SureBridge®
Underwritten by
The Chesapeake Life Insurance Company®

Critical Illness Coverage

CancerWise® Plus HeartWise™

Serious illness takes more than a physical toll — it can impact your finances as well. Our Critical Illness suite of products, can provide an extra layer of financial protection so you can focus on what really matters.

What is a Critical Illness?

A critical illness is a serious medical condition that can strike suddenly and disrupt your life physically and financially. Chances are someone close to you has had a critical illness diagnosis such as cancer, heart attack, stroke, Alzheimer's, or end-stage renal failure.

Our Critical Illness suite of products was created for people up to age 90 to help with some of the out-of-pocket expenses that can add up during diagnosis and recovery.

Can You Afford a Critical Illness?

- Can you afford $50,000? Time away from work can take its toll. The average loss of income due to critical illness is more than $50,000.[1]
- Can you afford 3 months? Most heart attack patients can't go back to work for up to 3 months.[2]
- Can you afford a surprise? If you're diagnosed with cancer, you might spend 1/3 of your income on expenses your health insurance doesn't cover.[3]

Critical Illness Coverage at a Glance

- Pays up to a $100,000 lump-sum cash benefit on a first diagnosis of a covered critical illness or qualifying event
- Benefits paid directly to you — not your doctor or hospital
- Coverage is available for the whole family — you, your spouse, and your kids
- Affordable premiums that do not increase as you get older with coverage starting at $8.00 per month[4]

[1]http://www.whymetlife.com/boi/downloads/MetLife_Accident_Critical_Illness_Whitepaper_Infographic.pdf | [2]American Heart Association, "Heart Attack Recovery FAQs" n.d. Web. 26 July 2011. www.heart.org | [3]Research Letter, "Out-of-Pocket Costs, Financial Distress, and Underinsurance in Cancer Care". JAMA Oncol. 2017;3(11):1582-1584. doi:10.1001/jamaoncol.2017.2148. https://jamanetwork.com/journals/jamaoncology/article-abstract/2648318 | [4]For 30-year-old female at $20,000 benefit level. Premium Rate Assumptions: Generic Pricing, Full Suite Configuration (Cancer, Heart/Stroke, and Critical Conditions)

How Can Critical Illness Coverage Help Your Family?

Our suite of products offers affordable benefit level options that pay lump-sum cash benefits directly to you. The money can be used to pay unexpected medical costs or everyday living expenses, so you and your family can focus on healing instead of finances.

Use Your Cash Benefits to Cover Out-of-Pocket Costs

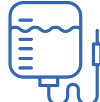
With lump-sum cash benefits up to $100,000, you can use them to help cover out-of-pocket costs including:

Transportation to and from Treatment Centers

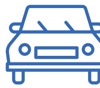
Out-of-Network Providers

Prescriptions

Hotel Stays


Experimental Treatments

Mortgage Payments


Car Payments

Utility Bills

Combining Critical Illness coverage with a health insurance plan can provide an extra layer of financial protection to help you feel more comfortable with your insurance coverage.

