EMC NATIONAL LIFE COMPANY
CANCER COVERAGE
POLICY FORM HP 3000
– OUTLINE OF COVERAGE –

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.
If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide 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 – Policies of this category are designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of cancer. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses. Coverage is provided for the benefits outlined in Paragraph III. The benefits described in Paragraph III may be limited by Paragraph IV.

III. BENEFITS

We will pay the following benefits for the medically necessary care of cancer. All benefits payable will reduce by 25% after the covered person has attained age 65 or over.

(1) Hospital Confinement – Pays the daily hospital confinement benefit selected by you for each of the first 70 days a covered person is confined to a hospital for treatment of cancer.

(2) Extended Benefits – If any covered person is hospital confined for more than 70 days, we will pay up to $1000 per day for the actual charges beginning on the 71st day for medically necessary hospital charges. This benefit is in lieu of all other benefits payable under the policy for the same time period.

(3) Government or Charity Hospital: Pays an indemnity equal to -

(a) $500 for each day a covered person is confined in a government or charity hospital for the treatment of cancer.

(b) $500 for each day a covered person receives outpatient radiation therapy, chemotherapy, or immunotherapy at a government or charity hospital for the treatment of cancer.

(4) Outpatient Surgery – Pays a one day benefit equivalent to the daily hospital confinement benefit selected by you if outpatient surgery is required.

(5) Surgical Benefit – Pays an amount equal to the actual charges made by a surgeon, up to the surgical benefits schedule selected by you, for surgery in or out of a hospital.

(6) Bone Marrow Transplant and Peripheral Stem Cell Transplant – Pays an amount equal to the actual charges for surgical and anesthetic expenses associated with bone marrow transplant and/or peripheral stem cell transplant up to a combined lifetime maximum of $10,000.

(7) Second and Third Opinion – Pays an amount equal to the actual charges up to $200 for a second or third opinion if necessary.

(8) Anesthesia – For the professional administration of an anesthic, pays an amount equal to the actual charges up to 25% of the amount payable under the surgical benefit.

(9) Blood and Blood Plasma – Pays an amount equal to the actual charges up to $150 per day for blood and blood plasma, blood administration, cross matching and transfusion fees, but not including clerical, storage and administrative expenses. If a covered person receives blood for treatment of leukemia, lymphoma or multiple myeloma, benefits will be payable under the radiation, chemotherapy, and immunotherapy benefit.

(10) Breast Reconstruction – Pays an amount equal to the actual charges up to a lifetime maximum of $5,000 for each breast to restore body contour lost due to breast cancer which is first diagnosed 30 days after the effective date of the policy and the policy is in force. This benefit is payable in lieu of all other benefits payable under the policy for the same time period, and it is not available for augmentation or breast reconstruction of unaffected breast.

(11) Breast Prosthesis – When a covered mastectomy is performed while the policy is in force, we will pay an amount equal to the actual charges up to a lifetime maximum of $1,500 for external postoperative prosthesis.

(12) Artificial Limb and Prosthesis – When a covered amputation is performed while the policy is in force, we will pay an amount equal to the actual charges up to a lifetime maximum of $1,500 for an artificial limb or prosthesis and procedure to affix or implant it.

(13) Positive Diagnosis Test – Pays an amount equal to the actual charges up to $250 for diagnostic tests to detect, support or confirm a positive diagnosis within 90 days of such test.

(14) Radiation, Radioactive Isotopes Treatment, Chemotherapy Agents, and Immunotherapy Agents – Pays an amount equal to the actual charges to the extent they do not exceed usual and customary amount in the area where the charges are made, up to the combined monthly maximum amount selected for (1) radiation and radioactive isotope delivery; (2) chemotherapy agents; (3) immunotherapy agents as specifically stated in the policy; and (4) blood received by a covered person for leukemia, lymphoma or multiple myeloma.

In no event will the aggregate benefit for radiation, radioactive isotopes treatment, chemotherapy agents, immunotherapy and blood exceed the monthly maximum selected.

(15) Self-administered Chemotherapy and Immunotherapy Agents – Pays an amount equal to the actual charges to the extent they do not exceed usual and customary amount in the area where the charges are made, up to the combined monthly maximum amount selected.

