Retain This Outline For Your Records

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OUTLINE OF COVERAGE FOR LUMP SUM CANCER INSURANCE POLICY or LUMP SUM CANCER AND HEART-STROKE INSURANCE POLICY

Policy Form B 21904 OH

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 contract and only the actual policy provisions will control. The policy itself sets forth in details the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

SPECIFIED DISEASE COVERAGE

Policies of this category are designed to provide, to persons insured, limited coverage paying benefits ONLY when certain losses occur as a result of specified diseases, subject to any limitations and waiting periods set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If you are eligible for Medicare, review the *Buyer's Guide to Health Insurance for People with Medicare* available from the insurance company. Bankers Fidelity Life Insurance Company® does not represent Medicare, the federal government or any state government.

THE POLICY PROVIDES SUPPLEMENTAL LIMITED COVERAGE FOR SPECIFIED DISEASES ONLY AND IS NOT A SUBSTITUTE FOR COMPREHENSIVE HEALTH OR MAJOR MEDICAL INSURANCE, NOR IS IT INTENDED TO COVER ALL MEDICAL EXPENSES.

BENEFITS

The policy contains a 30-day Waiting Period - Benefits are not payable for any Loss incurred within the first 30 days after the Effective Date of the Policy or any attached Rider.

The following is a brief description of the benefits, additional options and optional riders that are available with the Policy. All benefits are subject to the conditions, definitions, exclusions, limitations and provisions of the actual Policy and applicable Rider, **including the 30-day Waiting Period**.

LUMP SUM CANCER BENEFIT

A Lump Sum Cancer Benefit will be payable upon receipt of due proof of the Insured's Diagnosis with Invasive Cancer or Carcinoma In Situ. Benefits for Carcinoma In Situ may be elected at levels of 100% or/are payable at an amount equal to 25% of the benefit amount payable for Invasive Cancer.

OPTIONAL LUMP SUM HEART-STROKE BENEFIT – Requested ☐ Yes ☐ No

In addition to the Cancer benefits described above, an additional Lump Sum Heart-Stroke Benefit will be payable in accordance with the Policy provisions upon receipt of due proof of the Insured's Diagnosis with or Occurrence of any of the following conditions after the 30-day Waiting Period:

Covered Heart-Stroke Conditions	% Payable	Covered Heart-Stroke Conditions	% Payable
Aortic Aneurysm	100%	Cardiovascular Disease Requiring:	
Heart Attack	100%	Aortic Surgery	25%
Heart Disease Requiring Heart Transplant Surgery	100%	By-Pass Surgery	25%
		Angioplasty	10%
Stroke	100%	Stent	10%
Sudden Cardiac Arrest	100%	Valve Replacement/Repair Surgery	25%

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Payment of any benefits for Covered Cancer or Heart-Stroke Conditions (if included in the Policy) at an amount less than 100% will reduce any future payments for a Covered Cancer or Heart-Stroke Conditions that would normally be covered at 100% by an amount equal to the partial payment that had been made; except; if the Covered Cancer Condition is payable at less than 100%, then any previous partial payment that has already been paid will not be deducted from the current payment due, unless payment of such would result in the total sum of benefits paid for all Covered Cancer Conditions exceeding 100% of the Lump Sum Benefit Amount. We will not pay more than a combined total of 100% of the Lump Sum Benefit Amount indicated in the Policy for any Covered Cancer or any Heart-Stroke Condition.

OPTIONAL ADDITIONAL BENEFIT RIDERS – *May select as many as desired*

Additional Occurrence Benefit Rider (Form B 21904 CAO R9 or B 21904 HSAO R10) **– Requested: ☐ Yes ☐ No**

If requested and included in the Policy, benefits will be payable for additional occurrences of a Covered Cancer or Heart-Stroke* Condition in accordance with the schedule below, if: 1) at least 24 consecutive months or more have elapsed since the Covered Persons' Diagnosis with a Cancer or Heart-Stroke Condition; and 2) the Covered Person has been free of Treatment for a period of at least 24 consecutive months:

Time Period That Has Elapsed Since the Date of the Last Diagnosis of a Covered Cancer Condition or Covered Heart-Stroke* Condition	Restoration Percentage
Less than 24 months	0%
At least 24 months, but less than 5 years	25%
At least 5 years, but less than 10 years	75%
At least 10 years or more	100%

*Benefits for Heart-Stroke conditions are only included if the optional Heart-Stroke Benefit was elected and included in the Policy. Benefits for Heart-Stroke are only available for Heart Attack, Heart Disease Requiring Transplant Surgery, and Stroke; benefits are not payable under the Rider for any other condition.