Critical Illness Coverage

+

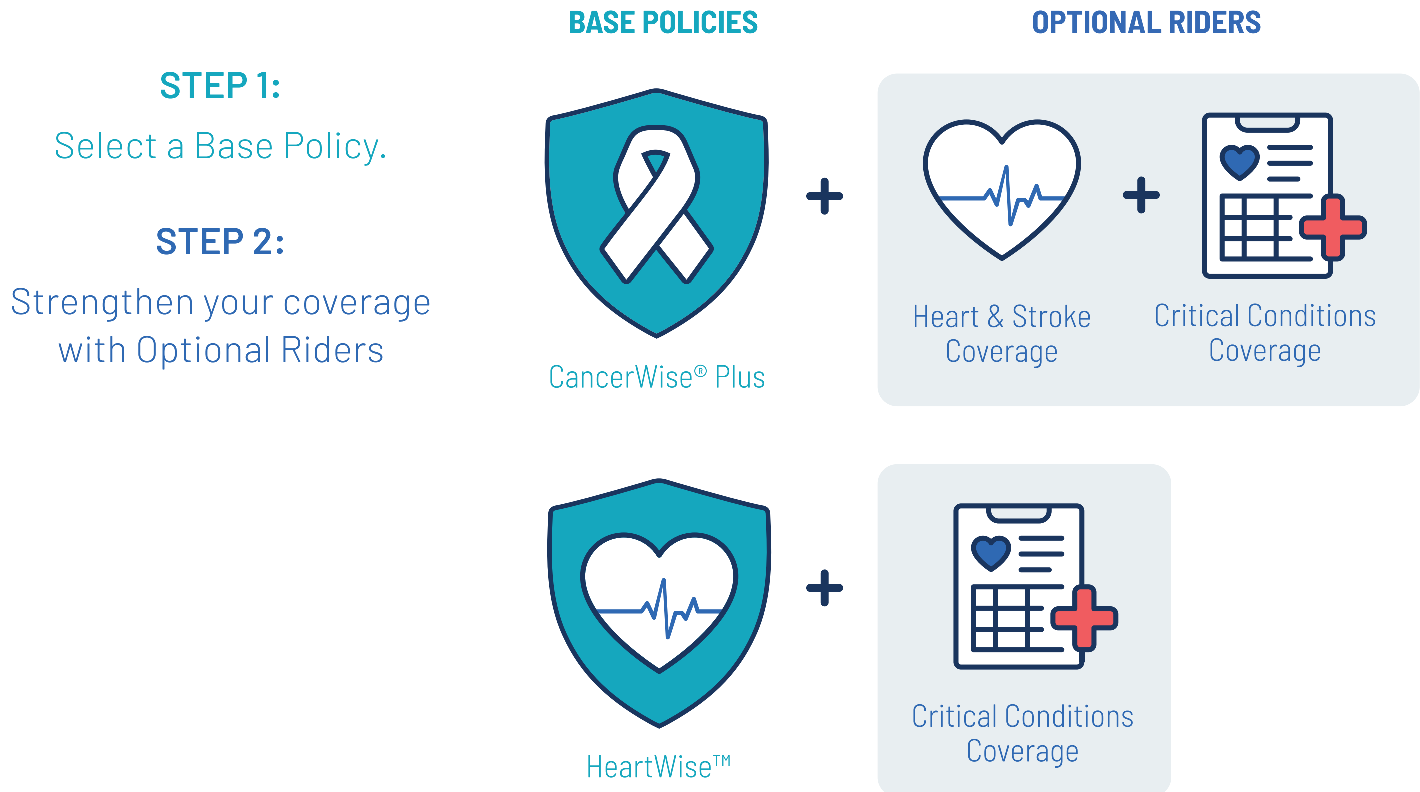
Health Insurance

=

More Financial Protection

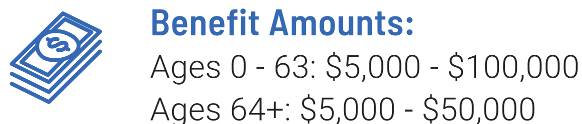
How Does the Coverage Work?

Our suite of critical illness products can provide as little or as much coverage as you need to fit your family and your budget. Choose the best option to customize your coverage:

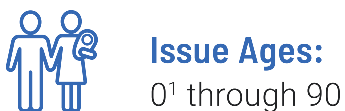


Insurance Features

A lump-sum cash benefit will be paid directly to you, in addition to any other health insurance coverage you may have, on the diagnosis of a covered critical illness or qualifying event.

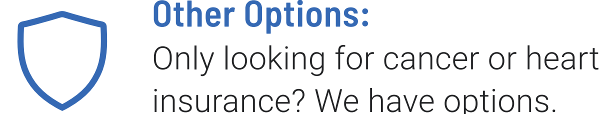


Benefit Amounts:
Ages 0 - 63: $5,000 - $100,000
Ages 64+: $5,000 - $50,000



Issue Ages:
0[1] through 90

Renewability:
Renewable for life!



Other Options:
Only looking for cancer or heart insurance? We have options.

Receive up to 100% of the benefit amount for ***each*** covered category: Cancer, Heart, Critical Conditions. The maximum benefit is payable up to three times, once for each covered category.

[1]Represents dependent child age, child primaries not allowed

How Much Does It Cover?

Did you know that nearly 10 million adults with health insurance will still accumulate medical bills they can't pay?[1] We can help protect you and your family with a suite of three coverage categories — you can choose what you need for the most financial protection.

The chart below lists the percentage of the benefit amount that you would be eligible to receive as a lump-sum cash payment upon the first diagnosis of a qualifying event with base policy and optional heart attack & stroke and/or critical conditions rider.

CANCER CATEGORY CancerWise® Plus		HEART CATEGORY HeartWise™ or Optional Heart Attack & Stroke Rider** Form CH-26144-IR GA		CRITICAL CONDITIONS CATEGORY Optional Critical Conditions Rider** Form CH-26145-IR GA	
Invasive Cancer	100%	Heart Attack	100%	ALS	100%
Cancer in Situ	25%	Stroke	100%	Alzheimer's	100%
Benign Brain Tumor	25%	Coronary Artery Bypass Graft	25%	Coma	100%
Skin Cancer	$250*	Angioplasty	10%	Major Organ Transplant	100%
				End-Stage Renal Failure	100%
				Loss of Independent Living	25%

* Provides a one-time $250 benefit upon the diagnosis of skin cancer.

Maximum Benefits: The benefit amount is payable up to 100% for each covered category (Cancer Category, Heart Category, Critical Conditions Category).

** Optional riders cost extra. Riders are subject to all Policy provisions, exclusions and limitations.

Boost Your Benefits With Additional Riders

Our optional riders provide access to more benefits, payable in addition to the base lump-sum benefits. The following optional riders are available for an additional cost.

Worried About Recurring Cancer?

Invasive Cancer Recurrence Rider[2] provides a one-time lump-sum benefit equal to 50% of the Invasive Cancer benefit for recurrent diagnosis of invasive cancer. Form CH-26146-IR.

Worried About Recurring Heart Attacks or Strokes?

Heart Attack and Stroke Recurrence Rider[2] provides a one-time lump-sum benefit equal to 50% of the Heart Attack and Stroke benefit for a recurrent diagnosis of heart attack or stroke. Form CH-26147-IR GA.

Wellness Rider (Great for Families!)

Our Wellness Rider offers an incentive to stay healthy and help keep health care costs under control because individuals who have annual preventive care exams could detect diseases and conditions early. The Wellness Rider pays a benefit of $50 per year per insured person for covered wellness exams, such as annual physicals, and vision and hearing exams. For example, that's a benefit of up to $300 for a family of six.[3] Form CH-26137-IR.

[1]Findings from NerdWallet Health's analysis of data from the U.S. Census, Centers for Disease Control, the federal court system, and the Commonwealth Fund. | [2]Qualifying recurrent diagnoses must be separated by a period of 365 consecutive days during which the insured was symptom- and treatment-free. | [3]Wellness Rider may be subject to a waiting period. Please refer to Rider for details.

IMPORTANT NOTICE TO PERSONS ON MEDICARE. THIS IS NOT MEDICARE SUPPLEMENT INSURANCE.

Some health care services paid for by Medicare may also trigger the payment of benefits under the Policy.

