

SERFF Tracking Number: WAKE-125907794 State: Arkansas  
Filing Company: Family Life Insurance Company State Tracking Number: 40897  
Company Tracking Number:  
TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other  
Product Name: FLIC Med Supp Forms 2008  
Project Name/Number: Family Life/112008

## Filing at a Glance

Company: Family Life Insurance Company  
Product Name: FLIC Med Supp Forms 2008 SERFF Tr Num: WAKE-125907794 State: ArkansasLH  
TOI: MS06 Medicare Supplement - Other SERFF Status: Closed State Tr Num: 40897  
Sub-TOI: MS06.000 Medicare Supplement - Other Co Tr Num: State Status: Approved-Closed  
Other  
Filing Type: Form/Rate Co Status: Reviewer(s): Stephanie Fowler  
Author: Jennifer Snell Disposition Date: 01/13/2009  
Date Submitted: 11/19/2008 Disposition Status: Approved  
Implementation Date Requested: On Approval Implementation Date:  
State Filing Description:

## General Information

Project Name: Family Life Status of Filing in Domicile: Pending  
Project Number: 112008 Date Approved in Domicile:  
Requested Filing Mode: Review & Approval Domicile Status Comments: This filing was submitted to the home domicile state of Texas on November 14, 2008 for review.  
Explanation for Combination/Other: Market Type: Individual  
Submission Type: New Submission Group Market Size:  
Overall Rate Impact: Group Market Type:  
Filing Status Changed: 01/13/2009 Deemer Date:  
State Status Changed: 01/13/2009  
Corresponding Filing Tracking Number:  
Filing Description:  
SUBMISSION  
Medicare Supplement Insurance Policies  
Plan A – Form Number MSIAA200810 AR  
Plan B – Form Number MSIAB200810 AR  
Plan C – Form Number MSIAC200810 AR

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Plan D – Form Number MSIAD200810 AR  
Plan E – Form Number MSIAE200810 AR  
Plan F – Form Number MSIAF200810 AR  
Plan G – Form Number MSIAG200810 AR  
Outline of Coverage - Form Number MSOC1200810 AR  
Application - Form Number MSAPP200810 AR  
Replacement – Form Number MSREPL200810  
Brochure – Form Number FLBRA 11-08

Wakely Actuarial Services, Inc. is filing the above-captioned forms, including rates on behalf of Family Life Insurance Company. A letter of authorization is included for reference. We are requesting the Department's review and approval of this filing.

The Company is submitting seven of the standardized plans to supplement Medicare. Agents licensed in your state will market these plans to consumers.

The application being submitted reflects the information regarding the guarantee issue period. The brochure will be used to advertise the above noted policy forms.

Wakely Actuarial Services, Inc. appreciates the Department's time and consideration in the review of this filing for Family Life Insurance Company.

## Company and Contact

### Filing Contact Information

(This filing was made by a third party - WAS01)

Jennifer Snell, Compliance Analyst jennifer.snell@wakelyactuarial.com  
34125 US Highway N (727) 373-4558 [Phone]  
Palm Harbor, FL 34684 (727) 373-4559[FAX]

### Filing Company Information

Family Life Insurance Company CoCode: 63053 State of Domicile: Texas  
P.O. Box 924408 Group Code: Company Type: Life and Health

SERFF Tracking Number: WAKE-125907794

State: Arkansas

Filing Company: Family Life Insurance Company

State Tracking Number: 40897

Company Tracking Number:

TOI: MS06 Medicare Supplement - Other

Sub-TOI: MS06.000 Medicare Supplement - Other

Product Name: FLIC Med Supp Forms 2008

Project Name/Number: Family Life/112008

Houston, TX 77292-4408  
(800) 877-7705 ext. [Phone]

Group Name:  
FEIN Number: 91-0550883  
-----

State ID Number:

SERFF Tracking Number: WAKE-125907794 State: Arkansas  
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## Filing Fees

Fee Required? Yes  
Fee Amount: \$375.00  
Retaliatory? No  
Fee Explanation:  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Family Life Insurance Company	\$375.00	11/19/2008	24040058

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Stephanie Fowler	01/13/2009	01/13/2009

### 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	01/06/2009	01/06/2009	Jennifer Snell	01/09/2009	01/09/2009

### Amendments

Item	Schedule	Created By	Created On	Date Submitted
Brochure	Form	Jennifer Snell	01/12/2009	01/12/2009
Application	Form	Jennifer Snell	12/02/2008	12/02/2008

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Possible typo on brochure	Note To Filer	Stephanie Fowler	01/09/2009	01/09/2009

*SERFF Tracking Number:* WAKE-125907794      *State:* Arkansas  
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*Product Name:* FLIC Med Supp Forms 2008  
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## **Disposition**

Disposition Date: 01/13/2009

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: WAKE-125907794

State: Arkansas

Filing Company: Family Life Insurance Company

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Company Tracking Number:

TOI: MS06 Medicare Supplement - Other

Sub-TOI: MS06.000 Medicare Supplement - Other

Product Name: FLIC Med Supp Forms 2008

Project Name/Number: Family Life/112008

<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice	Accepted for Informational Purposes	Yes
<b>Supporting Document</b>	Application		Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved	No
<b>Supporting Document</b>	Outline of Coverage		Yes
<b>Supporting Document</b>	Authorization Letter	Accepted for Informational Purposes	Yes
<b>Form (revised)</b>	Plan A	Approved	Yes
<b>Form</b>	Plan A	Disapproved	Yes
<b>Form (revised)</b>	Plan B	Approved	Yes
<b>Form</b>	Plan B	Disapproved	Yes
<b>Form (revised)</b>	Plan C	Approved	Yes
<b>Form</b>	Plan C	Disapproved	Yes
<b>Form (revised)</b>	Plan D	Approved	Yes
<b>Form</b>	Plan D	Disapproved	Yes
<b>Form (revised)</b>	Plan E	Approved	Yes
<b>Form</b>	Plan E	Disapproved	Yes
<b>Form (revised)</b>	Plan F	Approved	Yes
<b>Form</b>	Plan F	Disapproved	Yes
<b>Form (revised)</b>	Plan G	Approved	Yes
<b>Form</b>	Plan G	Disapproved	Yes
<b>Form (revised)</b>	Application	Approved	Yes
<b>Form</b>	Application	Disapproved	Yes
<b>Form (revised)</b>	Outline of Coverage	Approved	Yes
<b>Form</b>	Outline of Coverage	Disapproved	Yes
<b>Form</b>	Replacement Form	Accepted for Informational Purposes	Yes
<b>Form (revised)</b>	Brochure	Approved	Yes
<b>Form</b>	Brochure	Disapproved	Yes
<b>Form</b>	Brochure	Disapproved	Yes
<b>Rate (revised)</b>	Rate Pages	Approved	Yes
	Rate Pages	Disapproved	Yes

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**Rate**

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Product Name: FLIC Med Supp Forms 2008  
Project Name/Number: Family Life/112008

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 01/06/2009  
Submitted Date 01/06/2009  
Respond By Date 02/06/2009

Dear Jennifer Snell,

Thank you for your patience, this will acknowledge receipt of the captioned filing. Please see my comments below regarding this filing.

### Objection 1

- Plan A (Form)
- Plan B (Form)
- Plan C (Form)
- Plan D (Form)
- Plan E (Form)
- Plan F (Form)
- Plan G (Form)

Comment: AR Code Ann. 23-79-109(a)(4) states, "all Medicare supplement rates shall be based on a composite age basis only, and shall not be based on any age banding or other groupings." With that being stated, please revise the third sentence of the fifth paragraph on the cover pages of the policies.

### Objection 2

- Outline of Coverage (Form)

Comment: Please revise the "Premium Information" paragraph located on page 9 to comply with AR Code Ann. 23-79-109(a)(4), which has been previously referenced.

### Objection 3

- Brochure (Form)

Comment: Please reword the provisions on the "Your Family Life Benefits" page and the "As Medicare deductibles and coinsurance increase" provision found on the "Your Plan; The Facts" page to comply with AR Rule and Regulation 14 s 20 Guideline 7-A(1) (14) which states: "An advertisement which exaggerates the effects of statutorily mandated benefits or required policy provisions or which implies that such provisions are unique to the advertised policy is unacceptable. For example, the phrase, "Money Back Guarantee," is an exaggerated description of the thirty-day right to examine the policy and is not acceptable."

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Product Name: FLIC Med Supp Forms 2008  
Project Name/Number: Family Life/112008

#### Objection 4

- Brochure (Form)

Comment: Please revise the "Rates are based on your age" provision found on the "Your Plan; The Facts" page to comply with AR Code Ann. 23-79-109(a)(4).

#### Objection 5

- Rate Pages (Rate)

Comment: AR Rule and Regulation 27 s6(C) states "No Medicare supplement policy or certificate may include a policy fee or any other similar charge. Applicants cannot be required to pay any fee other than the approved premium".

Please feel free to contact me if you have questions.

Sincerely,

Stephanie Fowler

## Response Letter

Response Letter Status	Submitted to State
Response Letter Date	01/09/2009
Submitted Date	01/09/2009

Dear Stephanie Fowler,

#### Comments:

#### Response 1

Comments: Please note the following changes in the attached forms.

1. The GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE provision, on the cover page of each of the policies, has been revised in order to comply with AR Code Ann. 23-79-109(a)(4).
2. The Premium Information paragraph on page 9 of the Outline of Coverage has been revised in order to comply with AR Code Ann. 23-79-109(a)(4).
3. In order to comply with AR Rule and Regulation 14 Section 20 Guideline 7-A(1) (14), "Your Family Life Benefits" page has been corrected.
4. The "Rates are based on your age" provision in the brochure has been revised to comply with AR Code Ann. 23-79-109(a)(4).
5. Attached you will find revised rate pages with the policy fee language removed.

Feel free to contact me should you have any questions or concerns.

Thank you

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### **Related Objection 1**

Applies To:

- Plan A (Form)
- Plan B (Form)
- Plan C (Form)
- Plan D (Form)
- Plan E (Form)
- Plan F (Form)
- Plan G (Form)

Comment:

AR Code Ann. 23-79-109(a)(4) states, "all Medicare supplement rates shall be based on a composite age basis only, and shall not be based on any age banding or other groupings." With that being stated, please revise the third sentence of the fifth paragraph on the cover pages of the policies.

### **Related Objection 2**

Applies To:

- Outline of Coverage (Form)

Comment:

Please revise the "Premium Information" paragraph located on page 9 to comply with AR Code Ann. 23-79-109(a)(4), which has been previously referenced.

### **Related Objection 3**

Applies To:

- Brochure (Form)

Comment:

Please reword the provisions on the "Your Family Life Benefits" page and the "As Medicare deductibles and coinsurance increase" provision found on the "Your Plan; The Facts" page to comply with AR Rule and Regulation 14 s 20 Guideline 7-A(1) (14) which states: "An advertisement which exaggerates the effects of statutorily mandated benefits or required policy provisions or which implies that such provisions are unique to the advertised policy is unacceptable. For example, the phrase, "Money Back Guarantee," is an exaggerated description of the thirty-day right to examine the policy and is not acceptable."

### **Related Objection 4**

Applies To:

- Brochure (Form)

Comment:

Please revise the "Rates are based on your age" provision found on the "Your Plan; The Facts" page to comply with AR Code Ann. 23-79-109(a)(4).

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 Product Name: FLIC Med Supp Forms 2008  
 Project Name/Number: Family Life/112008

**Related Objection 5**

Applies To:

- Rate Pages (Rate)

Comment:

AR Rule and Regulation 27 s6(C) states "No Medicare supplement policy or certificate may include a policy fee or any other similar charge. Applicants cannot be required to pay any fee other than the approved premium".

**Changed Items:**

No Supporting Documents changed.

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Plan A	MSIAA200 810 AR		Policy/Contract/Fraternal Certificate	Initial		45	MSIAA200 810 AR.pdf
<b>Previous Version</b>							
Plan A	MSIAA200 810 AR		Policy/Contract/Fraternal Certificate	Initial		45	MSIAA200 810 AR.pdf
Plan B	MSIAB200 810 AR		Policy/Contract/Fraternal Certificate	Initial		45	MSIAB200 810 AR.pdf
<b>Previous Version</b>							
Plan B	MSIAB200 810 AR		Policy/Contract/Fraternal Certificate	Initial		45	MSIAB200 810 AR.pdf
Plan C	MSIAC20 0810 AR		Policy/Contract/Fraternal Certificate	Initial		46	MSIAC20 0810 AR.pdf
<b>Previous Version</b>							
Plan C	MSIAC20 0810 AR		Policy/Contract/Fraternal Certificate	Initial		46	MSIAC20 0810

<i>SERFF Tracking Number:</i>	WAKE-125907794	<i>State:</i>	Arkansas	
<i>Filing Company:</i>	Family Life Insurance Company	<i>State Tracking Number:</i>	40897	
<i>Company Tracking Number:</i>				
<i>TOI:</i>	MS06 Medicare Supplement - Other	<i>Sub-TOI:</i>	MS06.000 Medicare Supplement - Other	
<i>Product Name:</i>	FLIC Med Supp Forms 2008			
<i>Project Name/Number:</i>	Family Life/112008			AR.pdf
Plan D	MSIAD20 0810 AR	Policy/Contract/Fraternal Certificate	Initial	45 MSIAD20 0810 AR.pdf
<b>Previous Version</b>				
Plan D	MSIAD20 0810 AR	Policy/Contract/Fraternal Certificate	Initial	45 MSIAD20 0810 AR.pdf
Plan E	MSIAE200 810 AR	Policy/Contract/Fraternal Certificate	Initial	45 MSIAE200 810 AR.pdf
<b>Previous Version</b>				
Plan E	MSIAE200 810 AR	Policy/Contract/Fraternal Certificate	Initial	45 MSIAE200 810 AR.pdf
Plan F	MSIAF200 810 AR	Policy/Contract/Fraternal Certificate	Initial	46 MSIAF200 810 AR.pdf
<b>Previous Version</b>				
Plan F	MSIAF200 810 AR	Policy/Contract/Fraternal Certificate	Initial	46 MSIAF200 810 AR.pdf
Plan G	MSIAG20 0810 AR	Policy/Contract/Fraternal Certificate	Initial	45 MSIAG20 0810 AR.pdf
<b>Previous Version</b>				
Plan G	MSIAG20 0810 AR	Policy/Contract/Fraternal Certificate	Initial	45 MSIAG20 0810 AR.pdf
Outline of Coverage	MSOCI20 0810 AR	Outline of Coverage	Initial	47 MSOCI20 0810 AR.pdf
<b>Previous Version</b>				
Outline of Coverage	MSOCI20 0810 AR	Outline of Coverage	Initial	47 MSOCI20 0810

<i>SERFF Tracking Number:</i>	<i>WAKE-125907794</i>	<i>State:</i>	<i>Arkansas</i>	
<i>Filing Company:</i>	<i>Family Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>40897</i>	
<i>Company Tracking Number:</i>				
<i>TOI:</i>	<i>MS06 Medicare Supplement - Other</i>	<i>Sub-TOI:</i>	<i>MS06.000 Medicare Supplement - Other</i>	
<i>Product Name:</i>	<i>FLIC Med Supp Forms 2008</i>			
<i>Project Name/Number:</i>	<i>Family Life/112008</i>			
				<i>AR.pdf</i>
<b>Brochure</b>	<i>FLBRA</i>	<i>Advertising</i>	<i>Initial</i>	<i>FLBRA</i>
	<i>11-08 AR</i>			<i>10-08</i>
				<i>AR.pdf</i>
<b>Previous Version</b>				
<b>Brochure</b>	<i>FLBRA</i>	<i>Advertising</i>	<i>Initial</i>	<i>FLBRA</i>
	<i>11-08</i>			<i>11-08.pdf</i>

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**Rate/Rule Schedule Item Changes**

**Document Name: Affected Form Numbers: Rate Action: Rate Action Information: Attach Document:**

Rate Pages MSIAA200810 AR, New *Previous State Filing Number*  
 MSIAB200810 AR,  
 MSIAC200810 AR,  
 MSIAD200810 AR,  
 MSIAE200810 AR,  
 MSIAF200810 AR,  
 MSIAG200810 AR  
*Percent Rate Change Request*  
 0

**Previous Version**

Rate Pages MSIAA200810 AR, New *Previous State Filing Number*  
 MSIAB200810 AR,  
 MSIAC200810 AR,  
 MSIAD200810 AR,  
 MSIAE200810 AR,  
 MSIAF200810 AR,  
 MSIAG200810 AR  
*Percent Rate Change Request*  
 0

Sincerely,  
 Jennifer Snell

SERFF Tracking Number: WAKE-125907794 State: Arkansas  
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**Amendment Letter**

Amendment Date:  
 Submitted Date: 01/12/2009

**Comments:**

Attached you will find a revised brochure. The language in the "Guaranteed Renewable for Life" paragraph on page 4 has been corrected.