In addition to the Exclusions included in the Policy, no Benefits are provided for the following, nor will We pay any benefits for any Loss arising from or otherwise related to, directly or indirectly, any condition or disease which was not a Loss for which a valid benefit was previously paid under the Policy to which this Rider is attached. This includes a Loss for which a benefit was previously paid but was later determined to have been paid erroneously.

Specified Disease Benefit Rider (Form B 21904 SDB R1) **– Applied for: ☐ Yes ☐ No**

Upon receipt of due proof satisfactory to Us of the Covered Person's Diagnosis after the thirty (30) day Waiting Period with one of the Specified Diseases listed below, We will pay, subject to the conditions, definitions, exclusions and limitations of the Rider and the Policy, the Specified Disease Benefit Amount. Benefits are payable under the Rider only once per Covered Person, per their lifetime.

Specified Disease	
Blindness	Amyotrophic Lateral Sclerosis
Complete Loss of Hearing	Coma
End-Stage Renal Disease	Complete Loss of Speech
Multiple Sclerosis	Major Organ Failure requiring Transplant
Severe Burns	Permanent Paralysis

In addition to the Exclusions included in the Policy, no Benefits are provided for the following, nor will We pay any benefits for any Loss arising from or otherwise related to, directly or indirectly, any illness, disease, condition not specifically and exclusively a Diagnosis of one of the Specified Diseases defined and listed in the Rider.

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Cancer Hospitalization Rider (Form B 21904 CHC R4) **– Applied for: ☐ Yes ☐ No**

Hospital Confinement Benefit – Subject to the terms of the Rider, We will pay the Daily Hospital Confinement Benefit for each Day a Covered Person is Confined to a Hospital, after the 30-day Waiting Period, for the Medically Necessary Treatment of Cancer or a Complication of Cancer, subject to a Maximum of 30 Days in any one Period of Confinement and a Maximum of 30 Days during any one Policy Year.

Intensive Care Unit Confinement Benefit – In lieu of the Hospital Confinement Benefit, We will pay a benefit equal to double the Daily Hospital Confinement Benefit for each Day a Covered Person is Confined to an Intensive Care Unit, after the 30-day Waiting Period, for the Medically Necessary Treatment of Cancer or a Complication of Cancer, subject to a Maximum of 30 Days in any one Period of Confinement and a Maximum of 30 Days during any one Policy Year.

Benefits are payable for a Maximum of 30 Days in any one Period of Confinement, and are further subject to a Maximum of 30 Days during any one Policy Year. If the Covered Person is Confined to a Hospital and/or Intensive Care Unit on different days during the same Period of Confinement, all such Days will count towards the Maximum numbers of Days payable for both the Period of Confinement and the Policy Year.

We will not pay a benefit for both Hospital Confinement and Intensive Care Unit Confinement on the same Day, regardless of whether You were Confined and received Medically Necessary Treatment in both a Hospital and an Intensive Care Unit on the same Day. On such a Day, We will pay one benefit for either Hospital Confinement or Intensive Care Unit Confinement, whichever is the larger of the two.

In addition to the Exclusions in the Policy, no Benefits are provided for the following, nor will We pay any benefits for any Loss arising from or otherwise related to, directly or indirectly, for any: 1) Confinement or Period of Confinement: a) which is not Medically Necessary for the Treatment of Cancer or a Complication of Cancer; b) during which the services or supplies received are considered to be experimental, investigational, or for research purposes only; e) in a Hospital, Observation Unit or Intensive Care Unit located outside the United States, its possessions or territories, except for emergency admission due to Cancer or a Complication of Cancer occurring while traveling for business or pleasure; f) for cosmetic surgery or other elective procedures that are not Medically Necessary, except for reconstructive surgery following a mastectomy or lumpectomy ; or g) for dental treatment, except when Medically Necessary because of damage or deterioration to sound, natural teeth caused by Cancer; or 2) Cancer Diagnosed or any Loss that begins: a) while the Rider is not In Force for the Covered Person, except as provided in the Extension of Benefits; or b) during the thirty (30) day Waiting Period. No benefits are payable for any condition or disease which was not a Loss for which a valid benefit was concurrently or previously paid under the Policy. This includes a Loss for which a benefit was previously paid but was later determined to have been paid erroneously.

