



## Group Cancer Insurance

## Focus on the fight.

A cancer diagnosis may be both a physical and emotional drain. But thanks to advances in medicine and procedures to treat cancer, more and more people are beating the disease. However, with these advances also comes the continuing rise in the cost of cancer treatment.

**Limited Benefit Group Cancer Insurance** offers a solution to help you and your family focus on fighting the disease.

### Did You Know?

New cancer cases in America are diagnosed at the rate of about 5,255 per day.

*American Cancer Society: Cancer Facts and Figures 2022, P4*

## Plan Benefit Highlights

- **Helps cover expenses**  
for cancer treatment, transportation, hospitalization and more.
- **Benefits are paid directly to you**  
to be used however you see fit.
- **Portable to take with you**  
even if you leave employment.
- **Coverage options are available**  
for you, your spouse and your children under age 26.

## Benefits designed to help cover costs.

With over 25 benefits specifically designed to help with the financial impact of being diagnosed, **Group Cancer Insurance** may help pay for costs not covered by your primary medical insurance.

### Examples:



#### Diagnostic and Prevention

Annual benefit to help pay for covered diagnostic testing or screening. This benefit also qualifies for quick processing.



#### Travel Expenses

This benefit may help pay for qualified transportation and lodging for the patient and family.

# Plan Benefit Highlights

| BENEFITS                                                                                                                                                                                                                                                | BASIC                                                                      | ENHANCED PLUS                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------|
| <b>Radiation Therapy/Chemotherapy/Immunotherapy</b><br>Actual charges per 12 month period                                                                                                                                                               | \$10,000                                                                   | \$15,000                                          |
| <b>Administrative/Lab Work</b><br>Per calendar month                                                                                                                                                                                                    | \$50                                                                       | \$75                                              |
| <b>Hormone Therapy</b><br>Per treatment per calendar month up to a max of 12 per calendar year                                                                                                                                                          | \$50                                                                       | \$50                                              |
| <b>Experimental Treatment</b>                                                                                                                                                                                                                           | Paid in the same manner and under the same maximums as any other treatment |                                                   |
| <b>Blood, Plasma, and Platelets Basic:</b><br>Per day, up to \$10,000 per calendar year<br><b>Enhanced Plus:</b><br>Per day, up to \$15,000 per calendar year                                                                                           | \$200                                                                      | \$300                                             |
| <b>Medical Imaging</b><br>Per image up to 2 per calendar year                                                                                                                                                                                           | \$200                                                                      | \$300                                             |
| <b>Surgical</b>                                                                                                                                                                                                                                         | \$20 surgical unit/<br>Max per operation: \$2,000                          | \$40 surgical unit/<br>Max per operation: \$4,000 |
| <b>Anesthesia</b>                                                                                                                                                                                                                                       | 25% of the amount paid for covered surgery                                 |                                                   |
| <b>Second and Third Surgical Opinion</b><br>Per diagnosis                                                                                                                                                                                               | \$300                                                                      | \$300                                             |
| <b>Outpatient Hospital or Ambulatory Surgical Center</b><br>Per day of surgery                                                                                                                                                                          | \$200                                                                      | \$600                                             |
| <b>Bone Marrow or Stem Cell Transplant</b><br><b>Patient Provided</b> Per calendar year<br><b>Donor Provided</b> Per calendar year                                                                                                                      | \$500<br>\$1,500                                                           | \$1,500<br>\$4,500                                |
| <b>Prosthesis and Orthotic and Related Services</b><br><b>Surgical</b> 1 per site, lifetime max of 2 devices per covered person<br><b>Non-surgical</b> 1 per site, lifetime max of 3 devices per covered person<br><b>Hair Prosthesis</b> Once per life | \$1,000<br>\$100<br>\$100                                                  | \$2,000<br>\$200<br>\$200                         |
| <b>Hospital Confinement</b> Per day<br><b>Day 1-30</b><br><b>Day 31+</b>                                                                                                                                                                                | \$100<br>\$200                                                             | \$300<br>\$600                                    |
| <b>U.S. Government/Charity Hospital</b><br>Paid in lieu of most benefits per day<br>Inpatient and outpatient                                                                                                                                            | \$100                                                                      | \$300                                             |
| <b>Extended Care Facility</b><br>Per day, up to the same number of days of paid hospital confinement                                                                                                                                                    | \$100                                                                      | \$300                                             |
| <b>Home Health Care</b><br>Per day, up to the same number of days of paid hospital confinement                                                                                                                                                          | \$100                                                                      | \$300                                             |
| <b>Hospice Care Basic:</b><br>Per day, up to \$18,000 lifetime max<br><b>Enhanced Plus:</b><br>Per day, up to \$54,000 lifetime max                                                                                                                     | \$100                                                                      | \$300                                             |
| <b>Inpatient Special Nursing Services</b><br>Per day                                                                                                                                                                                                    | \$100                                                                      | \$300                                             |

