Critical Illness Policy

Limited Benefit Insurance

Critical Illness Policy – Outline of Coverage
Policy Form CIP2-WC-R (7-07)

READ YOUR POLICY CAREFULLY - This outline of coverage provides a brief description of the important features of your policy. THIS IS NOT THE INSURANCE CONTRACT, AND ONLY THE ACTUAL POLICY PROVISIONS WILL CONTROL. The policy sets forth, in detail, the rights and obligations of any covered person and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY. This is a limited benefit policy and is designed to provide coverage ONLY when certain losses occur as a result of the specified critical illnesses as defined below and more fully in the policy. This policy does not provide for basic hospital, basic medical-surgical or major medical expenses. This policy provides benefits only if the date of diagnosis of specified critical illness is while the policy is in force for the covered person so diagnosed AND after the waiting period has been satisfied by that covered person. Important: Benefits received under this policy may be taxable. You should consult your personal tax advisor to determine whether or not payments received are subject to taxation.

BENEFITS

- Lump sum payments paid directly to you upon first diagnosis of one of the covered critical illnesses shown below.
- Choice of two plans and face amounts from $5,000 - $50,000, in $5,000 increments.
- Coverage available for individual and family members.

<table>
<thead>
<tr>
<th>Covered Illnesses</th>
<th>With Cancer CIP2-WC (7-07) Percentage of Face Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>100%</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>100%</td>
</tr>
<tr>
<td>Stroke</td>
<td>100%</td>
</tr>
<tr>
<td>End Stage Renal Disease</td>
<td>100%</td>
</tr>
<tr>
<td>Amyotrophic Lateral Sclerosis (Lou Gehrig’s Disease)</td>
<td>100%</td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>100%</td>
</tr>
<tr>
<td>Major Organ Transplant Surgery</td>
<td>100%</td>
</tr>
<tr>
<td>Coronary Artery Bypass Surgery*</td>
<td>25%</td>
</tr>
<tr>
<td>Balloon Angioplasty, Stent, or Laser Relief Procedure*</td>
<td>10%</td>
</tr>
</tbody>
</table>

*The Coronary Artery Bypass Surgery and Balloon Angioplasty, Stent, or Laser Relief Procedure benefits are each payable only once per covered person. If one or more of these benefits are paid, the remaining amount payable will be the original face amount reduced by all prior benefit payments.

RECURRENT BENEFIT RIDER (OPTIONAL)

The covered person has the option to elect the Critical Illness coverage with or without the Recurrent Benefit Rider. If this rider is included, the covered person’s coverage terminates when 200% of the face amount of the base policy has been paid.
GROUP 1

• Cancer (if covered under your policy)
• Major Organ Transplant
• Amyotrophic Lateral Sclerosis (Lou Gehrig’s Disease)
• End Stage Renal Disease
• Quadriplegia

GROUP 2

• Heart Attack
• Stroke

We will pay an additional benefit if a covered person is diagnosed with a different Group 1 critical illness (a recurrence) than one for which payment was previously received under your policy.

We will pay an additional benefit if a covered person is diagnosed with a different Group 2 critical illness (a recurrence) than one for which payment was previously received under your policy.

We will pay an additional benefit if a covered person is diagnosed a second time with a Group 2 illness (a recurrence) for which payment was previously received, provided that treatment for such illness was not received during the 180-day period prior to the second illness.

BENEFIT PAYMENT INFORMATION

On the policy anniversary following attainment of age 75, the face amount of all benefits will be restated as 50% of the remaining amount payable. The covered person’s coverage terminates when 100% of the face amount has been paid, unless the Recurrent Benefit Rider is attached.

Waiting Period – No benefits will be paid for a specified critical illness diagnosed during the first 30 days following any covered person’s effective date of coverage. If the date of diagnosis of any covered person’s specified critical illness occurs during the waiting period, the policy or any increase in coverage will be cancelled and all premiums returned.

DEFINITIONS

These definitions provide a brief description of the specified critical illness covered by your policy. Only the actual policy definitions will control.

Amyotrophic Lateral Sclerosis (Lou Gehrig’s Disease) is a progressive wasting of motor neuron of the brain and spinal column.

Balloon Angioplasty, Stent, or Laser Relief Obstruction Procedures are therapeutic procedures used to correct narrowing or blockage of one or more coronary arteries.