Cancer Radiation and Chemotherapy Benefit Rider (Form B 21904 CRCB R5) **– Applied for: ☐ Yes ☐ No**

For each benefit listed below, the amount payable is equal to: 1) the Benefit Amount per Unit shown in the chart below; *multiplied by* 2) the Number of Units shown in the Rider.

Benefit	Benefit Amount per Unit
Anti-Nausea Drugs	$25 per Month
Experimental Drugs	$25 per Day
Immunotherapy	$100 per Month
Injected Chemotherapy	$100 per Week
Hormonal Oral Chemotherapy	$100 per Month
Non-Hormonal Oral Chemotherapy	$100 per Month
Radiation Therapy	$150 per Week

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Anti-Nausea Drugs – We will pay the benefit amount described above for each Month that a Covered Person incurs a charge for Anti-Nausea Drugs as prescribed by a Physician during the Treatment of Cancer. The Covered Person must also be concurrently receiving a form of Chemotherapy or Radiation Therapy for this benefit to be payable. This benefit is payable only once per Month that Anti-Nausea Drugs are received, even if a charge is incurred for more than one (1) Anti-Nausea Drug in that Month. This benefit is limited to a Maximum of ten (10) Months per Covered Person per Policy Year.

Experimental Drugs – We will pay the benefit amount described above for each Day a Covered Person incurs a charge for and receives Experimental Drugs as Treatment for Cancer. For a benefit to be payable, the Experimental Drugs and Treatment must be received in 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 Drugs or Treatments. This benefit is limited to a Maximum of thirty (30) Days per Covered Person per Policy Year.

Immunotherapy – We will pay the benefit amount described above for each Month in which a Covered Person incurs a charge for and receives Immunotherapy as prescribed by a Physician for the Treatment for Cancer. This benefit is payable only once per Month that Immunotherapy is received, even if Immunotherapy is received multiple times in that Month. This benefit is limited to a Maximum of five (5) Months per Covered Person, per Policy Year.

Injected Chemotherapy – We will pay the benefit amount described above for each Week in which a Covered Person incurs a charge for and receives Injected Chemotherapy as prescribed by a Physician for the Treatment of Cancer. This benefit is payable only once per Week that Injected Chemotherapy is received, even if Injected Chemotherapy is received multiple times in that Week.

Hormonal Oral Chemotherapy – We will pay the benefit amount described above for each Month in which a Covered Person incurs a charge for and receives Hormonal Oral Chemotherapy as prescribed by a Physician for the Treatment of Cancer. This benefit is payable only once per Month that Hormonal Oral Chemotherapy is received, even if Hormonal Oral Chemotherapy is received multiple times in that Month. This benefit is limited to a Maximum of thirty-six (36) Months per Covered Person, per lifetime.

Non-Hormonal Oral Chemotherapy – We will pay a benefit amount described above for each Month in which a Covered Person incurs a charge for and receives Non-Hormonal Oral Chemotherapy as prescribed by a Physician for the Treatment of Cancer. This benefit is payable only once per Month that Non-Hormonal Oral Chemotherapy is received, even if Non-Hormonal Oral Chemotherapy is received multiple times in that Month.

Radiation Therapy – We will pay the benefit amount described above for each Week a Covered Person incurs a charge for and receives Radiation Therapy as prescribed by a Physician for the Treatment of Cancer.

Benefit Maximum - Once we have paid the Maximum amount for a specific benefit for a Covered Person within a Policy Year, no further benefits will be payable for that benefit during the remainder of that Policy Year for that Covered Person. Once We have paid the Maximum for Non-Hormonal Oral Chemotherapy for a Covered Person within their lifetime, no further benefits are ever payable for Non-Hormonal Oral Chemotherapy for that Covered Person.

In addition to the Exclusions included in the Policy, no Benefits are provided for the following, nor will We pay any benefits for any Loss arising from or otherwise related to, directly or indirectly: 1) Skin Cancer; 2) services or Treatment received outside the territorial limits of the United States or its possessions; or 3) any condition or disease which was not a Loss for which a valid benefit was previously paid under the Policy to which this Rider is attached. This includes a Loss for which a benefit was previously paid but was later determined to have been paid erroneously.

