

SERFF Tracking Number: BFLI-125638536 State: Arkansas
 Filing Company: Bankers Fidelity Life Insurance Company State Tracking Number: 38993
 Company Tracking Number: AR B 9200 I
 TOI: MS05I Individual Medicare Supplement - Sub-TOI: MS05I.010 Plan I
 Standard Plans
 Product Name: Medicare Supplement Plan I
 Project Name/Number: /

Filing at a Glance

Company: Bankers Fidelity Life Insurance Company

Product Name: Medicare Supplement Plan I SERFF Tr Num: BFLI-125638536 State: ArkansasLH

TOI: MS05I Individual Medicare Supplement - SERFF Status: Closed State Tr Num: 38993

Standard Plans

Sub-TOI: MS05I.010 Plan I

Co Tr Num: AR B 9200 I

State Status: Under Review

Filing Type: Form/Rate

Co Status:

Reviewer(s): Stephanie Fowler

Authors: Jill Jones, Tina

Disposition Date: 06/19/2008

Cunningham

Date Submitted: 05/14/2008

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments: submitted to Georgia DOI via paper on 05-06-2007 (GA does not accept Med Supp on SERFF yet)

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 06/19/2008

State Status Changed: 06/16/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

The enclosed forms are being submitted to your department for formal review and approval and will not replace any previously approved forms. The policy forms are computer-generated, laser-printed and presented in final print with "John Doe" information. An actuarial memorandum with rates, demonstrating cost and benefit structure is enclosed.

SERFF Tracking Number: BFLI-125638536 State: Arkansas
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 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.010 Plan I
 Standard Plans
 Product Name: Medicare Supplement Plan I
 Project Name/Number: /

The policy form provides the benefits for standardized Medicare Supplement Plan I. The benefit chart will be incorporated into the Outline of Coverage, which has been previously approved by your department. Solicitation will be performed by personally producing, licensed and contracted agents and brokers.

Company and Contact

Filing Contact Information

Tina Cunningham, Compliance Analyst L1 tcunningham@atlam.com
 4370 Peachtree Road NE (404) 266-5723 [Phone]
 Atlanta, GA 30319 (404) 926-4092[FAX]

Filing Company Information

Bankers Fidelity Life Insurance Company CoCode: 61239 State of Domicile: Georgia
 4370 Peachtree Rd NE Group Code: 587 Company Type: Life & Health
 Atlanta, GA 30319 Group Name: 61239 State ID Number:
 (404) 266-5600 ext. [Phone] FEIN Number: 58-0658963

Filing Fees

Fee Required? Yes
 Fee Amount: \$125.00
 Retaliatory? Yes
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Bankers Fidelity Life Insurance Company	\$125.00	05/14/2008	20320685

SERFF Tracking Number: BFLI-125638536 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Stephanie Fowler	06/19/2008	06/19/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Stephanie Fowler	06/18/2008	06/18/2008	Tina Cunningham	06/19/2008	06/19/2008

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Benefit Chart Form - Plan I		Jill Jones	05/27/2008	05/27/2008
Health - Actuarial Justification	Supporting Document	Jill Jones	05/27/2008	05/27/2008
Actuarial Cover Letter	Supporting Document	Jill Jones	05/27/2008	05/27/2008

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Disposition

Disposition Date: 06/19/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document (revised)	Health - Actuarial Justification	Approved	No
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Actuarial Cover Letter	Approved	Yes
Form	Medicare Supplement Plan I	Approved	Yes
Form (revised)	Benefit Chart - Plan I	Approved	Yes
Form	Benefit Chart - Plan I		Yes

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Product Name: Medicare Supplement Plan I
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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 06/18/2008
Submitted Date 06/18/2008
Respond By Date 07/18/2008

Dear Tina Cunningham,

This will acknowledge receipt of the captioned filing.

Objection 1

- Medicare Supplement Plan I (Form)

Comment: Please revise the Time Limit on Certain Defenses to allow a three year period per ACA 23-85-107.

Please feel free to contact me if you have questions.

Sincerely,

Stephanie Fowler

Response Letter

Response Letter Status Submitted to State
Response Letter Date 06/19/2008
Submitted Date 06/19/2008

Dear Stephanie Fowler,

Comments:

Response 1

Comments: Good day Ms. Fowler. We respectfully request your reconsideration with regards to the Time Limit on Certain Defenses. We ask for this on the basis that the two year provision is more beneficial to the insured than a three year provision would be. We are basically forfeiting one year to contest a claim on the basis of misrepresentation.

Thank you for your time in review of this filing. If you have any questions, or need additional information, please contact me at: direct 404-266-5723; toll-free 1-800-241-1439, ext. 5723; fax 404-926-4092 or email tcunningham@atlam.com.

Related Objection 1

SERFF Tracking Number: BFLI-125638536 State: Arkansas
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Company Tracking Number: AR B 9200 I
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.010 Plan I
Standard Plans
Product Name: Medicare Supplement Plan I
Project Name/Number: /

Applies To:

- Medicare Supplement Plan I (Form)

Comment:

Please revise the Time Limit on Certain Defenses to allow a three year period per ACA 23-85-107.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,

Jill Jones, Tina Cunningham

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Amendment Letter

Amendment Date:
 Submitted Date: 05/27/2008

Comments:

It has been brought to my attention that the rate sheets included in this filing - both in the actuarial memorandum and the outline of coverage - had erroneous rates due to a clerical error. Our consulting actuary has provided a new actuarial memorandum, which not only includes the corrected rates for Plan I, but also the information necessary for our Annual Rate Certification. The rate sheet in the outline of coverage has been revised to include the corrected rates as well.

I apologize for any inconvenience this may have caused you. If you have any questions, please let us know.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
9300 I OC	Outline of Coverage	Benefit Chart - Plan I	Initial				0	AR B 9200 OC with I.pdf

Supporting Document Schedule Item Changes:

Satisfied -Name: Health - Actuarial Justification

Comment:
 B 9200 I (ARC) AR Act Memo 05-12-08.pdf

User Added -Name: Actuarial Cover Letter

Comment:
 Cover(ar1-2008).pdf

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Form Schedule

Lead Form Number: B 9200 I

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved	B 9200 I	Policy/Cont	Medicare ract/Fratern Supplement Plan I al Certificate	Initial		52	9200I doe.pdf
Approved	9300 I OC	Outline of	Benefit Chart - Plan I Coverage	Initial		0	AR B 9200 OC with I.pdf

BANKERS FIDELITY LIFE INSURANCE COMPANY

4370 Peachtree Road, N.E., Atlanta, Georgia 30319

MEDICARE SUPPLEMENT POLICY - PLAN I

Bankers Fidelity Life Insurance Company (hereinafter referred to as “We”, “Our”, “Us” or the “Company”) promises to insure You for the benefits described in this Policy. We make this promise in consideration of the application for this Policy and the payment of the premium.

GUARANTEED RENEWABLE - This Policy is guaranteed renewable for life. We cannot cancel this Policy. We guarantee to renew this Policy as long as You pay Your renewal premiums on time, either in advance or during the grace period.

PREMIUM SUBJECT TO CHANGE ON A CLASS BASIS - We may change the premium rates. A change will apply to all policies with the same form number, issue state, age and benefits as yours. A minimum of thirty (30) days advance written notice will be given. A change will apply on the next premium due date after We notify You. Each premium will be computed by the age shown in the application. We will not change Your rates because of a physical condition or on account of any claims paid under the Policy.

30-DAY RIGHT TO EXAMINE AND RETURN THIS POLICY - It is important to Us that You are satisfied with this Policy and that it meets Your insurance needs. If You are not satisfied You may return it within thirty (30) days of receipt. Send it to Us or to Your agent and You will receive a full refund of any premiums You have paid. This Policy will then be void from its beginning.

READ YOUR POLICY CAREFULLY!

