Physician, not to exceed 365 days per Insured person per Covered Accident. The Insured Person must become Confined within sixty (60) days for a Covered Injury suffered in a Covered Accident.

BLOOD, PLASMA, PLATELETS BENEFIT We will pay the Blood, Plasma, Platelets Benefit Amount shown on the Benefit Schedule if any Insured Person suffers a Covered Injury in a Covered Accident and requires the transfusion, administration, cross-matching, typing, and processing of blood, plasma, or platelets. The blood, plasma, or platelets must be administered within ninety (90) days after the Covered Accident.

This benefit is limited to one (1) payment per Insured Person per Covered Accident. We will not pay for immunoglobulins.

DIAGNOSTIC IMAGING BENEFIT We will pay the Diagnostic Imaging Benefit Amount shown on the Benefit Schedule for either an X-ray or a major diagnostic exam if any Insured Person requires one of the following in a Hospital, Urgent Care Center, Emergency Room, or a Physician's office.

a. an X-ray while receiving Emergency Treatment for a Covered Injury suffered in a Covered Accident; or
b. a major diagnostic exam, computerized tomography (CT) scan, computerized axial tomography (CAT), magnetic resonance imaging (MRI), positron emission tomography (PET), ultrasound, magnetic resonance angiography (MRA), electrocardiography (EKG), or electroencephalography (EEG)) while receiving Treatment for a Covered Injury suffered in a Covered Accident.

The X-ray benefit is limited to one (1) X-ray per Insured Person per Covered Accident and two (2) X-rays per Insured Person per Calendar Year. The X-ray benefit is not payable for major diagnostic exams.

The major diagnostic exam benefit is limited to one (1) major diagnostic exam per Insured Person per Covered Accident and two (2) major diagnostic exams per Insured Person per Calendar Year. Major diagnostic exams do not include X-rays.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

ACCIDENTAL DEATH BENEFIT If an Insured Person dies as a direct result of Covered Accident or a Covered Accident while riding as a passenger in, on, boarding, or alighting from a Common Carrier, We will pay the Accidental Death Benefit Amount shown on the Benefit Schedule if all of the following requirements are met:

a. Accidental Death occurs on or after the Insured Person's Rider Effective Date and while this Rider is in force;
b. We receive due proof of loss, satisfactory to Us, of the Insured Person's Accidental Death;
c. the proof shows that death resulted directly from a Covered Injury caused solely as a result of a Covered Accident and independent of disease, physical condition, bodily infirmity, or any other cause;
d. Accidental Death occurred within the first ninety (90) days after the Covered Accident, except in cases when, at the end of the ninety (90) Day period, an Insured Person is being kept clinically alive by an artificial life support system, the ninety (90) Day limit will be extended to 180 days; and
e. the benefit payment is not precluded by any general or specific exclusion, description, or any failure to meet any requirement stated in this Rider.

If We pay the Accidental Death – Common Carrier Benefit Amount, We will not pay the Accidental Death – Other Accidents Benefit Amount.

In the event that Accidental Death and Accidental Dismemberment result from the same Covered Accident, the total benefit payable will not exceed that of the Accidental Death Benefit Amount.

ACCIDENTAL DISMEMBERMENT BENEFIT If an Insured Person suffers an Accidental Dismemberment as a direct result of a Covered Accident, We will pay the Accidental Dismemberment Benefit Amount shown on the Benefit Schedule if all of the following requirements are met:

a. the Covered Accident and Accidental Dismemberment occur on or after the Insured Person's Rider Effective Date and while this Rider is in force;
b. Treatment for the Covered Injury is received within the United States;
c. the Accidental Dismemberment occurs within the first ninety (90) days after the Covered Accident; and
d. the benefit payment is not precluded by any general or specific exclusion, description, or any failure to meet any requirement stated in this Rider.

This benefit will be paid even if the severed body part is subsequently reattached. Only Accidental Dismemberments shown on the Benefit Schedule are eligible for payment under this Rider. Any dismemberment not listed on the Benefit Schedule is not eligible for payment under this Rider.