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Wellness Benefit Rider (Form B 21904 WB R6) **– Applied for: ☐ Yes ☐ No**

We will pay the Wellness Benefit, subject to the Benefit Maximum, when a Covered Person is given one of the following examination(s) or test(s) after the Waiting Period and while the Rider is in force, which examination or test has been recommended by or is administered or conducted under the supervision of a Physician, and for which a charge is incurred:

- Abdominal aortic aneurysm ultrasound
- Annual physical examination
- Blood test for triglycerides
- Bone marrow testing
- Bone density screening
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- Cancer Vaccine
- Carotid ultrasound
- CEA (blood test for colon cancer)
- Chest x-ray
- Colonoscopy
- Computed tomography (CT) angiogram
- Double contrast barium enema
- Electrocardiogram (EKG)
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap smear
- Prostate-specific antigen (PSA/blood test for prostate cancer)
- Serum cholesterol HDL/LDL
- Serum protein electrophoresis (blood test for myeloma)
- Stress test
- Thermography
- Immunizations

Benefit Maximum – We will only pay for one of the examinations or tests listed above for each Covered Person during a Policy Year, regardless of the number of examinations or tests the Covered Person undergoes, even if they are administered or conducted simultaneously. Once we have paid for any one examination or test for a Covered Person during the Policy Year, no further benefits will be payable for any examinations or tests administered or conducted during the remainder of that Year for that Covered Person. We will only pay for a Maximum of four (4) examinations or tests per Policy Year for all Covered Persons under this Rider combined.

In addition to the Exclusions included in the Policy, no Benefits are provided for the following, nor will We pay any benefits for any Loss arising from or otherwise related to, directly or indirectly, any examination or test not received or confirmed within the United States or its territories.

Second Opinion and Travel Benefit Rider (Form B 21904 TRVL R7) **– Applied for: ☐ Yes ☐ No**

We will pay the following benefits, subject to the conditions, definitions, exclusions and limitations of the Rider and the Policy, when a Covered Person incurs a Loss due to Cancer. No benefits are payable under the Rider for the treatment of a Cancer except those expressly stated.

Second Opinion Benefit – We will pay $500.00 when a Covered Person is recommended by a Physician to have surgery or Treatment for Cancer, and the Covered Person chooses to obtain the second opinion of a second Physician, who is at least a board-certified Oncologist. This second opinion must be: 1) rendered prior to surgery or Treatment being performed; and 2) obtained from a Physician not in practice with the Physician rendering the original recommendation. This benefit is payable only once per Covered Person, per Cancer.

Transportation Benefit – We will pay $0.50 per mile when a Covered Person is transported by motor vehicle or common carrier (bus, rail, air) to and from a Hospital or other medical facility if the Covered Person must travel more than 100 miles away from their primary residence to receive Specialized Cancer Treatment. Mileage is measured from the Covered Person's primary residence to the nearest facility. Benefits are not payable for transportation by ambulance or any other type of licensed medical transport vehicle. This benefit is limited to a Maximum of seven hundred (700) miles per trip. There is no lifetime maximum to this benefit.

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Lodging Benefit – We will pay $100.00 for each night a Covered Person incurs a charge for Lodging in order to receive Specialized Cancer Treatment at a medical facility that is located more than one hundred (100) miles from the Covered Persons' primary residence. This benefit is limited to a Maximum of thirty (30) nights per Covered Person, per Policy Year. There is no lifetime maximum to this benefit.

In addition to the Exclusions included in the Policy, no Benefits are provided for the following, nor will We pay any benefits for any Loss arising from or otherwise related to, directly or indirectly: 1) Skin Cancer; or 2) any condition or disease which was not a Loss for which a valid benefit was previously paid under the Policy to which this Rider is attached. This includes a Loss for which a benefit was previously paid but was later determined to have been paid erroneously.

Skin Cancer Benefit Rider (Form B 21904 SCB R8) **– Applied for: ☐ Yes ☐ No**

Upon receipt of due proof satisfactory to Us of the Covered Person's Diagnosis with Skin Cancer after the thirty (30) day Waiting Period, We will pay the Skin Cancer Benefit, subject to the conditions, definitions, exclusions and limitations of the Rider and the Policy. Benefits are payable one (1) time per Diagnosis, even if Skin Cancer is Diagnosed in multiple locations on the same occasion. Benefits are payable for subsequent upon receipt of due proof satisfactory to Us that: 1) at least twenty-four (24) consecutive months have elapsed since a Diagnosis of Skin Cancer; and 2) the Covered Person has not received Treatment for any Skin Cancer for a period of at least twenty-four (24) consecutive months. There is no lifetime maximum to this benefit.