IMPORTANT NOTICE GIVEN PURSUANT TO LAW: Please read the copy of the application attached to this Policy. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to the Company within ten (10) days if any information shown on it is not correct and complete or if any past medical history has been left out of the application. The application is part of this Policy, which was issued on the basis that the answers to all questions and the information shown on the application are correct and complete. No agent has the authority to change this Policy or waive any of its provisions.

“Notice to buyer: This policy may not fully cover all of your medical costs.”

The provisions on the following pages are a part of this policy, which was signed at Atlanta, Georgia, on the policy date.



President

INDEX

This policy is a legal contract between you and us.
READ YOUR POLICY CAREFULLY!

	Page
Benefits	8, 9
Claim Procedure.....	6
Definitions.....	4, 5
Effective Date	3
Grace Period.....	6
Premium	3, 7
Reinstatement.....	6
Renewal Provisions.....	1
Suspension of Benefits and Premium	5

Additional benefits or restrictions, if any, follow Page 9.

BANKERS FIDELITY LIFE INSURANCE COMPANY

4370 Peachtree Road, N.E., P.O. Box 105185, Atlanta, Georgia 30348-5185

For inquiries or to make a complaint, please contact the Policyholder Service Department at:
Direct (404) 266-5730; Toll-free (866) 458-7500; email bfphs@atlam.com

POLICY SPECIFICATIONS PAGE Medicare Supplement Policy - Plan I Policy Form B 9200 I

Covered Person

<u>Name:</u> JOHN D DOE	<u>Issue Age:</u> 65	<u>Sex:</u> M	<u>Effective Date:</u> 05-01-2008
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Premiums

<u>Initial Premium:</u>	\$1,115.00			
<u>Renewal Premiums:</u>	<u>Annual</u> \$1,115.00	<u>Semi-Annual</u> \$580.00	<u>Quarterly</u> \$301.00	<u>Monthly</u> \$97.00

Policy Identification

<u>Policy Number:</u>	005-2080500001
<u>Issue State:</u>	GA
<u>Issue Zip Code:</u>	300

THE POLICY SPECIFICATIONS PAGE IS ON THE REVERSE OF THIS PAGE.

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DEFINITIONS

When we use the following words this is what we mean:

ACTIVITIES OF DAILY LIVING - include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that normally are self administered, and changing bandages or other dressings.

AT HOME RECOVERY VISIT - the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty four (24) hour period of services provided by a care provider is one visit.

CALENDAR YEAR - a period of one (1) year which starts on January 1 and ends on December 31.

CARE PROVIDER - a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

CONFINED OR CONFINEMENT - assigned to a bed in a hospital on the advice of a physician. A charge for room and board must be made.

CO PAYMENT AMOUNT - the fixed amount per day Medicare does not pay from the 61st day through the 90th day of hospital confinement during a benefit period. It is set each year by Medicare.

COVERED INJURY - accidental bodily injury sustained by the insured which is the direct result of an accident, independent of any disease, bodily infirmity or any other cause and occurs while this policy is in force. Covered injuries do not include injuries for which benefits are provided or are available under any workers' compensation, employer's liability or similar law, or motor vehicle no fault plan, unless prohibited by law.

COVERED SICKNESS - illness or disease of the insured which manifests itself after the effective date of the policy and while this policy is in force. Covered sicknesses do not include sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

EFFECTIVE DATE - The original date Your coverage begins as shown on Page 3. It starts at 12:01 a.m., Standard Time, at your residence. It ends at 12:01 a.m., Standard Time, on the date any premium is due. Each renewal premium is due at the end of the term for which a premium has been paid.

EMERGENCY CARE - bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in: 1) placing the patient's health in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

HOME - any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

LIFETIME RESERVE CO PAYMENT AMOUNT - the fixed amount per day Medicare does not pay during the sixty (60) lifetime reserve days Medicare allows. It is set each year by Medicare.

DEFINITIONS, *continued*

MEDICARE - the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965 as Then Constituted or Later Amended.

MEDICARE ELIGIBLE EXPENSES - expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

PART A DEDUCTIBLE - the initial amount not covered by Medicare during the first sixty (60) days in a benefit period.

PART B DEDUCTIBLE - the initial amount not covered by Medicare for Part B eligible expenses in a calendar year.

POLICY AND CONTRACT - the policy, any endorsement thereon, and a copy of your original application constitute the entire contract between you and us.

YOU, YOUR, OR YOURS - the person who is insured under this policy. This person is named on Page 3.

SUSPENSION OF BENEFITS AND PREMIUM

1. The benefits and premiums under the policy shall be suspended at the request of the policyholder for the period (not to exceed 24 months) in which the policyholder has applied for and is determined to be entitled to Medical Assistance under Title XIX of the Social Security Act (42 U.S.C.A. §§ 1396--1396u), but only if the policyholder notifies the issuer of the policy within 90 days after the date the individual becomes entitled to this assistance.
2. If a suspension occurs and if the policyholder loses entitlement to Medical Assistance, the policy shall be automatically reinstated (effective as of the date of termination of the entitlement) as of the termination of the entitlement if the policyholder provides notice of loss of the entitlement within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of the entitlement.
3. The benefits and premiums under the policy shall be suspended at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act (42 U.S.C.A. § 426(b)) and is covered under a group health plan (as defined in section 1862 (b)(1)(A)(v) of the Social Security Act (42 U.S.C.A. § 1395y(b)(1)(A)(v))). If suspension occurs and if the policyholder loses coverage under the group health plan, the policy shall be automatically reinstated (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.
4. Reinstatement of these coverages as described in clauses 2 and 3:
 - A. May not provide for a waiting period with respect to treatment of preexisting conditions.
 - B. Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of the suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstatement of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension.
 - C. Shall provide for classification of premiums on terms at least as favorable to the policyholder as the premium classification terms that would have applied to the policyholder if the coverage had not been suspended.

GENERAL PROVISIONS

ENTIRE CONTRACT: CHANGES - This Policy, the applications and any endorsements or papers is the entire contract between You and Us. No change in this Policy will be effective until it is approved by one of Our executive officers. This approval must be noted on or attached to this Policy. No agent has the authority to change this Policy or waive any of its provisions. Any rider, endorsement or application which modifies, limits or excludes coverage under this Policy must be accepted by You in writing to be effective (unless required by state or federal law). No statement shall be used in defense of a claim under the Policy unless it is contained in a written application that is endorsed upon or attached to the policy when issued or delivered. All statements made by the Insured shall, in the absence of fraud, be deemed representations and not warranties.

TIME LIMIT ON CERTAIN DEFENSES - No misstatements made by You in the application for this Policy, attached hereto, shall be used to void this Policy or to deny a claim for loss or disability incurred after two (2) years from the Effective Date of this Policy.

GRACE PERIOD - This Policy has a thirty-one (31)-day grace period. This means if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the grace period this Policy will stay in force. Your premium payment must be received in Our home office within the thirty-one (31)-day period. This thirty-one (31)-day Grace Period does not apply to the first premium payment. The first premium payment must be paid when your policy is delivered.

REINSTATEMENT - If the renewal premium is not paid before the grace period ends, this Policy will lapse. Later acceptance of premium by Us (or by an agent authorized to accept payment) without requiring an application for the reinstatement will reinstate this Policy. If We or Our agent require an application, You will be given a conditional receipt for the premium. If the application is approved, this Policy will be reinstated as of the approved date. Lacking such approval, this Policy will be reinstated on the 45th day after the date of the conditional receipt unless We have previously notified You, in writing, of Our disapproval. The reinstated Policy will cover only loss that results from an injury sustained after the date of reinstatement, or sickness that begins more than ten (10) days after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated Policy.

NOTICE OF CLAIMS - Written notice of claim must be given within twenty (20) days after a covered loss begins or as soon as possible. The notice can be given to Us at Our Home Office, at 4370 Peachtree Road NE, Atlanta, GA 30319, or to any one of Our authorized agents. The notice should include Your name and the number of the Policy.