This benefit is limited to two (2) Benefit Amounts per Insured Person per lifetime. In the case of multiple dismemberments resulting from one (1) Covered Accident, only the highest single benefit will be paid per Insured Person. Loss of use does not constitute dismemberment except as stated for Loss of Sight of Eye injuries in the Rider.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR In addition to any benefit-specific conditions, limitations, or exclusions, no benefits will be payable for a Covered Injury which, directly or indirectly, in whole or in part, is caused by or results from any of the following:

a. an Insured Person's being intoxicated, as determined and defined by the laws and jurisdiction of the geographical area in which the injury or Illness or cause of injury or Illness was incurred, or under the influence of any narcotic unless administered under the advice of a Physician and taken as prescribed. The Insured Person's alcohol or narcotic impairment must be the cause or contributing cause of his or her injury or Sickness, irrespective of whether the injury or Sickness occurred while the Insured Person was driving a motor vehicle or engaged in any other activity;
b. flight in, boarding, or alighting from an aircraft or any craft designed to fly above the Earth's surface except as a fare-paying passenger on a regularly-scheduled commercial or charter airline;
c. elective or cosmetic surgery or complications of cosmetic surgery. This does not include reconstructive, cosmetic surgery: i) incidental to or following surgery for trauma, infection, or other disease of the involved part; or ii) due to congenital disease or anomaly of a covered dependent Child which has resulted in a functional defect;
d. dental treatment of the teeth, gums, or structures directly supporting the teeth including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints, and services for dental malocclusion for any condition are not covered, except if provided for or in connection with a Covered Injury to sound natural teeth and a continuous course of dental treatment is started within six (6) months of the Covered Injury. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support, and are functional in the arch;
e. commission of or attempt to commit an illegal activity or a felony;
f. participation in any high-risk activities such as bungee jumping, parachuting, skydiving, parasailing, hang-gliding, deep-sea scuba diving, parkour, free running, sail gliding, parakiting, bronc or bull riding, or any similar activity;
g. any motorized race or contest of speed, to include off-road vehicles that may not require a license;
h. any mental or nervous or emotional disorder, alcoholism, and drug addiction;
i. active-duty service in the military, naval, or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid during the Insured Person's time of active duty. Reserve or National Guard active-duty training is not excluded unless it extends beyond thirty-one (31) consecutive days;
j. suicide (while sane or insane), attempted suicide, or intentionally self-inflicted injury;

k. travel, activity, or Treatment outside the United States;
l. war or act of war (whether declared or undeclared);
m. commission of or active participation in a riot, insurrection, rebellion, or police action; or
n. voluntary self-administration of any narcotic, drug, poison, gas, or fumes unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage.

The following conditions, Treatments, and/or services are **not covered** under this Rider:
a. Care, services, or supplies received without charge or legal obligation to pay or while the Rider was not in force;
b. Treatment, services, and supplies for Experimental, Investigational, or Unproven purposes;
c. dental treatment of the teeth, gums, or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints, and services for dental malocclusion for any condition are not covered, except if provided for or in connection with a Covered Injury to sound natural teeth and a continuous course of dental treatment is started within six (6) months of the Covered Injury. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support, and are functional in the arch;
d. Treatment or services from a masseur, massage therapist or rolfer, massage therapy, and any type of holistic therapy which include but are not limited to meditation, aromatherapy, and relaxation therapy; or
e. repetitive or cumulative motions or stress traumas which include but are not limited to carpal tunnel syndrome, tennis elbow, and thoracic outlet syndrome.

☐ **LUMP SUM CANCER RIDER (Form #LY-LSC-RD-KS)**

CANCELLATION You may cancel this Rider at any time by written notice delivered or mailed to us. Your cancellation will be effective upon receipt of your notice or on such later date as may be specified in such notice. In the event of Cancellation or death, we will promptly return the unearned portion of any premium paid by you. We will determine the amount of the refund, if any, by prorating the last modal premium paid from the date of the Cancellation until the next modal premium due date. Cancellation will be without prejudice to any claim originating prior to the effective date of Cancellation.