Feel free to contact me should further information be needed.

Thank you

**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
FLBRA 11-08 AR	Advertising	Brochure	Initial					FLBRA 10-08 AR.pdf

*SERFF Tracking Number:* WAKE-125907794      *State:* Arkansas  
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**Note To Filer**

**Created By:**

Stephanie Fowler on 01/09/2009 01:14 PM

**Subject:**

Possible typo on brochure

**Comments:**

Thank you for your quick response to my comments. I just either need clarification on some wording or there is a typo on "Your policy is guaranteed renewable" paragraph on the "Your Plan; The Facts" page of the advertising. In comparing the revisions to the originals, it looks like some of the wording in the second sentence was removed.

Other than that, everything looks good.

Thank you.

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 Product Name: FLIC Med Supp Forms 2008  
 Project Name/Number: Family Life/112008

**Amendment Letter**

Amendment Date:  
 Submitted Date: 12/02/2008

**Comments:**

An error was found in health question 14 of the application. Attached you will find a corrected version.  
 Thank you

**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
MSAPP200811 AR	Application/Enrollment Form	Application/Enrollment Form	Initial				42	MSAPP200811 AR.pdf

SERFF Tracking Number: WAKE-125907794 State: Arkansas  
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## Form Schedule

**Lead Form Number:** MSIAA200810 AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved	MSIAA200810 AR	Policy/Cont ract/Fraternal Certificate	Plan A	Initial		45	MSIAA200810 AR.pdf
Approved	MSIAB200810 AR	Policy/Cont ract/Fraternal Certificate	Plan B	Initial		45	MSIAB200810 AR.pdf
Approved	MSIAC200810 AR	Policy/Cont ract/Fraternal Certificate	Plan C	Initial		46	MSIAC200810 AR.pdf
Approved	MSIAD200810 AR	Policy/Cont ract/Fraternal Certificate	Plan D	Initial		45	MSIAD200810 AR.pdf
Approved	MSIAE200810 AR	Policy/Cont ract/Fraternal Certificate	Plan E	Initial		45	MSIAE200810 AR.pdf
Approved	MSIAF200810 AR	Policy/Cont ract/Fraternal Certificate	Plan F	Initial		46	MSIAF200810 AR.pdf
Approved	MSIAG200810 AR	Policy/Cont ract/Fraternal Certificate	Plan G	Initial		45	MSIAG200810 AR.pdf
Approved	MSAPP200811 AR	Application/ Enrollment Form	Application	Initial		42	MSAPP200811 AR.pdf
Approved	MSOCI200	Outline of Coverage	Outline of Coverage	Initial		47	MSOCI20081

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<i>Product Name:</i>	FLIC Med Supp Forms 2008		
<i>Project Name/Number:</i>	Family Life/112008		
	810 AR Coverage		0 AR.pdf
Accepted for Information al Purposes	MSREPL20Other Replacement Form 0808	Initial	43 MSREPL2008 08.pdf
Approved	FLBRA 11- Advertising Brochure 08 AR	Initial	FLBRA 10-08 AR.pdf



**FAMILY LIFE INSURANCE COMPANY**

P.O. Box 924408, Houston, Texas 77292-4408

**MEDICARE SUPPLEMENT INSURANCE POLICY - PLAN A**

**THIS IS A LEGAL CONTRACT BETWEEN YOU AND US**

**READ YOUR POLICY CAREFULLY**

This Policy provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Policy. In this Policy, "You" and "Your" means the Insured named on the application and shown on the Policy Schedule. "We", "Our" and "Us" means Family Life Insurance Company.

**NOTICE TO BUYER. THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

**IMPORTANT NOTICE:** Issuance of this Medicare Supplement Insurance Policy is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Policy to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Our Office at:

**P.O. Box 924408  
Houston, Texas 77292-4408  
800-877-7705**

**POLICY EFFECTIVE DATE AND CONSIDERATION**

We have issued this Policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Policy. The term of this Policy begins at twelve (12:00) o'clock, midnight, Standard Time, at the place where You reside on the Policy Effective Date shown on the Policy Schedule. It ends at twelve (12:00) o'clock, midnight, the same Standard Time, on the date Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Policy is shown on the Policy Schedule. An annual premium will maintain the Policy in force for twelve (12) months, semi-annual for six (6) months, quarterly for three (3) months and monthly for one (1) month.

**THIRTY DAY RIGHT TO EXAMINE AND RETURN POLICY**

Please read Your Policy carefully. If, for any reason, You are not satisfied, You may return Your Policy to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded, less any claims paid.

**GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE**

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as state and zip code of residence. We will give You the advance written notice required by Your state prior to any premium change.

**THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION**

**CAUTION**

**POLICY BENEFITS ARE LIMITED TO THOSE APPROVED BY MEDICARE FOR PAYMENT**

**THIS IS A NON-PARTICIPATING POLICY**

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**POLICY SCHEDULE**

**INSURED:** [John Doe]

**POLICY EFFECTIVE DATE:** [01/01/2009]

**POLICY NUMBER:** [123456]

**ISSUE AGE:** [65]

**SEX:** [Male]

**STATE OF ISSUE:** [Arizona]

**MODE AT ISSUE:** [Annual]

**MODAL PREMIUM:** [\$XXXX]

**PREMIUM TERM:** [Annual]

**UNDERWRITING CLASS:** [Preferred]

**SPOUSE DISCOUNT:** [No]

**TYPE OF COVERAGE:** MEDICARE SUPPLEMENT POLICY PLAN A

## DEFINITIONS

**Benefit Period** means the period as determined by Medicare which begins on the date You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

**Calendar Year** means the period of time beginning on January 1 and ending on December 31 of that same year.

**Coinsurance Amount** means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

**Hospital** means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

**Hospitalized or Hospitalization** means being confined in a Hospital on an inpatient basis.

**Immediate Family** means Your spouse, parents, grandparents, children, or siblings, and their spouses.

**Injury** means a bodily injury which is the direct result of an accident and independent of all other causes.

**Lifetime Inpatient Reserve Days** means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

**Medicaid** means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

**Medically Necessary** means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards or medical practice; and (4) not solely for the convenience of You or the Physician.

**Medicare** means 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** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

**Physician** means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

**Policy Effective Date** means the effective date of this Policy and is shown on the Policy Schedule. The Policy Effective Date is not the date You signed the application for coverage.

**Sickness** means illness or disease which first manifests itself after the Policy Effective Date and while this Policy is in force.

**Skilled Nursing Facility** means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

## BENEFIT PROVISIONS

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

**The benefits paid under this Policy will not duplicate benefits paid by Medicare.**

### Basic (Core) Benefits

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first (61<sup>st</sup>) day through the ninetieth (90<sup>th</sup>) day in any Medicare Benefit Period;

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;

Upon exhaustion of Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A Eligible Expenses for Hospitalization paid at applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days;

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;

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.

### GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **PREMIUMS SUBJECT TO CHANGE** provision on page 1.

### EXTENSION OF BENEFITS

Termination of this Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

## **MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN**

Benefits and premiums under this Policy are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Policy is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this Policy shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstatement of Your coverage provides for:

1. Coverage equivalent to coverage in effect before the date of suspension; and
2. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, and You enrolled in Medicare Part D while the Policy was suspended, the reinstated policy for Medicare Part D enrollees will not have outpatient prescription drug coverage, but will be substantially equivalent to Your coverage before the date of suspension.

## **EXCLUSIONS**

We will not pay benefits for:

- (a) expense incurred while this Policy is not in force, except as provided in the Extension of Benefits section;
- (b) Hospital or skilled nursing facility confinement incurred during a Medicare Part A Benefit Period that begins while this Policy is not in force.
- (c) that portion of any expense incurred which is paid for by Medicare;
- (d) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take home drugs and eye refractions;
- (e) services for which a charge is not normally made in the absence of insurance; or
- (f) loss or expense that is payable under any other Medicare Supplement Insurance Policy or certificate.

## GENERAL POLICY PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This Policy, including the endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the two (2) year period.

**GRACE PERIOD:** A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Policy shall continue in force.

**REINSTATEMENT:** If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after that date. In all other respects We and You shall have the same rights thereunder as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

**NOTICE OF CLAIMS:** We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on behalf of You to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

**CLAIM FORMS:** When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

**PROOF OF LOSS:** We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

**TIME OF PAYMENT OF CLAIMS:** All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

**PAYMENT OF CLAIMS:** Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

## GENERAL POLICY PROVISIONS CONTINUED

**OTHER INSURANCE WITH US:** You can be insured under only one of Our Medicare Supplement Policies at any one time. If You are insured under more than one such Policy, You can select the one that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return all premiums paid (less any claims paid) for any Policy that does not remain in effect.

**PHYSICAL EXAMINATIONS:** At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

**LEGAL ACTION:** No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

**UNPAID PREMIUM:** Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

**CONFORMITY WITH STATE LAWS:** Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

**ASSIGNMENT:** No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408.

**CLERICAL ERROR:** Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

**PRO RATA REFUND:** If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after the Policy month that death occurs.

**CANCELLATION BY INSURED:** You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

**This Policy is signed for Family Life Insurance Company by its President.**



President



Secretary

**FAMILY LIFE INSURANCE COMPANY**

P.O. Box 924408, Houston, Texas 77292-4408

**MEDICARE SUPPLEMENT INSURANCE POLICY - PLAN B**

**THIS IS A LEGAL CONTRACT BETWEEN YOU AND US**

**READ YOUR POLICY CAREFULLY**

This Policy provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Policy. In this Policy, "You" and "Your" means the Insured named on the application and shown on the Policy Schedule. "We", "Our" and "Us" means Family Life Insurance Company.

**NOTICE TO BUYER. THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

**IMPORTANT NOTICE:** Issuance of this Medicare Supplement Insurance Policy is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Policy to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Our Office at:

**P.O. Box 924408  
Houston, Texas 77292-4408  
800-877-7705**

**POLICY EFFECTIVE DATE AND CONSIDERATION**

We have issued this Policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Policy. The term of this Policy begins at twelve (12:00) o'clock, midnight, Standard Time, at the place where You reside on the Policy Effective Date shown on the Policy Schedule. It ends at twelve (12:00) o'clock, midnight, the same Standard Time, on the date Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Policy is shown on the Policy Schedule. An annual premium will maintain the Policy in force for twelve (12) months, semi-annual for six (6) months, quarterly for three (3) months and monthly for one (1) month.

**THIRTY DAY RIGHT TO EXAMINE AND RETURN POLICY**

Please read Your Policy carefully. If, for any reason, You are not satisfied, You may return Your Policy to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded, less any claims paid.

**GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE**

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as state and zip code of residence. We will give You the advance written notice required by Your state prior to any premium change.

**THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION**

**CAUTION**

**POLICY BENEFITS ARE LIMITED TO THOSE APPROVED BY MEDICARE FOR PAYMENT**

**THIS IS A NON-PARTICIPATING POLICY**

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**POLICY SCHEDULE**

**INSURED:** [John Doe]

**POLICY EFFECTIVE DATE:** [01/01/2009]

**POLICY NUMBER:** [123456]

**ISSUE AGE:** [65]

**SEX:** [Male]

**STATE OF ISSUE:** [Arizona]

**MODE AT ISSUE:** [Annual]

**MODAL PREMIUM:** [\$XXXX]

**PREMIUM TERM:** [Annual]

**UNDERWRITING CLASS:** [Preferred]

**SPOUSE DISCOUNT:** [No]

**TYPE OF COVERAGE:** MEDICARE SUPPLEMENT POLICY PLAN B

## DEFINITIONS

**Benefit Period** means the period as determined by Medicare which begins on the date You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

**Calendar Year** means the period of time beginning on January 1 and ending on December 31 of that same year.

**Coinsurance Amount** means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

**Hospital** means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

**Hospitalized or Hospitalization** means being confined in a Hospital on an inpatient basis.

**Immediate Family** means Your spouse, parents, grandparents, children, or siblings, and their spouses.

**Injury** means a bodily injury which is the direct result of an accident and independent of all other causes.

**Lifetime Inpatient Reserve Days** means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

**Medicaid** means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

**Medically Necessary** means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards or medical practice; and (4) not solely for the convenience of You or the Physician.

**Medicare** means 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** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

**Medicare Part A Initial Deductible** means the fixed amount Medicare does not pay during the first sixty (60) days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

**Physician** means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

**Policy Effective Date** means the effective date of this Policy and is shown on the Policy Schedule. The Policy Effective Date is not the date You signed the application for coverage.

**Sickness** means illness or disease which first manifests itself after the Policy Effective Date and while this Policy is in force.

**Skilled Nursing Facility** means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

## **BENEFIT PROVISIONS**

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

**The benefits paid under this Policy will not duplicate benefits paid by Medicare.**

### **Basic (Core) Benefits**

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first (61<sup>st</sup>) day through the ninetieth (90<sup>th</sup>) day in any Medicare Benefit Period;

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;

Upon exhaustion of Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A Eligible Expenses for Hospitalization paid at applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days.