CLAIM FORMS - When We receive notice of claim, We will send You forms for filing proof of loss, if these forms are not given to You within ten (10) days, You can meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time stated in the Proof of Loss provision.

PROOF OF LOSS - Written proof of loss must be given to Us within ninety (90) days after We send You the claim forms. If it was not reasonably possible for You to give Us proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than one year from the time specified unless You were legally incapacitated.

TIME OF PAYMENT OF CLAIMS - Benefits payable under this policy will be paid as soon as we receive proper written proof of loss.

PAYMENT OF CLAIM - All benefits will be paid to you, or your assignee. Any benefits unpaid at your death may be paid to your estate. If benefits are payable to your estate, we may pay up to \$1,000 to any relative of yours who we find is entitled to them. Any payment made in good faith will fully discharge us to the extent of the payment. We may pay all or a portion of any indemnities provided for health care services to the provider, unless you direct us otherwise in writing by the time proofs of loss are filed. We cannot require that the services be rendered by a particular provider.

PHYSICAL EXAMINATION AND AUTOPSY - We, at our own expense, have the right to have you examined as often as reasonably necessary while a claim is pending. We may also have an autopsy made, unless prohibited by law.

NOTICE; WAIVER - Furnishing forms for filing Proof Of Loss, receipt of Notice Of Claim or investigation of any claim shall not waive any of Our rights in defense of any such claim.

LEGAL ACTION - No legal action may be brought to recover on this policy within sixty (60) days after written proof of loss has been given as required by this policy. No such action may be brought after three (3) years from the time written proof of loss is required to be given.

EXTENSION OF BENEFITS - Termination of this policy shall be without prejudice to any continuous loss which commenced while this policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Any premium due and unpaid shall be deducted from the claim payment.

ADDITIONAL PROVISIONS

MISSTATEMENT OF AGE - If your age has been misstated, all amounts payable under this policy shall be such as the premium would have purchased at the correct age.

CONFORMITY WITH STATE STATUTES - Any provision of this policy which, on its effective date, is in conflict with the laws of the State in which it was delivered on that date is amended to conform to the minimum requirements of such laws.

UNPAID PREMIUM - When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

PREMIUM PAYMENT - Renewal premiums are payable to us. The payment of any premium shall not continue this policy in force beyond the next premium due date, except as provided in the Grace Period provision.

PREMIUM REFUND AT DEATH - We will refund that part of any premium paid which covers a period beyond the date of Your death.

ASSIGNMENT - No Assignment of interest in this Policy will be binding on Us unless it is received by Us in Our home office. We are not responsible for the validity of any Assignment.

PARTICIPATION - This Policy is non-participating.

OTHER INSURANCE WITH US - You may have only one (1) Medicare Supplement policy with us. If, through an error, we issue more than one (1) policy, you may select which policy will remain in force. We will refund the money you paid on any other policy, minus any claims paid.

BENEFITS - PLAN I

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance;
4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations; and
5. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

ADDITIONAL BENEFITS

1. Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period;
2. Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post hospital skilled nursing facility care eligible under Medicare Part A;
3. Coverage for 100% of the difference between the actual Medicare Part B charge billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge;
4. Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars (\$250) and a lifetime maximum benefit of fifty thousand dollars (\$50,000); and
5. Coverage for services to provide short term, at home assistance with activities of daily living for those recovering from an illness, injury or surgery.
 - A. For purposes of this benefit, the following definitions shall apply:
 - (1) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self administered, and changing bandages or other dressings.
 - (2) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.
 - (3) "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.
 - (4) "At home recovery visit" means the period of a visit required to provide at home recovery care, without limit on duration of the visit, except each consecutive 4 hours in a 24 hour period of services provided by a care provider is one visit.

BENEFITS CONTINUED

B. Coverage Requirements and Limitations

- (1) At home recovery services provided must be primarily services which assist in activities of daily living.
- (2) The insured's attending physician must certify that the specific type and frequency of at home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.
- (3) Coverage is limited to:
 - (a) No more than the number and type of at home recovery visits certified as necessary by the insured's attending physician. The total number of at home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.
 - (b) The actual charges for each visit up to a maximum reimbursement of forty dollars (\$40) per visit.
 - (c) One thousand six hundred dollars (\$1,600) per calendar year.
 - (d) Seven (7) visits in any one week.
 - (e) Care furnished on a visiting basis in the insured's home.
 - (f) Services provided by a care provider as defined in this section.
 - (g) At home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.
 - (h) At home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.

Coverage is excluded for:

- (1) Home care visits paid for by Medicare or other government programs; and
- (2) Care provided by family members, unpaid volunteers or providers who are not care providers.

For these benefits to be payable payment for the expense must be made under Part A or Part B of Medicare for the portion payable by Medicare.

If Medicare changes its definitions or amounts, which affects what you must pay, we will change the corresponding benefits, if any, of this policy to cover the new amounts. We may change the premium to match a benefit change, subject to the approval of the Department of Insurance. The premium would change on the first premium due date on or after the date the new benefits go into effect.

THE BACK COVER OF THE POLICY IS ON THE REVERSE OF THIS PAGE.

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BANKERS FIDELITY LIFE INSURANCE COMPANY

4370 Peachtree Road, N.E., Atlanta, Georgia 30319

MEDICARE SUPPLEMENT POLICY - PLAN I

Bankers Fidelity Life Insurance Company

4370 Peachtree Road, N.E., P. O. Box 105185, Atlanta, Georgia 30348-5185

Outline of Medicare Supplement Coverage—Cover Page 1 of 2

Benefit Plans A, B, C, D, E, F, G & I

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan “A.” Some plans may not be available in your state.

See Outline of Coverage section for details about all plans.

BASIC BENEFITS: For Plans A—J.

Hospitalization:

Part A co-insurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses:

Part B co-insurance (generally 20% of Medicare-approved expenses) for hospital outpatient services.

Blood:

First three (3) pints of blood each year.

PLANS									
A	B	C	D	E	F/F*	G	H†	I	J†/J*/†
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
				Preventive Care not covered by Medicare					Preventive Care not covered by Medicare

*Plan F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same or offer the same benefits as standard Plan F and Plan J after one has paid a calendar year [\$1,900] deductible. Benefits from high deductible Plan F and Plan J will not begin until out-of-pocket expenses are [\$1,900]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but does not include, in Plan F and Plan J, the plan’s separate foreign travel emergency deductible.

† BFLIC does not currently offer these plans.

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Outline of Medicare Supplement Coverage—Cover Page 2

Basic Benefits for Plans K and L include similar services as plans A—J, but cost-sharing for the basic benefits is at different levels.

PLANS		
J†	K**/†	L**/†
Basic Benefits	100 % of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100 % of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care not covered by Medicare		
	\$4,400 Out-of-pocket Annual Limit***	\$2,200 Out-of-pocket Annual Limit***

**Plans K and L provide for different cost-sharing for items and services than Plans A—J.

Once you reach the annual limit, the plan pays 100% of the Medicare co-payment, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called “Excess Charges.” You will be responsible for paying excess charges.

***The out-of-pocket annual limit will increase each year for inflation.

† BFLIC does not currently offer these plans.

See Outline of Coverage section for details about all plans.