Cancer is a disease characterized by the spread of malignant cells and must be positively diagnosed with histopathological confirmation by a medical practitioner. (See Exceptions and Limitations)

Carcinoma in Situ is a disease characterized by malignant neoplasm of epithelial origin that is confined to the basement membrane. Carcinoma in situ must be diagnosed with histopathological confirmation. Pre-malignant lesions and carcinoma in situ of the skin, including melanoma in situ, are excluded (See Exceptions and Limitations)

Coronary Artery Bypass Surgery is a major surgical procedure requiring median sternotomy to correct narrowing or blockage of one or more coronary arteries with bypass grafts.

End Stage Renal Disease (ESRD) is chronic irreversible failure of both kidneys to function which requires at least weekly hemodialysis or peritoneal dialysis or transplantation.

Heart Attack is characterized by diagnosis of the death of a portion of the heart muscle resulting from inadequate blood supply.

Major Organ Transplant is human to human organ transplant of the liver, heart, lung, pancreas or the transplantation of bone marrow from a donor to covered person.

Quadriplegia means the complete, irreversible paralysis and loss of use of both upper and lower limbs without severance.

Stroke is a cerebrovascular event resulting in permanent neurological deficit.

RENEWABILITY AND CONTINUATION

The policy is guaranteed renewable during the covered person’s lifetime. USAble Life may change the premium rate, but only if the rate is changed for all policies in the covered person’s state.
This policy will not be issued to anyone 65 years of age or over on the initial effective date. If the covered person purchases the policy prior to his 65th birthday, he may continue coverage after age 65 as long as he continues to pay the premium rate by the due date or during the 31 days that follow.

Children born while the policy is in force will be covered immediately from the moment of birth under the Individual and Family plans. If you wish to continue coverage on newborn children under the Individual or Individual/Spouse Plan, you must apply within 90 days of the child's birth date.

A Covered dependent who no longer meets eligibility requirements may convert to an individual policy without evidence of insurability. A covered person's spouse's coverage will terminate on the first renewal date following the covered persons death or at the time of divorce.

**EXCEPTIONS AND LIMITATIONS**

**PRE-EXISTING CONDITIONS LIMITATIONS FOR CERTAIN CONDITIONS**

The benefits of the policy will not be payable for any loss caused by a pre-existing condition during the first 24 months the policy is in force. After this 24-month period, however, loss due to such conditions will be payable unless specifically excluded from coverage. This 24-month period is measured from the effective date of coverage for each covered person.

A pre-existing condition means a specified critical illness that is diagnosed or for which treatment is received within 24 months prior to the effective date of coverage for each covered person. "Treatment" means consultation, care, or services provided by a physician including diagnostic measures and taking prescription drugs and medicines. If the issuance of a covered person's coverage was based on the medical history disclosed on the application, such conditions which were fully disclosed and not excluded or limited by us are not considered pre-existing conditions.

**EXCEPTIONS - WHAT WE WILL NOT PAY FOR:**

This policy pays only for loss resulting from specified critical illnesses or surgeries as defined in the policy. We will not pay benefits for a specified critical illness or surgery that occurs as a result of the following:

1. Conditions other than the specified critical illnesses or surgeries defined in this policy, unless directly caused or aggravated by said specified critical illness surgery.
2. The covered person being diagnosed with a specified critical illness during the waiting period.
3. The covered person voluntarily participating or attempting to participate in an illegal activity.
4. The covered person intentionally causing a self-inflicted injury.
5. The covered person committing or attempting to commit suicide, whether sane or insane.
6. The covered person's voluntary involvement in any period of armed conflict, even if it is not declared.
7. Surgeries performed outside of the United States or its Territories.
8. Other Exclusions: We will not pay the Specified Critical Illness Benefit for the following:
   a. Cerebral symptoms due to transient ischemic attack (TIA), migraine, cerebral injury resulting from trauma or hypoxia, and vascular disease affecting the eye, optic nerve, or vestibular functions.
   b. Leukemia, other than chronic lymphocytic leukemia, if there is no generalized dissemination of leukemia cells in the blood-forming bone marrow.
   c. All skin cancers, unless there is evidence of metastasis or the tumor is a malignant melanoma of greater than 1.5 mm maximum thickness as determined by histological examination using the Breslow method.
   d. All tumors which are histologically described as pre-malignant or non-invasive (including cervical dysplasia CIN-1, CIN-2, CIN-3).
   e. Non life-threatening cancers, such as prostate cancers which are histologically described as TNM Classification T1(a), or T1(b), or are of another equivalent or lesser classification.
(f) Papillary micro-carcinoma of the thyroid.
(g) Non-invasive papillary cancer of the bladder histologically described as TaNOMO or a lesser classification.
(h) Chronic lymphocytic leukemia less than RAI stage I or Binet Stage A-I.