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;

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 For Plan "B"**

**Medicare Part A Deductible:** Coverage for all of the Medicare Part A Initial Deductible amount per Benefit Period.

## **GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS**

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **PREMIUMS SUBJECT TO CHANGE** provision on page 1.

### **EXTENSION OF BENEFITS**

Termination of this Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

### **MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN**

Benefits and premiums under this Policy are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Policy is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this Policy shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstatement of Your coverage provides for:

1. Coverage equivalent to coverage in effect before the date of suspension; and
2. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, and You enrolled in Medicare Part D while the Policy was suspended, the reinstated policy for Medicare Part D enrollees will not have outpatient prescription drug coverage, but will be substantially equivalent to Your coverage before the date of suspension.

### **EXCLUSIONS**

We will not pay benefits for:

- (a) expense incurred while this Policy is not in force, except as provided in the Extension of Benefits section;
- (b) Hospital or skilled nursing facility confinement incurred during a Medicare Part A Benefit Period that begins while this Policy is not in force.
- (c) that portion of any expense incurred which is paid for by Medicare;
- (d) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take home drugs and eye refractions;
- (e) services for which a charge is not normally made in the absence of insurance; or
- (f) loss or expense that is payable under any other Medicare Supplement Insurance Policy or certificate.

## GENERAL POLICY PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This Policy, including the endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the two (2) year period.

**GRACE PERIOD:** A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Policy shall continue in force.

**REINSTATEMENT:** If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after that date. In all other respects We and You shall have the same rights thereunder as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

**NOTICE OF CLAIMS:** We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on behalf of You to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

**CLAIM FORMS:** When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

**PROOF OF LOSS:** We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

**TIME OF PAYMENT OF CLAIMS:** All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

**PAYMENT OF CLAIMS:** Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

## GENERAL POLICY PROVISIONS CONTINUED

**OTHER INSURANCE WITH US:** You can be insured under only one of Our Medicare Supplement Policies at any one time. If You are insured under more than one such Policy, You can select the one that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return all premiums paid (less any claims paid) for any Policy that does not remain in effect.

**PHYSICAL EXAMINATIONS:** At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

**LEGAL ACTION:** No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

**UNPAID PREMIUM:** Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

**CONFORMITY WITH STATE LAWS:** Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

**ASSIGNMENT:** No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408.

**CLERICAL ERROR:** Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

**PRO RATA REFUND:** If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after the Policy month that death occurs.

**CANCELLATION BY INSURED:** You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

**This Policy is signed for Family Life Insurance Company by its President.**



President



Secretary

**FAMILY LIFE INSURANCE COMPANY**

P.O. Box 924408, Houston, Texas 77292-4408

**MEDICARE SUPPLEMENT INSURANCE POLICY - PLAN C**

**THIS IS A LEGAL CONTRACT BETWEEN YOU AND US**

**READ YOUR POLICY CAREFULLY**

This Policy provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Policy. In this Policy, "You" and "Your" means the Insured named on the application and shown on the Policy Schedule. "We", "Our" and "Us" means Family Life Insurance Company.

**NOTICE TO BUYER. THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

**IMPORTANT NOTICE:** Issuance of this Medicare Supplement Insurance Policy is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Policy to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Our Office at:

**P.O. Box 924408  
Houston, Texas 77292-4408  
800-877-7705**

**POLICY EFFECTIVE DATE AND CONSIDERATION**

We have issued this Policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Policy. The term of this Policy begins at twelve (12:00) o'clock, midnight, Standard Time, at the place where You reside on the Policy Effective Date shown on the Policy Schedule. It ends at twelve (12:00) o'clock, midnight, the same Standard Time, on the date Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Policy is shown on the Policy Schedule. An annual premium will maintain the Policy in force for twelve (12) months, semi-annual for six (6) months, quarterly for three (3) months and monthly for one (1) month.

**THIRTY DAY RIGHT TO EXAMINE AND RETURN POLICY**

Please read Your Policy carefully. If, for any reason, You are not satisfied, You may return Your Policy to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded, less any claims paid.

**GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE**

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as state and zip code of residence. We will give You the advance written notice required by Your state prior to any premium change.

**THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION**

**CAUTION**

**POLICY BENEFITS ARE LIMITED TO THOSE APPROVED BY MEDICARE FOR PAYMENT**

**THIS IS A NON-PARTICIPATING POLICY**

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**POLICY SCHEDULE**

**INSURED: [John Doe]**

**POLICY EFFECTIVE DATE: [01/01/2009]**

**POLICY NUMBER: [123456]**

**ISSUE AGE: [65]**

**SEX: [Male]**

**STATE OF ISSUE: [Arizona]**

**MODE AT ISSUE: [Annual]**

**MODAL PREMIUM: [\$XXXX]**

**PREMIUM TERM: [Annual]**

**UNDERWRITING CLASS: [Preferred]**

**SPOUSE DISCOUNT: [No]**

**TYPE OF COVERAGE: MEDICARE SUPPLEMENT POLICY PLAN C**

## DEFINITIONS

**Benefit Period** means the period as determined by Medicare which begins on the date You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

**Calendar Year** means the period of time beginning on January 1 and ending on December 31 of that same year.

**Coinsurance Amount** means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

**Emergency Care** means care needed immediately because of an Injury or an illness of sudden and unexpected onset.

**Hospital** means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

**Hospitalized or Hospitalization** means being confined in a Hospital on an inpatient basis.

**Immediate Family** means Your spouse, parents, grandparents, children, or siblings, and their spouses.

**Injury** means a bodily injury which is the direct result of an accident and independent of all other causes.

**Lifetime Inpatient Reserve Days** means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

**Medicaid** means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

**Medically Necessary** means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards or medical practice; and (4) not solely for the convenience of You or the Physician.

**Medicare** means 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** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

**Medicare Part A Initial Deductible** means the fixed amount Medicare does not pay during the first 60 days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

**Medicare Part B Deductible** means the fixed amount You must pay each Calendar Year before Medicare starts paying Part B expenses. This amount is set each year by Medicare. Medicare does not pay this amount.

**Physician** means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

**Policy Effective Date** means the effective date of this Policy and is shown on the Policy Schedule. The Policy Effective Date is not the date You signed the application for coverage.

**Sickness** means illness or disease which first manifests itself after the Policy Effective Date and while this Policy is in force.

**Skilled Nursing Facility** means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

## BENEFIT PROVISIONS

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

**The benefits paid under this Policy will not duplicate benefits paid by Medicare.**

### Basic (Core) Benefits

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first (61<sup>st</sup>) day through the ninetieth (90<sup>th</sup>) day in any Medicare Benefit Period;

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;

Upon exhaustion of Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A Eligible Expenses for Hospitalization paid at applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days;

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;

Coverage for the Coinsurance Amount, or in the case of hospital outpatient department services paid under a prospective payment plan, the copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B deductible.

### Additional Benefits For Plan "C"

**Medicare Part A Deductible:** Coverage for all of the Medicare Part A Initial Deductible amount per Benefit Period.

**Skilled Nursing Facility Care:** Coverage for the actual billed charges up to the Coinsurance Amount from the twenty first (21<sup>st</sup>) day through the one hundredth (100<sup>th</sup>) day in a Medicare Benefit Period for posthospital Skilled Nursing Facility care eligible under Medicare Part A.

**Medicare Part B Deductible:** Coverage for all of the Medicare Part B Deductible amount per Calendar Year regardless of Hospital confinement.

**Medically Necessary Emergency Care in a Foreign Country:** 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).

## **GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS**

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **PREMIUMS SUBJECT TO CHANGE** provision on page 1.

## **EXTENSION OF BENEFITS**

Termination of this Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

## **MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN**

Benefits and premiums under this Policy are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Policy is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this Policy shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstatement of Your coverage provides for:

1. Coverage equivalent to coverage in effect before the date of suspension; and
2. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, and You enrolled in Medicare Part D while the Policy was suspended, the reinstated policy for Medicare Part D enrollees will not have outpatient prescription drug coverage, but will be substantially equivalent to Your coverage before the date of suspension.

## **EXCLUSIONS**

We will not pay benefits for:

- (a) expense incurred while this Policy is not in force, except as provided in the Extension of Benefits section;
  - (b) Hospital or skilled nursing facility confinement incurred during a Medicare Part A Benefit Period that begins while this Policy is not in force.
  - (c) that portion of any expense incurred which is paid for by Medicare;
  - (d) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take home drugs and eye refractions;
  - (e) services for which a charge is not normally made in the absence of insurance; or
- loss or expense that is payable under any other Medicare Supplement Insurance Policy or certificate.

## GENERAL POLICY PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This Policy, including the endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the two (2) year period.

**GRACE PERIOD:** A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Policy shall continue in force.

**REINSTATEMENT:** If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after that date. In all other respects We and You shall have the same rights thereunder as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

**NOTICE OF CLAIMS:** We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on behalf of You to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

**CLAIM FORMS:** When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

**PROOF OF LOSS:** We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

**TIME OF PAYMENT OF CLAIMS:** All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

**PAYMENT OF CLAIMS:** Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

**GENERAL POLICY PROVISIONS CONTINUED**

**OTHER INSURANCE WITH US:** You can be insured under only one of Our Medicare Supplement Policies at any one time. If You are insured under more than one such Policy, You can select the one that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return all premiums paid (less any claims paid) for any Policy that does not remain in effect.

**PHYSICAL EXAMINATIONS:** At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

**LEGAL ACTION:** No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

**UNPAID PREMIUM:** Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

**CONFORMITY WITH STATE LAWS:** Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

**ASSIGNMENT:** No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408.

**CLERICAL ERROR:** Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

**PRO RATA REFUND:** If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after the Policy month that death occurs.

**CANCELLATION BY INSURED:** You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

**This Policy is signed for Family Life Insurance Company by its President.**



President



Secretary

**FAMILY LIFE INSURANCE COMPANY**

P.O. Box 924408, Houston, Texas 77292-4408

**MEDICARE SUPPLEMENT INSURANCE POLICY - PLAN D**

**THIS IS A LEGAL CONTRACT BETWEEN YOU AND US**

**READ YOUR POLICY CAREFULLY**

This Policy provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Policy. In this Policy, "You" and "Your" means the Insured named on the application and shown on the Policy Schedule. "We", "Our" and "Us" means Family Life Insurance Company.

**NOTICE TO BUYER. THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

**IMPORTANT NOTICE:** Issuance of this Medicare Supplement Insurance Policy is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Policy to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Our Office at:

**P.O. Box 924408  
Houston, Texas 77292-4408  
800-877-7705**

**POLICY EFFECTIVE DATE AND CONSIDERATION**

We have issued this Policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Policy. The term of this Policy begins at twelve (12:00) o'clock, midnight, Standard Time, at the place where You reside on the Policy Effective Date shown on the Policy Schedule. It ends at twelve (12:00) o'clock, midnight, the same Standard Time, on the date Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Policy is shown on the Policy Schedule. An annual premium will maintain the Policy in force for twelve (12) months, semi-annual for six (6) months, quarterly for three (3) months and monthly for one (1) month.

**THIRTY DAY RIGHT TO EXAMINE AND RETURN POLICY**

Please read Your Policy carefully. If, for any reason, You are not satisfied, You may return Your Policy to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded, less any claims paid.

**GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE**

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as state and zip code of residence. We will give You the advance written notice required by Your state prior to any premium change.

**THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION**

**CAUTION**

**POLICY BENEFITS ARE LIMITED TO THOSE APPROVED BY MEDICARE FOR PAYMENT**

**THIS IS A NON-PARTICIPATING POLICY**

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**POLICY SCHEDULE**

**INSURED:** [John Doe]

**POLICY EFFECTIVE DATE:** [01/01/2009]

**POLICY NUMBER:** [123456]

**ISSUE AGE:** [65]

**SEX:** [Male]

**STATE OF ISSUE:** [Arizona]

**MODE AT ISSUE:** [Annual]

**MODAL PREMIUM:** [\$XXXX]

**PREMIUM TERM:** [Annual]

**UNDERWRITING CLASS:** [Preferred]

**SPOUSE DISCOUNT:** [No]

**TYPE OF COVERAGE:** MEDICARE SUPPLEMENT POLICY PLAN D

## DEFINITIONS

**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.

**At-Home Recovery Visit** means 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-hour period of services provided by a Care Provider is one visit.

**Benefit Period** means the period as determined by Medicare which begins on the date You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

**Calendar Year** means the period of time beginning on January 1 and ending on December 31 of that same year.

**Care Provider** means a duly qualified or licensed home health aide or 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.

**Coinsurance Amount** means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

**Emergency Care** means care needed immediately because of an Injury or illness of sudden and unexpected onset.

**Home** shall mean any place used by the Insured as a place of residence, provided that the 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.

**Hospital** means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

**Hospitalized or Hospitalization** means being confined in a Hospital on an inpatient basis.

**Immediate Family** means Your spouse, parents, grandparents, children, or siblings, and their spouses.

**Injury** means a bodily injury which is the direct result of an accident and independent of all other causes.

**Lifetime Inpatient Reserve Days** means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

**Medicaid** means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

**Medically Necessary** means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards or medical practice; and (4) not solely for the convenience of You or the Physician.

## DEFINITIONS CONTINUED

**Medicare** means 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** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

**Medicare Part A Initial Deductible** means the fixed amount Medicare does not pay during the first sixty (60) days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

**Physician** means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

**Policy Effective Date** means the effective date of this Policy and is shown on the Policy Schedule. The Policy Effective Date is not the date You signed the application for coverage.

**Sickness** means illness or disease which first manifests itself after the Policy Effective Date and while this Policy is in force.

**Skilled Nursing Facility** means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

## BENEFIT PROVISIONS

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

**The benefits paid under this Policy will not duplicate benefits paid by Medicare.**

### Basic (Core) Benefits

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first ( 61<sup>st</sup> ) day through the ninetieth (90<sup>th</sup>) day in any Medicare Benefit Period;

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;

Upon exhaustion of Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A Eligible Expenses for Hospitalization paid at applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days;

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;

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 For Plan "D"**

**Medicare Part A Deductible:** Coverage for all of the Medicare Part A Initial Deductible amount per Benefit Period.

**Skilled Nursing Facility Care:** Coverage for the actual billed charges up to the Coinsurance Amount from the twenty first (21<sup>st</sup>) day through the one hundredth (100<sup>th</sup>) day in a Medicare Benefit Period for posthospital Skilled Nursing Facility care eligible under Medicare Part A.

**Medically Necessary Emergency Care in a Foreign Country:** 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).

**At-Home Recovery Benefit:** Coverage for services to provide short term, at-home assistance with Activities of Daily Living for those recovering from an illness, Injury or surgery.

### **Coverage Requirements and Limitations**

At-home recovery services provided must be primarily services which assist in Activities of Daily Living.

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.