MEDICARE SUPPLEMENT PREMIUM RATES – POLICY FORM B 9200 ARKANSAS

		PREFERRED UNDERWRITING														
		STANDARD					NON-TOBACCO					TOBACCO				
PLAN	ISSUE AGE	ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY DIRECT	MONTHLY BANK DRAFT	ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY DIRECT	MONTHLY BANK DRAFT	ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY DIRECT	MONTHLY BANK DRAFT
A	65+	\$1,125	\$585	\$304	\$101	\$98	\$956	\$497	\$258	\$86	\$83	\$1,099	\$571	\$297	\$99	\$96
B	65+	1,688	878	456	152	147	1,435	746	387	129	125	1,650	858	446	149	144
C	65+	1,944	1,011	525	175	169	1,653	860	446	149	144	1,901	989	513	171	166
D	65+	2,017	1,049	545	182	175	1,715	892	463	154	149	1,972	1,025	532	177	172
E	65+	1,583	823	427	142	138	1,131	588	305	102	98	1,301	677	351	117	113
F	65+	2,456	1,277	663	221	213	1,715	892	463	154	150	1,972	1,025	532	177	172
F2 High Deductible	65+	737	383	199	66	64	515	268	139	46	45	592	308	160	53	52
G	65+	1,583	823	427	142	138	1,131	588	305	102	98	1,301	677	351	117	113
I	65+	1,583	823	427	142	138	1,131	588	305	102	98	1,301	677	351	117	113

Bankers Fidelity Life Insurance Company

4370 Peachtree Road, N.E., P. O. Box 105185, Atlanta, Georgia 30348-5185

Local: 404-266-5600; Toll Free: 800-241-1439, Fax: 404-266-5699

PREMIUM INFORMATION

Bankers Fidelity Life Insurance Company can only raise the premium if we raise the premium for all policies like yours in your state.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to us at the above address. If you send the policy back to us within thirty (30) days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

The policy may not fully cover all of your medical costs.

Neither Bankers Fidelity Life Insurance Company nor its agents are connected with Medicare, the Federal government or the state government.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "The Medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

BENEFITS-PLAN A

Medicare (Part A)-Hospital Services-Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[1,024] All but \$[256] a day All but \$[512] a day \$[0] \$[0]	\$[0] \$[256] a day \$[512] a day 100% of Medicare eligible expenses \$[0]	\$[1,024] (Part A deductible) \$[0] \$[0] \$[0] All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$[128] a day \$[0]	\$[0] \$[0] \$[0]	\$[0] Up to \$[128] a day All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for outpatient drugs and inpatient respite care.	\$[0]	Balance

Medicare (Part B)-Medical Services-Per Calendar Year

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (above Medicare approved amounts)	\$[0] Generally 80% \$[0]	\$[0] Generally 20% \$[0]	\$[135] (Part B deductible) \$[0] All costs
BLOOD - First 3 pints Next \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$[0] \$[0] 80%	All costs \$[0] 20%	\$[0] \$[135] (Part B deductible) \$[0]
CLINICAL LABORATORY SERVICES-BLOOD TEST FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

Medicare (Parts A & B) - Medicare Services-Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	[\$0]	[\$0]
- Durable medical equipment			
First \$[135] of Medicare approved amounts*	[\$0]	[\$0]	[\$135] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	[\$0]

BENEFITS-PLAN B

Medicare (Part A)-Hospital Services-Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION * Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[1,024] All but \$[256] a day All but \$[512] a day \$[0] \$[0]	\$[1,024] (Part A deductible) \$[256] a day \$[512] a day 100% of Medicare eligible expenses \$[0]	\$[0] \$[0] \$[0] \$[0] All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$[128] a day \$[0]	\$[0] \$[0] \$[0]	\$[0] Up to \$[128] a day All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for outpatient drugs and inpatient respite care.	\$[0]	Balance

Medicare (Part B)-Medical Services-Per Calendar Year

*Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (above Medicare approved amounts)	\$[0] Generally 80% \$[0]	\$[0] Generally 20% \$[0]	\$[135] (Part B deductible) \$[0] All costs
BLOOD - First 3 pints Next \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$[0] \$[0] 80%	All costs \$[0] 20%	\$[0] \$[135] (Part B deductible) \$[0]
CLINICAL LABORATORY SERVICES-BLOOD TEST FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

Medicare (Parts A & B) - Medicare Services-Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	[\$0]	[\$0]
- Durable medical equipment			
First \$[135] of Medicare approved amounts*	[\$0]	[\$0]	[\$135] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	[\$0]

BENEFITS-PLAN C

Medicare (Part A)-Hospital Services-Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION * Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[1,024] All but \$[256] a day All but \$[512] a day \$[0] \$[0]	\$[1,024] (Part A deductible) \$[256] a day \$[512] a day 100% of Medicare eligible expenses \$[0]	\$[0] \$[0] \$[0] \$[0] All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$[128] a day \$[0]	\$[0] Up to \$[128] a day \$[0]	\$[0] \$[0] All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for outpatient drugs and inpatient respite care.	\$[0]	Balance

Medicare (Part B)-Medical Services-Per Calendar Year

*Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (above Medicare approved amounts)	\$[0] Generally 80% \$[0]	\$[135] (Part B deductible) Generally 20% \$[0]	\$[0] \$[0] All costs
BLOOD - First 3 pints Next \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$[0] \$[0] 80%	All costs \$[135] (Part B deductible) 20%	\$[0] \$[0] \$[0]
CLINICAL LABORATORY SERVICES-BLOOD TEST FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

Medicare (Parts A & B) - Medicare Services-Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment	100%	\$[0]	\$[0]
First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$[0] 80%	\$[135] (Part B deductible) 20%	\$[0] \$[0]

Other Benefits - Not Covered By Medicare

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A. - First \$[250] each calendar year - Remainder of charges	\$[0] \$[0]	\$[0] 80% to a lifetime maximum benefit of \$[50,000]	\$[250] 20% and amounts over the \$[50,000] lifetime maximum
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BENEFITS-PLAN D

Medicare (Part A)-Hospital Services-Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION * Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[1,024] All but \$[256] a day All but \$[512] a day \$[0] \$[0]	\$[1,024] (Part A deductible) \$[256] a day \$[512] a day 100% of Medicare eligible expenses \$[0]	\$[0] \$[0] \$[0] \$[0] All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$[128] a day \$[0]	\$[0] Up to \$[128] a day \$[0]	\$[0] \$[0] All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for outpatient drugs and inpatient respite care.	\$[0]	Balance

Medicare (Part B)-Medical Services-Per Calendar Year

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (above Medicare approved amounts)	\$[0] Generally 80% \$[0]	\$[0] Generally 20% \$[0]	\$[135] (Part B deductible) \$[0] All costs
BLOOD - First 3 pints Next \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$[0] \$[0] 80%	All costs \$[0] 20%	\$[0] \$[135] (Part B deductible) \$[0]
CLINICAL LABORATORY SERVICES-BLOOD TEST FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

Medicare (Parts A & B) - Medicare Services-Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
<p>HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts</p>	<p>100% \$[0] 80%</p>	<p>\$[0] \$[0] 20%</p>	<p>\$[0] \$[135] (Part B deductible) \$[0]</p>
<p>HOME HEALTH CARE - (cont'd) AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan - Benefit for each visit - Number of visits covered (must be received within 8 weeks of last Medicare approved visit) - Calendar year maximum</p>	<p>\$[0] \$[0] \$[0]</p>	<p>Actual charges to \$[40] a visit Up to the number of Medicare approved visits, not to exceed 7 each week \$[1,600]</p>	<p>Balance</p>

Other Benefits - Not Covered By Medicare

<p>FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A. - First \$[250] each calendar year - Remainder of charges</p>	<p>\$[0] \$[0]</p>	<p>\$[0] 80% to a lifetime maximum benefit of \$[50,000]</p>	<p>\$[250] 20% and amounts over the \$[50,000] lifetime maximum</p>
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BENEFITS-PLAN E

Medicare (Part A)-Hospital Services-Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION * Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[1,024] All but \$[256] a day All but \$[512] a day \$[0] \$[0]	\$[1,024] (Part A deductible) \$[256] a day \$[512] a day 100% of Medicare eligible expenses \$[0]	\$[0] \$[0] \$[0] \$[0] All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$[128] a day \$[0]	\$[0] Up to \$[128] a day \$[0]	\$[0] \$[0] All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for outpatient drugs and inpatient respite care.	\$[0]	Balance

