

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY

P.O. Box 4884 • 200 Westlake Park Blvd. • Houston, Texas 77210-4884

(herein called "We", "Our" or "Us")

CANCER COVERAGE POLICY FORM C36 TX

—OUTLINE OF COVERAGE—

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

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

- I. **READ YOUR POLICY CAREFULLY** - This outline of coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. It is therefore important that you **READ YOUR POLICY CAREFULLY!**
- II. Cancer coverage is designed to provide you with coverage paying benefits only when certain losses occur as a result of cancer. Coverage is provided for the benefits outlined in Paragraph III. The benefits described in Paragraph III may be limited by Paragraph IV.
- III. The benefits of the policy are payable for loss that results from a positive diagnosis of a cancer under the terms of the policy.

Benefits for experimental treatment are payable on the same basis as any other benefit under the policy.

Benefits for the treatment of breast cancer include a minimum of 48 hours of inpatient care following a mastectomy and a minimum of 24 hours of inpatient care following a lymph node dissection for the treatment of breast cancer. Minimum hours of inpatient care will not apply if the patient's attending Physician determines that a shorter period of care is appropriate.

We will pay the following benefits for the treatment of cancer.

- (1) Hospital Confinement – pays the daily hospital confinement benefit selected by you for each day of covered hospital confinement.
- (2) Government or Charity Hospital – pays the daily hospital confinement benefit for each day of covered confinement in a government or charity hospital. The benefits received under this benefit provision are in lieu of all other benefits provided in the policy and riders, except First Occurrence or Hospital Intensive Care Benefit (if selected), Transportation and Lodging Benefit, and Adult Companion Lodging and Transportation Benefit.
- (3) Outpatient Surgery Facility Benefit – pays a benefit two times the daily hospital confinement benefit for covered outpatient surgery in a hospital or in a free-standing surgical facility. This benefit is not payable for surgery in a physician's office or clinic. This benefit is also not payable for skin cancer as defined in the policy.
- (4) Surgical Benefit – pays up to \$10,000 per calendar year for each insured person for charges made by a surgeon for surgery in or out of a hospital as outlined in the Surgical Benefits Schedule in the policy. The maximum amount payable for surgical procedures related to skin cancer is \$500 per calendar year for each insured person.
- (5) Second Surgical Option – pays the charges incurred up to \$250 for a second, if necessary, surgical opinion.
- (6) Anesthesia – pays 25% of the amount payable under the Surgical Benefit for the administration of an anesthetic. Not payable for skin cancer.
- (7) Blood and Blood Plasma – pays the charges incurred up to \$100 per day for blood, blood plasma, platelets, therapeutic pheresis, transfusion, administration, cross-matching, typing and processing of blood, blood plasma and platelets when given on a day when Hospital Confinement or Outpatient Surgical Facility Benefit is payable. Does not pay for blood which is donated or replaced. This benefit is limited to \$5,000 per calendar year for each insured person. Does not pay for immunoglobulins, immunotherapy or colony-stimulating factors.

- (8) Breast Reconstruction/Breast Prostheses – pays: (a) the charges incurred up to \$5,000 for surgically implanted breast prostheses, breast tissue expanders and natural breast reconstruction that is performed as a direct result of surgery for cancer treatment. Limited to a lifetime maximum of \$5,000 per insured person; and (b) the charges incurred up to \$250 for external breast prostheses prescribed as a direct result of surgery for cancer treatment. Limited to a lifetime maximum of \$250 per insured person.
- (9) Cancer Screening Test(s) – pays the scheduled amount up to \$100 per calendar year for each insured person for cancer screening tests performed by a physician more than 60 days after the policy effective date. A positive diagnosis of cancer is not required for this benefit to be payable.
- (10) Ambulance Benefit – pays the charges incurred per trip to transfer an insured person to the hospital for confinement as an inpatient. Also pays the charges incurred for the trip home from the hospital upon discharge. The ambulance service must be performed by a licensed or professional ambulance service. This benefit is limited to \$5,000 per calendar year for each insured person.
- (11) Transportation and Lodging – pays up to \$10,000 per calendar year for each insured person for any combination of the following for non-local treatment prescribed by the attending physician as necessary:
 - (a) for treatment which requires hospital confinement: (i) up to \$1,500 of the charges incurred for the round trip coach fare on a common carrier to the hospital that provides the prescribed covered treatment; or (ii) 50¢ per mile for personal automobile expense for non-local trips, not to exceed 700 miles round trip. This benefit is payable once for each period of continuous confinement.
 - (b) for treatment which does not require hospital confinement: (i) up to \$1,500 of the charges incurred for the round trip coach fare on a common carrier to the facility that provides the prescribed covered treatment, or 50¢ per mile for personal automobile expense for non-local trips, not to exceed 700 miles round trip; and (ii) the charges incurred for a single room in a motel, hotel or other accommodations acceptable to us, up to a maximum of \$50 per day. This benefit is limited to the number of days non-local covered treatment is received.