PRE-EXISTING CONDITIONS LIMITATION

For benefits payable under the Policy, benefits are not payable during the first 12 months the Policy is In Force for Losses incurred due to a Pre-Existing Condition. For benefits payable under any optional benefit rider attached to the Policy, benefits are not payable during the first 12 months the rider is In Force for Losses incurred due to a Pre-Existing Condition.

EXCLUSIONS AND LIMITATIONS

The Policy does not provide any benefits for any Loss arising from or otherwise related to, directly or indirectly, any: 1) illness, disease, condition not specifically and exclusively a Diagnosis of a Covered Cancer or Heart-Stroke Condition and as defined within the Policy; 2) Loss that begins or Diagnosed during the 30-day Waiting Period; 3) Diagnosis not received or confirmed within the United States or its' territories; 4) services or treatment occurring outside the territorial limits of the United States or its possessions, except for emergency admission or acute onset of sickness or injury sustained while traveling for business or pleasure; 5) attempted suicide or intentionally self-inflicted injury; 6) voluntary administration of any narcotic, poison, gas or fumes, unless prescribed by or taken under the direction of a Physician and taken in accordance with the prescribed dosage.

In addition to any exclusions noted in the description of the Riders, the Riders also do not provide benefits for any Loss arising from or otherwise related to, directly or indirectly, any Diagnosis that is made or Loss that begins: 1) prior to the Effective Date of the Rider; 2) while the Rider is not In Force for the Covered Person; or 3) during the Rider's thirty (30) day Waiting Period.

RENEWAL CONDITIONS

The Policy is guaranteed renewable for life, as long as renewal premiums are paid on time, either in advance or during the Grace Period. However, the Policy will Terminate on the earliest of the following events: 1) at the end of the Grace Period in which a renewal premium remains unpaid; 2) on the date that all Covered Persons have exhausted all benefits under this Policy and any attached riders; or 3) on the date of death of the Insured. Coverage under the Policy will end for a Covered Person on the date that: 1) the Covered Person has exhausted all their benefits under the Policy and any attached riders, 2) the date the Policy Terminates, 3) the date of death of that Covered Person.

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PREMIUMS SUBJECT TO CHANGE
The premium rates may be changed. A change will apply to all policies with the same form number, issue age group, tobacco status and state of issue as the Policy issued to the Insured. A minimum of 30 days advance written notice will be given. A change will apply on the next premium due date after notification is given. Each premium will be computed by the issue age and tobacco status shown in the application. We will not change the rates because of the Insured's physical condition or on account of any claims paid.

$_____Annual $_____Semi-Annual $_____Quarterly

$_____Monthly Bank Draft $_____Monthly Credit Card

IMPORTANT TERMS
When we use the following terms from the Policy, this is what we mean:

CARCINOMA IN SITU – for the purposes of the Policy, means a pre-malignant neoplasm limited to the epithelium which has not invaded the basement membrane. It is a group of abnormal cells that show cytological characteristics of cancer and has the potential to become cancer, but has so far stayed in place where it began and has not spread to surrounding tissues. "Carcinoma In Situ" may be referred to as "Stage 0" cancer and includes: 1) early prostate Cancer Diagnosed as T1N0M0 or equivalent staging; and 2) melanoma not invading the dermis. Carcinoma In Situ does not include: 1) other skin malignancies; 2) pre-malignant lesions (such as intraepithelial neoplasia); or 3) benign tumors or polyps.

DIAGNOSIS; DIAGNOSED; DATE OF DIAGNOSIS – the definitive establishment of a specified condition through the use of clinical and/or laboratory findings. The Diagnosis must be made: 1) after both the: a) Effective Date of the Policy; and b) the thirty (30) days Waiting Period; 2) during the lifetime of the Covered Person and while the Policy is in force; 2) by a Physician who is a board-certified specialist where required under the Policy; and 3) or confirmed within the United States or its' territories.The Date Of Diagnosis is the earliest of: 1) the date the specimen used to Diagnose a condition was taken; 2) the date any test was run that was used to establish the Diagnosis of a condition; or 3) the date a condition was positively Diagnosed. Diagnosis of any condition will be considered to have been made prior to the Effective Date of the Policy if medical advice or Treatment received prior to the Effective Date results in a Diagnosis of that condition.