Medicare (Part B)-Medical Services-Per Calendar Year

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (above Medicare approved amounts)	\$[0] Generally 80% \$[0]	\$[0] Generally 20% \$[0]	\$[135] (Part B deductible) \$[0] All costs
BLOOD - First 3 pints Next \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$[0] \$[0] 80%	All costs \$[0] 20%	\$[0] \$[135] (Part B deductible) \$[0]
CLINICAL LABORATORY SERVICES-BLOOD TEST FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

Medicare (Parts A & B) - Medicare Services-Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$[0] 80%	\$[0] \$[0] 20%	\$[0] \$[135] (Part B deductible) \$[0]

Other Benefits - Not Covered By Medicare

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A. - First \$[250] each calendar year - Remainder of charges	\$[0] \$[0]	\$[0] 80% to a lifetime maximum benefit of \$[50,000]	\$[250] 20% and amounts over the \$[50,000] lifetime maximum
PREVENTIVE MEDICARE CARE BENEFIT- NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diptheria booster and education, administered or ordered by your doctor when not covered by Medicare - First \$[120] each calendar year - Additional charges	\$[0] \$[0]	\$[120] \$[0]	\$[0] All costs

BENEFITS-PLAN F OR HIGH DEDUCTIBLE PLAN F

Medicare (Part A)-Hospital Services-Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

****HIGH DEDUCTIBLE PLAN ONLY:** This high deductible plan pays the same or offers the same benefits as standard Plan F after one has paid a calendar year [\$1,900] deductible. Benefits for high deductible Plan F will not begin until out-of-pocket expenses are [\$1,900]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductible for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Services	Medicare Pays	After You Pay \$1,900 Deductible,** Plan Pays	In Addition to \$1,900 Deductible,** You Pay
HOSPITALIZATION * Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[1,024] All but \$[256] a day All but \$[512] a day \$[0] \$[0]	\$[1,024](Part A deductible) \$[256] a day \$[512] a day 100% of Medicare eligible expenses \$[0]	\$[0] \$[0] \$[0] \$[0] All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$[128] a day \$[0]	\$[0] Up to \$[128] a day \$[0]	\$[0] \$[0] All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coin-surance for outpatient drugs and inpatient respite care.	\$[0]	Balance

Continued on reverse

Medicare (Part B)-Medical Services-Per Calendar Year

*Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

****HIGH DEDUCTIBLE PLAN ONLY:** This high deductible plan pays the same or offers the same benefits as standard Plan F after one has paid a calendar year [\$1,900] deductible. Benefits for high deductible Plan F will not begin until out-of-pocket expenses are [\$1,900]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductible for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Services	Medicare Pays	After You Pay \$1,900 Deductible,** Plan Pays	In Addition to \$1,900 Deductible,** You Pay
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (above Medicare approved amounts)	\$[0] 80% \$[0]	\$[135] (Part B deductible) 20% 100%	\$[0] \$[0] \$[0]
BLOOD - First 3 pints Next \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$[0] \$[0] 80%	All costs \$[135] (Part B deductible) 20%	\$[0] \$[0] \$[0]
CLINICAL LABORATORY SERVICES-BLOOD TEST FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

Medicare (Parts A & B) - Medicare Services-Per Calendar Year

HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$[0] 80%	\$[0] \$[135] (Part B deductible) 20%	\$[0] \$[0] \$[0]
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Other Benefits - Not Covered By Medicare

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A. - First \$[250] each calendar year - Remainder of charges	\$[0] \$[0]	\$[0] 80% to a lifetime maximum benefit of \$[50,000]	\$[250] 20% and amounts over the \$[50,000] lifetime maximum
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BENEFITS-PLAN G

Medicare (Part A)-Hospital Services-Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION * Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[1,024] All but \$[256] a day All but \$[512] a day \$[0] \$[0]	\$[1,024] (Part A deductible) \$[256] a day \$[512] a day 100% of Medicare eligible expenses \$[0]	\$[0] \$[0] \$[0] \$[0] All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$[128] a day \$[0]	\$[0] Up to \$[128] a day \$[0]	\$[0] \$[0] All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for outpatient drugs and inpatient respite care.	\$[0]	Balance

Medicare (Part B)-Medical Services-Per Calendar Year

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (above Medicare approved amounts)	\$[0] Generally 80% \$[0]	\$[0] Generally 20% 80%	\$[135] (Part B deductible) \$[0] 20%
BLOOD - First 3 pints Next \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$[0] \$[0] 80%	All costs \$[0] 20%	\$[0] \$[135] (Part B deductible) \$[0]
CLINICAL LABORATORY SERVICES-BLOOD TEST FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

Medicare (Parts A & B) - Medicare Services-Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
<p>HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts</p>	<p>100%</p> <p>\$[0]</p> <p>80%</p>	<p>\$[0]</p> <p>\$[0]</p> <p>20%</p>	<p>\$[0]</p> <p>\$[135] (Part B deductible) \$[0]</p>
<p>HOME HEALTH CARE - (cont'd) AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan - Benefit for each visit - Number of visits covered (must be received within 8 weeks of last Medicare approved visit) - Calendar year maximum</p>	<p>\$[0]</p> <p>\$[0]</p> <p>\$[0]</p>	<p>Actual charges to \$[40] a visit Up to the number of Medicare approved visits, not to exceed 7 each week \$[1,600]</p>	<p>Balance</p>

Other Benefits - Not Covered By Medicare

<p>FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A. - First \$[250] each calendar year - Remainder of charges</p>	<p>\$[0]</p> <p>\$[0]</p>	<p>\$[0]</p> <p>80% to a lifetime maximum benefit of \$[50,000]</p>	<p>\$[250]</p> <p>20% and amounts over the \$[50,000] lifetime maximum</p>
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BENEFITS-PLAN I

Medicare (Part A)-Hospital Services-Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION * Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[1,024] All but \$[256] a day All but \$[512] a day \$[0] \$[0]	\$[1,024] (Part A deductible) \$[256] a day \$[512] a day 100% of Medicare eligible expenses \$[0]	\$[0] \$[0] \$[0] \$[0] All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$[128] a day \$[0]	\$[0] Up to \$[128] a day \$[0]	\$[0] \$[0] All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for outpatient drugs and inpatient respite care.	\$[0]	Balance

Medicare (Part B)-Medical Services-Per Calendar Year

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (above Medicare approved amounts)	\$[0] Generally 80% \$[0]	\$[0] Generally 20% 100%	\$[135] (Part B deductible) \$[0] \$[0]
BLOOD - First 3 pints Next \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$[0] \$[0] 80%	All costs \$[0] 20%	\$[0] \$[135] (Part B deductible) \$[0]
CLINICAL LABORATORY SERVICES-BLOOD TEST FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

Medicare (Parts A & B) - Medicare Services-Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
<p>HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts</p>	<p>100% \$[0] 80%</p>	<p>\$[0] \$[0] 20%</p>	<p>\$[0] \$[135] (Part B deductible) \$[0]</p>
<p>HOME HEALTH CARE - (cont'd) AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan - Benefit for each visit - Number of visits covered (must be received within 8 weeks of last Medicare approved visit) - Calendar year maximum</p>	<p>\$[0] \$[0] \$[0]</p>	<p>Actual charges to \$[40] a visit Up to the number of Medicare approved visits, not to exceed 7 each week \$[1,600]</p>	<p>Balance</p>

Other Benefits - Not Covered By Medicare

<p>FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A. - First \$[250] each calendar year - Remainder of charges</p>	<p>\$[0] \$[0]</p>	<p>\$[0] 80% to a lifetime maximum benefit of \$[50,000]</p>	<p>\$[250] 20% and amounts over the \$[50,000] lifetime maximum</p>
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SERFF Tracking Number: BFLI-125638536 State: Arkansas
 Filing Company: Bankers Fidelity Life Insurance Company State Tracking Number: 38993
 Company Tracking Number: AR B 9200 I
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.010 Plan I
 Standard Plans
 Product Name: Medicare Supplement Plan I
 Project Name/Number: /

Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved 06/19/2008
Comments:
Attachments:
 B 9200 I Flesch Cert.pdf
 Consumer Notice.pdf
 Guaranty Association.pdf
 Certificate of Compliance B 9200 I.pdf

Satisfied -Name: Application **Review Status:** Approved 06/19/2008
Comments:
 Applications B 9200 PRF AP2008 and B 9200 STND AP2008 will be used with this policy. They were submitted via SERFF 5/07/08. SERFF Tracking Number is BFLI-125630644.