This insurance pays a fixed dollar amount, regardless of your expenses, if you meet the policy conditions for one of the specific diseases or health conditions named in the Policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- outpatient prescription drugs if you are enrolled in Medicare Part D
- hospice
- other approved items and services

The Policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Other Important Information

DEFINITIONS FOR CANCERWISE PLUS AND HEARTWISE POLICIES (See Policy for Other Important Definitions):

- **Cancer Benefit Qualifying Event** includes the diseases or conditions listed below for which positive diagnosis is made by a legally qualified physician based on diagnostic criteria generally accepted by the medical profession.
  - **Benign Brain Tumor** means a non-malignant mass present within the substance of the brain tissue resulting in permanent deficit to the neurological system. Benign Brain Tumor does not include cysts, granulomas, meningiomas, malformations of the intracranial arteries or veins and tumors of the cranial nerves, pituitary or spinal cord, unless documented by a legally qualified physician as causing damage to surrounding neurological tissue.
  - **Cancer In Situ** means a diagnosis of cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue, except as specifically excluded below. As used herein, stage 0 disease and early prostate cancer requiring medical treatment shall be considered Cancer In Situ. Cancer In Situ does not include: premalignant lesions, tumors or polyps; benign tumors or polyps; or Skin Cancer.
  - **Invasive Cancer** means only those types of cancer manifested by the presence of a malignant neoplasm characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Invasive Cancer also includes but is not limited to leukemia, Hodgkin's disease, myeloproliferative and myelodysplastic blood disorders, and invasive melanoma in the dermis or deeper. Invasive Cancer does not include: premalignant lesions, tumors or polyps; benign tumors or polyps; Cancer In Situ; or Skin Cancer.
  - **Skin Cancer** means a type of disease for which malignant cancer cells are found in the outer layer of the skin and has not been diagnosed as a malignant melanoma in the dermis or deeper or skin malignancy that has become Invasive Cancer, as defined in the Policy. Skin Cancer does not include: premalignant lesions, tumors or polyps; or benign tumors of polyps.
- **Heart Attack and Stroke Qualifying Event** includes the diseases, conditions or procedures listed below for which positive diagnosis is made by a legally qualified physician based on a diagnostic criteria generally accepted by the medical profession.
  - **Angioplasty** means a medically necessary surgical technique for restoring normal blood flow through one or more coronary arteries narrowed or blocked by atherosclerosis, either by inserting a balloon into the narrowed section and inflating it or by using a laser beam. The procedure must be performed by a legally qualified physician who is a board certified cardiologist.
  - **Coronary Artery Bypass** means coronary artery revascularization surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, performed by a legally qualified physician who is a board certified cardiothoracic surgeon.
  - **Heart Attack** means irreversible damage and death of a portion of the myocardium of heart muscle caused by either: 1) coronary thrombosis (complete occlusion of a coronary artery); or 2) severe stenosis or narrowing of a coronary artery causing an occlusion of a coronary artery; which is first positively diagnosed by a legally qualified physician. We may require medical records and appropriate test results to show that the onset of such acute myocardial infarction is confirmed by: (a) significant abnormal electrocardiographic findings; and/or (b) clinical findings and cardiac blood enzyme abnormalities. Heart Attack does not include cardiac arrest.
  - **Stroke** means any acute cerebrovascular incident producing neurological impairment and resulting in paralysis or other measurable objective neurological deficit persisting for at least 96 hours and expected to be permanent, except as specifically excluded below. In order for Stroke to be covered under the Policy, the Stroke must be positively diagnosed by a legally qualified physician based upon generally accepted diagnostic criteria. Stroke does not include: 1) head injury by any external force; 2) transient ischemic attack (TIA) (i.e. mini stroke); or 3) indications or symptoms related to chronic cerebrovascular insufficiency.
- **First Diagnosis or First Diagnosed** means a diagnosis, as defined in the Policy, which initially occurs for the first time in the insured person's lifetime after the waiting period and while the insured person's coverage is in effect under the Policy.
- **Qualifying Event** includes any of the specific diseases, conditions or procedures as shown in the Policy Schedule as defined in the Policy and any attached riders.
- **Pre-Existing Condition** means a condition, disease, infection, or disorder not excluded by name or specific description for which: 1) medical advice or treatment was recommended by or received from a legally qualified physician within the two-year period before the effective date of coverage; or 2) symptoms existed within the one-year period before the effective date of coverage, which would cause an ordinarily prudent person to seek diagnosis, examination, care or treatment.

For a complete listing of benefits, exclusions and limitations, please refer to your Policy. In the event of any discrepancies contained in this brochure, the terms and conditions contained in the Policy documents shall govern. Form CH-26143-IP (02/18) GA and Form CH-26150-IP (02/18) GA.

THE CHESAPEAKE LIFE INSURANCE COMPANY®
A Stock Company
(Hereinafter called: the Company, We, Our or Us)
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Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-815-8535
www.Chesapeakeplus.com

SPECIFIED DISEASE CANCER BENEFIT POLICY
OUTLINE OF COVERAGE FOR POLICY FORM CH-26143-IP (02/18) GA

NOTICE TO BUYER: THE POLICY PROVIDES LIMITED BENEFITS. The Policy is designed to provide, to Insured Persons, restricted coverage paying benefits ONLY for the First Diagnosis of a Cancer Benefit Qualifying Event while coverage is in force under the Policy, subject to the Waiting Period and Pre-Existing Condition Limitation stated in the Policy. This coverage is supplemental and should not be considered a substitute for comprehensive health insurance coverage.

This is NOT a Medicare supplement Policy and should not be considered a substitute for comprehensive health insurance coverage.

1. **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 Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY.**

2. **SPECIFIED DISEASE CANCER BENEFIT POLICY –** Specified disease coverage is designed to provide restricted coverage paying benefits ONLY when certain losses are First Diagnosed as a result of a Cancer Benefit Qualifying Event, subject to the Waiting Period and Pre-Existing Condition Limitation. **Coverage is NOT provided for basic hospital, basic medical-surgical, or major medical expenses or loss from Injury or accident**.

3. **SCHEDULE OF BENEFITS -** Benefits are payable under the Policy as follows:

CANCER

WAITING PERIOD: 30 days from the Effective Date of Coverage.