#### **Coverage is limited to:**

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;

The actual charges for each visit up to a maximum reimbursement of \$40 per visit;

\$1,600 per calendar year;

Seven (7) visits in any one week;

Care furnished on a visiting basis in the Insured's Home;

Services provided by a Care Provider as defined in this Policy;

At-Home Recovery Visits while the Insured is covered under the Policy and not otherwise excluded;

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:**

Home care visits paid for by Medicare or other government programs; and

Care provided by family members, unpaid volunteers or providers who are not Care Providers.

## **GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS**

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **PREMIUMS SUBJECT TO CHANGE** provision on page 1.

### **EXTENSION OF BENEFITS**

Termination of this Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

### **MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN**

Benefits and premiums under this Policy are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Policy is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this Policy shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstatement of Your coverage provides for:

1. Coverage equivalent to coverage in effect before the date of suspension; and
2. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, and You enrolled in Medicare Part D while the Policy was suspended, the reinstated policy for Medicare Part D enrollees will not have outpatient prescription drug coverage, but will be substantially equivalent to Your coverage before the date of suspension.

### **EXCLUSIONS**

We will not pay benefits for:

- (a) expense incurred while this Policy is not in force, except as provided in the Extension of Benefits section;
- (b) Hospital or skilled nursing facility confinement incurred during a Medicare Part A Benefit Period that begins while this Policy is not in force.
- (c) that portion of any expense incurred which is paid for by Medicare;
- (d) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take home drugs and eye refractions;
- (e) services for which a charge is not normally made in the absence of insurance; or
- (f) loss or expense that is payable under any other Medicare Supplement Insurance Policy or certificate.

## GENERAL POLICY PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This Policy, including the endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the two (2) year period.

**GRACE PERIOD:** A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Policy shall continue in force.

**REINSTATEMENT:** If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after that date. In all other respects We and You shall have the same rights thereunder as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

**NOTICE OF CLAIMS:** We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on behalf of You to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

**CLAIM FORMS:** When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

**PROOF OF LOSS:** We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

**TIME OF PAYMENT OF CLAIMS:** All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

**PAYMENT OF CLAIMS:** Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

## GENERAL POLICY PROVISIONS CONTINUED

**OTHER INSURANCE WITH US:** You can be insured under only one of Our Medicare Supplement Policies at any one time. If You are insured under more than one such Policy, You can select the one that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return all premiums paid (less any claims paid) for any Policy that does not remain in effect.

**PHYSICAL EXAMINATIONS:** At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

**LEGAL ACTION:** No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

**UNPAID PREMIUM:** Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

**CONFORMITY WITH STATE LAWS:** Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

**ASSIGNMENT:** No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408.

**CLERICAL ERROR:** Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

**PRO RATA REFUND:** If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after the Policy month that death occurs.

**CANCELLATION BY INSURED:** You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

**This Policy is signed for Family Life Insurance Company by its President.**



President



Secretary

**FAMILY LIFE INSURANCE COMPANY**

P.O. Box 924408, Houston, Texas 77292-4408

**MEDICARE SUPPLEMENT INSURANCE POLICY - PLAN E**

**THIS IS A LEGAL CONTRACT BETWEEN YOU AND US**

**READ YOUR POLICY CAREFULLY**

This Policy provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Policy. In this Policy, "You" and "Your" means the Insured named on the application and shown on the Policy Schedule. "We", "Our" and "Us" means Family Life Insurance Company.

**NOTICE TO BUYER. THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

**IMPORTANT NOTICE:** Issuance of this Medicare Supplement Insurance Policy is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Policy to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Our Office at:

**P.O. Box 924408  
Houston, Texas 77292-4408  
800-877-7705**

**POLICY EFFECTIVE DATE AND CONSIDERATION**

We have issued this Policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Policy. The term of this Policy begins at twelve (12:00) o'clock, midnight, Standard Time, at the place where You reside on the Policy Effective Date shown on the Policy Schedule. It ends at twelve (12:00) o'clock, midnight, the same Standard Time, on the date Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Policy is shown on the Policy Schedule. An annual premium will maintain the Policy in force for twelve (12) months, semi-annual for six (6) months, quarterly for three (3) months and monthly for one (1) month.

**THIRTY DAY RIGHT TO EXAMINE AND RETURN POLICY**

Please read Your Policy carefully. If, for any reason, You are not satisfied, You may return Your Policy to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded, less any claims paid.

**GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE**

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as state and zip code of residence. We will give You the advance written notice required by Your state prior to any premium change.

**THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION**

**CAUTION**

**POLICY BENEFITS ARE LIMITED TO THOSE APPROVED BY MEDICARE FOR PAYMENT**

**THIS IS A NON-PARTICIPATING POLICY**

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**POLICY SCHEDULE**

**INSURED:** [John Doe]

**POLICY EFFECTIVE DATE:** [01/01/2009]

**POLICY NUMBER:** [123456]

**ISSUE AGE:** [65]

**SEX:** [Male]

**STATE OF ISSUE:** [Arizona]

**MODE AT ISSUE:** [Annual]

**MODAL PREMIUM:** [\$XXXX]

**PREMIUM TERM:** [Annual]

**UNDERWRITING CLASS:** [Preferred]

**SPOUSE DISCOUNT:** [No]

**TYPE OF COVERAGE:** MEDICARE SUPPLEMENT POLICY PLAN E

## DEFINITIONS

**Benefit Period** means the period as determined by Medicare which begins on the date You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

**Calendar Year** means the period of time beginning on January 1 and ending on December 31 of that same year.

**Coinsurance Amount** means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

**Emergency Care** means care needed immediately because of an Injury or illness of sudden and unexpected onset.

**Hospital** means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

**Hospitalized or Hospitalization** means being confined in a Hospital on an inpatient basis.

**Immediate Family** means Your spouse, parents, grandparents, children, or siblings, and their spouses.

**Injury** means a bodily injury which is the direct result of an accident and independent of all other causes.

**Lifetime Inpatient Reserve Days** means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

**Medicaid** means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

**Medically Necessary** means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards or medical practice; and (4) not solely for the convenience of You or the Physician.

**Medicare** means 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** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

**Medicare Part A Initial Deductible** means the fixed amount Medicare does not pay during the first sixty (60) days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

**Physician** means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

**Policy Effective Date** means the effective date of this Policy and is shown on the Policy Schedule. The Policy Effective Date is not the date You signed the application for coverage.

**Sickness** means illness or disease which first manifests itself after the Policy Effective Date and while this Policy is in force.

**Skilled Nursing Facility** means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

## BENEFIT PROVISIONS

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

**The benefits paid under this Policy will not duplicate benefits paid by Medicare.**

### Basic (Core) Benefits

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first ( 61<sup>st</sup> ) day through the ninetieth (90<sup>th</sup>) day in any Medicare Benefit Period;

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;

Upon exhaustion of Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A Eligible Expenses for Hospitalization paid at applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days;

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;

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 For Plan "E"

**Medicare Part A Deductible:** Coverage for all of the Medicare Part A Initial Deductible amount per Benefit Period.

**Skilled Nursing Facility Care:** Coverage for the actual billed charges up to the Coinsurance Amount from the twenty first ( 21<sup>st</sup> ) day through the one hundredth ( 100<sup>th</sup> ) day in a Medicare Benefit Period for posthospital Skilled Nursing Facility care eligible under Medicare Part A.

**Medically Necessary Emergency Care in a Foreign Country:** 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).

**Preventive Care:** Coverage for the following preventive health services **not** covered by Medicare:

- (a) An annual clinical preventive medical history and physical examination that may include tests and services listed below and patient education to address preventive health care measures;
- (b) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

Reimbursement shall be for the actual charges up to 100% of the Medicare approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of \$120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

## **GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS**

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **PREMIUMS SUBJECT TO CHANGE** provision on page 1.

### **EXTENSION OF BENEFITS**

Termination of this Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

### **MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN**

Benefits and premiums under this Policy are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Policy is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this Policy shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstatement of Your coverage provides for:

1. Coverage equivalent to coverage in effect before the date of suspension; and
2. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, and You enrolled in Medicare Part D while the Policy was suspended, the reinstated policy for Medicare Part D enrollees will not have outpatient prescription drug coverage, but will be substantially equivalent to Your coverage before the date of suspension.

## **EXCLUSIONS**

We will not pay benefits for:

- (a) expense incurred while this Policy is not in force, except as provided in the Extension of Benefits section;
- (b) Hospital or skilled nursing facility confinement incurred during a Medicare Part A Benefit Period that begins while this Policy is not in force.
- (c) that portion of any expense incurred which is paid for by Medicare;
- (d) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take home drugs and eye refractions;
- (e) services for which a charge is not normally made in the absence of insurance; or
- (f) loss or expense that is payable under any other Medicare Supplement Insurance Policy or certificate.

## GENERAL POLICY PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This Policy, including the endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the two (2) year period.

**GRACE PERIOD:** A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Policy shall continue in force.

**REINSTATEMENT:** If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after that date. In all other respects We and You shall have the same rights thereunder as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

**NOTICE OF CLAIMS:** We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on behalf of You to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

**CLAIM FORMS:** When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

**PROOF OF LOSS:** We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

**TIME OF PAYMENT OF CLAIMS:** All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

**PAYMENT OF CLAIMS:** Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

## GENERAL POLICY PROVISIONS CONTINUED

**OTHER INSURANCE WITH US:** You can be insured under only one of Our Medicare Supplement Policies at any one time. If You are insured under more than one such Policy, You can select the one that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return all premiums paid (less any claims paid) for any Policy that does not remain in effect.

**PHYSICAL EXAMINATIONS:** At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

**LEGAL ACTION:** No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

**UNPAID PREMIUM:** Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

**CONFORMITY WITH STATE LAWS:** Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

**ASSIGNMENT:** No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408.

**CLERICAL ERROR:** Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

**PRO RATA REFUND:** If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after the Policy month that death occurs.

**CANCELLATION BY INSURED:** You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

**This Policy is signed for Family Life Insurance Company by its President.**



President



Secretary

**FAMILY LIFE INSURANCE COMPANY**

P.O. Box 924408, Houston, Texas 77292-4408

**MEDICARE SUPPLEMENT INSURANCE POLICY - PLAN F**

**THIS IS A LEGAL CONTRACT BETWEEN YOU AND US**

**READ YOUR POLICY CAREFULLY**

This Policy provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Policy. In this Policy, "You" and "Your" means the Insured named on the application and shown on the Policy Schedule. "We", "Our" and "Us" means Family Life Insurance Company.

**NOTICE TO BUYER. THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

**IMPORTANT NOTICE:** Issuance of this Medicare Supplement Insurance Policy is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Policy to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Our Office at:

**P.O. Box 924408  
Houston, Texas 77292-4408  
800-877-7705**

**POLICY EFFECTIVE DATE AND CONSIDERATION**

We have issued this Policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Policy. The term of this Policy begins at twelve (12:00) o'clock, midnight, Standard Time, at the place where You reside on the Policy Effective Date shown on the Policy Schedule. It ends at twelve (12:00) o'clock, midnight, the same Standard Time, on the date Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Policy is shown on the Policy Schedule. An annual premium will maintain the Policy in force for twelve (12) months, semi-annual for six (6) months, quarterly for three (3) months and monthly for one (1) month.

**THIRTY DAY RIGHT TO EXAMINE AND RETURN POLICY**

Please read Your Policy carefully. If, for any reason, You are not satisfied, You may return Your Policy to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded, less any claims paid.

**GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE**

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as state and zip code of residence. We will give You the advance written notice required by Your state prior to any premium change.

**THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION**

**CAUTION**

**POLICY BENEFITS ARE LIMITED TO THOSE APPROVED BY MEDICARE FOR PAYMENT**

**THIS IS A NON-PARTICIPATING POLICY**

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**POLICY SCHEDULE**

**INSURED:** [John Doe]

**POLICY EFFECTIVE DATE:** [01/01/2009]

**POLICY NUMBER:** [123456]

**ISSUE AGE:** [65]

**SEX:** [Male]

**STATE OF ISSUE:** [Arizona]

**MODE AT ISSUE:** [Annual]

**MODAL PREMIUM:** [\$XXXX]

**PREMIUM TERM:** [Annual]

**UNDERWRITING CLASS:** [Preferred]

**SPOUSE DISCOUNT:** [No]

**TYPE OF COVERAGE:** MEDICARE SUPPLEMENT POLICY PLAN F

## DEFINITIONS

**Benefit Period** means the period as determined by Medicare which begins on the date You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

**Calendar Year** means the period of time beginning on January 1 and ending on December 31 of that same year.

**Coinsurance Amount** means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

**Emergency Care** means care needed immediately because of an Injury or an illness of sudden and unexpected onset.

**Hospital** means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

**Hospitalized or Hospitalization** means being confined in a Hospital on an inpatient basis.

**Immediate Family** means Your spouse, parents, grandparents, children, or siblings, and their spouses.

**Injury** means a bodily injury which is the direct result of an accident and independent of all other causes.

**Lifetime Inpatient Reserve Days** means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

**Medicaid** means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

**Medically Necessary** means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards or medical practice; and (4) not solely for the convenience of You or the Physician.

**Medicare** means 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** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

**Medicare Part A Initial Deductible** means the fixed amount Medicare does not pay during the first sixty (60) days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

**Medicare Part B Deductible** means the fixed amount You must pay each Calendar Year before Medicare starts paying Part B expenses. This amount is set each year by Medicare. Medicare does not pay this amount.

**Physician** means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

## DEFINITIONS CONTINUED

**Policy Effective Date** means the effective date of this Policy and is shown on the Policy Schedule. The Policy Effective Date is not the date You signed the application for coverage.

**Sickness** means illness or disease which first manifests itself after the Policy Effective Date and while this Policy is in force.

**Skilled Nursing Facility** means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

## BENEFIT PROVISIONS

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

**The benefits paid under this Policy will not duplicate benefits paid by Medicare.**

### Basic (Core) Benefits

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first (61<sup>st</sup>) day through the ninetieth (90<sup>th</sup>) day in any Medicare Benefit Period;

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;

Upon exhaustion of Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A Eligible Expenses for Hospitalization paid at applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days;

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;

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 For Plan "F"

**Medicare Part A Deductible:** Coverage for all of the Medicare Part A Initial Deductible amount per Benefit Period.

**Skilled Nursing Facility Care:** Coverage for the actual billed charges up to the Coinsurance Amount from the twenty first (21<sup>st</sup>) day through the one hundredth (100<sup>th</sup>) day in a Medicare benefit period for posthospital Skilled Nursing Facility care eligible under Medicare Part A.

**Medicare Part B Deductible:** Coverage for all of the Medicare Part B Deductible amount per Calendar Year regardless of Hospital confinement.

### **Additional Benefits For Plan "F" Continued**

**One Hundred Percent (100%) of the Medicare Part B Excess Charges:** Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

**Medically Necessary Emergency Care in a Foreign Country:** 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).

### **GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS**

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **PREMIUMS SUBJECT TO CHANGE** provision on page 1.