| BENEFITS                                                                                                                                                                                                               | BASIC                                    | ENHANCED PLUS                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|------------------------------------------|
| <b>Dread Disease</b><br>Per day while hospital confined<br><b>Day 1-30</b><br><b>Day 31+</b>                                                                                                                           | \$100<br>\$200                           | \$300<br>\$600                           |
| <b>Donor</b>                                                                                                                                                                                                           | \$1,000/donation                         |                                          |
| <b>Drugs and Medicine</b><br><b>Inpatient</b> Per confinement<br><b>Outpatient</b> \$50 per prescription up to maximum shown per calendar month                                                                        | \$50<br>\$50                             | \$200<br>\$100                           |
| <b>Attending Physician</b><br>While hospital confined, per day                                                                                                                                                         | \$50                                     | \$50                                     |
| <b>Transportation &amp; Lodging (Patient &amp; Family Member)</b><br><b>Transportation</b><br>\$1,500 max per round trip, max 12 trips per calendar year<br><b>Lodging</b><br>Per day, up to 90 days per calendar year | Coach fare or \$.50/ mile by car<br>\$50 | Coach fare or \$.50/ mile by car<br>\$75 |
| <b>Ambulance</b><br><b>Ground</b> Per trip, up to 2 per confinement<br><b>Air</b> Per trip, up to 2 per confinement                                                                                                    | \$200<br>\$2,000                         | \$200<br>\$2,000                         |
| <b>Physical or Speech Therapy</b><br>Per visit, up to 4 per calendar month, lifetime max of \$1,000.                                                                                                                   | \$50                                     | \$50                                     |
| <b>Diagnostic and Prevention</b><br>One per calendar year                                                                                                                                                              | \$25                                     | \$75                                     |
| <b>Cancer Screening Follow-Up</b><br>One per calendar year                                                                                                                                                             | \$25                                     | \$75                                     |
| <b>Waiver of Premium</b><br>Employee only                                                                                                                                                                              | After 90 days of continuous disability   |                                          |
| <b>Internal Cancer Diagnosis</b><br>One per covered person per lifetime, benefits reduce 50% at age 70                                                                                                                 | \$2,500                                  | \$5,000                                  |
| <b>Heart Attack or Stroke Diagnosis</b><br>One per covered person per lifetime, benefits reduce 50% at age 70                                                                                                          | N/A                                      | \$5,000                                  |
| <b>Hospital Intensive Care Unit</b><br>Per day, up to 30 days per confinement; benefits reduced 50% at age 70<br><b>Ambulance</b>                                                                                      |                                          | \$600<br>\$100                           |

Unless otherwise indicated, benefits are for a specified indemnity amount listed in the above schedule and are subject to applicable maximums. Refer to the following pages for more complete descriptions and limits to this plan.

| MONTHLY PREMIUMS | BASIC   | ENHANCED PLUS |
|------------------|---------|---------------|
| Individual       | \$15.80 | \$31.62       |
| Family           | \$26.86 | \$53.80       |

The premium and benefit amounts vary depending upon the plan selected.

# Plan Benefit Highlights

**Only loss for Cancer** Unless otherwise indicated, benefits are payable only for loss resulting from definitive Cancer diagnosis or treatment, including direct extension, metastatic spread, or recurrence. Proof must be submitted to support each claim. The Policy also covers other conditions or diseases directly caused by Cancer or the treatment of Cancer. The Policy does not cover any other disease, sickness or incapacity, even though after contracting Cancer it may have been aggravated or affected by Cancer or the treatment of Cancer except for conditions specifically covered under the Dread Disease Benefit; Hospital Intensive Care Unit Benefit; or Heart Attack or Stroke Diagnosis Benefit, if included.