Cancer Lifetime Maximum Benefit Amount*:

Primary Insured:	$____________ ($5,000 - $100,000)
Dependent spouse/domestic partner:	☐No Benefit ☐$____________ ($5,000 - $100,000)
Dependent child(ren):	☐No Benefit ☐$____________ ($5,000 - $100,000)

Cancer Benefit Qualifying Events	First Diagnosis Benefit
Invasive Cancer	100% of Lifetime Maximum Benefit Amount
Cancer In Situ *(Limited to one benefit payable, per Insured Person, per lifetime)*	25% of Lifetime Maximum Benefit Amount
Benign Brain Tumor *(Limited to one benefit payable, per Insured Person, per lifetime)*	25% of Lifetime Maximum Benefit Amount

Skin Cancer *(Limited to one benefit payable, per Insured Person, per lifetime)*	$250 of Lifetime Maximum Benefit Amount

***Once the Cancer Lifetime Maximum Benefit Amount is exhausted by an Insured Person, no further benefits will be paid under the Policy for a Cancer Benefit Qualifying Event for that Insured Person, unless where coverage for such Insured Person includes the Invasive Cancer Recurrence Rider.**

OPTIONAL RIDER BENEFITS

LUMP-SUM HEART ATTACK AND STROKE RIDER

WAITING PERIOD: 30 days from the Effective Date of Coverage.

Heart Attack and Stroke Lifetime Maximum Benefit Amount*:

Primary Insured:	$____________ ($5,000 - $100,000)
Dependent spouse/domestic partner:	☐No Benefit ☐$____________ ($5,000 - $100,000)
Dependent child(ren):	☐No Benefit ☐$____________ ($5,000 - $100,000)

Heart Attack and Stroke Rider Qualifying Events	First Diagnosis Benefit
Heart Attack	100% of Lifetime Maximum Benefit Amount
Stroke	100% of Lifetime Maximum Benefit Amount
Coronary Artery Bypass *(Limited to one benefit payable, per Insured Person, per lifetime)*	25% of Lifetime Maximum Benefit Amount
Angioplasty *(Limited to one benefit payable, per Insured Person, per lifetime)*	10% of Lifetime Maximum Benefit Amount

***Once the Heart Attack and Stroke Lifetime Maximum Benefit Amount is exhausted by an Insured Person, no further benefits will be paid under the Lump-Sum Heart Attack and Stroke Rider for that Insured Person, unless where coverage for such Insured Person includes the Heart Attack and Stroke Recurrence Rider.**

CRITICAL CONDITION RIDER

WAITING PERIOD: 30 days from the Effective Date of Coverage.

Critical Condition Lifetime Maximum Benefit Amount*:

Primary Insured:	$____________ ($5,000 - $100,000)
Dependent spouse/domestic partner:	☐No Benefit ☐$____________ ($5,000 - $100,000)
Dependent child(ren):	☐No Benefit ☐$____________ ($5,000 - $100,000)

Critical Condition Rider Qualifying Events	**First Diagnosis Benefit**
Advanced Alzheimer's Disease	100% of Lifetime Maximum Benefit Amount
Amyotrophic Lateral Sclerosis (ALS)	100% of Lifetime Maximum Benefit Amount
Coma *(Lasting for a period of at least 7 consecutive days)*	100% of Lifetime Maximum Benefit Amount
End Stage Renal Failure	100% of Lifetime Maximum Benefit Amount
Loss of Independent Living *(Payable for the permanent inability to perform two or more Activities of Daily Living for a period of at least 90 consecutive days)*	25% of Lifetime Maximum Benefit Amount
Major Organ Transplant:	
At time of registry by the United Network of Organ Sharing (UNOS) as a transplant candidate:	25% of Lifetime Maximum Benefit Amount
At time of Major Organ Transplant procedure:	75% of Lifetime Maximum Benefit Amount

***Once the Critical Condition Lifetime Maximum Benefit Amount is exhausted by an Insured Person, no further benefits will be paid under the Critical Condition Rider for that Insured Person.**

INVASIVE CANCER RECURRENCE RIDER

Invasive Cancer Recurrence Benefit following Period of Remission*	50% of Cancer Lifetime Maximum Benefit Amount

***Once an Invasive Cancer Recurrence benefit is paid to an Insured Person, no further benefits will be paid under the Invasive Cancer Recurrence Rider for that Insured Person.**

HEART ATTACK AND STROKE RECURRENCE RIDER

Heart Attack or Stroke Recurrence Benefit following Period of Remission*	50% of Heart Attack and Stroke Lifetime Maximum Benefit Amount

***Once a Recurrent Heart Attack or Stroke benefit is paid to an Insured Person, no further benefits will be paid under the Heart Attack and Stroke Recurrence Rider for that Insured Person.**

WELLNESS RIDER
(Subject to 90 day Waiting Period)

Benefit amount:	$50 per Insured Person, per exam
Limited to:	1 exam, per Insured Person, per calendar year

4. **BENEFITS -** Upon receipt of proof of the First Diagnosis of a Cancer Benefit Qualifying Event under the Policy, We will pay the applicable First Diagnosis benefit, as shown in the POLICY SCHEDULE – SCHEDULE OF BENEFITS, subject to the Pre-Existing Condition Limitation and the Waiting Period.

   If an Insured Person is Diagnosed with a subsequent Qualifying Event while coverage is in effect under the Policy and any attached Riders, no benefit will be payable if the subsequent Qualifying Event is resulting from, caused by, connected to, or associated with a prior Qualifying Event for which a benefit was paid under the Policy or any attached Riders, unless the Insured Person's coverage includes the Invasive Cancer Recurrence Rider, and only to the extent coverage for the subsequent Qualifying Event is provided under the Invasive Cancer Recurrence Rider.

   Benefit Payment Limitation

   In no event will We pay more than the Cancer Lifetime Maximum Benefit Amount during an Insured Person's lifetime, unless where coverage for such Insured Person includes the Invasive Cancer Recurrence Rider.

5. **EXCLUSIONS AND LIMITATIONS -** We will not provide any benefits for any loss caused by, resulting from or in connection with:

   1. Any care or benefits which are not specifically provided for in the Policy;
   2. Any Diagnosis, as defined in the Policy, which is determined to be caused by war or act of war, declared or undeclared;
   3. Any Diagnosis, as defined in the Policy, which is made by You or a member of Your Immediate Family, Domestic Partner or household;
   4. Any Diagnosis, as defined in the Policy, which occurs prior to an Insured Person's Effective Date of Coverage;
   5. Any Diagnosis, as defined in the Policy, which is made outside the U.S.; or
   6. Any Diagnosis, as defined in the Policy, which occurs after the date on which coverage under the Policy has been terminated.