### **EXTENSION OF BENEFITS**

Termination of this Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

### **MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN**

Benefits and premiums under this Policy are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Policy is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this Policy shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862 (b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstatement of Your coverage provides for:

1. Coverage equivalent to coverage in effect before the date of suspension; and
2. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, and You enrolled in Medicare Part D while the Policy was suspended, the reinstated policy for Medicare Part D enrollees will not have outpatient prescription drug coverage, but will be substantially equivalent to Your coverage before the date of suspension.

## EXCLUSIONS

We will not pay benefits for:

- (a) expense incurred while this Policy is not in force, except as provided in the Extension of Benefits section;
- (b) Hospital or skilled nursing facility confinement incurred during a Medicare Part A Benefit Period that begins while this Policy is not in force.
- (c) that portion of any expense incurred which is paid for by Medicare;
- (d) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take home drugs and eye refractions;
- (e) services for which a charge is not normally made in the absence of insurance; or
- (f) loss or expense that is payable under any other Medicare Supplement Insurance Policy or certificate.

## GENERAL POLICY PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This Policy, including the endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the two (2) year period.

**GRACE PERIOD:** A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Policy shall continue in force.

**REINSTATEMENT:** If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after that date. In all other respects We and You shall have the same rights thereunder as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

**NOTICE OF CLAIMS:** We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on behalf of You to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

**CLAIM FORMS:** When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

**PROOF OF LOSS:** We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

**TIME OF PAYMENT OF CLAIMS:** All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

**PAYMENT OF CLAIMS:** Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

## GENERAL PROVISIONS CONTINUED

**OTHER INSURANCE WITH US:** You can be insured under only one of Our Medicare Supplement Policies at any one time. If You are insured under more than one such Policy, You can select the one that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return all premiums paid (less any claims paid) for any Policy that does not remain in effect.

**PHYSICAL EXAMINATIONS:** At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

**LEGAL ACTION:** No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

**UNPAID PREMIUM:** Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

**CONFORMITY WITH STATE LAWS:** Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

**ASSIGNMENT:** No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408.

**CLERICAL ERROR:** Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

**PRO RATA REFUND:** If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after the Policy month that death occurs.

**CANCELLATION BY INSURED:** You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

**This Policy is signed for Family Life Insurance Company by its President.**



President



Secretary

**FAMILY LIFE INSURANCE COMPANY**

P.O. Box 924408, Houston, Texas 77292-4408

**MEDICARE SUPPLEMENT INSURANCE POLICY - PLAN G**

**THIS IS A LEGAL CONTRACT BETWEEN YOU AND US**

**READ YOUR POLICY CAREFULLY**

This Policy provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Policy. In this Policy, "You" and "Your" means the Insured named on the application and shown on the Policy Schedule. "We", "Our" and "Us" means Family Life Insurance Company.

**NOTICE TO BUYER. THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

**IMPORTANT NOTICE:** Issuance of this Medicare Supplement Insurance Policy is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Policy to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Our Office at:

**P.O. Box 924408  
Houston, Texas 77292-4408  
800-877-7705**

**POLICY EFFECTIVE DATE AND CONSIDERATION**

We have issued this Policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Policy. The term of this Policy begins at twelve (12:00) o'clock, midnight, Standard Time, at the place where You reside on the Policy Effective Date shown on the Policy Schedule. It ends at twelve (12:00) o'clock, midnight, the same Standard Time, on the date Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Policy is shown on the Policy Schedule. An annual premium will maintain the Policy in force for twelve (12) months, semi-annual for six (6) months, quarterly for three (3) months and monthly for one (1) month.

**THIRTY DAY RIGHT TO EXAMINE AND RETURN POLICY**

Please read Your Policy carefully. If, for any reason, You are not satisfied, You may return Your Policy to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded.

**GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE**

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as state and zip code of residence. We will give You the advance written notice required by Your state prior to any premium change.

**THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION**

**CAUTION**

**POLICY BENEFITS ARE LIMITED TO THOSE APPROVED BY MEDICARE FOR PAYMENT**

**THIS IS A NON-PARTICIPATING POLICY**

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**POLICY SCHEDULE**

**INSURED:** [John Doe]

**POLICY EFFECTIVE DATE:** [01/01/2009]

**POLICY NUMBER:** [123456]

**ISSUE AGE:** [65]

**SEX:** [Male]

**STATE OF ISSUE:** [Arizona]

**MODE AT ISSUE:** [Annual]

**MODAL PREMIUM:** [\$XXXX]

**PREMIUM TERM:** [Annual]

**UNDERWRITING CLASS:** [Preferred]

**SPOUSE DISCOUNT:** [No]

**TYPE OF COVERAGE:** MEDICARE SUPPLEMENT POLICY PLAN G

## DEFINITIONS

**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.

**At-Home Recovery Visit** means 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-hour period of services provided by a Care Provider is one visit.

**Benefit Period** means the period as determined by Medicare which begins on the date You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

**Calendar Year** means the period of time beginning on January 1 and ending on December 31 of that same year.

**Care Provider** means a duly qualified or licensed home health aide or 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.

**Coinsurance Amount** means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

**Emergency Care** means care needed immediately because of an Injury or illness of sudden and unexpected onset.

**Home** shall mean any place used by the Insured as a place of residence, provided that the 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.

**Hospital** means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

**Hospitalized or Hospitalization** means being confined in a Hospital on an inpatient basis.

**Immediate Family** means Your spouse, parents, grandparents, children, or siblings, and their spouses.

**Injury** means a bodily injury which is the direct result of an accident and independent of all other causes.

**Lifetime Inpatient Reserve Days** means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

**Medicaid** means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

**Medically Necessary** means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards or medical practice; and (4) not solely for the convenience of You or the Physician.

## DEFINITIONS CONTINUED

**Medicare** means 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** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

**Medicare Part A Initial Deductible** means the fixed amount Medicare does not pay during the first sixty (60) days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

**Physician** means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

**Policy Effective Date** means the effective date of this Policy and is shown on the Policy Schedule. The Policy Effective Date is not the date You signed the application for coverage.

**Sickness** means illness or disease which first manifests itself after the Policy Effective Date and while this Policy is in force.

**Skilled Nursing Facility** means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

## BENEFIT PROVISIONS

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

**The benefits paid under this Policy will not duplicate benefits paid by Medicare.**

### Basic (Core) Benefits

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first ( 61<sup>st</sup> ) day through the ninetieth (90<sup>th</sup>) day in any Medicare Benefit Period;

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;

Upon exhaustion of Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A Eligible Expenses for Hospitalization paid at applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days;

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;

Coverage for the Coinsurance Amount, or in the case of 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 For Plan "G"**

**Medicare Part A Deductible:** Coverage for all of the Medicare Part A Initial Deductible amount per Benefit Period.

**Skilled Nursing Facility Care:** Coverage for the actual billed charges up to the Coinsurance Amount from the twenty first (21<sup>st</sup>) day through the one hundredth (100<sup>th</sup>) day in a Medicare Benefit Period for posthospital Skilled Nursing Facility care eligible under Medicare Part A.

**Eighty Percent (80%) of the Medicare Part B Excess Charges:** Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

**Medically Necessary Emergency Care in a Foreign Country:** 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).

**At-Home Recovery Benefit:** Coverage for services to provide short term, at-home assistance with Activities of Daily Living for those recovering from an illness, Injury or surgery.

### **Coverage Requirements and Limitations**

At-home recovery services provided must be primarily services which assist in Activities of Daily Living.

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.

### **Coverage is limited to:**

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;

The actual charges for each visit up to a maximum reimbursement of \$40 per visit;

\$1,600 per calendar year;

Seven (7) visits in any one week;

Care furnished on a visiting basis in the Insured's Home;

Services provided by a Care Provider as defined in this Policy;

At-Home Recovery Visits while the Insured is covered under the Policy and not otherwise excluded;

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:**

Home care visits paid for by Medicare or other government programs; and

Care provided by family members, unpaid volunteers or providers who are not Care Providers.

## **GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS**

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **PREMIUMS SUBJECT TO CHANGE** provision on page 1.

### **EXTENSION OF BENEFITS**

Termination of this Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

### **MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN**

Benefits and premiums under this Policy are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Policy is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this Policy shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstatement of Your coverage provides for:

1. Coverage equivalent to coverage in effect before the date of suspension; and
2. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, and You enrolled in Medicare Part D while the Policy was suspended, the reinstated policy for Medicare Part D enrollees will not have outpatient prescription drug coverage, but will be substantially equivalent to Your coverage before the date of suspension.

### **EXCLUSIONS**

We will not pay benefits for:

- (a) expense incurred while this Policy is not in force, except as provided in the Extension of Benefits section;
- (b) Hospital or skilled nursing facility confinement incurred during a Medicare Part A Benefit Period that begins while this Policy is not in force.
- (c) that portion of any expense incurred which is paid for by Medicare;
- (d) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take home drugs and eye refractions;
- (e) services for which a charge is not normally made in the absence of insurance; or
- (f) loss or expense that is payable under any other Medicare Supplement Insurance Policy or certificate.

## GENERAL POLICY PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This Policy, including the endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the two (2) year period.

**GRACE PERIOD:** A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Policy shall continue in force.

**REINSTATEMENT:** If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after that date. In all other respects We and You shall have the same rights thereunder as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

**NOTICE OF CLAIMS:** We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on behalf of You to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

**CLAIM FORMS:** When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

**PROOF OF LOSS:** We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

**TIME OF PAYMENT OF CLAIMS:** All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

**PAYMENT OF CLAIMS:** Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

## GENERAL POLICY PROVISIONS CONTINUED

**OTHER INSURANCE WITH US:** You can be insured under only one of Our Medicare Supplement Policies at any one time. If You are insured under more than one such Policy, You can select the one that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return all premiums paid (less any claims paid) for any Policy that does not remain in effect.

**PHYSICAL EXAMINATIONS:** At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

**LEGAL ACTION:** No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

**UNPAID PREMIUM:** Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

**CONFORMITY WITH STATE LAWS:** Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

**ASSIGNMENT:** No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408.

**CLERICAL ERROR:** Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

**PRO RATA REFUND:** If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after the Policy month that death occurs.

**CANCELLATION BY INSURED:** You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

**This Policy is signed for Family Life Insurance Company by its President.**



President



Secretary



**PART I – HEALTH QUESTIONS CONTINUED**

- b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human immunodeficiency virus (HIV) infection?  Yes  No
- c. Diabetes that has required more than 50 units of insulin daily or more than two medications (insulin or oral), Chronic Kidney Disease or Insufficiency, or Renal Failure requiring dialysis?  Yes  No
- d. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any Chronic Pulmonary condition?  Yes  No
- e. Internal Cancer, Leukemia, Malignant Melanoma, Hodgkin's Disease, or Lymphoma?  Yes  No
- f. Congestive Heart Failure (CHF), heart attack, Coronary or Carotid Artery Disease, Peripheral Vascular Disease, Stroke or Transient Ischemic Attack (TIA)?  Yes  No
- 7. Within the past two years have you had atrial fibrillation, heart valve surgery, cardiac pacemaker replaced or implanted, or been treated with a heart defibrillating device?  Yes  No
- 8. Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Cirrhosis of the Liver, Hepatitis, Alcohol or Drug Abuse, or Systemic Lupus?  Yes  No
- 9. Have you had an organ transplant or been advised to have an organ transplant?  Yes  No
- 10. Are you currently using the services of a home health care agency?  Yes  No
- 11. Do you require or receive any assistance with any of your activities of daily living such as transferring, bathing, toileting, eating, dressing, or continence?  Yes  No
- 12. Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Disabling Arthritis, Paget's Disease of the bone, or Rheumatoid Arthritis?  Yes  No
- 13. Do you now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for Osteoporosis with fracture?  Yes  No
- 14. Are you diabetic, and if so do you have or have you been treated for any of the following conditions: diabetic retinopathy, peripheral vascular disease, kidney disease, kidney failure, neuropathy, stroke, congestive heart failure, heart condition, or high blood pressure treated with three or more medications?  Yes  No

Do you take prescription medications? If yes, please list below all the prescription medications you are currently taking. Attach an additional sheet if necessary.  Yes  No

Prescription Medication Name	Date Originally Prescribed	Frequency and Dosage	**Diagnosis/Condition

**\*\* PLEASE DO NOT LIST WATER PILL, WATER RETENTION, FLUID RETENTION OR BLOOD THINNER AS THESE ARE NOT MEDICAL CONDITIONS.**

**Primary Physician Information**

**Name:**

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**Address:**

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**Telephone:**

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Did you turn age 65 in the last 6 months?  Yes  No

Did you enroll in Medicare Part B in the last 6 months?  Yes  No If yes, what is the effective date? \_\_\_\_\_

## PART II – MEDICAL COVERAGE REPLACEMENT (MUST BE COMPLETED)

**If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement policy, or that you had certain rights to buy such a policy you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with our application. PLEASE ANSWER ALL QUESTIONS. Please Mark Yes or No with an "X."**

To the best of your knowledge:

1. Are you covered for medical assistance through the state Medicaid program?  Yes  No

NOTE TO APPLICANT: If you are participating in a "Spend-Down" program and have not met your "Share of Cost," please answer NO to this question.

**IF YES,**

(a) Will Medicaid pay your premiums for this Medicare Supplement policy?  Yes  No

(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?  Yes  No

2. (a) If you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates. START END  
/ / / /

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?  Yes  No

(c) Was this your first time in this type of Medicare plan?  Yes  No

(d) Did you drop a Medicare Supplement plan to enroll in the Medicare plan?  Yes  No

3. (a) Do you have another Medicare Supplement policy in force?  Yes  No

(b) If so, with which company: \_\_\_\_\_

with which plan: \_\_\_\_\_

and what paid-to-date do you have? \_\_\_\_\_

(c) If so, do you intend to replace your current Medicare Supplement policy with this policy?  Yes  No

4. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)?  Yes  No

(a) If yes, with what company, what kind of policy and reason for termination?

\_\_\_\_\_  
(b) What are your dates of coverage under the other policy? START END  
/ / / /

## IMPORTANT STATEMENTS TO BE READ AND SIGNED BY THE APPLICANT

- (1) You do not need more than one Medicare Supplement Insurance Policy.
- (2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- (3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance Policy.
- (4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance Policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- (5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing your employer or union based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- (6) Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

## OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

**Open Enrollment:** You are eligible for Open Enrollment and will not need to answer Health Questions 1-14 on Pages 1 and 2 of this application if (a) you are within six months of purchasing Medicare Part B coverage for the first time; or (b) you were eligible for early Medicare and you are within six months of turning age 65.

**Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997:** The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

- (a) Enrolled under an employee welfare benefit plan that either: (1) supplements Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits; or (2) is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan; or
- (b) Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (d) Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency or other involuntary termination of coverage under the policy, substantial violation of a material policy provision, or material misrepresentation; or
- (e) Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage plan, a risk or cost contract, a Medicare Select plan, or a PACE provider, and then the insured person terminates coverage within 12 months of enrollment; or
- (f) Upon *first* becoming eligible for benefits under Part A at age 65, you enrolled in a Medicare Advantage plan or PACE provider and then you disenroll within 12 months; or
- (g) Lost eligibility for health benefits under Medicaid.