In addition, Diagnosis of Invasive Cancer or Carcinoma In Situ must be: 1) made by a Physician who is board certified by the American Board of Pathology to practice Pathologic Anatomy, or by Physician who is a board-certified Osteopathic Pathologist; and 2) established by Pathological Diagnosis. The Physician establishing the Diagnosis shall base his or her judgment solely on the criteria of malignancy as accepted by the American Board of Pathology or Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen. A Clinical Diagnosis will be accepted only if: 1) a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; 2) there is medical evidence to support the Diagnosis; and 3) a Physician is treating the Insured for Invasive Cancer or Carcinoma In Situ.

Diagnosis of Invasive Cancer or Carcinoma In Situ includes a Diagnosis of a recurrence of an Invasive Cancer or Carcinoma In Situ that was previously Diagnosed before the Effective Date of the Policy if, after the previous Diagnosis and before the date of Diagnosis of the recurrence, the Covered Person is free of any symptoms and treatment of the Invasive Cancer or Carcinoma In Situ for the twelve (12) months immediately preceding the Effective Date of coverage or any twelve (12) months thereafter

HEART ATTACK – an acute myocardial infarction resulting in the death of a portion of the heart muscle (myocardium) due to a blockage of one or more coronary arteries and resulting in the loss of the normal function of the heart. The Diagnosis must be made by a Physician board-certified as a Cardiologist and based on both: a) new clinical presentation and electrocardiographic changes consistent with an evolving Heart Attack; and b) serial measurement of cardiac biomarkers showing a pattern and to a level consistent with a diagnosis of Heart Attack. A "Heart Attack" does not include: 1) established (old) myocardial infarction prior to the Effective Date, or 2) a heart attack that occurs during a medical procedure.

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INVASIVE CANCER – 1) a disease manifested by the presence of a malignant neoplasm characterized by the uncontrolled growth and spread of malignant cells, the invasion of tissue; 2) Carcinoma, Hodgkin's Disease, Leukemia, Lymphoma, Multiple Myeloma, and Sarcoma. "Invasive Cancer" does not include: 1) pre-malignant tumors or polyps; 2) pre-malignant lesions, Carcinoma In Situ, or 3) any skin cancer (except invasive malignant melanoma in the dermis or deeper skin malignancies that have become metastatic).

Invasive Cancer must be Diagnosed pursuant to Pathological Diagnosis. A Clinical Diagnosis will be accepted only if: 1) a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; 2) there is medical evidence to support the Diagnosis; and 3) a Physician is treating the Covered Person for Invasive Cancer.

SUDDEN CARDIAC ARREST – the sudden and unexpected loss of normal heart function due to a malfunction in the electrical system of the heart, resulting in serious irregularity (cardiac arrhythmia) and/or cessation (asystole) of a normal heart rhythm. "Sudden Cardiac Arrest" includes: 1) cardiovascular collapse; 2) cardiac arrest; or 3) sudden cardiac death. "Sudden Cardiac Arrest" does not include Heart Attack (myocardial infarction). The Diagnosis must be made by a Physician board-certified as a Cardiologist. A benefit for Sudden Cardiac Arrest is only payable if it is a primary Diagnosis, or in the event of death, the primary cause of death.

TREATMENT – care or services provided by a Physician or other member of the medical profession, acting within the scope of his or her license, including: 1) surgery; 2) therapeutic measures; or 3) diagnostic x rays and the diagnostic procedure or laboratory tests directly or indirectly related to a surgical procedure. For purposes of this benefit, "Treatment" does not include maintenance drug therapy, cardiac medications, immunosuppressant (anti-rejection) drugs, or routine follow-up office visits to verify if a condition has returned. "Maintenance drug therapy" means ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer due to primary treatment, meant to decrease the risk of cancer recurrence rather than the palliation or suppression of a cancer that is still present. "Immunosuppressant (anti-rejection) drugs" are drugs that prevent your immune system from attacking or rejecting the donor organ and typically must be taken for the lifetime of the transplanted organ. For purposes of the Policy, "immunosuppressant (anti-rejection) drugs" include any drug that must be taken in conjunction with the immunosuppressant (anti-rejection) drugs to aid them or control their side effects.

WAITING PERIOD – the first 30 days after the Effective Date of the Policy or a Rider during which if a Loss is incurred, benefits are not payable.