**Cancer** means a disease that is manifested by autonomous growth (malignancy) in which there is uncontrolled growth, function or spread (local or distant) of cells in any part of the body. This includes Cancer in situ and malignant melanoma. It does not include other conditions which may be considered precancerous or have malignant potential such as leukoplakia; hyperplasia; acquired immune deficiency syndrome (AIDS); polycythemia; actinic keratosis; aplastic anemia; atypia; non-malignant monoclonal gammopathy; or pre-malignant lesions, benign tumors or polyps.

Such Cancer must be positively diagnosed by a legally licensed doctor of medicine certified by the American Board of Pathology or American Board of Osteopathic Pathology. Pathologic interpretation of the histology of skin lesions will be accepted by dermatologists certified by the American Board of Dermatopathology. Diagnosis must be made based on a microscopic examination of fixed tissue or preparations from the hemic system (either during life or post-mortem). The pathologist establishing the diagnosis shall base his judgment solely on the criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue and/or specimen.

## **Radiation Therapy, Chemotherapy or Immunotherapy Benefit**

We will pay the actual charges up to the benefit listed in the schedule per 12-month period. If Proof of Loss regarding actual charges for treatment is not submitted, we will pay the daily amount shown in your certificate for each day treatment is received, up to the actual charge's maximum per 12-month period. Upon receipt of actual charges Proof of Loss, we will pay the difference, up to the maximum per 12-month period. Actual charges are the amount paid by or on behalf of the Covered Person and accepted by the provider for services provided.

This benefit does not cover other related procedures such as treatment planning, treatment management or consultation, design and construction of treatment devices, radiation dosimetry calculation, lab tests, x-rays, scans, medical supplies, and equipment used in administration (IV solutions, needles, dressings, pumps, catheters, etc.).

**Administrative and Lab Work Benefit** Paid if the Covered Person is also receiving the Radiation Therapy, Chemotherapy or Immunotherapy Benefit during the same calendar month.

**Hormone Therapy Benefit** Drugs and medicines covered under the Drugs and Medicine Benefit or the Radiation Therapy, Chemotherapy or Immunotherapy Benefit are not included. This benefit does not cover associated administrative processes.

**Experimental Treatment Benefit** Benefits for experimental treatment prescribed by a physician for treatment of Cancer will be provided the same as non-experimental treatment. Coverage for treatments received outside the United States or its territories is not provided.

**Blood, Plasma and Platelets Benefit** Laboratory processes are not included. Colony-stimulating factors are not covered. Benefits for blood, plasma, and platelets are only provided under this benefit.

**Medical Imaging Benefit** Payable for a Covered Person who has been diagnosed with Cancer who receives either an MRI, CT scan, CAT scan, PET scan, or RAIU (thyroid) test requested by a Physician.

**Surgical Benefit** Payable when a surgical operation is performed for covered diagnosed Cancer, Skin Cancer, or reconstructive surgery due to Cancer. Benefits are calculated up to a maximum benefit by multiplying the surgical unit value assigned to the procedure, as shown in the most current Physician's Relative Value Table, by the unit dollar amount shown in your certificate schedule. Two or more surgical procedures performed through the same incision will be considered one operation and benefits will be limited to the most expensive procedure. Diagnostic surgeries that result in a negative diagnosis of Cancer are not covered under this benefit. Bone marrow surgeries, surgeries to implant a permanent prosthetic device, surgeries required for administration of Radiation Therapy, Chemotherapy or Immunotherapy are not covered under this benefit.

**Anesthesia Benefit** Services of an anesthesiologist for Skin Cancer or surgical prosthesis implantation are not covered.

**Second and Third Surgical Opinion Benefit** Payable once per diagnosis of Cancer for a second surgical opinion and a third if the second disagrees with the first. Surgical opinions for reconstructive, Skin Cancer or prosthesis surgeries are not covered.