**Documentation of these events must be submitted with the application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.**

## AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person including Medicare, that has any records or knowledge of me or my health or having any non-medical information concerning me to give Family Life Insurance Company, or its reinsurers, any such information. I understand that I am authorizing Family Life Insurance Company to receive my health information, prescription drug usage history and my non-medical information. I understand that prescription drug usage may be used to verify the presence of certain medical conditions and that such history will not be used to decline coverage. These medical conditions will be confirmed by a telephone interview prior to being used in the underwriting process. The released information received by Family Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Medical information will not be used to decline coverage if you are applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Family Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Family Life Insurance Company *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying Family Life Insurance Company in writing at their Medicare Supplement Administrative Office: P.O. Box 924408, Houston, Texas 77292-4408. I understand that such revocation will not have any effect on actions Family Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be treated in the same manner as the original.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part.

**WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for Insurance is guilty of a crime and may be subject to fines and confinement in prison.**

I acknowledge receiving: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed At: \_\_\_\_\_  
(City /State)

Dated: \_\_\_\_\_ Applicant's Signature: \_\_\_\_\_  
(Month/Day/Year)

**AGENT'S CERTIFICATION**

The undersigned Agent certifies that the Applicant has read, or had read to the Applicant, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

**TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)**

1. List any other health insurance policy you have sold to the Applicant that is still in force.

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2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

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I certify that:

1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for and a Guide To Health Insurance for People With Medicare to the Applicant.

\_\_\_\_\_  
**Agent's Signature:**

\_\_\_\_\_  
**Date:**

\_\_\_\_\_  
**Agent's Printed Name:**

\_\_\_\_\_  
**Agent No.:**

AUTHORIZATION	<b>IN FAVOR OF:</b> <b>Family Life Insurance Company</b> <b>Administrative office</b> <b>P.O. Box 924408, Houston, Texas 77292-4408</b>	
	<b>Name of Bank Customer:</b> _____	<b>Policy Numbers</b>
	<b>Insured's Name:</b> _____	
	<b>Account Number :</b> _____	<b>Routing Number:</b> _____
	<b>To (Name of Bank):</b> _____ <b>Address of Bank:</b> _____	
<p>You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Company indicated above, (hereinafter referred to as THE COMPANY), on my account by and payable to the order of The Company for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Company shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or other orders drawn by The Company. I further agree that if any such checks or other orders drawn by The Company be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.</p>		
<b>Date</b>	<b>Signature of Depositor</b>	
<b>Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.</b>		
<b>To:    The Bank above</b>		
<p>In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our order, we agree:</p> <ul style="list-style-type: none"> <li>➤ To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.</li> <li>➤ In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.</li> <li>➤ To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.</li> </ul>		

AUTHORIZATION

(Attach Voided Check)

**AUTHORITY TO HONOR PREMIUM CHECKS**

**FAMILY LIFE INSURANCE COMPANY**  
**Outline of Medicare Supplement Coverage-Cover Page 1 of 2**  
**Benefit Plans A, B, C, D, E, F AND G**

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. Family Life Insurance Company offers seven of the fourteen plans available.

**See Outlines of Coverage sections for details about ALL plans**

**Basic Benefits for Plans A-J:**

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.

Blood: First three pints of blood each year.

<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>F</b>	<b>F*</b>	<b>G</b>	<b>H</b>	<b>I</b>	<b>J</b>	<b>J*</b>
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance				
	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	

\*Plans 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 benefits as Plans F and J after one has paid a calendar year \$2000 deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed \$2000. 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 do not include the plan's separate foreign travel emergency deductible.

**FAMILY LIFE INSURANCE COMPANY**  
**Outline of Medicare Supplement Coverage-Cover Page 2 of 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.**

<b>J</b>	<b>K**</b>	<b>L**</b>
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 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		
Preventative Care NOT covered by Medicare		
	\$4620 Out of Pocket Annual Limit***	\$2310 Out of Policy 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 plans pays 100% of the Medicare copayments, 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.**

**See Outlines of Coverage for details and exceptions.**

**FAMILY LIFE INSURANCE COMPANY OF AMERICA**

**PREFERRED PREMIUM RATES  
FOR USE IN ARKANSAS ZIP CODES**

**722, 72002, 72053, 72065, 72076, 72078, 72099, 72103, 722113-72120, 72124,  
72135, 72142, 72164, 72180, 72190, 72198, 72199**

**ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	<b>[1186]</b>	<b>[1444]</b>	<b>[1658]</b>	<b>[1514]</b>	<b>[1519]</b>	<b>[1696]</b>	<b>[1521]</b>

**SEMI-ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	<b>[593]</b>	<b>[722]</b>	<b>[829]</b>	<b>[757]</b>	<b>[760]</b>	<b>[848]</b>	<b>[761]</b>

**QUARTERLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	<b>[297]</b>	<b>[361]</b>	<b>[415]</b>	<b>[379]</b>	<b>[380]</b>	<b>[424]</b>	<b>[380]</b>

**MONTHLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	<b>[99]</b>	<b>[120]</b>	<b>[138]</b>	<b>[126]</b>	<b>[127]</b>	<b>[141]</b>	<b>[127]</b>

**Spousal Discount Factor: .93**

**FAMILY LIFE INSURANCE COMPANY OF AMERICA**

**STANDARD PREMIUM RATES  
FOR USE IN ARKANSAS ZIP CODES**

**722, 72002, 72053, 72065, 72076, 72078, 72099, 72103, 722113-72120, 72124,  
72135, 72142, 72164, 72180, 72190, 72198, 72199**

**ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	<b>[1318]</b>	<b>[1604]</b>	<b>[1842]</b>	<b>[1681]</b>	<b>[1688]</b>	<b>[1885]</b>	<b>[1691]</b>

**SEMI-ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	<b>[659]</b>	<b>[802]</b>	<b>[921]</b>	<b>[841]</b>	<b>[844]</b>	<b>[943]</b>	<b>[846]</b>

**QUARTERLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	<b>[330]</b>	<b>[401]</b>	<b>[461]</b>	<b>[420]</b>	<b>[422]</b>	<b>[471]</b>	<b>[423]</b>

**MONTHLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	<b>[110]</b>	<b>[134]</b>	<b>[154]</b>	<b>[140]</b>	<b>[141]</b>	<b>[157]</b>	<b>[141]</b>

**Spousal Discount Factor: .93**

**FAMILY LIFE INSURANCE COMPANY OF AMERICA**

**PREFERRED PREMIUM RATES**

**FOR USE IN ALL ARKANSAS ZIP CODES BEGINNING WITH 720 and 721 EXCEPT  
72002, 72053, 72065, 72076, 72078, 72099, 72103, 722113-72120, 72124,  
72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199**

**ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[1127]	[1372]	[1575]	[1438]	[1443]	[1611]	[1445]

**SEMI-ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[564]	[686]	[788]	[719]	[722]	[806]	[723]

**QUARTERLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[282]	[343]	[394]	[360]	[361]	[403]	[361]

**MONTHLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[94]	[114]	[131]	[120]	[120]	[134]	[120]

**Spousal Discount Factor: .93**

**FAMILY LIFE INSURANCE COMPANY OF AMERICA**

**STANDARD PREMIUM RATES**

**FOR USE IN ALL ARKANSAS ZIP CODES BEGINNING WITH 720 and 721 EXCEPT  
72002, 72053, 72065, 72076, 72078, 72099, 72103, 722113-72120, 72124,  
72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199**

**ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	<b>[1252]</b>	<b>[1524]</b>	<b>[1750]</b>	<b>[1597]</b>	<b>[1604]</b>	<b>[1791]</b>	<b>[1606]</b>

**SEMI-ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	<b>[626]</b>	<b>[762]</b>	<b>[875]</b>	<b>[799]</b>	<b>[802]</b>	<b>[896]</b>	<b>[803]</b>

**QUARTERLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	<b>[313]</b>	<b>[381]</b>	<b>[438]</b>	<b>[399]</b>	<b>[401]</b>	<b>[448]</b>	<b>[402]</b>

**MONTHLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	<b>[104]</b>	<b>[127]</b>	<b>[146]</b>	<b>[133]</b>	<b>[134]</b>	<b>[149]</b>	<b>[134]</b>

**Spousal Discount Factor: .93**

**FAMILY LIFE INSURANCE COMPANY OF AMERICA**

**PREFERRED PREMIUM RATES  
FOR USE IN ALL ARKANSAS ZIP CODES  
EXCEPT 720-722**

**ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[1008]	[1227]	[1409]	[1287]	[1291]	[1442]	[1293]

**SEMI-ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[504]	[614]	[705]	[644]	[646]	[721]	[647]

**QUARTERLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[252]	[307]	[352]	[322]	[323]	[361]	[323]

**MONTHLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[84]	[102]	[117]	[107]	[108]	[120]	[108]

**Spousal Discount Factor: .93**

**FAMILY LIFE INSURANCE COMPANY OF AMERICA**

**STANDARD PREMIUM RATES  
FOR USE IN ALL ARKANSAS ZIP CODES  
EXCEPT 720-722**

**ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[1120]	[1363]	[1566]	[1429]	[1435]	[1602]	[1437]

**SEMI-ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[560]	[682]	[783]	[715]	[718]	[801]	[719]

**QUARTERLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[280]	[341]	[392]	[357]	[359]	[401]	[359]

**MONTHLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[93]	[114]	[131]	[119]	[120]	[134]	[120]

**Spousal Discount Factor: .93**

### **PREMIUM INFORMATION**

Family Life Insurance Company may change your premium if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class on the date of change. Class is defined as state and zip code of residence.

### **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 Family Life Insurance Company.

### **RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to our Medicare Supplement Administrative Office at P. O. Box 924408, Houston, Texas 77292-4408. If you send the policy back to us within 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**

This policy may not fully cover all of your medical costs. Neither Family Life Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

### **LIMITATIONS AND EXCLUSIONS**

This policy does not contain a pre-existing condition limitation and this policy does not pay benefits for (a) Expenses incurred while this policy is not in force except as provided in the Extension of Benefits section; (b) Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force; (c) That portion of any expense incurred which is paid for by Medicare; (d) Services for non-Medicare Eligible Expenses unless specifically covered in the policy, including, but not limited to, routine exams, take-home drugs and eye refractions; (e) Services for which a charge is not normally made in the absence of insurance; or (f) Loss or expense that is payable under any other Medicare Supplement insurance policy or certificate.

### **REFUND OF PREMIUMS**

The Policy does contain a Pro-Rata Refund provision which provides for the partial refund of premium upon death.

The Policy does contain a Cancellation By Insured provision which provides for a refund of premium upon surrender of the Policy.

### **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.**

**Please refer to your policy for details.**

**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 60 days in a row.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61<sup>st</sup> thru 90<sup>th</sup> day 91<sup>st</sup> day and after:</p> <ul style="list-style-type: none"> <li>— While using 60 lifetime reserve days</li> <li>— Once lifetime reserve days are used:                             <ul style="list-style-type: none"> <li>— Additional 365 days</li> <li>— Beyond the additional 365 days</li> </ul> </li> </ul>	<p>All but [\$1068] All but [\$267] a day</p> <p>All but [\$534] a day</p> <p>\$0</p> <p>\$0</p>	<p>\$0 [\$267] a day</p> <p>[\$534] a day</p> <p>100% of Medicare eligible expenses</p> <p>\$0</p>	<p>[\$1068] (Part A deductible) \$0**</p> <p>\$0**</p> <p>\$0**</p> <p>All costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> 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 21<sup>st</sup> thru 100<sup>th</sup> day 101<sup>st</sup> day and after</p>	<p>All approved amounts All but [\$133.50] a day \$0</p>	<p>\$0 \$0 \$0</p>	<p>\$0** Up to [\$133.50] a day All costs</p>
<p><b>BLOOD</b> First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0** \$0**</p>
<p><b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for out-patient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN A**

**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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES –</b> 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	\$0 Generally 80%	\$0 Generally 20%	[\$135] (Part B deductible) \$0**
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> 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**
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0**

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> 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**

**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 60 days in a row.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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 [\$1068] All but [\$267] a day  All but [\$534] a day  \$0  \$0	[\$1068] (Part A deductible) [\$267] a day  [\$534] a day  100% of Medicare eligible expenses  \$0	\$0** \$0**  \$0**  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day  101 <sup>st</sup> day and after	All approved amounts All but [\$133.50] a day  \$0	\$0 \$0  \$0	\$0** Up to [\$133.50] a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0** \$0**
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN B**

**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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES –</b> 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	 \$0 Generally 80%	 \$0 Generally 20%	 [\$135] (Part B deductible) \$0**
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> 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**
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0**

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> 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**

**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 60 days in a row.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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 [\$1068] All but [\$267] a day  All but [\$534] a day  \$0  \$0	[\$1068] (Part A deductible) [\$267] a day  [\$534] a day  100% of Medicare eligible expenses  \$0	\$0** \$0**  \$0**  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$133.50] a day \$0	\$0** \$0** All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0** \$0**
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN C**

**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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES –</b> 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	\$0 Generally 80%	[\$135] (Part B deductible) Generally 20%	\$0** \$0**
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> 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**
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0**

**PARTS A & B**

<b>HOME HEALTH CARE</b> 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**

<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA 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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**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 60 days in a row.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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 [\$1068] All but [\$267] a day All but [\$534] a day \$0 \$0	[\$1068] (Part A deductible) [\$267] a day [\$534] a day 100% of Medicare eligible expenses \$0	\$0** \$0** \$0** \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$133.50] a day \$0	\$0** \$0** All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0** \$0**
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN D**

**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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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	       \$0   Generally 80%	       \$0   Generally 20%	       [\$135] (Part B deductible)   \$0**
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> 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**
<b>CLINICAL LABORATORY                      SERVICES – TESTS FOR                      DIAGNOSTIC SERVICES</b>	100%	\$0	\$0**

(continued)

**PLAN D**  
**PARTS A & B**

\*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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b>			
<b>MEDICARE APPROVED SERVICES</b>			
— 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**
<b>AT HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE</b>			
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	\$0	Actual charges to [\$40] a visit	Balance
— Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	Balance
— Calendar Year maximum	\$0	[\$1,600]	Balance

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	[\$250]
Remainder of charges	\$0	80% to a lifetime maximum benefit of [\$50,000].	20% and amounts over the [\$50,000] lifetime maximum.