The Transportation and Lodging benefit will not be paid for periodic checkups, for visits to see the person requiring treatment or when an insured person is receiving non-covered treatment.

- (12) Adult Companion Lodging and Transportation – pays the following expenses up to \$7,500 per calendar year for one adult companion to be near you or any insured person when you or such person has been confined in a non-local hospital for covered treatment: (a) the charges incurred for a single room in a motel, hotel, or other accommodations acceptable to us, up to a maximum of \$50 per day. This benefit is limited to the number of days of the confined person's hospitalization; and (b) up to \$1,500 of the charges incurred for the round trip coach fare on a common carrier or a personal automobile allowance of 50¢ per mile for non-local trips from the visiting adult companion's residence to the hospital in which the hospitalized person is confined. Does not pay the personal automobile allowance in excess of 700 miles round trip. This benefit will be payable for an adult companion residing in the continental United States.

In the event that the insured person receiving treatment is a dependent child, pays up to another \$7,500 per calendar year for the benefits listed above for a second adult companion. This benefit will not be paid for visits when the insured person receives non-covered treatments or periodic checkups.

- (13) Bone Marrow or Peripheral Stem Cell Donors – pays up to \$5,000 per calendar year for the following expenses of a bone marrow or peripheral stem cell donor when the donor is someone other than the insured person (when the insured person is the recipient of the bone marrow or peripheral stem cell transplant): (a) the charges incurred up to \$2,000 for medical expenses, including hospital charges directly relating to the transplant; (b) the charges incurred up to \$1,500 for the round trip coach fare on a common carrier to the city where the transplant is performed; and (c) the charges incurred up to \$50 per day for lodging and meal expenses when the donor is asked to remain near the hospital for possible donation of additional blood components.
- (14) Extended Care Facility – pays the charges incurred up to \$60 per day for confinement in an extended care facility. Such confinement must: (a) be at the recommendation of the attending physician; and (b) begin within 30 days of a covered hospital confinement. Extended Care Facility benefits will be limited to the number of covered days of the prior hospital confinement, up to a lifetime

maximum of 365 days for each insured person. For each day this benefit is payable, hospital confinement benefits are NOT payable.

- (15) Hospice Care – pays the charges incurred up to \$100 per day for care provided by a hospice if the insured person has been diagnosed as terminally ill. This benefit is payable for a lifetime maximum of 120 days and for confinement in a hospice care center, including centers that are in designated areas of a hospital, or in the insured person's home.
- (16) Home Health Care Services – pays the charges incurred up to \$100 per day for services provided at home, not to exceed a maximum of 60 days per calendar year when an insured person is provided services by a licensed home health care agency. Such care must be prescribed by a physician and cannot be provided by a relative. This benefit will not be payable on the same day that hospice care is payable.
- (17) Artificial Limb – pays the charges incurred up to \$2,500 when an amputation is performed for an artificial limb and the procedure to affix or implant it. This benefit is limited to a lifetime maximum of \$2,500 for each insured person.
- (18) Hairpiece Benefit – pays the charges incurred up to a lifetime maximum of \$200 per insured person for a hairpiece when hair loss is the result of cancer treatment.
- (19) Durable Medical Equipment – pays the charges incurred, not to exceed \$1,000 per calendar year, for the rental or purchase of the following pieces of durable medical equipment: (a) a respirator or similar mechanical device; (b) brace; (c) crutches; (d) hospital bed; or (e) wheel chair.
- (20) Physical or Speech Therapy – pays the charges incurred up to \$25 per day for physical or speech therapy received as a result of cancer not to exceed a lifetime maximum of \$1,000 for each insured person.
- (21) Waiver of Premium – premiums will be waived starting with the first policy renewal date following a 90-day period of disability by you if the disability begins before you turn age 65 due to cancer . Premiums are waived for as long as you remain disabled and are receiving treatment for cancer for which benefits are payable.