   Benefits will not be payable for:

   1. The First Diagnosis of a Cancer Benefit Qualifying Event, which occurs within the Waiting Period as specified in the POLICY SCHEDULE – SCHEDULE OF BENEFITS;
   2. Any Cancer Benefit Qualifying Event caused directly or indirectly by Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex;
   3. Any condition that is not Diagnosed as a Cancer Benefit Qualifying Event, as defined in the Policy; or
   4. Loss resulting from any other disease, sickness or incapacity, other than loss resulting from a Cancer Benefit Qualifying Event, as defined in the Policy. This includes any other disease or incapacity which may have been complicated or directly or indirectly affected or caused by a Cancer Benefit Qualifying Event or as a result of treatment of a Cancer Benefit Qualifying Event.

   Pre-Existing Condition Limitation - Benefits will not be payable for a Cancer Benefit Qualifying Event resulting from a Pre-Existing Condition unless the First Diagnosis of such Cancer Benefit Qualifying Event occurs more than 6 months after the Insured Person's Effective Date of Coverage.

   Qualifying Event occurring during the Waiting Period - If a Qualifying Event occurs during the Waiting Period, subject to the Pre-Existing Condition Limitation, You will be given the option to either void coverage from inception and receive a full refund of premium or keep the Policy in force. If the Policy remains in force, the Qualifying Event diagnosed within the Waiting Period will not be a covered Qualifying Event under the Policy or any attached Riders; however, the Policy will provide for other Qualifying Events that occur after the Waiting Period as set forth in the POLICY SCHEDULE – SCHEDULE OF BENEFITS.

6. **RENEWABILITY -** The Policy is guaranteed renewable, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of the Policy. The Company reserves the right to change the applicable table of premium rates on a Class Basis. The premium for the Policy is based on the issue age of the Insured Person at the time in which the Policy becomes effective.

7. **BEGINNING OF COVERAGE -** Once We have approved Your application based upon the information You provided therein, the Effective Date of Coverage for You and Your Eligible Dependents, if any, listed in the application and accepted by Us will be the Policy Date shown in the POLICY SCHEDULE.

8. **TERMINATION OF COVERAGE -**

You

Your coverage will terminate and no benefits will be payable under the Policy and attached riders, if any:

1. On the date that all benefits have been exhausted under the Policy and all attached riders, if any;
2. At the end of the period for which premium has been paid (subject to the Grace Period);
3. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
4. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
5. On the date You:
   a. perform an act or practice that constitutes fraud subject to the Time Limit on Certain Defenses provision appearing under the General Provisions section of the Policy; or
   b. make an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Policy, including claims for benefits under the Policy, subject to the Time Limit on Certain Defenses provision appearing under the General Provisions section of the Policy;
6. On the date We elect to discontinue this plan or type of coverage. We will give You at least 90 days written notice before the date coverage will be discontinued. You will be offered an option to purchase any other similar coverage that We offer without regard to health status;
7. On the date We elect to discontinue all coverage in Your state. We will give You and the Commissioner at least 180 days written notice before the date coverage will be discontinued; or
8. On the date an Insured Person is no longer a permanent resident of the United States.

Premium will only be refunded for any full months paid beyond the termination date.

Covered Dependents

Your Covered Dependent's coverage will terminate under the Policy and any attached riders on:

1. The date Your coverage terminates;
2. At the end of the month following the date such dependent ceases to be an Eligible Dependent;
3. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
4. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date; or
5. On the date the Covered Dependent:
   a. performs an act or practice that constitutes fraud, subject to the Time Limit on Certain Defenses provision appearing under the General Provisions section of the Policy; or
   b. makes an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Policy, including claims for benefits under the Policy, subject to the Time Limit on Certain Defenses provision appearing under the General Provisions section of the Policy.

Premium will only be refunded for any full months paid beyond the termination date.

The attainment of the Limiting Age for an Eligible Dependent will not cause coverage to terminate while that person is and continues to be both:

1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap, as determined by the Department of Behavioral Health and Developmental Disabilities; and
2. Chiefly Dependent on You for support and maintenance. For the purpose of this provision "Chiefly Dependent" means the Eligible Dependent receives the majority of his or her financial support from You.

We will require that You provide written proof that the dependent is in fact a disabled and dependent person within 31 days after his or her attainment of the Limiting Age. Thereafter, We may require such written proof not more frequently than annually after the two-year period following the child's attainment of the Limiting Age. In the absence of such proof We may terminate the coverage of such person after the attainment of the Limiting Age.

9. RIDER BENEFITS –

Lump-Sum Heart Attack and Stroke Rider (Form CH-26144-IR GA) - After the 30 day Waiting Period, upon receipt of proof of the First Diagnosis of a Heart Attack and Stroke Rider Qualifying Event, We will pay the applicable First Diagnosis benefit shown in the POLICY SCHEDULE for the Rider. If an Insured Person is Diagnosed with a subsequent Qualifying Event while coverage is in effect under the Rider, no benefit will be payable if the subsequent Qualifying Event is resulting from, caused by, connected to, or associated with a prior Qualifying Event for which a benefit was paid under the Rider or the attached Policy, unless the Insured Person's coverage includes the Heart Attack and Stroke Recurrence Rider, and only to the extent coverage for the subsequent Qualifying Event is provided under the Heart Attack and Stroke Recurrence Rider. In no event will We pay more than the Heart Attack and Stroke Lifetime Maximum Benefit Amount during an Insured Person's lifetime, unless where coverage for such Insured Person includes the Heart Attack and Stroke Recurrence Rider.