Bypassed -Name: Outline of Coverage **Review Status:** Approved 06/19/2008
Bypass Reason: Included in Form Schedule for review and approval
Comments:

Satisfied -Name: Actuarial Cover Letter **Review Status:** Approved 06/19/2008
Comments:
Attachment:
 Cover(ar1-2008).pdf

BANKERS FIDELITY LIFE INSURANCE COMPANY
Atlanta, Georgia

FLESCH SCORE CERTIFICATION

B 9200 I - Medicare Supplement Policy - Plan I

Words: 2,895
Sentences: 190
Syllables: 4,790
Score: 51.78

I hereby certify that the Flesch reading ease score of the above forms is as shown.



Sharon A. Busch
Vice President; Legal/Compliance

05-06-08
Date

BANKERS FIDELITY LIFE INSURANCE COMPANY

Atlanta, Georgia

The following information is being provided to you in accordance with Act 197 of the Arkansas Department of Insurance Regulations:

Bankers Fidelity Life Insurance Company

Policyholder Service Department

4370 Peachtree Road, N.E.

Atlanta, Georgia 30319

Toll-Free: 866-458-7500

Fax: (404) 926-4033

bflphs@atlam.com

If we at Bankers Fidelity Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Department of Insurance

Consumer Service Division

1200 West Third Street

Little Rock, Arkansas 72201-1904

(510) 371-2640, (800) 852-5494

Fax: (501) 371-2749

insurance.consumers@arkansas.gov

Your Agent:

{FId0240}

{FId0241} {FId0242}

{FId0243} {FId0244}

{FId0245}

This notice is for information only and does not become a part or condition of your policy.

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are member of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting the insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice.

The Arkansas Life and Health Insurance Guaranty Association
C/o The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, Arkansas 72202

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 – no matter how many policies and contracts there were with the same company, even if they provided different type of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

Certificate of Compliance

I, the undersigned, declare that I am an officer, or authorized representative of an officer, of Bankers Fidelity Life Insurance Company, and that I have the authority to bind that organization by my signature. I have reviewed the contents of this filing and all applicable sections of the Arkansas Insurance code, rules and bulletins. I certify that all documents contained herein comply with said code, rules and bulletins, are in final printed format and all terms contained therein appear exactly as they will appear when offered for issuance of delivery in the State of Arkansas.



Officer Signature

May 14, 2008

Date

Sharon A. Busch

Print Name of Officer

Vice President, Legal/Compliance

Officer's Title



T. ALLEN PARK & ASSOCIATES, INC.

9441 LBJ FREEWAY, SUITE 102 DALLAS, TX 75243
972-664-0272 x 202 Fax: 469-621-7385 tallenpark@aol.com

May 25, 2008

Ms. Rosalind D. Minor
Certified Rate and Form Analyst
Life and Health Division
1200 W. Third St.
Little Rock, Arkansas 72201-1904

Dear Ms. Minor:

Subject: 2008 Annual Rate Certification for Policy Form B 9200 (Plans A-G, F2, I)
Bankers Fidelity Life Insurance Company, Atlanta, Georgia (NAIC # 61239)

Enclosed for your review and approval are proposed rates for the current year for the above Standardized Medicare Supplement plans. There are insureds in Arkansas only on Plan B. **There are no increases requested herein.** Rates for Plans E and F2 are being reduced for marketing or loss ratio reasons. Please see the rate sheets for actual changes. Plan I will use the same rates as Plan G because of benefit similarities until experience is credible.

If you have any questions, please call me at (972) 664-0272 x202 or you may e-mail me at tallenpark@aol.com. Thank you for your time and effort on this matter.

Sincerely,

T. Allen Park, FSA, MAAA
Consulting Actuary

Enclosure

SERFF Tracking Number: BFLI-125638536 State: Arkansas
 Filing Company: Bankers Fidelity Life Insurance Company State Tracking Number: 38993
 Company Tracking Number: AR B 9200 I
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.010 Plan I
 Standard Plans
 Product Name: Medicare Supplement Plan I
 Project Name/Number: /

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Benefit Chart - Plan I	05/14/2008	AR B 9200 OC with I.pdf

Bankers Fidelity Life Insurance Company

4370 Peachtree Road, N.E., P. O. Box 105185, Atlanta, Georgia 30348-5185

Outline of Medicare Supplement Coverage—Cover Page 1 of 2

Benefit Plans A, B, C, D, E, F, G & I

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan “A.” Some plans may not be available in your state.

See Outline of Coverage section for details about all plans.

BASIC BENEFITS: For Plans A—J.

Hospitalization:

Part A co-insurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses:

Part B co-insurance (generally 20% of Medicare-approved expenses) for hospital outpatient services.

Blood:

First three (3) pints of blood each year.

PLANS									
A	B	C	D	E	F/F*	G	H†	I	J†/J*/†
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
				Preventive Care not covered by Medicare					Preventive Care not covered by Medicare

*Plan F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same or offer the same benefits as standard Plan F and Plan J after one has paid a calendar year [\$1,900] deductible. Benefits from high deductible Plan F and Plan J will not begin until out-of-pocket expenses are [\$1,900]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but does not include, in Plan F and Plan J, the plan’s separate foreign travel emergency deductible.

† BFLIC does not currently offer these plans.

Bankers Fidelity Life Insurance Company

4370 Peachtree Road, N.E., P. O. Box 105185, Atlanta, Georgia 30348-5185

Outline of Medicare Supplement Coverage—Cover Page 2

Basic Benefits for Plans K and L include similar services as plans A—J, but cost-sharing for the basic benefits is at different levels.

PLANS		
J†	K**/†	L**/†
Basic Benefits	100 % of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100 % of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care not covered by Medicare		
	\$4,400 Out-of-pocket Annual Limit***	\$2,200 Out-of-pocket Annual Limit***

**Plans K and L provide for different cost-sharing for items and services than Plans A—J.

Once you reach the annual limit, the plan pays 100% of the Medicare co-payment, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called “Excess Charges.” You will be responsible for paying excess charges.

***The out-of-pocket annual limit will increase each year for inflation.

† BFLIC does not currently offer these plans.

See Outline of Coverage section for details about all plans.