OPTIONAL BENEFIT RIDERS (check if applied for and additional premium, if any paid):

- INTERNAL CANCER FIRST OCCURRENCE BENEFIT RIDER FORM 8288N –
Benefit (check one): \$2,500 \$5,000
Pays the first time an insured person is diagnosed as having internal cancer. This benefit is payable one time only for each insured person.
- HOSPITAL INTENSIVE CARE CONFINEMENT BENEFIT RIDER FORM 8290N TX –
Daily Benefit (Check one): \$300 \$600
Pays the daily benefit selected for each day of confinement in a hospital intensive care unit as the result of a covered injury or sickness. Benefits begin on the first day of confinement for a covered injury or a covered sickness.
Pays \$150 for each day of confinement in a sub-acute intensive care unit, if the sub-acute intensive care unit confinement immediately follows an intensive care unit confinement. We will pay \$150 per day for confinement in a regular hospital room if the regular room confinement was immediately preceded by an intensive care unit confinement, or by sub-acute intensive care confinement which was immediately preceded by an intensive care unit confinement. The number of days paid for confinement in a sub-acute intensive care unit, a regular hospital room, or any combination thereof will not exceed the number of covered days of hospital intensive care confinement.
Pays ambulance charges incurred per trip to transfer an insured person to the hospital for confinement as an inpatient in a hospital intensive care unit. This benefit is limited to \$5,000 per calendar year for each insured person.
Total benefits for any one period of confinement are limited to 30 days, and all benefits reduce 50% after an insured person is age 70 or older.
Benefits are not payable for any disease or disorder of the heart if the insured person has been treated for, or diagnosed as having a heart attack, heart condition, heart trouble, or any abnormality of the heart prior to the Rider Effective Date.

The benefits for such insured person will be limited to three days coverage in connection with any other hospital intensive care confinement.

Also, the rider does not cover confinement resulting from intentionally self-inflicted injuries or suicide attempts.

RADIATION TREATMENT, CHEMOTHERAPY, HORMONE THERAPY, IMMUNOTHERAPY AND RELATED SERVICES BENEFIT RIDERS (must check only one):

Form 8305N –

The benefits payable under this portion of the rider are limited to the charges incurred up to a maximum of \$5,000 per calendar year for each insured person for any combination of the following when used for the treatment of cancer.

(a) Radiation treatment.

(b) Chemotherapy, hormone therapy and immunotherapy drugs that are administered intravenously or directly by a physician.

(c) Chemotherapy, hormone therapy and immunotherapy drugs that are self-administered or taken orally, up to a maximum of \$300 for each filled prescription or supply of drugs received from a medical provider. Always subject to a maximum of \$1,200 per calendar month.

In addition, pays the charges incurred for services related to the above benefit up to \$500 per calendar year for any combination of the following: (a) professional fees for administering the covered drugs; (b) medical supplies, equipment and solutions; (c) laboratory tests; (d) X-rays, port films, MRIs, scans and ultrasounds; (e) clinical treatment planning, clinical treatment management, medical radiation physics, dosimetry, treatment devices and special services; (f) treatment consultation, planning and office visits; or (g) supportive and protective care drugs.

Form 8306N –

The benefits payable under this portion of the rider are limited to the charges incurred up to a maximum of \$10,000 per calendar year for each insured person for any combination of the following when used for the treatment of cancer.

(a) Radiation treatment.

(b) Chemotherapy, hormone therapy and immunotherapy drugs that are administered intravenously or directly by a physician.

(c) Chemotherapy, hormone therapy and immunotherapy drugs that are self-administered or taken orally, up to a maximum of \$300 for each filled prescription or supply of drugs received from a medical provider. Always subject to a maximum of \$1,200 per calendar month.

In addition, pays the charges incurred for services related to the above benefit up to \$500 per calendar year for any combination of the following: (a) professional fees for administering the covered drugs; (b) medical supplies, equipment and solutions; (c) laboratory tests; (d) X-rays, port films, MRIs, scans and ultrasounds; (e) clinical treatment planning, clinical treatment management, medical radiation physics, dosimetry, treatment devices and special services; (f) treatment consultation, planning and office visits; or (g) supportive and protective care drugs.

□ SPECIFIED DISEASE BENEFIT RIDER FORM 8311N TX -

The benefits of the rider are payable for loss that results from a positive diagnosis of a specified disease under the terms of the rider.

The benefits for Radiation Treatment, Chemotherapy, Hormone Therapy and Immunotherapy for the treatment of Specified Disease and the Related Services benefit are subject to a lifetime maximum of \$25,000 for each insured person.

Pays \$200 per day for each day of covered hospital confinement up to a lifetime maximum of 500 days.

Pays 50% of the charges incurred up to a maximum of \$1,200 per calendar month for each insured person for any combination of the following when used for the treatment of a specified disease.

- (a) Radiation treatment.
- (b) Chemotherapy, hormone therapy and immunotherapy drugs that are administered intravenously or directed by a physician.
- (c) Chemotherapy, hormone therapy and immunotherapy drugs that are self-administered or taken orally, up to a maximum of \$300 for each filled prescription or supply of drugs received from a medical provider.

Pays the charges incurred for services related to the above benefit up to \$500 per calendar year for any combination of the following: (a) professional fees for administering the covered drugs; (b) medical supplies, equipment and solutions; (c) laboratory tests; (d) X-rays, port films, MRIs, scans and ultrasounds; (e) clinical treatment planning, clinical treatment management, medical radiation physics, dosimetry, treatment devices and special services; (f) treatment consultation, planning and office visits; or (g) supportive and protective care drugs.