Critical Condition Rider (Form CH-26145-IR GA) - After the 30 day Waiting Period, upon receipt of proof of the First Diagnosis of a Critical Condition Qualifying Event under the Rider, We will pay the applicable First Diagnosis benefit shown in the POLICY SCHEDULE for the Rider. If an Insured Person is Diagnosed with a subsequent Qualifying Event while coverage is in effect under the Rider, no benefit will be payable if the subsequent Qualifying Event is resulting from, caused by, connected to, or associated with a prior Qualifying Event for which a benefit was paid under the Rider or the attached Policy. In no event will We pay more than the Critical Condition Rider Lifetime Maximum Benefit Amount during an Insured Person's lifetime.

Invasive Cancer Recurrence Rider (Form CH-26146-IR) - If an Insured Person experiences an Invasive Cancer Recurrence, We will pay the Percentage of Cancer Lifetime Maximum Benefit Amount shown in the POLICY SCHEDULE provided the Insured Person was Symptom and Treatment-Free for the Period of Remission prior to the date of Diagnosis of the Invasive Cancer Recurrence. Once an Invasive Cancer Recurrence benefit is paid to an Insured Person, no further benefits will be paid under the Invasive Cancer Recurrence Rider for that Insured Person.

Heart Attack and Stroke Recurrence Rider (Form CH-26147-IR GA) - If an Insured Person experiences a Recurrent Heart Attack or Stroke, We will pay the Percentage of Heart Attack or Stroke Lifetime Maximum Benefit Amount shown in the POLICY SCHEDULE provided the Insured Person was Symptom and Treatment-Free for the Period of Remission prior to the date of Diagnosis of the Recurrent Heart Attack or Stroke. Once a Recurrent Heart Attack or Stroke benefit is paid to an Insured Person, no further benefits will be paid under the Heart Attack and Stroke Recurrence Rider for that Insured Person.

Wellness Rider (Form CH-26137-IR) – After the 90 day Waiting Period, benefits are payable for one of the following Wellness exams, while coverage under the Rider is in force: annual physical, blood test for triglycerides, CA 19-9 (blood test for cancer), fast blood glucose test, hemocult stool analysis, PSA (blood test for prostate cancer, pap smear, immunizations/vaccinations, vision/hearing exams, serum protein electrophoresis (blood test for myeloma), stress test, biopsy for skin cancer, bone marrow biopsy and aspiration, breast ultrasound, CA 15-3 (blood test for cancer), CA 125 (blood test for cancer), CEA (blood test for cancer), chest X-ray, colonoscopy, flexible sigmoidoscopy, serum cholesterol test to determine level of HDL and LDL, mammography, and low-dose computed tomography (lung cancer screening). Benefits are limited to one exam per Insured Person, per Calendar Year.
Benefit Amount: $50 per Insured Person, per exam

10. PREMIUMS - We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy at any time and from time to time; provided, We have given You written notice of at least 60 days prior to the effective date of the new rates. Such change will be on a Class Basis. The premium for the Policy is based on the issue age of the Insured Person at the time in which the Policy becomes effective.

Premium Due (at time of application) $ _______________

THE CHESAPEAKE LIFE INSURANCE COMPANY®
A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-815-8535
www.Chesapeakeplus.com

SPECIFIED DISEASE HEART ATTACK AND STROKE POLICY OUTLINE OF COVERAGE FOR POLICY FORM CH-26150-IP (02/18) GA

NOTICE TO BUYER: THE POLICY PROVIDES LIMITED BENEFITS. The Policy is designed to provide, to Insured Persons, restricted coverage paying benefits ONLY for the First Diagnosis of a Heart Attack and Stroke Qualifying Event while coverage is in force under the Policy, subject to the Waiting Period and Pre-Existing Condition Limitation stated in the Policy. This coverage is supplemental and should not be considered a substitute for comprehensive health insurance coverage.

This is NOT a Medicare supplement Policy and should not be considered a substitute for comprehensive health insurance coverage.

1. **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 Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY.**

2. **SPECIFIED DISEASE HEART ATTACK AND STROKE POLICY –** Specified disease coverage is designed to provide restricted coverage paying benefits ONLY when certain losses are First Diagnosed as a result of a Heart Attack and Stroke Qualifying Event, subject to the Waiting Period and Pre-Existing Condition Limitation. **Coverage is NOT provided for basic hospital, basic medical-surgical, or major medical expenses or loss from Injury or accident**.

3. **SCHEDULE OF BENEFITS -** Benefits are payable under the Policy as follows:

HEART ATTACK AND STROKE

WAITING PERIOD: 30 days from the Effective Date of Coverage.

Heart Attack and Stroke Lifetime Maximum Benefit Amount*:

Primary Insured:	$____________ ($5,000 - $100,000)
Dependent spouse/domestic partner:	☐No Benefit ☐$____________ ($5,000 - $100,000)
Dependent child(ren):	☐No Benefit ☐$____________ ($5,000 - $100,000)

Heart Attack and Stroke Qualifying Events	First Diagnosis Benefit
Heart Attack	100% of Lifetime Maximum Benefit Amount
Stroke	100% of Lifetime Maximum Benefit Amount
Coronary Artery Bypass *(Limited to one benefit payable, per Insured Person, per lifetime)*	25% of Lifetime Maximum Benefit Amount
Angioplasty *(Limited to one benefit payable, per Insured Person, per lifetime)*	10% of Lifetime Maximum Benefit Amount

***Once the Heart Attack and Stroke Lifetime Maximum Benefit Amount is exhausted by an Insured Person, no further benefits will be paid under the Policy for a Heart Attack and Stroke Qualifying Event for that Insured Person, unless where coverage for such Insured Person includes the Heart Attack and Stroke Recurrence Rider.**

OPTIONAL RIDER BENEFITS

CRITICAL CONDITION RIDER

WAITING PERIOD: 30 days from the Effective Date of Coverage.