(16) Private Duty Nursing Service – Pays the actual charges up to $150 per day for private duty nursing care and attendance. The maximum number of days of care payable will be equal to the number of days of covered hospital confinement.

(17) Ambulance Benefit – Pays the actual charges up to $500 per trip, including air ambulance, if the covered person is taken to the hospital for a covered confinement.

(18) Transportation and Lodging – For non-local treatment covered under the policy we will pay: (1) If hospital confinement is required, the actual charges for round trip coach fare on a common carrier to the hospital that provides the treatment or $.50 per mile for personal automobile expense, not to exceed 700 miles round trip. (2) If hospital confinement is not required, $.50 per mile for personal automobile expense not to exceed 700 miles round trip and the actual charges of a single room in a motel, hotel or other accommodations acceptable to us, up to a maximum of $75 per day.

(19) Adult Companion Transportation and Lodging – Pays the following expenses for one adult companion to be near you or any covered person when you or such person has been confined in a non-local hospital: (1) the actual charges of a single room in a motel, hotel, or other accommodations acceptable to us, up to a maximum of $75 per day and limited to the number of days of the confined person's hospitalization, up to $2,400; and (2) the actual charges of round trip coach fare on a common carrier or personal automobile allowance of $.50 per mile not to exceed 700 miles per round trip measured from the visiting adult companion's residence to the hospital.

(20) Medical, Transportation, and Lodging for Bone Marrow Donors and Peripheral Stem Cell Transplant Donors – Pays the following expenses of a bone marrow donor and peripheral stem cell transplant donor when the donor is either a covered person or someone donating to a covered person: (1) the actual charges up to $1,000 for medical expenses, including hospital charges directly relating to the transplant; (2) the actual charges for round trip coach fare on a common carrier to the city where the transplant is performed; (3) $.50 per mile for personal automobile expense, not to exceed 700 miles round trip; and (4) the actual charges up to $75 per day for lodging and meal expenses when it is necessary for the donor to remain near the hospital for possible donation of additional blood components.

(21) Extended Care Facility – Pays the actual charges up to $100 per day for confinement in an extended care facility when prescribed by the attending physician and beginning within 14 days of a covered hospital confinement. Extended care facility benefits will be limited to the number of days of the most recent hospital confinement.

(22) Hospice Care – Pays the actual charges up to $150 per day for hospice care, if the covered person has been diagnosed as terminally ill, not to exceed a lifetime maximum of 90 days.

(23) Home Health Care Services – Pays the actual charges up to $100 per day for home health care or health supportive services when provided to a covered person within seven days of release from a covered hospital confinement. Limited to a lifetime maximum of 30 visits for each covered person.

(24) Hairpiece Benefit – Pays actual charges up to a lifetime maximum of $100 for a hairpiece.

(25) Rental or Purchase of Durable Medical Equipment – Pays the actual charges for the following pieces of medical equipment not to exceed $1,000 per calendar year: (1) respirator or similar mechanical device; (2) brace; (3) crutches; (4) hospital bed; or (5) wheelchair.

(26) Physical, Occupational or Speech Therapy – Pays the actual charges up to $25 per session not to exceed a lifetime maximum of $1,000.

(27) Professional Mental Health Consultation – Pays actual charges up to $50 per session not to exceed a lifetime maximum of ten sessions for consultation with a mental health professional for any covered person receiving treatment for cancer.

(28) Tutorial – While any dependent child is receiving treatment for which benefits are payable under the policy, we will pay actual charges for a tutor up to $50 per one hour session, not to exceed a lifetime maximum of 50 sessions.

(29) We will pay the following benefits for the treatment of skin cancer: (1) Surgical Benefit – an amount equal to the actual charges up to $100 per event for the removal of skin cancer. If more than one skin cancer is removed at the same time, we will pay the actual charges up to $50 per skin cancer removed after the first. (2) Anesthesia – an amount equal to the actual charges up to $50 per skin cancer operation. (3) Positive Diagnosis Test – an amount equal to the actual charges up to $30 per diagnosis for skin cancer diagnostic tests.

(30) Cancer Screening Test Benefit – We will pay an amount equal to the actual charges up to $50 per calendar year for each covered person who has cancer screening tests such as but not limited to:
1) mammogram;
2) flexible sigmoidoscopy;
3) pap smear;
4) chest x-ray;
5) hemoccult stool specimen; and
6) prostate-specific antigen testing.

