KEMPER
Health

Allegacy | BENEFIT SOLUTIONS

EMPLOYEE GUIDE

Cancer Insurance

Policy features and benefits specially prepared for:
Allegacy Members

Offered through Allegacy's Healthlink

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Help when you need it most

When you or a loved one is diagnosed with cancer, the financial burden can be overwhelming. While primary health insurance is there to cover the medical bills, many patients face challenges due to time away from work and expenses not covered by other insurance.

Stay focused on getting well

A Kemper Health* Cancer insurance plan gives you an extra layer of financial security during these tough times—providing cash benefits that you can use to help keep the bills paid and protect your savings. That way, your focus can be on getting better.

How it Works

The plan pays a one-time, lump-sum first cancer diagnosis benefit. As treatment begins, the plan pays additional benefits including:

- Radiation/chemotherapy/immunotherapy
- New or Experimental Treatment
- Second and third surgical opinions, drugs and medicines, lodging and transportation, and other expenses

Cash benefits are paid directly to the insured with no restrictions on how the funds can be used.

*Kemper Health is the brand name for insurance products issued by subsidiary insurance companies controlled by Kemper Corporation. Each subsidiary of Kemper Corporation is solely responsible for the insurance products it underwrites and issues. The underwriting company for the worksite voluntary Cancer policy is **Reserve National Insurance Company.**

Cancer Insurance Plan – Benefits*

The following is a summary of the benefits included in the Kemper Health Cancer insurance plan. This is a brief description and does not replace or modify the comprehensive description of all benefits, limitations and exclusions contained in the policy/certificate and riders that are subject to the laws of the state having jurisdiction. Benefits, limitations, exclusions and rates may vary by state; plans not available in all states.

First Diagnosis Benefit

Pays a one-time benefit per insured when first diagnosed with cancer as defined in the policy (or specified disease, if selected). The first diagnosis must occur after the certificate effective date.

Positive Diagnosis Test

Pays a one-time benefit per insured person for one diagnostic test that leads to positive diagnosis of cancer (or a specified disease) up to a maximum of $300 per calendar year. This benefit is not payable if the same cancer (or specified disease, if selected) recurs.

Second and Third Surgical Opinions

Pays an insured's expense incurred for a written second or third surgical opinion as to the need for a surgical procedure.

Non-Local Transportation

Pays an insured's expenses for non-local travel to a hospital (inpatient or outpatient); radiation therapy center; chemotherapy or oncology clinic; or any other specialized treatment either at a common carrier fare; or 50 cents per mile for up to 700 miles per treatment for round-trip personal vehicle transportation for round trips over 60 miles. This benefit is payable if the insured's treatment is not available locally and is available non-locally.

Adult Companion Lodging and Transportation

Pays for the insured's one adult companion lodging and transportation expenses if the insured is confined in a non-local hospital for cancer (or specified disease) treatment. This benefit is payable for up to $75 per day for a single room in a motel, hotel or other accommodations up to a maximum stay of 60 days. This benefit is not payable for lodging expenses incurred more than 24 hours before the treatment nor for lodging expenses incurred more than 24 hours following treatment. This benefit pays a common carrier fare or 50 cents per mile round-trip personal vehicle transportation for round trips over 60 miles up to 700 miles per hospital stay for treatment. If we pay for personal vehicle mileage under the non-local transportation benefit we will pay personal vehicle mileage under this benefit only if the adult companion lives in another town other than where the insured lives.

Ambulance

Pays an insured's expenses for ambulance service if the insured is taken to the hospital by a licensed or hospital-owned ambulance and is admitted as an inpatient.

Bone Marrow and Peripheral Stem Cell Transplant

Pays for an insured's expenses for surgical and anesthetic charges associated with bone marrow transplant and/or peripheral stem cell transplant up to a combined lifetime maximum of $15,000.

Anesthesia

Pays an insured's expenses incurred for the services of an anesthesiologist in connection with surgery up to 25% of the amount paid for such surgery. For anesthesia in connection with the treatment of skin cancer, the benefit is limited to $100.