MEDICARE SUPPLEMENT PREMIUM RATES – POLICY FORM B 9200 ARKANSAS

		PREFERRED UNDERWRITING														
		STANDARD					NON-TOBACCO					TOBACCO				
PLAN	ISSUE AGE	ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY DIRECT	MONTHLY BANK DRAFT	ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY DIRECT	MONTHLY BANK DRAFT	ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY DIRECT	MONTHLY BANK DRAFT
A	65+	\$1,125	\$585	\$304	\$101	\$98	\$956	\$497	\$258	\$86	\$83	\$1,099	\$571	\$297	\$99	\$96
B	65+	1,688	878	456	152	147	1,435	746	387	129	125	1,650	858	446	149	144
C	65+	1,944	1,011	525	175	169	1,653	860	446	149	144	1,901	989	513	171	166
D	65+	2,017	1,049	545	182	175	1,715	892	463	154	149	1,972	1,025	532	177	172
E	65+	1,583	823	427	142	138	1,131	588	305	102	98	1,301	677	351	117	113
F	65+	2,456	1,277	663	221	213	1,715	892	463	154	150	1,972	1,025	532	177	172
F2 High Deductible	65+	737	383	199	66	64	515	268	139	46	45	592	308	160	53	52
G	65+	1,583	823	427	142	138	1,131	588	305	102	98	1,301	677	351	117	113
I	65+	1,947	1,012	526	175	169	1,389	722	375	125	121	1,598	831	431	144	139

Bankers Fidelity Life Insurance Company

4370 Peachtree Road, N.E., P. O. Box 105185, Atlanta, Georgia 30348-5185

Local: 404-266-5600; Toll Free: 800-241-1439, Fax: 404-266-5699

PREMIUM INFORMATION

Bankers Fidelity Life Insurance Company can only raise the premium if we raise the premium for all policies like yours in your state.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to us at the above address. If you send the policy back to us within thirty (30) days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

The policy may not fully cover all of your medical costs.

Neither Bankers Fidelity Life Insurance Company nor its agents are connected with Medicare, the Federal government or the state government.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "The Medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

BENEFITS-PLAN A

Medicare (Part A)-Hospital Services-Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[1,024] All but \$[256] a day All but \$[512] a day \$[0] \$[0]	\$[0] \$[256] a day \$[512] a day 100% of Medicare eligible expenses \$[0]	\$[1,024] (Part A deductible) \$[0] \$[0] \$[0] All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$[128] a day \$[0]	\$[0] \$[0] \$[0]	\$[0] Up to \$[128] a day All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for outpatient drugs and inpatient respite care.	\$[0]	Balance

Medicare (Part B)-Medical Services-Per Calendar Year

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (above Medicare approved amounts)	\$[0] Generally 80% \$[0]	\$[0] Generally 20% \$[0]	\$[135] (Part B deductible) \$[0] All costs
BLOOD - First 3 pints Next \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$[0] \$[0] 80%	All costs \$[0] 20%	\$[0] \$[135] (Part B deductible) \$[0]
CLINICAL LABORATORY SERVICES-BLOOD TEST FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

Medicare (Parts A & B) - Medicare Services-Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	[\$0]	[\$0]
- Durable medical equipment			
First \$[135] of Medicare approved amounts*	[\$0]	[\$0]	[\$135] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	[\$0]

BENEFITS-PLAN B

Medicare (Part A)-Hospital Services-Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION * Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[1,024] All but \$[256] a day All but \$[512] a day \$[0] \$[0]	\$[1,024] (Part A deductible) \$[256] a day \$[512] a day 100% of Medicare eligible expenses \$[0]	\$[0] \$[0] \$[0] \$[0] All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$[128] a day \$[0]	\$[0] \$[0] \$[0]	\$[0] Up to \$[128] a day All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for outpatient drugs and inpatient respite care.	\$[0]	Balance

Medicare (Part B)-Medical Services-Per Calendar Year

*Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (above Medicare approved amounts)	\$[0] Generally 80% \$[0]	\$[0] Generally 20% \$[0]	\$[135] (Part B deductible) \$[0] All costs
BLOOD - First 3 pints Next \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$[0] \$[0] 80%	All costs \$[0] 20%	\$[0] \$[135] (Part B deductible) \$[0]
CLINICAL LABORATORY SERVICES-BLOOD TEST FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

Medicare (Parts A & B) - Medicare Services-Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	[\$0]	[\$0]
- Durable medical equipment			
First \$[135] of Medicare approved amounts*	[\$0]	[\$0]	[\$135] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	[\$0]

BENEFITS-PLAN C

Medicare (Part A)-Hospital Services-Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION * Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[1,024] All but \$[256] a day All but \$[512] a day \$[0] \$[0]	\$[1,024] (Part A deductible) \$[256] a day \$[512] a day 100% of Medicare eligible expenses \$[0]	\$[0] \$[0] \$[0] \$[0] All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$[128] a day \$[0]	\$[0] Up to \$[128] a day \$[0]	\$[0] \$[0] All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for outpatient drugs and inpatient respite care.	\$[0]	Balance

Medicare (Part B)-Medical Services-Per Calendar Year

*Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (above Medicare approved amounts)	\$[0] Generally 80% \$[0]	\$[135] (Part B deductible) Generally 20% \$[0]	\$[0] \$[0] All costs
BLOOD - First 3 pints Next \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$[0] \$[0] 80%	All costs \$[135] (Part B deductible) 20%	\$[0] \$[0] \$[0]
CLINICAL LABORATORY SERVICES-BLOOD TEST FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

Medicare (Parts A & B) - Medicare Services-Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment	100%	\$[0]	\$[0]
First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$[0] 80%	\$[135] (Part B deductible) 20%	\$[0] \$[0]

Other Benefits - Not Covered By Medicare

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A. - First \$[250] each calendar year - Remainder of charges	\$[0] \$[0]	\$[0] 80% to a lifetime maximum benefit of \$[50,000]	\$[250] 20% and amounts over the \$[50,000] lifetime maximum
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BENEFITS-PLAN D

Medicare (Part A)-Hospital Services-Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION * Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[1,024] All but \$[256] a day All but \$[512] a day \$[0] \$[0]	\$[1,024] (Part A deductible) \$[256] a day \$[512] a day 100% of Medicare eligible expenses \$[0]	\$[0] \$[0] \$[0] \$[0] All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$[128] a day \$[0]	\$[0] Up to \$[128] a day \$[0]	\$[0] \$[0] All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for outpatient drugs and inpatient respite care.	\$[0]	Balance

Medicare (Part B)-Medical Services-Per Calendar Year

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (above Medicare approved amounts)	\$[0] Generally 80% \$[0]	\$[0] Generally 20% \$[0]	\$[135] (Part B deductible) \$[0] All costs
BLOOD - First 3 pints Next \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$[0] \$[0] 80%	All costs \$[0] 20%	\$[0] \$[135] (Part B deductible) \$[0]
CLINICAL LABORATORY SERVICES-BLOOD TEST FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

Medicare (Parts A & B) - Medicare Services-Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
<p>HOME HEALTH CARE MEDICARE APPROVED SERVICES</p> <ul style="list-style-type: none"> - Medically necessary skilled care services and medical supplies - Durable medical equipment <p>First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts</p>	<p>100%</p> <p>\$[0]</p> <p>80%</p>	<p>\$[0]</p> <p>\$[0]</p> <p>20%</p>	<p>\$[0]</p> <p>\$[135] (Part B deductible) \$[0]</p>
<p>HOME HEALTH CARE - (cont'd) AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE</p> <p>Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan</p> <ul style="list-style-type: none"> - Benefit for each visit - Number of visits covered (must be received within 8 weeks of last Medicare approved visit) - Calendar year maximum 	<p>\$[0]</p> <p>\$[0]</p> <p>\$[0]</p>	<p>Actual charges to \$[40] a visit</p> <p>Up to the number of Medicare approved visits, not to exceed 7 each week</p> <p>\$[1,600]</p>	<p>Balance</p>

Other Benefits - Not Covered By Medicare

<p>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</p> <p>Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A.</p> <ul style="list-style-type: none"> - First \$[250] each calendar year - Remainder of charges 	<p>\$[0]</p> <p>\$[0]</p>	<p>\$[0]</p> <p>80% to a lifetime maximum benefit of \$[50,000]</p>	<p>\$[250]</p> <p>20% and amounts over the \$[50,000] lifetime maximum</p>
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BENEFITS-PLAN E

Medicare (Part A)-Hospital Services-Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION * Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[1,024] All but \$[256] a day All but \$[512] a day \$[0] \$[0]	\$[1,024] (Part A deductible) \$[256] a day \$[512] a day 100% of Medicare eligible expenses \$[0]	\$[0] \$[0] \$[0] \$[0] All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$[128] a day \$[0]	\$[0] Up to \$[128] a day \$[0]	\$[0] \$[0] All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for outpatient drugs and inpatient respite care.	\$[0]	Balance