CANCER DIAGNOSIS BENEFIT Subject to the Reduction Schedule and Benefit Payment Conditions listed below, if an Insured Person receives a Diagnosis of Cancer from a Physician, We will pay You the Cancer Diagnosis Benefit Amount shown on the Policy Schedule Page or policy endorsement. After payment of the Cancer Diagnosis Benefit Amount for an Insured Person, coverage for that Insured Person under the Rider will terminate.

BENEFIT PAYMENT CONDITIONS Payment of the Cancer Diagnosis Benefit shall be subject to the following conditions:
a. Diagnosis must be made within the United States;
b. the Date of Diagnosis shall occur while the Insured Person is covered by the Rider; and
c. payment shall be precluded by any general or specific exclusion, limitation, or reduction set forth in the Rider and the policy (including, without limitation, the exclusion for any Pre-Existing Condition) or any failure by the Insured Person to meet any condition precedent.

REDUCTION SCHEDULE For any Cancer Diagnosed within the first thirty (30) days after the Rider Effective Date the Cancer Diagnosis Benefit Amount shall be reduced. The reduced Benefit Amount for Cancer will be 10% of the Cancer Diagnosis Benefit Amount shown on the Policy Schedule Page or policy endorsement.

In the event an Insured Person is Diagnosed with Cancer within the first thirty (30) days following their Rider Effective Date and the reduced Benefit Amount for Cancer is paid, no other benefits shall be payable and coverage for that Insured Person under the Rider will terminate.

EXCLUSIONS AND LIMITATIONS The Rider is subject to the following Exclusions and Limitations, in addition to those outlined in the policy.

In addition to any benefit-specific conditions, limitations, or exclusions, no benefits will be payable under the Rider for:

a. any disease, Sickness, or incapacity other than Cancer as defined; this is so even though such disease, Sickness, or incapacity may have been complicated, affected (directly or indirectly), or caused by Cancer;
b. loss that begins prior to the Rider Effective Date;
c. Diagnosis received outside the United States or its territories, unless otherwise specified in the Rider; or
d. any Illness specifically excluded from the definition of Cancer or Carcinoma in Situ.

PRE-EXISTING CONDITION(S) The benefits of the Rider will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Rider Effective Date for each Insured Person.

CONTINUITY OF COVERAGE If this Rider replaced another specified disease policy or rider, or is issued in addition to existing specified disease coverage, the issuing company shall give credit for the expired portion of any waiting period, elimination period, probationary period, pre-existing condition limitation or exclusion provision or conditions for any similar provision.

If coverage is provided for two (2) or more individuals, such coverage will be determined separately for each Insured Person.

☐ **SPECIFIED DISEASE BENEFIT RIDER (Form #LY-LSD2-RD.v2-KS)**

CANCELLATION You may cancel this Rider at any time by written notice delivered or mailed to us. Your cancellation will be effective upon receipt of your notice or on such later date as may be specified in such notice. In the event of Cancellation or death, we will promptly return the unearned portion of any premium paid by you. We will determine the amount of the refund, if any, by prorating the last modal premium paid from the date of the Cancellation until the next modal premium due date. Cancellation will be without prejudice to any claim originating prior to the effective date of Cancellation.

SPECIFIED DISEASE BENEFIT We will pay You the Specified Disease Benefit Amount, shown on the Policy Schedule Page, if an Insured Person receives a Diagnosis or procedure from a Physician for one (1) of the Specified Diseases shown in the chart below and subject to the following conditions:

a. Diagnosis must be made within the United States; and
b. the Date of Diagnosis or Procedure shall occur while the Insured Person is covered by this Rider.

MODERATE ALZHEIMER'S DEMENTIA/SEVERE ALZHEIMER'S DEMENTIA To qualify for coverage under this Rider, You must be Diagnosed by either a board-certified neurologist or a psychiatrist with **either** Moderate Alzheimer's Dementia **or** Severe Alzheimer's Dementia. A qualifying Diagnosis must include:

a. a score on the MMSE of less than 18 for Moderate Alzheimer's Dementia or less than 11 for Severe Alzheimer's Dementia; and
b. the conclusion that You are permanently unable to perform three (3) or more Activities of Daily Living.