Ambulatory Surgical Center

Pays an Insured's expenses incurred for surgery performed at an ambulatory surgical center up to a maximum of $250 per day.

Drugs and Medicines

Pays an insured's expenses for drugs and medicine while confined in a hospital up to a maximum of $25 for each day of confinement, subject to a calendar year maximum of $600.

See the certificate and any attached rider(s) for details on benefit requirements, provisions, terms, conditions, limitations and exclusions.

Cancer Insurance Plan – Benefits (continued)*

Outpatient Anti-Nausea Drugs

Pays an insured's expenses for drugs prescribed by a physician and used for suppressing nausea during cancer (or specified disease, if selected) treatment up to a maximum of $250 per calendar year.

Miscellaneous Therapy Charges

Pays an insured's expenses up to a lifetime maximum of $10,000 for laboratory work and its interpretation and routine or diagnostic x-rays, scans and their interpretations. Service must be performed while receiving treatment(s) in radiation therapy, radioactive isotopes therapy; chemotherapy or immunotherapy or within 30 days following a covered treatment.

Self-Administering Drugs

Pays an insured's expenses up to $4,000 per month for self-administered chemotherapy, including hormone therapy, or immunotherapy agents.

Blood, Plasma and Platelets

Pays for an insured person's expenses incurred up to a maximum of $200 per day for:

1. Blood, plasma and platelets;
2. Transfusions;
3. The administration of 1 and 2 above;
4. Processing and procurement costs; and
5. Cross matching.

Will not pay for blood replaced by donors.

Physician's Attendance

Pays an insured's expenses up to a maximum of $35 per day for one visit per day by a physician while the insured is confined in a hospital.

Private Duty Nursing Services

Pays an insured's expenses up to a maximum of $100 per day for private nursing care by a nurse required and ordered by the attending physician, and while the insured is confined in a hospital.

National Cancer Institute Designated Comprehensive Cancer Treatment Center Evaluation/Consultation Benefit

Pays an insured's expenses up to a lifetime maximum of $750 for evaluation if diagnosed with cancer and seeking evaluation or consultation from a National Cancer Institute Designated Comprehensive Cancer Treatment Center. If the Comprehensive Cancer Treatment Center is located more than 30 miles from the insured's place of residence, it also pays for transportation and lodging expenses up to a lifetime maximum of up to $350.

This benefit is not payable on the same day a second or third surgical opinion benefit is payable and is in lieu of the non-local transportation benefits of the policy.

Breast Prosthesis

Pays an insured's expenses for a breast prosthesis to restore body contour lost due to breast cancer and the implantation of the prosthesis.

*Some provisions and benefits may not be available in all states or may vary by state. See each state's policy/certificate for details.

Cancer Insurance Plan – Benefits (continued)*

Artificial Limb or Prosthesis

Pays an insured's expenses incurred when an amputation is performed up to a lifetime maximum of $1,500 per insured person for amputation per an artificial limb or prosthesis and the procedure to affix or implant it.

Physical Therapy or Speech Therapy

Pays an insured's expenses up to $35 per therapy session for physical or speech therapy for restoration of normal bodily function.

New or Experimental Treatment

Pays an insured's expenses up to a maximum of $7,500 per calendar year for new or experimental treatment, which is judged necessary by the attending physician and received in the United States or in its territories.

Hospice Care

Pays an insured's expenses up to $50 per day for care received in a free standing hospice care center or at home if diagnosed as terminally ill. The attending physician must approve the stay or care, and the stay or care must begin within 14 days after a hospital stay. Admission or benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital stays. We will not pay for food services or meals other than dietary counseling; services related to well-baby care; services provided by volunteers; or support for the family after the death of the Insured Person.

Government or Charity Hospital

Pays an insured up to $200 per day for confinement in a hospital operated by or for the United States Government (including the Veteran's Administration) or a hospital that does not charge for the services it provides (charity). The daily benefit is paid in lieu of all other benefits provided in the policy.