Medicare (Part B)-Medical Services-Per Calendar Year

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (above Medicare approved amounts)	\$[0] Generally 80% \$[0]	\$[0] Generally 20% \$[0]	\$[135] (Part B deductible) \$[0] All costs
BLOOD - First 3 pints Next \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$[0] \$[0] 80%	All costs \$[0] 20%	\$[0] \$[135] (Part B deductible) \$[0]
CLINICAL LABORATORY SERVICES-BLOOD TEST FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

Medicare (Parts A & B) - Medicare Services-Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$[0] 80%	\$[0] \$[0] 20%	\$[0] \$[135] (Part B deductible) \$[0]

Other Benefits - Not Covered By Medicare

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A. - First \$[250] each calendar year - Remainder of charges	\$[0] \$[0]	\$[0] 80% to a lifetime maximum benefit of \$[50,000]	\$[250] 20% and amounts over the \$[50,000] lifetime maximum
PREVENTIVE MEDICARE CARE BENEFIT- NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diptheria booster and education, administered or ordered by your doctor when not covered by Medicare - First \$[120] each calendar year - Additional charges	\$[0] \$[0]	\$[120] \$[0]	\$[0] All costs

BENEFITS-PLAN F OR HIGH DEDUCTIBLE PLAN F

Medicare (Part A)-Hospital Services-Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

****HIGH DEDUCTIBLE PLAN ONLY:** This high deductible plan pays the same or offers the same benefits as standard Plan F after one has paid a calendar year [\$1,900] deductible. Benefits for high deductible Plan F will not begin until out-of-pocket expenses are [\$1,900]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductible for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Services	Medicare Pays	After You Pay \$1,900 Deductible,** Plan Pays	In Addition to \$1,900 Deductible,** You Pay
HOSPITALIZATION * Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[1,024] All but \$[256] a day All but \$[512] a day \$[0] \$[0]	\$[1,024](Part A deductible) \$[256] a day \$[512] a day 100% of Medicare eligible expenses \$[0]	\$[0] \$[0] \$[0] \$[0] All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$[128] a day \$[0]	\$[0] Up to \$[128] a day \$[0]	\$[0] \$[0] All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coin-surance for outpatient drugs and inpatient respite care.	\$[0]	Balance

Continued on reverse

Medicare (Part B)-Medical Services-Per Calendar Year

*Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

****HIGH DEDUCTIBLE PLAN ONLY:** This high deductible plan pays the same or offers the same benefits as standard Plan F after one has paid a calendar year [\$1,900] deductible. Benefits for high deductible Plan F will not begin until out-of-pocket expenses are [\$1,900]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductible for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Services	Medicare Pays	After You Pay \$1,900 Deductible,** Plan Pays	In Addition to \$1,900 Deductible,** You Pay
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (above Medicare approved amounts)	\$[0] 80% \$[0]	\$[135] (Part B deductible) 20% 100%	\$[0] \$[0] \$[0]
BLOOD - First 3 pints Next \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$[0] \$[0] 80%	All costs \$[135] (Part B deductible) 20%	\$[0] \$[0] \$[0]
CLINICAL LABORATORY SERVICES-BLOOD TEST FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

Medicare (Parts A & B) - Medicare Services-Per Calendar Year

HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$[0] 80%	\$[0] \$[135] (Part B deductible) 20%	\$[0] \$[0] \$[0]
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Other Benefits - Not Covered By Medicare

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A. - First \$[250] each calendar year - Remainder of charges	\$[0] \$[0]	\$[0] 80% to a lifetime maximum benefit of \$[50,000]	\$[250] 20% and amounts over the \$[50,000] lifetime maximum
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BENEFITS-PLAN G

Medicare (Part A)-Hospital Services-Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION * Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[1,024] All but \$[256] a day All but \$[512] a day \$[0] \$[0]	\$[1,024] (Part A deductible) \$[256] a day \$[512] a day 100% of Medicare eligible expenses \$[0]	\$[0] \$[0] \$[0] \$[0] All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$[128] a day \$[0]	\$[0] Up to \$[128] a day \$[0]	\$[0] \$[0] All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for outpatient drugs and inpatient respite care.	\$[0]	Balance

Medicare (Part B)-Medical Services-Per Calendar Year

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (above Medicare approved amounts)	\$[0] Generally 80% \$[0]	\$[0] Generally 20% 80%	\$[135] (Part B deductible) \$[0] 20%
BLOOD - First 3 pints Next \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$[0] \$[0] 80%	All costs \$[0] 20%	\$[0] \$[135] (Part B deductible) \$[0]
CLINICAL LABORATORY SERVICES-BLOOD TEST FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

Medicare (Parts A & B) - Medicare Services-Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
<p>HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts</p>	<p>100% \$[0] 80%</p>	<p>\$[0] \$[0] 20%</p>	<p>\$[0] \$[135] (Part B deductible) \$[0]</p>
<p>HOME HEALTH CARE - (cont'd) AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan - Benefit for each visit - Number of visits covered (must be received within 8 weeks of last Medicare approved visit) - Calendar year maximum</p>	<p>\$[0] \$[0] \$[0]</p>	<p>Actual charges to \$[40] a visit Up to the number of Medicare approved visits, not to exceed 7 each week \$[1,600]</p>	<p>Balance</p>

Other Benefits - Not Covered By Medicare

<p>FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A. - First \$[250] each calendar year - Remainder of charges</p>	<p>\$[0] \$[0]</p>	<p>\$[0] 80% to a lifetime maximum benefit of \$[50,000]</p>	<p>\$[250] 20% and amounts over the \$[50,000] lifetime maximum</p>
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BENEFITS-PLAN I

Medicare (Part A)-Hospital Services-Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION * Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$[1,024] All but \$[256] a day All but \$[512] a day \$[0] \$[0]	\$[1,024] (Part A deductible) \$[256] a day \$[512] a day 100% of Medicare eligible expenses \$[0]	\$[0] \$[0] \$[0] \$[0] All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$[128] a day \$[0]	\$[0] Up to \$[128] a day \$[0]	\$[0] \$[0] All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for outpatient drugs and inpatient respite care.	\$[0]	Balance

Medicare (Part B)-Medical Services-Per Calendar Year

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (above Medicare approved amounts)	\$[0] Generally 80% \$[0]	\$[0] Generally 20% 100%	\$[135] (Part B deductible) \$[0] \$[0]
BLOOD - First 3 pints Next \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$[0] \$[0] 80%	All costs \$[0] 20%	\$[0] \$[135] (Part B deductible) \$[0]
CLINICAL LABORATORY SERVICES-BLOOD TEST FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

Medicare (Parts A & B) - Medicare Services-Per Calendar Year

Services	Medicare Pays	Plan Pays	You Pay
<p>HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$[135] of Medicare approved amounts* Remainder of Medicare approved amounts</p>	<p>100% \$[0] 80%</p>	<p>\$[0] \$[0] 20%</p>	<p>\$[0] \$[135] (Part B deductible) \$[0]</p>
<p>HOME HEALTH CARE - (cont'd) AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan - Benefit for each visit - Number of visits covered (must be received within 8 weeks of last Medicare approved visit) - Calendar year maximum</p>	<p>\$[0] \$[0] \$[0]</p>	<p>Actual charges to \$[40] a visit Up to the number of Medicare approved visits, not to exceed 7 each week \$[1,600]</p>	<p>Balance</p>

Other Benefits - Not Covered By Medicare

<p>FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A. - First \$[250] each calendar year - Remainder of charges</p>	<p>\$[0] \$[0]</p>	<p>\$[0] 80% to a lifetime maximum benefit of \$[50,000]</p>	<p>\$[250] 20% and amounts over the \$[50,000] lifetime maximum</p>
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