**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 60 days in a row.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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 [\$1068] All but [\$267] a day All but [\$534] a day \$0 \$0	[\$1068] (Part A deductible) [\$267] a day [\$534] a day 100% of Medicare eligible expenses \$0	\$0** \$0** \$0** \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$133.50] a day \$0	\$0** \$0** All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0** \$0**
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN E**

**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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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	 \$0 Generally 80%	 \$0 Generally 20%	 [\$135] (Part B deductible) \$0**
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> 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**
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0**

**PARTS A & B**

<b>HOME HEALTH CARE</b> 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**
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(continued)

**PLAN E**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

\*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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA 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.
<b>†PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE</b> Some annual physical and preventive tests and services 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

†Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

**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 60 days in a row.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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 [\$1068]  All but [\$267] a day  All but [\$534] a day  \$0  \$0	[\$1068] (Part A deductible) [\$267] a day  [\$534] a day  100% of Medicare eligible expenses  \$0	\$0**  \$0**  \$0**  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$133.50] a day \$0	\$0** \$0** All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0** \$0**
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN F**

**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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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*	\$0	[\$135] (Part B deductible)	\$0**
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0**
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0**
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0**
Next \$135 of Medicare Approved amounts*	\$0	[\$135] (Part B deductible)	\$0**
Remainder of Medicare Approved amounts	80%	20%	\$0**
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0**

(continued)

**PLAN F**  
**PARTS A & B**

\*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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b>			
MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0**
— Durable medical equipment			
First \$135 of Medicare Approved Amounts*	\$0	[\$135] (Part B deductible)	\$0**
Remainder of Medicare Approved Amounts	80%	20%	\$0**

**OTHER SERVICES – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	[\$250]
Remainder of charges	\$0	80% to a lifetime maximum benefit of [\$50,000]	20% and amounts over the [\$50,000] lifetime maximum

**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 60 days in a row.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days 61<sup>st</sup> thru 90<sup>th</sup> day 91<sup>st</sup> day and after:</p> <ul style="list-style-type: none"> <li>— While using 60 lifetime reserve days</li> <li>— Once lifetime reserve days are used: <ul style="list-style-type: none"> <li>— Additional 365 days</li> <li>— Beyond the additional 365 days</li> </ul> </li> </ul>	<p>All but [\$1068] All but [\$267] a day</p> <p>All but [\$534] a day</p> <p>\$0</p> <p>\$0</p>	<p>[\$1068] (Part A deductible) [\$267] a day</p> <p>[\$534] a day</p> <p>100% of Medicare eligible expenses</p> <p>\$0</p>	<p>\$0** \$0**</p> <p>\$0**</p> <p>\$0**</p> <p>All costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> 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</p> <p>First 20 days 21<sup>st</sup> thru 100<sup>th</sup> day 101<sup>st</sup> day and after</p>	<p>All approved amounts All but [\$133.50] a day \$0</p>	<p>\$0 Up to [\$133.50] a day \$0</p>	<p>\$0** \$0** All costs</p>
<p><b>BLOOD</b> First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0** \$0**</p>
<p><b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for out-patient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN G**

**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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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	\$0  Generally 80%	\$0  Generally 20%	\$0  \$0**  [\$135] (Part B deductible)
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	80%	20%
<b>BLOOD</b> 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**
<b>CLINICAL LABORATORY                      SERVICES – TESTS FOR                      DIAGNOSTIC SERVICES</b>	100%	\$0	\$0**

(continued)

**PLAN G  
PARTS A & B**

\*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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
— 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**
<b>AT HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE</b>			
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	\$0	Actual charges to [\$40] a visit	Balance
— Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	Balance
— Calendar Year maximum	\$0	[\$1600]	Balance

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	[\$250]
Remainder of Charges	\$0	80% to a lifetime maximum benefit of [\$50,000].	20% and amounts over the [\$50,000] lifetime maximum

**NOTICE TO APPLICANT REGARDING REPLACEMENT  
OF MEDICARE SUPPLEMENT INSURANCE  
OR MEDICARE ADVANTAGE**

**FAMILY LIFE INSURANCE COMPANY**

Home Office: Houston, Texas

Administrative Office: P. O. Box 924408 Houston, Texas 77292-4408

**SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE**

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Family Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the certificate.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

**STATEMENT TO APPLICANT BY AGENT:**

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- Change in benefits. **(Gaining additional benefit(s) but losing some existing benefit(s)).**
- My plan has outpatient drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.  
\_\_\_\_\_
- Other (please specify) \_\_\_\_\_

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

\_\_\_\_\_  
Signature of Agent, Broker or Other Representative

\_\_\_\_\_  
Typed Name and Address of Agent

The above "Notice to Applicant" was delivered to me on:

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date



## Medicare Supplement Insurance Plans

*“Insuring your tomorrow  
with star treatment today.”*

# Family Life Medicare Supplements

## Protection from the Bills Medicare Doesn't Pay

Medicare was never meant to cover all of your doctor and hospital bills. Many people do not realize this and expect them to pay all. Reliance on Medicare in this situation can mean financial difficulty with out-of-pocket expenses.

## Family Life Offers 7 Standardized Insurance Plans

Family Life insurance plans are designed to give you choices. Choices you need to help cover health care costs today! Our plans allow you to choose a Medicare Supplement to suit your life's situation, budget and needs. All plans may not be available in all states.

## Initial Hospital Deductible

Medicare Part A hospital deductibles have risen [\$984] since 1968 - just [40] years!

[\$1024]

[2 0 0 8]

\$ 40  
1 9 6 8

## All Medicare Supplement Plans Offer These Benefits:

**Part A Co-Insurance** pays if you are confined to a hospital. Should you require more than 60 continuous days hospitalization, Family Life will pay the co-insurance amounts up to the 150th day of confinement and also for the first 3 pints of blood each year. Additionally, if you use your lifetime reserve days, Family Life will provide coverage for up to an additional 365 days.

**Part B Co-Insurance** pays the Medicare Part B coinsurance amount, reducing your out-of-pocket expenses when you require medical services.

**FAMILY LIFE**  
INSURANCE COMPANY

# Your Benefits

## Medicare Part A Hospital Coverage

**Deductible** - Medicare Supplement Plans B, C, D, E, F and G all pay the [\$1024] inpatient hospital deductible for each benefit period.

**First 60 Days** - After the Part A deductible, Medicare pays all eligible expenses for services from your first through 60th day of hospital confinement. Services include semiprivate room and board, general nursing and miscellaneous hospital services and supplies.

**Coinsurance** - All Medicare Supplement Plans pay up to [\$256] a day when you're hospitalized from the 61st through the 90th day. And when you're in the hospital from the 91st through 150th day, Medicare Supplement Plans pay you up to [\$512] a day for each Lifetime Reserve day used.

**Extended Hospital Coverage** - When you're in the hospital longer than 150 days during a Benefit Period, and you've exhausted your 60 Medicare Lifetime Reserve days, all Medicare Supplement Plans pay the Part A Medicare eligible expenses for hospitalization, paid at the Prospective Payment System (PPS) rate or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days.

**Benefit for Blood** - Medicare has one calendar-year deductible for blood that is the cost of the first three pints needed. All Medicare Supplement Plans pay this deductible.

### Skilled Nursing Facility Care

**First 20 Days** - Medicare pays all eligible expenses.

**Coinsurance** - Medicare Supplement Plans C, D, E, F and G pay up to [\$128] a day from the 21st through the 100th day during which you receive skilled nursing care. You must enter a Medicare-certified skilled nursing facility within 30 days of being hospitalized for at least three days.

## Medicare Part B Physician's Services and Supplies

**Deductible** - Medicare Supplement Plans C and F pay the [\$135] calendar year deductible.

**Coinsurance** - After the Part B deductible, All Medicare Supplement Plans generally pay 20% of Medicare Eligible Expenses for physician's services, hospital outpatient services and supplies, physical and speech therapy, and ambulance service.

**Excess Benefits** - Your bill for Part B services and supplies may exceed the Medicare Eligible Expense. When that occurs, Medicare Supplement Plan F pays 100% of the difference, up to the charge limitation established by Medicare. Medicare Supplement Plan G Pays 80% of the difference, up to the charge limitation established by Medicare.

**Benefit for Blood** - Medicare has one calendar year deductible for blood that is the cost of the first three pints needed. All Medicare Supplement Plans pay this deductible.

### Additional Benefits

**Emergency Care Received Outside the U.S.** - After you pay a [\$250] calendar-year deductible, Medicare Supplement Plans C, D, E, F and G pay you 80% of eligible expenses incurred during the first 60 days for emergency care received outside the U.S. up to a lifetime maximum of \$50,000. Benefits are payable for emergency health care you need immediately because of a covered injury or illness of sudden and unexpected onset.

**At-Home Recovery Visits** - Medicare Supplement Plans D and G pay for seven visits a week, up to \$40 a visit up to a maximum of \$1,600 a year for assistance with activities of daily living. Benefits are payable for services necessary for your recovery from an illness, injury or surgery in your home by a Medicare approved provider.

**Preventive Care Benefit** - Medicare Supplement Plan E pays \$120 per year for some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.

# Your Plan; The Facts

**Family Life** helps pay some eligible expenses not paid for by Medicare Part A and Medicare Part B. **There may be charges above what Medicare and Family Life pay.**

**Medicare Part A Eligible Expenses for Hospital/Skilled Nursing Facility Care** include expenses for semiprivate room and board, general nursing, miscellaneous services and supplies.

**Medicare Part B Eligible Expenses for Medical Services** include expenses for physician's services, hospital outpatient services and supplies, physical and speech therapy, and ambulance service.

**"Medicare Eligible Expenses"** means expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

**A Benefit Period** begins the first full day you are hospitalized and ends when you have not been in a hospital or skilled nursing facility for 60 days in a row.

**Coinsurance** is the portion of the Medicare Eligible Expense you have to pay. It does not include Part A and B deductible amounts not paid by Medicare.

**As Medicare deductibles and coinsurance increase**, your Medicare Supplement benefits will automatically increase. Medicare Supplement benefits will not duplicate benefits paid by Medicare.

**Benefits are paid to you** or to your hospital or doctor.

**You have 31 days from your renewal date to pay your premium.** Your policy will stay in force during this 31 day grace period.

**Your policy is guaranteed renewable.** Your policy cannot be cancelled. It will be renewed as long as the premiums are paid on time.

Premium rate adjustments may be made based on current health care cost experience for benefits paid. Family Life reserves the right to establish new premium rates for all insureds based on a class basis, but only after giving you advance notice. **However, we will not increase premiums based on your own claims.**

**You're covered immediately.** There is no waiting period for pre-existing conditions. Benefits will be paid from the time your policy is in force.

**Family Life Medicare Supplements will not pay for:**

- Expenses incurred while the policy is not in force except as provided in the Extension of Benefits section;
- Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while the policy is not in force;
- That portion of any expense incurred which is paid for by Medicare;
- Services for non-Medicare Eligible Expenses unless specifically covered in the policy, including, but not limited to, routine exams, take-home drugs and eye refractions;
- Services for which a charge is not normally made in the absence of insurance; or
- Loss or expense that is payable under any other Medicare Supplement insurance policy or certificate.

**THIS IS A BRIEF DESCRIPTION** of your coverage. For complete information on benefits, exceptions and limitations, **PLEASE READ YOUR ACCOMPANYING OUTLINE OF COVERAGE.**

**Neither Family Life nor its agents** are connected in any way with the Federal or state Government or Medicare.

# A Plan to Meet Your Every Need

	Medicare Pays	Plan A Pays	Plan B Pays	Plan C Pays	Plan D Pays	Plan E Pays	Plan F Pays	Plan G Pays
<b>Medicare Part A Hospital Coverage</b>								
Deductible	All but [\$1024]	-	[\$1024]	[\$1024]	[\$1024]	[\$1024]	[\$1024]	[\$1024]
First 60 days	100%	-	-	-	-	-	-	-
Coinsurance 61-90 days	All but [\$256]	Up to [\$256]	Up to [\$256]	Up to [\$256]	Up to [\$256]	Up to [\$256]	Up to [\$256]	Up to [\$256]
Coinsurance 91-150 days	All but [\$512]	Up to [\$512]	Up to [\$512]	Up to [\$512]	Up to [\$512]	Up to [\$512]	Up to [\$512]	Up to [\$512]
Extended Hospital Coverage (up to an additional 365 days in your lifetime)	-	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses
Benefit for Blood First Three Pints	\$0	Three pints	Three pints	Three pints	Three pints	Three pints	Three pints	Three pints
Addtl. Amounts	100%	-	-	-	-	-	-	-
<b>Skilled Nursing Facility Care</b>								
First 20 days	100%	-	-	-	-	-	-	-
Coinsurance 21-100 days	All but [\$128] A day	-	-	Up to [\$128] A day	Up to [\$128] A day	Up to [\$128] A day	Up to [\$128] A day	Up to [\$128] A day
<b>Medicare Part B Physician's Services And Supplies</b>								
Deductible	-	-	-	[\$135]	-	-	[\$135]	-
Coinsurance	Generally 80%	Generally 20%	Generally 20%	Generally 20%	Generally 20%	Generally 20%	Generally 20%	Generally 20%
Excess Benefits	-	-	-	-	-	-	100% up to Medicare's Limit	80% up to Medicare's Limit
Benefit for Blood First Three Pints	\$0	Three pints	Three pints	Three pints	Three pints	Three pints	Three pints	Three pints
Addtl. Amounts	100%	-	-	-	-	-	-	-
<b>Additional Benefits</b>								
Emergency Care Received Outside The U.S.	-	-	-	Up to \$50,000	Up to \$50,000	Up to \$50,000	Up to \$50,000	Up to \$50,000
At-home Recovery Visits	-	-	-	-	Up to \$1,600 Per Year	-	-	Up to \$1,600 Per Year
Preventive Care Benefit	-	-	-	-	-	\$120 Per Year	-	-

**FOR CLAIMS, PLEASE CALL:  
1-800-877-7705**

**This brochure is an illustration, not a contract. Consult your outline of coverage for a complete description of benefits available to you.**

RECEIPT

Received of \_\_\_\_\_

this \_\_\_\_\_ day of \_\_\_\_\_ the sum of \$ \_\_\_\_\_

being the payment of \_\_\_\_\_ Premium.

This insurance applied for shall not take effect until the effective date of the policy and the payment of the first premium. In the event the application is declined, any payments made by the Applicant will be returned.

\_\_\_\_\_  
Agent's Signature

Underwritten by:  
**Family Life  
Insurance Company**  
PO Box 924408  
Houston, Texas 77292-4408  
1-800-987-1593

Make checks payable to Family Life Insurance Company.  
Do not make payable to agent or leave payee blank.