Hairpiece

Pays for an insured's expenses up to a lifetime maximum of $150 for a hairpiece when hair loss is the result of cancer treatment.

Rental or Purchase of Durable Goods

Pays for an insured's expenses up to $1,500 per calendar year for the rental or purchase of the following pieces of durable medical equipment:

1. A respirator or similar mechanical device;
2. Brace;
3. Crutches;
4. Hospital bed; and
5. Wheelchair.

Waiver of Premium

Premiums are waived following a 60-day period of disability due to cancer (or specified disease, if selected). An insured must be receiving treatment for such cancer (or specified disease, if selected) for which benefits are payable under the policy and remain disabled for 60 consecutive days. Premiums are waived for the period of disability.

*Some provisions and benefits may not be available in all states or may vary by state. See each state's policy/certificate for details.

Cancer Insurance Plan – Benefits (continued)*

Specified Disease

Specified disease means any of the following: Addison's Disease, Amyotrophic Lateral Sclerosis, Cystic Fibrosis, Diphtheria, Encephalitis, Epilepsy, Hansen's Disease, Legionnaire's Disease, Lupus Erythematosus, Lyme Disease, Malaria, Meningitis(epidemic cerebrospinal), Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Niemann-Pick Disease, Osteomyelitis, Poliomyelitis, Rabies, Reye's Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Scarlet Fever, Sickle Cell Anemia, Tay-Sachs Disease, Tetanus, Toxic Epidermal Necrolysis, Tuberculosis, Tularemia, Typhoid Fever, Undulant Fever, Whipple's Disease

Hospital Confinement Benefit

Pays a daily benefit for each day an insured is charged the daily room rate by a hospital. The available daily benefit amount is $100. This benefit is payable up to 60 days for one period of continuous stay. For covered dependent child(ren) under the age of 21, the benefit is two times the daily benefit for Hospital Confinement shown in the policy's Schedule of Benefits.

Colony Stimulating Factors

Pays the insured's expense incurred up to the selected monthly maximum benefit for the cost of chemical substances and their administration to stimulate the production of blood cells. The available monthly maximum benefit amount is $500.

Radiation/Chemotherapy/Immunotherapy

Pays a daily or monthly benefit for expenses incurred for covered treatment to modify or destroy cancerous tissue. The available daily benefit amount is N/A and the available monthly benefit amount is $1,000.

Surgery

Pays the insured's expense incurred for a surgeon's fee up to the amount shown in the policy's Surgical Schedule for an operation and for care by the surgeon after the operation. Payment will not include charges by an assistant or co-surgeons. Benefits for surgery performed on an outpatient basis will be 150% of the scheduled amount shown on the surgical schedule not to exceed the actual surgeon's fees for the surgery. The available maximum Surgical Schedule amount is $1,500.

Extended Benefits

This pays a benefit of three times the Hospital Confinement Benefit if the insured is confined in a hospital for more than 60 continuous days. Payment will begin on the 61st day of continuous hospital confinement. This benefit is payable in lieu of the Hospital Confinement Benefit.

Extended Care Facility

This pays an insured's expenses incurred for confinement in an extended care facility for a maximum of $50 per day, up to the number of days that the Hospital Confinement Benefit was paid. The confinement in the extended care facility must be at the direction of the attending physician and must begin within 14 days after a hospital confinement.

At Home Nursing

This benefit is only available if the Hospital Confinement Benefit is included. It pays an insured's expenses incurred for a private duty nurse at home up to $100 per day and up to the number of days that the Hospital Confinement Benefit was paid. The nursing services must be required and authorized by the attending physician and must begin immediately following a hospital confinement.