The following are the specified diseases covered by the rider:

Addison's Disease	Lupus Erythematosus	Rheumatic Fever
Budd-Chiari Syndrome	Multiple Sclerosis	Rocky Mountain Spotted Fever
Cerebral Palsy	Meningitis	Sickle Cell Anemia
Cystic-Fibrosis	Muscular Dystrophy	Tay-Sachs Disease
Encephalitis	Osteomyelitis	Tetanus
Huntington's Disease	Polio	Toxic Shock Syndrome
Legionnaire's Disease	Rabies	Tuberculosis
Lou Gehrig's Disease	Reye's Syndrome	Whooping Cough

IV. EXCLUSIONS AND LIMITATIONS

PRE-EXISTING CONDITIONS-LIMITATIONS FOR CERTAIN CONDITIONS

If you were under 65 years of age on the Policy Effective Date, the benefits of this policy will not be payable for loss caused by pre-existing conditions during the first two years this policy is in force. After this two-year period, however, loss due to such conditions will be payable unless specifically excluded from coverage. This two-year period is measured from the effective date of coverage for each Insured Person.

If you were 65 years of age or older on the Policy Effective Date, the benefits of this policy will not be payable for loss caused by pre-existing conditions during the first six months this policy is in force. After this six-month period, however, loss due to such conditions will be payable unless specifically excluded from coverage.

A pre-existing condition means the existence of symptoms of a Cancer or Specified Disease (if applied for) which would cause an ordinarily prudent person to seek diagnosis, care or treatment within five years prior to the effective date of coverage for each Insured Person or a condition of a Cancer or Specified Disease (if applied for) for which medical advice or treatment was recommended by a Physician or received from a Physician within five years prior to the effective date of coverage for each Insured Person. Conditions that are fully disclosed to Us on the application and not excluded or limited by Us, are not considered pre-existing conditions.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR

The policy pays only for loss resulting from cancer or specified diseases (if applied for), as defined in the policy where there was a positive diagnosis more than 30 days after the effective date of coverage for each insured person and while this policy is in force. It DOES NOT cover:

- (1) Any other disease or sickness.
- (2) Injuries.
- (3) Evaluation or treatment of any condition, disease, illness or incapacity that has been caused, complicated, worsened, or affected by cancer or a specified disease (if applied for), or which results from cancer or specified disease (if applied for) treatment.
- (4) Hospital confinement or expenses that are incurred in a government or charity hospital, except as specifically provided in the government or charity hospital benefit.
- (5) Hospital confinement or expenses that are incurred prior to the effective date of coverage, regardless of the date of positive diagnosis.
- (6) Hospital confinement or expenses that are incurred while the policy is not in force or has lapsed.
- (7) Hospital confinement or expenses that are incurred for breast reconstruction or breast prostheses, except as specifically provided in the Breast Reconstruction/Breast Prostheses benefit.

WAITING PERIOD

Benefits will only be payable for loss resulting from a positive diagnosis of cancer or specified disease (if applied for) that begins more than 30 days after the policy effective date for each insured person, including insured dependents. If the insured person has a positive diagnosis within the first 30 days, benefits will not be paid for any condition or charges incurred related to that positive diagnosis during the first two years after the policy effective date for each insured person.

INTOXICANTS AND NARCOTICS

We will not be liable for any loss sustained or contracted as the result of an insured person being physically or mentally impaired due to being under the influence of alcohol or any narcotic unless administered on the advice of a physician. "Being under the influence of alcohol", for purposes of the policy, means a blood alcohol level of 0.08 or more. 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 those injuries occurred while the insured person was driving a motor vehicle or engaged in any other activity.

V. RENEWABILITY

The policy is guaranteed renewable for life. We will renew the policy each time you send us the premium. It must be paid on or before the date it is due or during the 31 days that follow.

VI. PREMIUM CHANGE

We may change the premium rates for the policy. The change will be based on a new table of rates. We can only change the premium if we change it for all policies like yours in your class.

VII. The Annual Premium is \$_____ ; if other than annual \$_____, mode_____.

Premiums are payable in advance or during the grace period (you have a 31-day grace period to pay your premium).

I hereby acknowledge that this Outline of Coverage was delivered to me on _____
by _____ (Date)

(Signature of Agent)

(Signature of Applicant)

This Outline of Coverage is not a contract. It is intended only as a general description of the policy provisions in the planning of your insurance program. The benefits are determined by the terms and conditions of the policy alone. IN ALL CASES, CONSULT YOUR POLICY FOR FULL DETAILS.

RETAIN THIS OUTLINE FOR YOUR RECORDS