The benefit provided by this Rider for a Diagnosis of Alzheimer's Dementia (whether Diagnosed as Moderate or Severe) is a one-time payment equal to 50% of the Alzheimer's Dementia Amount noted on the Policy Schedule Page, with no further payout for any other Specified Disease nor for the worsening of Your Alzheimer's Dementia.

Specified Diseases	Benefit Paid One Time
Alzheimer's Dementia (Moderate or Severe)	50%
Amyotrophic Lateral Sclerosis (ALS)	100%
Blindness	100%
Coma	100%
End Stage Renal Failure	100%
Loss of Hearing	100%
Loss of Speech	100%
Major Organ Transplant	100%
Multiple Sclerosis (MS)	100%
Paralysis	100%
Severe Burns	100%

Each Insured Person is limited to one (1) Specified Disease Benefit Amount under the terms of this Rider. After payment of the Specified Disease Benefit Amount shown on the Policy Schedule Page for an Insured Person, We will not pay any additional benefits for any additional Specified Diseases covered by this Rider for the same Insured Person.

If the Date of Diagnosis of two (2) or more Specified Diseases is the same Day, We will pay only one (1) Specified Disease Benefit Amount. We will pay the larger of the Specified Disease benefits Diagnosed on the same Day.

No benefits are payable for conditions other than the Specified Diseases defined in this Rider. Payment of the Specified Disease Benefit is subject to all terms and conditions of this Rider and the policy to which it is attached.

EXCLUSIONS AND LIMITATIONS This Rider does not cover any Sickness, illness, incapacity, or procedure other than the Specified Diseases defined above.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR This Rider is subject to the Exclusions and Limitations outlined in the policy. In addition to any benefit-specific conditions, limitations, or exclusions, no benefits will be payable under this Rider for:

a. intentionally self-inflicted injury, suicide, or any attempt while sane or insane;
b. loss that begins prior to the effective date of coverage; or
c. voluntary self-administration of any narcotic, drug, poison, gas, or fumes unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage.

PRE-EXISTING CONDITION(S) The benefits of the Rider will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Rider Effective Date for each Insured Person.

CONTINUITY OF COVERAGE If this Rider replaced another specified disease policy or rider, or is issued in addition to existing specified disease coverage, the issuing company shall give credit for the expired portion of any waiting period, elimination period, probationary period, pre-existing condition limitation or exclusion provision or conditions for any similar provision.

If coverage is provided for two (2) or more individuals, such coverage will be determined separately for each Insured Person.

☐ **HEART AND STROKE RESTORATION BENEFIT RIDER (Form #LY-HR-RD-KS)**

CANCELLATION You may cancel this Rider at any time by written notice delivered or mailed to us. Your cancellation will be effective upon receipt of your notice or on such later date as may be specified in such notice. In the event of Cancellation or death, we will promptly return the unearned portion of any premium paid by you. We will determine the amount of the refund, if any, by prorating the last modal premium paid from the date of the Cancellation until the next modal premium due date. Cancellation will be without prejudice to any claim originating prior to the effective date of Cancellation.

When 100% of the Heart and Stroke Diagnosis Benefit Amount under the policy to which the Rider is attached has been paid for an Insured Person, We will pay You the Heart and Stroke Restoration Benefit when an Insured Person receives a Diagnosis of a Heart Attack, Stroke, or Heart Transplant. However, for the Heart and Stroke Restoration Benefit to be payable, such Heart and Stroke Restoration Benefit Diagnosis must be separated by at least twenty-four (24) consecutive months from an Insured Person's last Date of Diagnosis for a Heart Attack, Stroke, or Heart Transplant under the policy to which the Rider is attached.

The amount payable for the Diagnosis of a Heart Attack, Stroke, or Heart Transplant is equal to the percentage times the Heart and Stroke Restoration Benefit Amount shown on the Policy Schedule Page or policy endorsement. The percentage of the Heart and Stroke Restoration Benefit Amount payable is shown in the chart below.