Donor Benefit Bone Marrow and Stem Cell Transplant

This pays for the expenses incurred, up to $50 per day, by an insured and his or her live donor. Also pays: (a) two times the Hospital Confinement Benefit for medical expenses, (b) charges for round trip coach fare on a common carrier to the city where the transplant is performed, (c) 50 cents per mile personal vehicle transportation from the insured's or donor's home to the hospital in which the insured is staying up to 700 miles per hospital stay and (d) for lodging and meals expenses for donor to remain near hospital.

*Some provisions and benefits may not be available in all states or may vary by state. See each state's policy/certificate for details.

Cancer Insurance Plan – Benefits (continued)*

Wellness

Pays an insured's expenses incurred up to the selected benefit amount for cancer screening, including, but not limited to, the following:

- Abdominal aortic aneurysm ultrasound
- Blood test for triglycerides
- Bone marrow testing
- Bone density screening
- Breast ultrasound
- Cancer Antigen 125 blood test
- Cancer Antigen 15-3 blood test
- Carcinoembryonic antigen (CEA) blood test
- Carotid ultrasound
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- CT Angiography
- EKG
- Double contrast barium enema
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap test
- Prostate Specific Antigen (PSA) blood test
- Serum cholesterol test to determine HDL/LDL level
- Serum Protein Electrophoresis (SPEP) blood test
- Stress test
- Thermography

Cancer Insurance Plan Limitations and Exclusions

Limitations

During the first 1 month, following the effective date of coverage for an insured person, losses incurred for pre-existing conditions are not covered. After this 1 month period, benefits for such conditions will be payable unless specifically excluded from coverage. We will give credit for any time the insured person was covered under a similar policy immediately prior to the certificate effective date.

This pre-existing condition limitation does not apply to the Wellness Benefit.

The pre-existing condition exclusion period will be reduced for each insured person to the extent the pre-existing condition exclusion period was previously satisfied by similar coverage in force immediately prior to the insured's effective date of coverage under the policy.

Pre-Existing Conditions means Cancer or a specified disease for which an insured person has received medical consultation, treatment, care, services, or for which diagnostic test(s) have been recommended for which medication has been prescribed during the 12 months immediately preceding the effective date of coverage for the insured person.

Exclusions

Benefits under the policy and any attached rider(s) will only be payable for diagnosis resulting from cancer as defined in the policy (or specified diseases, if included). Benefits are not payable for any loss caused in whole or in part by or resulting in whole or part from the following:

1. Any other disease or sickness;
2. Injuries;
3. Any disease, condition, or incapacity that has been caused, complicated, worsened, or affected by:
   a. Specified disease or specified disease treatment (if included); or
   b. Cancer or cancer treatment, or unless otherwise defined in the policy;
4. Care and treatment received outside the United States or its territories; or
5. New and experimental treatment by any program that does not qualify as new and experimental treatment under the Policy.

Cancer does not include:

1. **Pre-malignant tumors or polyps or other conditions which may be considered precancerous, including but not limited to leukoplakia, actinic keratosis, carcinoid, hyperplasia, polycythemia, nonmalignant melanoma, moles or similar diseases or lesions;**
2. **Intraductal non-invasive carcinoma of the breast, carcinoma of the appendix, Stage 1 transitional carcinoma of the urinary bladder;**
3. **Any Non-Melanoma Skin Cancers other than melanomas; or**
4. **Tumors in presence of HIV.**

Plan is available in the following states: North Carolina

GROUP VOLUNTARY ACCIDENT RATES

	Member	Member+Spouse	Member+Children	Family
Monthly	$19.21	$29.61	$34.25	$50.67
Annual	$230.52	$355.32	$411.00	$608.04
Annual Wellness Benefit	- $200	- $400	- $400	- $400
***Net Annual Cost**	$30.52	($44.68)	$11.00	$208.04

Rates include $5.00 per month administrative/billing fee.

*Net annual cost assumes each covered person files the available wellness benefits.