**Outpatient Hospital or Ambulatory Surgical Center Benefit** Surgical procedures for Skin Cancer are not covered.

**Bone Marrow or Stem Cell Transplant Benefit** Harvesting of bone marrow or stem cells from a donor are not covered under this benefit.

**Prosthesis and Orthotic Benefit and Related Services** Payable for a Prosthetic Device or Orthotic Device and, if surgery required, its surgical implantation. Prosthetic-related supplies such as special bras or ostomy pouches and supplies are not covered. Benefits for a hair prosthesis will only be covered under the Hair Prosthesis Benefit.

Covered benefits under this provision are limited to the most appropriate model of Prosthetic Device or Orthotic Device that adequately meets the medical needs of the covered person as determined by the covered person's treating physician or podiatrist and prosthetist or orthotist, as applicable. The Prosthesis Benefit will include repair and replacement of a Prosthetic Device or Orthotic Device, unless the repair or replacement is necessitated by misuse by the covered person. "Orthotic Device" means a custom-fitted or custom-fabricated medical device that is applied to a part of the human body to correct a deformity, improve function, or relieve symptoms of a disease. "Prosthetic Device" means an artificial device designed to replace, wholly or partly, an arm or leg.

**Hospital Confinement Benefit** Pays when the Covered Person requires Hospital confinement for at least 18 continuous hours. We will not pay this benefit for outpatient treatment or a stay of less than 18 hours in an observation unit or emergency room. Hospital shall not include an institution, or part thereof, used by the Covered Person as a place for rehabilitation; a hospice unit, including any bed designated as a hospice or swing bed; a place for rest or for the aged; a nursing or convalescent home; a long-term nursing unit or geriatrics ward; or an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

**U.S. Government or Charity Hospital Benefit** Payable when an itemized list of services is not available and the Covered Person is confined in a charity Hospital or a Hospital owned or operated by the U.S. government as a result of Cancer or Dread Disease or covered under a Diagnostic Related Group where no charges are made to the Covered Person for treatment of Cancer or Dread Disease. This benefit will be paid in lieu of most benefits listed on the schedule.

**Extended Care Facility Benefit** Pays a daily benefit for Physician authorized confinement that begins within 14 days after Hospital confinement.

**Home Health Care Benefit** Pays a daily benefit for Physician authorized private nursing care that begins within 14 days of hospital confinement. This benefit does not include nutrition counseling, medical social services, medical supplies, prosthesis or orthopedic appliances, rental or purchase of durable medical equipment, drugs or medicines, child care, meals or housekeeping services or physical or speech therapy.

## Plan Benefit Highlights (cont.)

**Hospice Care Benefit** Pays a daily benefit when a Physician determines terminal illness with life expectancy of 6 months or less and approves hospice care at home or in a hospice facility. This benefit does not include well baby care, volunteer services, meals, housekeeping services, or family support after the death.

**Inpatient Special Nursing Services Benefit** Pays a daily benefit when receiving Physician authorized special nursing care (other than that regularly furnished by a Hospital) for at least eight consecutive hours during 24 hours.

**Dread Disease Benefit** Covered Dread Diseases are Addison's Disease; Amyotrophic Lateral Sclerosis; Cystic Fibrosis; Diphtheria; Encephalitis; Grand Mal Epilepsy; Legionnaire's Disease; Meningitis; Multiple Sclerosis; Muscular Dystrophy; Myasthenia Gravis; Niemann-Pick Disease; Osteomyelitis; Poliomyelitis; Reye's Syndrome; Rheumatic Fever; Rocky Mountain Spotted Fever; Sickle Cell Anemia; Systemic Lupus Erythematosus; Tay-Sachs Disease; Tetanus; Toxic Epidermal; Toxic Shock Syndrome; Tuberculosis; Tularemia; Typhoid Fever; Whipple's Disease.

**Donor Benefit** Blood donor expenses are not covered.

**Drugs and Medicine Benefit** Pays a benefit for anti-nausea and pain medication for cancer treatment. It does not include associated administrative processes, drugs, or medicines covered under the Radiation Therapy, Chemotherapy or Immunotherapy Benefit or the Hormone Therapy Benefit.