This cancer screening benefit is payable only if such test occurs more than 60 days after the policy effective date. Benefits are paid for the tests only, not the associated office visit. Positive diagnosis of cancer is not required for this benefit.

IV. EXCLUSIONS AND LIMITATIONS

PRE-EXISTING CONDITIONS – LIMITATIONS FOR CERTAIN CONDITIONS

The benefits of the policy will not be payable for pre-existing conditions during the first two years the policy is in force. During the first two years following the date a covered person makes a change in coverage that increases his or her benefits, the increase will not be paid for pre-exisitng conditions. After this two-year period, however, benefits for such conditions will be payable unless specifically excluded from coverage. This two year period is measured from the effective date of coverage for each covered person. A pre-existing condition means cancer for which a covered person has received medical consultation, treatment, care, services, or for which diagnostic test(s) have been recommended or for which medication has been prescribed during the 24 months immediately preceding the effective date of coverage.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR

The policy pays benefits for cancer as defined in the policy. It does not cover the following: (1) any other disease or sickness; (2) injuries; (3) any disease, condition, or incapacity that has been caused, complicated, worsened, or affected by cancer or cancer treatment; (4) care and treatment received outside the United States; (5) treatment not medically necessary; (6) experimental treatment by any program that does not qualify as experimental treatment as defined in the policy; (7) hospital confinement or expenses that are incurred prior to the policy date, regardless of the date of positive diagnosis except if interim coverage is applied for; or (8) non-prescription medications, vitamins, nutritional supplements and minerals.

WAITING PERIOD

Benefits will only be payable for a positive diagnosis that occurs more than 30 days after the policy has been in force.

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 state.

VII. PREMIUMS

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).

VIII. OPTIONAL BENEFIT RIDERS *(check if applied for and additional premium paid):*

☐ HOSPITAL CORONARY CARE OR INTENSIVE CARE CONFINEMENT BENEFIT RIDER

Daily Benefit (check one) ☐ $300 ☐ $400 ☐ $600

The following benefits will not exceed a combined total of 30 days per confinement:
(a) coronary care or intensive care benefit - daily benefit selected for each day of confinement
(b) step-down or hospital sub-acute intensive care benefit - one-half of the daily benefit selected for each day

The daily benefit will be paid beginning with the first day of confinement due to an accidental injury and with the second day of confinement due to sickness.

Pays the actual ambulance charges per trip to transfer an insured person to the hospital for confinement as an inpatient in a hospital intensive care unit.

All benefits will reduce by 50% for a confinement beginning after the insured person has attained age 65 or over.

Benefits are not payable for loss caused by pre-existing conditions during the first two years the rider is in force. Also, the rider does not cover confinement resulting from intentionally self-inflicted injuries or suicide attempts.

☐ INTERNAL CANCER FIRST OCCURRENCE BENEFIT RIDER
Pays $2500 or $5000, depending on the benefit amount selected by the insured, the first time a covered person is diagnosed as having internal cancer. Benefit will reduce by 25% after the insured person has attained age 65 or over.

☐ SPECIFIED DISEASE RIDER
Pays $2500 the first time a covered person has been diagnosed as having a covered specified disease. This benefit is only payable once per covered person regardless of any subsequent specified disease occurrence.

All benefits will reduce by 25% after the covered person has attained age 65 or over.

The following are the specified diseases covered by the rider:

Addison's Disease
Amyotrophic Lateral Sclerosis
Botulism
Cystic Fibrosis
Diphtheria
Encephalitis
Histoplasmosis
Legionnaires' Disease
Lupus Erythematosus
Lyme Disease
Malaria
Meningitis (bacterial)
Multiple Sclerosis
Muscular Dystrophy
Myasthenia Gravis
Osteomyelitis
Poliomyelitis
Q Fever
Rabies
Reye's Syndrome
Rheumatic Fever
Rocky Mountain Spotted Fever
Sickle Cell Anemia
Tetanus
Toxic Shock Syndrome
Trichinosis
Tuberculosis
Tularemia
Typhoid Fever
Undulant Fever
West Nile Virus

I hereby acknowledge that this Outline of Coverage was delivered to me on ______________________
(month, day, year)

by ______________________ ______________________
(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

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