Critical Condition Lifetime Maximum Benefit Amount*:

Primary Insured:	$____________ ($5,000 - $100,000)
Dependent spouse/domestic partner:	□No Benefit □$____________ ($5,000 - $100,000)
Dependent child(ren):	□No Benefit □$____________ ($5,000 - $100,000)

Critical Condition Rider Qualifying Events	First Diagnosis Benefit
Advanced Alzheimer's Disease	100% of Lifetime Maximum Benefit Amount
Amyotrophic Lateral Sclerosis (ALS)	100% of Lifetime Maximum Benefit Amount
Coma *(lasting for a period of at least 7 consecutive days)*	100% of Lifetime Maximum Benefit Amount
End Stage Renal Failure	100% of Lifetime Maximum Benefit Amount
Loss of Independent Living *(payable for the permanent inability to perform two or more Activities of Daily Living for a period of at least 90 consecutive days)*	25% of Lifetime Maximum Benefit Amount
Major Organ Transplant:	
At time of registry by the United Network of Organ Sharing (UNOS) as a transplant candidate:	25% of Lifetime Maximum Benefit Amount
At time of Major Organ Transplant procedure:	75% of Lifetime Maximum Benefit Amount

***Once the Critical Condition Lifetime Maximum Benefit Amount is exhausted by an Insured Person, no further benefits will be paid under the Critical Condition Rider for that Insured Person.**

HEART ATTACK AND STROKE RECURRENCE RIDER

Heart Attack or Stroke Recurrence Benefit following Period of Remission*	50% of Heart Attack and Stroke Lifetime Maximum Benefit Amount

***Once a Recurrent Heart Attack or Stroke benefit is paid to an Insured Person, no further benefits will be paid under the Heart Attack and Stroke Recurrence Rider for that Insured Person.**

WELLNESS RIDER

(Subject to 90 day Waiting Period)

Benefit amount:	$50 per Insured Person, per exam
Limited to:	1 exam, per Insured Person, per calendar year

4. **BENEFITS -** Upon receipt of proof of the First Diagnosis of a Heart Attack and Stroke Qualifying Event under the Policy, We will pay the applicable First Diagnosis benefit, as shown in the POLICY SCHEDULE – SCHEDULE OF BENEFITS, subject to the Pre-Existing Condition Limitation and the Waiting Period.

   If an Insured Person is Diagnosed with a subsequent Qualifying Event while coverage is in effect under the Policy and any attached Riders, no benefit will be payable if the subsequent Qualifying Event is resulting from, caused by, connected to, or associated with a prior Qualifying Event for which a benefit was paid under the Policy or any attached Riders, unless the Insured Person's coverage includes the Heart Attack and Stroke Recurrence Rider, and only to the extent coverage for the subsequent Qualifying Event is provided under the Heart Attack and Stroke Recurrence Rider.

   Benefit Payment Limitation

   In no event will We pay more than the Heart Attack and Stroke Lifetime Maximum Benefit Amount during an Insured Person's lifetime, unless where coverage for such Insured Person includes the Heart Attack and Stroke Recurrence Rider.

5. **EXCLUSIONS AND LIMITATIONS -** We will not provide any benefits for any loss caused by, resulting from or in connection with:

   1. An Injury or accident;
   2. Any care or benefits which are not specifically provided for in the Policy;
   3. Any act of war, declared or undeclared;
   4. Active military duty in the service of any country;
   5. Participation in a riot, civil commotion or insurrection;
   6. Suicide, attempted suicide, or any intentionally self-inflicted injury, while sane or insane;
   7. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
   8. Experimental or investigational medicine;
   9. Cosmetic surgery;
   10. Any Diagnosis, as defined in the Policy, which is made by You or a member of Your Immediate Family, Domestic Partner or household;
   11. Any Diagnosis, as defined in the Policy, which occurs prior to an Insured Person's Effective Date of Coverage;
   12. Any Diagnosis, as defined in the Policy, which is made outside the U.S.;
   13. Any Diagnosis, as defined in the Policy, which occurs after the date on which coverage under the Policy has been terminated;
   14. Being intoxicated or under the influence of intoxicants or any narcotics, unless administered upon the advice of a Legally Qualified Physician; or
   15. Commission of or attempt to commit a felony or being engaged in an illegal occupation.

   Benefits will not be payable for:

   1. The First Diagnosis of a Heart Attack and Stroke Qualifying Event, which occurs within the Waiting Period as specified in the POLICY SCHEDULE – SCHEDULE OF BENEFITS;
   2. Any Heart Attack and Stroke Qualifying Event caused directly or indirectly by Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex;
   3. Any condition that is not Diagnosed as a Heart Attack and Stroke Qualifying Event, as defined in the Policy; or
   4. Loss resulting from any other disease, sickness or incapacity, other than loss resulting from a Heart Attack and Stroke Qualifying Event, as defined in the Policy. This includes any other disease or incapacity which may have been complicated or directly or indirectly affected or caused by a Heart Attack and Stroke Qualifying Event or as a result of treatment of a Heart Attack and Stroke Qualifying Event.

   Pre-Existing Condition Limitation - Benefits will not be payable for a Heart Attack and Stroke Qualifying Event resulting from a Pre-Existing Condition unless the First Diagnosis of such Heart Attack and Stroke Qualifying Event occurs more than 6 months after the Insured Person's Effective Date of Coverage.

   Qualifying Event occurring during the Waiting Period - If a Qualifying Event occurs during the Waiting Period, subject to the Pre-Existing Condition Limitation, You will be given the option to either void coverage from inception and receive a full refund of premium or keep the Policy in force. If the Policy

remains in force, the Qualifying Event diagnosed within the Waiting Period will not be a covered Qualifying Event under the Policy or any attached Riders; however, the Policy will provide for other Qualifying Events that occur after the Waiting Period as set forth in the POLICY SCHEDULE – SCHEDULE OF BENEFITS.

6. **RENEWABILITY -** The Policy is guaranteed renewable, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of the Policy. The Company reserves the right to change the applicable table of premium rates on a Class Basis. The premium for the Policy is based on the issue age of the Insured Person at the time in which the Policy becomes effective.

7. **BEGINNING OF COVERAGE -** Once We have approved Your application based upon the information You provided therein, the Effective Date of Coverage for You and Your Eligible Dependent, if any, listed in the application and accepted by Us will be the Policy Date shown in the POLICY SCHEDULE.