Time Period From Last Date of Diagnosis for a Heart Attack, Stroke, or Heart Transplant	% of Restoration Benefit Amount Payable for a Heart Attack, Stroke, or Heart Transplant	Maximum Percentage of Benefit Amount Payable
Less than 24 months	0%	100%
24 months or more but less than 5 years	25%	
5 years or more but less than 10 years	75%	
10 years or more	100%	

If an Insured Person receives benefits payable for a Heart Attack, Stroke, or Heart Transplant that is less than 100% of the Heart and Stroke Restoration Benefit Amount payable and later receives a Diagnosis for a different Heart Attack, Stroke, or Heart Transplant, We will pay the specified percentage in the chart above, less any prior amounts paid or payable under this benefit. However, for the Heart and Stroke Restoration Benefit to be payable, such Heart and Stroke Restoration Benefit Diagnosis must be separated by at least twenty-four (24) consecutive months from an Insured Person's last Date of Diagnosis for a Heart Attack, Stroke, or Heart Transplant under the Rider.

After payment of the maximum percentage of the Heart and Stroke Restoration Benefit Amount for an Insured Person shown in the chart above, coverage for that Insured Person will terminate under the Rider.

EXCLUSIONS AND LIMITATIONS The exclusions and limitations that apply to the Rider are the same as the Exclusions and Limitations of the Policy.

CONTINUITY OF COVERAGE If this Rider replaced another specified disease policy or rider, or is issued in addition to existing specified disease coverage, the issuing company shall give credit for the expired portion of any waiting period, elimination period, probationary period, pre-existing condition limitation or exclusion provision or conditions for any similar provision.

If coverage is provided for two (2) or more individuals, such coverage will be determined separately for each Insured Person.

☐ **LUMP SUM HEART AND STROKE BENEFIT BUILDER RIDER (Form #LY-HBB-RD.v2-KS)**

CANCELLATION You may cancel this Rider at any time by written notice delivered or mailed to us. Your cancellation will be effective upon receipt of your notice or on such later date as may be specified in such notice. In the event of Cancellation or death, we will promptly return the unearned portion of any premium paid by you. We will determine the amount of the refund, if any, by prorating the last modal premium paid from the date of the Cancellation until the next modal premium due date. Cancellation will be without prejudice to any claim originating prior to the effective date of Cancellation.

This Rider, beginning with the Rider Effective Date, increases the policy Benefit Amount annually by the amount shown on the Policy Schedule Page.

This benefit will be paid under the same terms as the policy to which this Rider is attached. For the benefit to be payable:

a. the Date of Diagnosis must occur after the Rider Waiting Period has expired;
b. the Date of Diagnosis must occur while the Insured Person is covered by this Rider; and
c. the Rider premiums must continue to be paid for the accrued benefit to remain in force.

The annual benefit will increase each year for all Insured Persons until the thirty-fifth (35^{th}) Rider anniversary. After the thirty-fifth (35^{th}) year, no additional amounts will be accrued.

If an Insured Person receives benefits for a Qualifying Event under the Heart and Stroke Diagnosis Benefit that is less than 100% of the Heart and Stroke Diagnosis Benefit Amount, the same percentage will be applied to the benefits accrued under this Rider. The accumulated benefit amount payable for the subsequent Qualifying Event(s) is the total accrued benefit amount minus the total benefit amount received for all previous Qualifying Events.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR This Rider is subject to the Exclusions and Limitations outlined in the policy. In addition to any benefit-specific conditions, limitations, or exclusions, no benefits will be payable under this Rider for:

a. loss that begins prior to the Rider Effective Date; or
b. a Qualifying Event Diagnosed during the Waiting Period.

WAITING PERIOD This Rider has a thirty (30) Day Waiting Period. No benefits will be paid for a Qualifying Event that is Diagnosed during the Waiting Period. If an Insured Person is Diagnosed with a Qualifying Event during the Waiting Period, We will terminate the Insured Person's coverage under this Rider and refund the applicable portion of premium paid for that Insured Person's coverage.

PRE-EXISTING CONDITION(S) The benefits of this Rider will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Rider Effective Date for each Insured Person.