**CARCINOMA IN SITU BENEFIT RIDER**

**BENEFITS**
- Lump sum paid directly to you upon first diagnosis of carcinoma in situ.
- Amount paid will be 10%, 25%, 50% of your Critical Illness Policy original face amount reduced by all prior benefit payments.
- Coverage is available for individual and family members.

**BENEFIT PAYMENT INFORMATION**

On the policy anniversary following attainment of age 75, the amount of this rider will be restated as 50% of the remaining amount payable.

**Waiting Period** – No benefit will be paid for carcinoma in situ diagnosed during the first thirty days following the covered person’s effective date under this rider or the first 30 days following an increase in coverage under this rider. No benefits will be paid for a covered carcinoma in situ that is diagnosed during the waiting period. If the date of diagnosis of any covered person’s carcinoma in situ occurs during the waiting period of the initial coverage, this rider will be cancelled and all premiums refunded. If the date of diagnosis of any covered person’s carcinoma in situ occurs during the waiting period of an increase in coverage, the increase will be cancelled and all premiums paid for the increase in coverage will be refunded.

**DEFINITIONS**

“Carcinoma in situ,” for the purposes of this rider, means a malignant neoplasm of epithelial origin that is confined to the basement membrane. Carcinoma in situ must be diagnosed with histopathological confirmation. Pre-malignant lesions and carcinoma in situ of the skin, including melanoma in situ, are excluded.

Carcinoma in situ must be diagnosed in one of two ways:

**Pathological Diagnosis**
A pathological diagnosis of carcinoma in situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a certified pathologist whose diagnosis of malignancy is in keeping with the standards set by the American Board of Pathology.

**Clinical Diagnosis**
A clinical diagnosis of carcinoma in situ is based on the study of symptoms. We will pay benefits for a clinical diagnosis only if:

1. a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening; and,
2. there is medical evidence to support the diagnosis; and
3. a physician is treating you for carcinoma in situ.

“Date of Diagnosis” means the day the tissue specimen, blood samples and/or titer(s) are taken on which the diagnosis of carcinoma in situ is based.

“Pre-existing Condition” means a carcinoma in situ that is diagnosed or for which treatment is received within 24 months prior to the effective date of coverage for each covered person.
“Treatment” means consultation, care, or services provided by a physician including diagnostic measures and taking prescription drugs and medicines. If the issuance of an covered person’s coverage was based on the medical history disclosed on the application, such conditions which were fully disclosed and not excluded or limited by us are not considered pre-existing conditions.

RENEWABILITY

This rider is guaranteed renewable as long as the policy to which it is attached remains in force and the premium for the rider are paid when due.

EXCEPTIONS AND LIMITATIONS

EXCEPTIONS - WHAT WE WILL NOT PAY FOR:

This rider pays only for loss resulting from carcinoma in situ, as defined in this rider. This rider does not pay benefits for any other condition, nor will it pay benefits for a carcinoma in situ that results from a pre-existing condition as defined in this rider, or occurs as a result of the following:

1. The covered person being diagnosed with a carcinoma in situ during the waiting period.
2. Other Exclusions: We will not pay the Carcinoma In Situ for the following:
   (a) Leukemia, other than chronic lymphocytic leukemia, if there is no generalized dissemination of leukemia cells in the blood-forming bone marrow.
   (b) Chronic lymphocytic leukemia less than RAI Stage I or Binet Stage A-I.

We will pay an additional benefit if a covered person is diagnosed with carcinoma in situ. The covered person has the option to select one of the benefit percentages listed below.

☐ 10%    ☐ 25%    ☐ 50%

If no elections are made, the policy will pay the Carcinoma in situ benefit at 10%.