8. **TERMINATION OF COVERAGE -**

You

Your coverage will terminate and no benefits will be payable under the Policy and attached riders, if any:

1. On the date that all benefits have been exhausted under the Policy and all attached riders, if any;
2. At the end of the period for which premium has been paid (subject to the Grace Period);
3. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
4. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
5. On the date You:
   a. perform an act or practice that constitutes fraud, subject to the Time Limit on Certain Defenses provision appearing under the General Provisions section of the Policy; or
   b. make an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Policy, including claims for benefits under the Policy, subject to the Time Limit on Certain Defenses provision appearing under the General Provisions section of the Policy;
6. On the date We elect to discontinue this plan or type of coverage. We will give You at least 90 days written notice before the date coverage will be discontinued. You will be offered an option to purchase any other similar coverage that We offer without regard to health status;
7. On the date We elect to discontinue all coverage in Your state. We will give You and the Commissioner at least 180 days written notice before the date coverage will be discontinued; or
8. On the date an Insured Person is no longer a permanent resident of the United States.

Premium will only be refunded for any full months paid beyond the termination date.

Covered Dependents

Your Covered Dependent's coverage will terminate under the Policy and any attached riders on:

1. The date Your coverage terminates;
2. At the end of the month following the date such dependent ceases to be an Eligible Dependent;
3. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
4. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date; or
5. On the date the Covered Dependent:
   a. performs an act or practice that constitutes fraud, subject to the Time Limit on Certain Defenses provision appearing under the General Provisions section of the Policy; or
   b. makes an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Policy, including claims for benefits under the Policy, subject to the Time Limit on Certain Defenses provision appearing under the General Provisions section of the Policy.

Premium will only be refunded for any full months paid beyond the termination date.

The attainment of the Limiting Age for an Eligible Dependent will not cause coverage to terminate while that person is and continues to be both:

1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap, as determined by the Department of Behavioral Health and Developmental Disabilities; and
2. Chiefly Dependent on You for support and maintenance. For the purpose of this provision "Chiefly Dependent" means the Eligible Dependent receives the majority of his or her financial support from You.

We will require that You provide written proof that the dependent is in fact a disabled and dependent person within 31 days after his or her attainment of the Limiting Age. Thereafter, We may require such written proof not more frequently than annually after the two-year period following the child's attainment of the Limiting Age. In the absence of such proof We may terminate the coverage of such person after the attainment of the Limiting Age.

9. RIDER BENEFITS –

Critical Condition Rider (Form CH-26145-IR GA) - After the 30 day Waiting Period, upon receipt of proof of the First Diagnosis of a Critical Condition Qualifying Event under the Rider, We will pay the applicable First Diagnosis benefit shown in the POLICY SCHEDULE for the Rider. If an Insured Person is Diagnosed with a subsequent Qualifying Event while coverage is in effect under the Rider, no benefit will be payable if the subsequent Qualifying Event is resulting from, caused by, connected to, or associated with a prior Qualifying Event for which a benefit was paid under the Rider or the attached Policy. In no event will We pay more than the Critical Condition Rider Lifetime Maximum Benefit Amount during an Insured Person's lifetime.

Heart Attack and Stroke Recurrence Rider (Form CH-26147-IR GA) - If an Insured Person experiences a Recurrent Heart Attack or Stroke, We will pay the Percentage of Heart Attack or Stroke Lifetime Maximum Benefit Amount shown in the POLICY SCHEDULE provided the Insured Person was Symptom and Treatment-Free for the Period of Remission prior to the date of Diagnosis of the Recurrent Heart Attack or Stroke. Once a Recurrent Heart Attack or Stroke benefit is paid to an Insured Person, no further benefits will be paid under the Heart Attack and Stroke Recurrence Rider for that Insured Person.

Wellness Rider (Form CH-26137-IR) – After the 90 day Waiting Period, benefits are payable for one of the following Wellness exams, while coverage under the Rider is in force: annual physical, blood test for triglycerides, CA 19-9 (blood test for cancer), fast blood glucose test, hemocult stool analysis, PSA (blood test for prostate cancer, pap smear, immunizations/vaccinations, vision/hearing exams, serum protein electrophoresis (blood test for myeloma), stress test, biopsy for skin cancer, bone marrow biopsy and aspiration, breast ultrasound, CA 15-3 (blood test for cancer), CA 125 (blood test for cancer), CEA (blood test for cancer), chest X-ray, colonoscopy, flexible sigmoidoscopy, serum cholesterol test to determine level of HDL and LDL, mammography, and low-dose computed tomography (lung cancer screening). Benefits are limited to one exam per Insured Person, per Calendar Year.
Benefit Amount: $50 per Insured Person, per exam

10. PREMIUMS - We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy at any time and from time to time; provided, We have given You written notice of at least 60 days prior to the effective date of the new rates. Such change will be on a Class Basis. The premium for the Policy is based on the issue age of the Insured Person at the time in which the Policy becomes effective.

Premium Due (at time of application) $ _______________

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About Us

SureBridge is one of the leading brands of supplemental insurance coverage in the United States, helping to provide financial security for Americans of all ages and their families. Our comprehensive portfolio of products is available from licensed insurance agents in 46 states and the District of Columbia and is available through HealthMarkets Insurance Agency Inc., as well as through other unaffiliated insurance distributors. SureBridge policyholders can receive direct cash benefits for expenses caused by unexpected medical issues, sustained illnesses, and end-of-life challenges.

The SureBridge portfolio includes dental, vision, and other insurance plans that complement an individual's health insurance. These plans help provide an additional layer of protection in the event of accidental injury, catastrophic illness, hospitalization, or cancer.

Notice to Our Customers About Supplemental Insurance

- The supplemental plan discussed in this document is separate from any health insurance coverage you may have purchased with another carrier.
- This plan provides optional coverage for an additional premium. It is intended to supplement your health insurance and provide additional protection.
- This plan is not required in order to purchase health insurance with another carrier.
- This plan should not be used as a substitute for comprehensive health insurance coverage. It is not considered Minimum Essential Coverage under the Affordable Care Act.

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