CONTINUITY OF COVERAGE If this Rider replaced another specified disease policy or rider, or is issued in addition to existing specified disease coverage, the issuing company shall give credit for the expired portion of any waiting period, elimination period, probationary period, pre-existing condition limitation or exclusion provision or conditions for any similar provision.

If coverage is provided for two (2) or more individuals, such coverage will be determined separately for each Insured Person.

☐ **RETURN OF PREMIUM RIDER (Form #LY-ROP-D)**

In the event You die while this Rider is in force, a Return of Premium Benefit may be payable to your named beneficiary or estate. If this Rider is added to the policy after the policy was issued, only the premium paid for the policy on or after the Rider Effective Date will be returned. The Return of Premium Benefit is Original Premium less Claims Paid.

The benefit provided by this rider is payable only once during the entire time that the policy and this rider is in force.

If a payable claim is incurred on a date when the Return of Premium Benefit would otherwise be payable, regardless of whether it has been reported or adjudicated, We will:

a. pay the claim if it is payable upon the terms of the policy or Rider and then reduce the Return of Premium Benefit by the sum of all Claims Paid; or
b. pay the Return of Premium Benefit and then reduce the claim by the amount of the Return of Premium Benefit; or
c. pay the Return of Premium Benefit if the claim is not payable upon the terms of the policy or Rider.

☐ **WELLNESS BENEFIT RIDER (Form #LY-WL-RD) (only available through Worksite)**

We will pay the benefit shown on the Policy Schedule Page, if an Insured Person undergoes or receives Health Screening Tests, as set forth below, while coverage under this Rider is in force. Benefits are subject to the Rider Benefit Waiting Period.

For the benefit to be payable:

a. the testing must be rendered by a Physician or a licensed health care professional under the supervision of a Physician; and
b. the date of the health screening test is after the Rider Waiting Period has expired.

Only one (1) benefit will be paid per Insured Person per Rider year. A Rider year is a full twelve (12) month period from the Rider Effective Date.

Health Screening Tests
- Mammography;
- Pap smear for women over Age 18;
- Flexible sigmoidoscopy;
- Hemoccult stool specimen;
- Colonoscopy;
- Prostate specific antigen (for prostate cancer);
- Stress test on a bicycle or treadmill;
- Fasting blood glucose test;
- Blood test for triglycerides;
- Serum cholesterol test to determine levels of HDL and LDL;
- Bone marrow testing;
- Breast ultrasound;
- CA 15-3 (blood test for breast cancer);
- CA125 (blood test for ovarian cancer);
- CEA (blood test for colon cancer);
- Chest X-ray;
- Serum protein electrophoresis (blood test for myeloma); and
- Thermography

This Rider does not cover any health screening tests other than the Health Screening Tests defined above.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR This Rider is subject to the Exclusions and Limitations outlined in the policy. In addition to any benefit-specific conditions, limitations, or exclusions, no benefits will be payable under this Rider for loss that begins prior to the effective date of coverage.

WAITING PERIOD This Rider has a thirty (30) Day Waiting Period.

8. YOUR TOTAL ANNUAL PREMIUM (at time of application)

Lump Sum Heart and Stroke Policy	$_____
Accident Fixed Indemnity Benefit Rider	$_____
Lump Sum Cancer Rider	$_____
Specified Disease Benefit Rider	$_____
Heart and Stroke Restoration Benefit Rider	$_____
Lump Sum Heart and Stroke Benefit Builder Rider	$_____
Return of Premium Rider	$_____
Wellness Benefit Rider	$_____
TOTAL	$_____

_____
Agent's name (print)

_____
Agent's signature Date

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LOYAL AMERICAN LIFE INSURANCE COMPANY®
PO Box 5700, Scranton, PA 18505-5700

SPECIFIED CRITICAL ILLNESS INSURANCE POLICY
MEDICARE DUPLICATION NOTICE

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions for one of the specified diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnosis named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program.

Loyal American Life Insurance Company®
PO Box 5725, Scranton, PA 18505-5725 • Toll Free: 866-459-4272

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application and information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Loyal American Life Insurance Company®. Your new policy provides 30 days in which you may decide, without cost, whether or not you decide to keep this policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on any application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____
Date

_____
Applicant's Signature