**Transportation and Lodging Benefits** Pays a benefit for transportation by scheduled bus, plane or train, or by car and outpatient lodging for Radiation Therapy, Chemotherapy, or Immunotherapy treatment, Bone Marrow or Stem Cell Transplant, or surgery in a Hospital not available locally and at least 50 miles from the Covered Person's residence. Payable for the Covered Person and one adult family member. If traveling in the same car or lodging in the same room, the benefit is payable only to the Covered Person.

**Ambulance Benefit** If air and ground ambulance services are required on the same day, we will only pay the higher benefit amount. A Covered Person must be admitted as an inpatient and hospital confined for at least 18 consecutive hours.

**Waiver of Premium** Premium is waived if you are disabled due to Cancer for longer than 90 continuous days. This benefit does not apply if your spouse or children become disabled. We will require proof annually that you remain Disabled during that time.

**Physical or Speech Therapy Benefit** Therapy must be provided by a caregiver licensed in physical or speech therapy.

**Diagnostic and Prevention Benefit** Pays for a generally medically recognized screening test to detect Internal Cancer. This benefit is not payable for any test covered under the Medical Imaging Benefit.

**Cancer Screening Follow-Up Benefit** Payable for one follow-up invasive screening test when a Covered Person receives abnormal results from a covered screening test. For tests involving an incision or surgery, payable only for tests that result in a negative diagnosis of Cancer.

*This product may contain limitations, exclusions, and waiting periods. This product is not intended for people who are eligible for Medicaid coverage. This is a brief description of the coverage. For complete benefits and other provisions, please refer to your certificate. Policy provisions and benefits may vary if you reside in a state other than your employer's state of domicile. This policy is considered an employee welfare benefit plan and/or maintained by an association or employer intended to be covered by ERISA, and will be administrated and enforced under ERISA. Group policies issued to governmental entities may be exempt from ERISA guidelines.*

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**Internal Cancer Diagnosis Benefit** Payable if a Physician diagnoses the Covered Person with Internal Cancer after coverage is active for that person.

**Heart Attack or Stroke Diagnosis Benefit** Payable if a Physician diagnoses the Covered Person as having a Heart Attack or Stroke after the coverage is active for that person. This benefit is payable only for the first occurrence of either the Heart Attack or Stroke.

## Limitations and Exclusions

**Pre-existing condition** means a Specified Disease for which the Covered Person: had treatment; or received advice from a Physician during the 12 months immediately before the Covered Person's Effective Date of coverage.

**Pre-existing condition limitation** No benefit will be payable for any loss caused by or resulting from a Pre-Existing Condition that occurs before a Covered Person has been continuously covered under the Policy for 12 consecutive months. Pre-Existing Conditions specifically named or described as excluded in any part of this contract are never covered. Increases or changes in coverage will be subject to an additional Pre-Existing Condition Limitation.

**Hospital intensive care unit benefit limitations** No benefits will be payable during the first two years of coverage for confinement caused by any heart condition diagnosed or treated before 30 days following the Effective Date of coverage. (The heart condition causing confinement need not be the same condition diagnosed or treated before the Effective Date).

**Exclusions** We will not pay benefits resulting from or caused by:

- (a) intentionally self-inflicted bodily injury, suicide or attempted suicide, whether sane or insane;
- (b) alcoholism or drug addiction;
- (c) any act of war, declared or undeclared, or any act related to war;
- (d) military service for any country at war;
- (e) participation in any activity or event while intoxicated or under the influence of any narcotic unless administered by a Physician or taken according to the Physician's instructions; or
- (f) participation in, or attempting to participate in, a felony, riot or insurrection (A felony is as defined by the law of the jurisdiction in which the activity takes place).

Benefits are also not payable for services performed by a Physician who is related to the Covered Person.

**Termination of Insurance** Your coverage may continue for up to 1 year during a leave of absence approved in writing by your employer. Coverage will continue as long as the group policy remains in force, the premiums are paid, and you remain eligible for the coverage under the Policy. Your coverage will end when you no longer qualify as an insured, retire, you are not on active employment, your employment terminates or you die. Your dependent's coverage will end if your coverage ends, premiums are not paid, they no longer meet the definition of a dependent or the Policy is modified to exclude dependents. Your coverage can be terminated on any premium due date with 31 days advance notice. If premium rates are increased, we will provide a 60 day advance notice.