GROUP VOLUNTARY CANCER RATES

	Member	Member+Spouse	Member+Children	Family
Monthly	$21.51	$37.02	$24.89	$39.23
Annual	$258.12	$444.24	$298.68	$470.76
Annual Wellness Benefit	- $100	- $200	- $200	- $300
***Net Annual Cost**	$158.12	$244.68	$98.68	$170.76

Rates include $5.00 per month administrative/billing fee.

*Net annual cost assumes each covered person files the available wellness benefits.

GROUP VOLUNTARY ACCIDENT & CANCER RATES

	Member	Member+Spouse	Member+Children	Family
Monthly	$35.72	$61.63	$54.14	$84.90
Annual	$428.64	$739.56	$649.68	$1,018.80
Annual Wellness Benefit	- $300	- $600	- $600	- $700
***Net Annual Cost**	$128.64	$139.56	$49.68	$318.80

Rates include $5.00 per month administrative/billing fee.

*Net annual cost assumes each covered person files the available wellness benefits.

Benefits and insurance services are offered by Allegacy Benefit Solutions, LLC, a subsidiary of Allegacy Services, LLC, and are not insured by the NCUA nor guaranteed by Allegacy Federal Credit Union.

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Kemper Health is the brand name for insurance products issued by subsidiary insurance companies controlled by Kemper Corporation. Each subsidiary of Kemper Corporation is solely responsible for the insurance products it underwrites and issues.

The underwriting company for the Accident Expense, Accident Indemnity, Cancer, Critical Illness, Dental, Short Term Disability and Whole Life Insurance Products is **Reserve National Insurance Company**, which is responsible for the underwriting risks, financial and contractual obligations and support functions associated with the products it issues. The underwriting company for the Hospital Indemnity, Signature Gap, Indemnity Outpatient Prescription Drug, Limited Medical, and Vision Insurance Products is **Fidelity Security Life Insurance Company ®(FSL). FSL** is not financially affiliated with Kemper Corporation. All products are subject to the terms, conditions, limitations and exclusions of the specific policy. Product availability may vary by state. FSL is located in Kansas City, Missouri, and has been rated "A" (Excellent) based on an analysis of financial position and operating performance by A.M. Best Company, an independent analyst of the insurance industry. For the latest rating, access www.ambest.com.

Neither **Reserve National Insurance Company, FSL,** nor their agents, representatives, associates or employees render legal or tax advice. The employer should seek the expert assistance of its own legal or tax adviser.

Policy Form Number Series KB-EC-PO-0117 and KB-MC-0117, with Rider Form Series KB-EC-HASFDB and KB-MC-HASFDB-0117, KB-EC-ICU-0117 and KB-MC-ICU-0117, and KB-EC-BER-0117 and KB-MC-BER-0117. Form numbers may vary by state.

This is only a summary of products and services offered. Actual offerings may vary by group size and other underwriting considerations and are subject to the requirements of state insurance laws and regulations, and the benefits/provisions as described may vary due to such requirements. All products are subject to the terms, conditions, limitations and exclusions of the specific policy. Please see the specific policy and certificate for details. Policies are not available in all states.

The Kemper Health voluntary insurance plans, either alone or in combination with each other, are not "minimum essential coverage" under the federal Affordable Care Act.

IMPORTANT: If an individual is insured under one or more Kemper Health voluntary insurance plans, and plans and is also covered by Medicaid or a state variation of Medicaid, most non-disability benefits are automatically assigned according to state regulations. This means that instead of paying the benefits to the insured individual, we must pay the benefits to Medicaid or the medical provider to reduce the charges billed to Medicaid. Proposed insureds should consider their circumstances before enrolling in Kemper Health coverage.

If you are an employer offering one or more of these insurance products to your employees, the product(s) may constitute a part of an employee benefit plan under the Employee Retirement Income Security Act of 1974 ("ERISA"). An employer offering an ERISA employee benefit plan will be responsible for a number of obligations applicable under ERISA, including, without limitation, the obligation to make required disclosures to employees and file reports with the federal government. You should consult with an experienced attorney concerning the requirements for compliance with ERISA.

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