*SERFF Tracking Number:*      *WAKE-125907794*                      *State:*                      *Arkansas*  
*Filing Company:*              *Family Life Insurance Company*                      *State Tracking Number:*      *40897*  
*Company Tracking Number:*  
*TOI:*                      *MS06 Medicare Supplement - Other*                      *Sub-TOI:*                      *MS06.000 Medicare Supplement - Other*  
*Product Name:*              *FLIC Med Supp Forms 2008*  
*Project Name/Number:*      *Family Life/112008*

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: WAKE-125907794 State: Arkansas  
 Filing Company: Family Life Insurance Company State Tracking Number: 40897  
 Company Tracking Number:  
 TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other  
 Product Name: FLIC Med Supp Forms 2008  
 Project Name/Number: Family Life/112008

## Rate/Rule Schedule

Review Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved	Rate Pages	MSIAA200810 AR, MSIAB200810 AR, MSIAC200810 AR, MSIAD200810 AR, MSIAE200810 AR, MSIAF200810 AR, MSIAG200810 AR	New		AR Rates.pdf

Gross Annual Premiums

**Family Life Insurance Company**

Medicare Supplement Policy  
Standardized Plan A

Issue Age	Preferred	Standard
All	1,186	1,318

There is no modal loading.  
A discount factor of 0.93 is applied for married applicants.

Area Factors:

<u>Arkansas</u>	
722.....	1.00
72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113- 72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199.....	1.00
All other zip codes beginning with 720 and 721.....	0.95
Rest of State.....	0.85

Gross Annual Premiums

**Family Life Insurance Company**

Medicare Supplement Policy  
Standardized Plan B

Issue Age	Preferred	Standard
All	1,444	1,604

There is no modal loading.  
A discount factor of 0.93 is applied for married applicants.

Area Factors:

<u>Arkansas</u>	
722.....	1.00
72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113- 72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199.....	1.00
All other zip codes beginning with 720 and 721.....	0.95
Rest of State.....	0.85

Gross Annual Premiums

**Family Life Insurance Company**

Medicare Supplement Policy  
Standardized Plan C

Issue Age	Preferred	Standard
All	1,658	1,842

There is no modal loading.  
A discount factor of 0.93 is applied for married applicants.

Area Factors:

<u>Arkansas</u>	
722.....	1.00
72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113- 72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199.....	1.00
All other zip codes beginning with 720 and 721.....	0.95
Rest of State.....	0.85

Gross Annual Premiums

**Family Life Insurance Company**

Medicare Supplement Policy  
Standardized Plan D

Issue Age	Preferred	Standard
All	1,514	1,681

There is no modal loading.  
A discount factor of 0.93 is applied for married applicants.

Area Factors:

<u>Arkansas</u>	
722.....	1.00
72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113- 72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199.....	1.00
All other zip codes beginning with 720 and 721.....	0.95
Rest of State.....	0.85

Gross Annual Premiums

**Family Life Insurance Company**

Medicare Supplement Policy  
Standardized Plan E

Issue Age	Preferred	Standard
All	1,519	1,688

There is no modal loading.  
A discount factor of 0.93 is applied for married applicants.

Area Factors:

<u>Arkansas</u>	
722.....	1.00
72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113- 72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199.....	1.00
All other zip codes beginning with 720 and 721.....	0.95
Rest of State.....	0.85

Gross Annual Premiums

**Family Life Insurance Company**

Medicare Supplement Policy  
Standardized Plan F

Issue Age	Preferred	Standard
All	1,696	1,885

There is no modal loading.  
A discount factor of 0.93 is applied for married applicants.

Area Factors:

<u>Arkansas</u>	
722.....	1.00
72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113- 72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199.....	1.00
All other zip codes beginning with 720 and 721.....	0.95
Rest of State.....	0.85

Gross Annual Premiums

**Family Life Insurance Company**

Medicare Supplement Policy  
Standardized Plan G

Issue Age	Preferred	Standard
All	1,521	1,691

There is no modal loading.  
A discount factor of 0.93 is applied for married applicants.

Area Factors:

<u>Arkansas</u>	
722.....	1.00
72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113- 72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199.....	1.00
All other zip codes beginning with 720 and 721.....	0.95
Rest of State.....	0.85

SERFF Tracking Number: WAKE-125907794

State: Arkansas

Filing Company: Family Life Insurance Company

State Tracking Number: 40897

Company Tracking Number:

TOI: MS06 Medicare Supplement - Other

Sub-TOI: MS06.000 Medicare Supplement - Other

Product Name: FLIC Med Supp Forms 2008

Project Name/Number: Family Life/112008

## Supporting Document Schedules

**Satisfied -Name:** Certification/Notice

**Review Status:**

Accepted for Informational Purposes 01/13/2009

**Comments:**

**Attachments:**

R&R19 Cert.pdf  
R&R27 Cert.pdf  
Readability.pdf

**Bypassed -Name:** Application

**Review Status:**

11/18/2008

**Bypass Reason:** See Form Schedule

**Comments:**

**Bypassed -Name:** Outline of Coverage

**Review Status:**

11/18/2008

**Bypass Reason:** See Form Schedule

**Comments:**

**Satisfied -Name:** Authorization Letter

**Review Status:**

Accepted for Informational Purposes 01/13/2009

**Comments:**

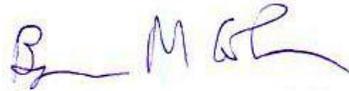
**Attachment:**

FLIC Auth Ltr.PDF

**ARKANSAS  
Rule and Regulation 19 Certification**

<u>Title of Form(s)</u>	<u>Form Number</u>
Medicare Supplement Policy – Plan A	MSIAA200810 AR
Medicare Supplement Policy – Plan B	MSIAB200810 AR
Medicare Supplement Policy – Plan C	MSIAC200810 AR
Medicare Supplement Policy – Plan D	MSIAD200810 AR
Medicare Supplement Policy – Plan E	MSIAE200810 AR
Medicare Supplement Policy – Plan F	MSIAF200810 AR
Medicare Supplement Policy – Plan G	MSIAG200810 AR
Outline of Coverage	MSOCI200810 AR
Application	MSAPP200810 AR
Replacement Form	MSREPL200808

I hereby certify that the above noted forms meet the provisions of Rule and Regulation 19, the Unfair Sex Discrimination in the Sale of Insurance.



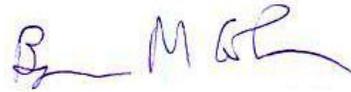
\_\_\_\_\_  
Signature

\_\_\_\_\_  
Benjamin M. Cohen, FSA, MAAA  
Name

\_\_\_\_\_  
Consulting Actuary  
Title

**ARKANSAS  
Rule and Regulation 27 Certification**

This is to certify that it is Family Life Insurance Company's intent to comply with Rule and Regulation 27, Section 16, the Permitted Compensation Arrangements.



\_\_\_\_\_  
Signature

\_\_\_\_\_  
Benjamin M. Cohen, FSA, MAAA  
Name

\_\_\_\_\_  
Consulting Actuary  
Title

# READABILITY COMPLIANCE CERTIFICATION

**Name and Address of Insurer:**

**Family Life Insurance Company  
P.O. Box 924408  
Houston, Texas 77292-4408**

I hereby certify that the Flesch Reading Ease Test Score of the listed forms are as follows:

<b>Type and/or Title of Form(s)</b>	<b>Form Number(s)</b>	<b>Flesch Score</b>
Medicare Supplement Policy – Plan A	MSIAA200810 AR	44.7
Medicare Supplement Policy – Plan B	MSIAB200810 AR	45.1
Medicare Supplement Policy – Plan C	MSIAC200810 AR	46.1
Medicare Supplement Policy – Plan D	MSIAD200810 AR	45.2
Medicare Supplement Policy – Plan E	MSIAE200810 AR	44.6
Medicare Supplement Policy – Plan F	MSIAF200810 AR	46.5
Medicare Supplement Policy – Plan G	MSIAG200810 AR	45.1
Outline of Coverage	MSOCI200810 AR	46.9
Application	MSAPP200810 AR	41.6
Replacement Form	MSREPL200808	43.2

The type size of the text is at least 10-pointed leaded.

I also certify to the best of my knowledge and belief that the form is in compliance with the Insurance Code and with all other applicable requirements of the Insurance Department in this state.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Jennifer G. Snell  
Name

\_\_\_\_\_  
Compliance Analyst  
Title



November 6, 2008

To Whom It May Concern:

The firm of Wakely Actuarial Services, Inc., located at 34125 US Highway 19 North, Suite 310, Palm Harbor, Florida 34684, is hereby authorized to submit form filings for approval on behalf of Family Life Insurance Company.

This authorization includes the power to provide necessary assurances and certifications related to such forms, rates and or products except as prohibited by law.

This authorization is to be effective until revoked in writing by an authorized representative of Family Life Insurance Company.

Sincerely,

Lee Ann Blakey  
Vice President, Operations



10700 Northwest Freeway  
Houston, TX 77092



800-877-7705



[www.familylifeins.com](http://www.familylifeins.com)

*SERFF Tracking Number:* WAKE-125907794      *State:* Arkansas  
*Filing Company:* Family Life Insurance Company      *State Tracking Number:* 40897  
*Company Tracking Number:*  
*TOI:* MS06 Medicare Supplement - Other      *Sub-TOI:* MS06.000 Medicare Supplement - Other  
*Product Name:* FLIC Med Supp Forms 2008  
*Project Name/Number:* Family Life/112008

## 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.

<b>Original Date:</b>	<b>Schedule</b>	<b>Document Name</b>	<b>Replaced Date</b>	<b>Attach Document</b>
No original date	Form	Plan A	11/19/2008	MSIAA200810 AR.pdf
No original date	Form	Plan B	11/19/2008	MSIAB200810 AR.pdf
No original date	Form	Plan C	11/19/2008	MSIAC200810 AR.pdf
No original date	Form	Plan D	11/19/2008	MSIAD200810 AR.pdf
No original date	Form	Plan E	11/19/2008	MSIAE200810 AR.pdf
No original date	Form	Plan F	11/19/2008	MSIAF200810 AR.pdf
No original date	Form	Plan G	11/19/2008	MSIAG200810 AR.pdf
No original date	Form	Application	11/19/2008	MSAPP200810 AR.pdf
No original date	Form	Outline of Coverage	11/19/2008	MSOCI200810 AR.pdf

*SERFF Tracking Number:* WAKE-125907794      *State:* Arkansas  
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*Company Tracking Number:*  
*TOI:* MS06 Medicare Supplement - Other      *Sub-TOI:* MS06.000 Medicare Supplement - Other  
*Product Name:* FLIC Med Supp Forms 2008  
*Project Name/Number:* Family Life/112008

No original date	Form	Brochure	01/09/2009	FLBRA 10-08 AR.pdf
No original date	Form	Brochure	11/19/2008	FLBRA 11-08.pdf
No original date	Rate and Rule	Rate Pages	11/19/2008	AR Rates.pdf

**FAMILY LIFE INSURANCE COMPANY**

P.O. Box 924408, Houston, Texas 77292-4408

**MEDICARE SUPPLEMENT INSURANCE POLICY - PLAN A**

**THIS IS A LEGAL CONTRACT BETWEEN YOU AND US**

**READ YOUR POLICY CAREFULLY**

This Policy provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Policy. In this Policy, "You" and "Your" means the Insured named on the application and shown on the Policy Schedule. "We", "Our" and "Us" means Family Life Insurance Company.

**NOTICE TO BUYER. THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

**IMPORTANT NOTICE:** Issuance of this Medicare Supplement Insurance Policy is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Policy to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Our Office at:

**P.O. Box 924408  
Houston, Texas 77292-4408  
800-877-7705**

**POLICY EFFECTIVE DATE AND CONSIDERATION**

We have issued this Policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Policy. The term of this Policy begins at twelve (12:00) o'clock, midnight, Standard Time, at the place where You reside on the Policy Effective Date shown on the Policy Schedule. It ends at twelve (12:00) o'clock, midnight, the same Standard Time, on the date Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Policy is shown on the Policy Schedule. An annual premium will maintain the Policy in force for twelve (12) months, semi-annual for six (6) months, quarterly for three (3) months and monthly for one (1) month.

**THIRTY DAY RIGHT TO EXAMINE AND RETURN POLICY**

Please read Your Policy carefully. If, for any reason, You are not satisfied, You may return Your Policy to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded, less any claims paid.

**GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE**

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. Premiums are based on Your issue age. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as issue age, underwriting class, state and zip code of residence. We will give You the advance written notice required by Your state prior to any premium change.

**THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION**

**CAUTION**

**POLICY BENEFITS ARE LIMITED TO THOSE APPROVED BY MEDICARE FOR PAYMENT**

**THIS IS A NON-PARTICIPATING POLICY**

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**IMPORTANT NOTICE ... 1**

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**THIRTY DAY RIGHT TO EXAMINE AND RETURN POLICY ... 1**

**GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE ... 1**

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**POLICY SCHEDULE**

**INSURED:** [John Doe]

**POLICY EFFECTIVE DATE:** [01/01/2009]

**POLICY NUMBER:** [123456]

**ISSUE AGE:** [65]

**SEX:** [Male]

**STATE OF ISSUE:** [Arizona]

**MODE AT ISSUE:** [Annual]

**MODAL PREMIUM:** [\$XXXX]

**PREMIUM TERM:** [Annual]

**UNDERWRITING CLASS:** [Preferred]

**SPOUSE DISCOUNT:** [No]

**TYPE OF COVERAGE:** MEDICARE SUPPLEMENT POLICY PLAN A

## DEFINITIONS

**Benefit Period** means the period as determined by Medicare which begins on the date You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

**Calendar Year** means the period of time beginning on January 1 and ending on December 31 of that same year.

**Coinsurance Amount** means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

**Hospital** means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

**Hospitalized or Hospitalization** means being confined in a Hospital on an inpatient basis.

**Immediate Family** means Your spouse, parents, grandparents, children, or siblings, and their spouses.

**Injury** means a bodily injury which is the direct result of an accident and independent of all other causes.

**Lifetime Inpatient Reserve Days** means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

**Medicaid** means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

**Medically Necessary** means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards or medical practice; and (4) not solely for the convenience of You or the Physician.

**Medicare** means 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** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

**Physician** means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

**Policy Effective Date** means the effective date of this Policy and is shown on the Policy Schedule. The Policy Effective Date is not the date You signed the application for coverage.

**Sickness** means illness or disease which first manifests itself after the Policy Effective Date and while this Policy is in force.

**Skilled Nursing Facility** means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

## BENEFIT PROVISIONS

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

**The benefits paid under this Policy will not duplicate benefits paid by Medicare.**

### Basic (Core) Benefits

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first (61<sup>st</sup>) day through the ninetieth (90<sup>th</sup>) day in any Medicare Benefit Period;

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;

Upon exhaustion of Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A Eligible Expenses for Hospitalization paid at applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days;

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;

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.

### GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **PREMIUMS SUBJECT TO CHANGE** provision on page 1.

### EXTENSION OF BENEFITS

Termination of this Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

## **MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN**

Benefits and premiums under this Policy are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Policy is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this Policy shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstatement of Your coverage provides for:

1. Coverage equivalent to coverage in effect before the date of suspension; and
2. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, and You enrolled in Medicare Part D while the Policy was suspended, the reinstated policy for Medicare Part D enrollees will not have outpatient prescription drug coverage, but will be substantially equivalent to Your coverage before the date of suspension.

## **EXCLUSIONS**

We will not pay benefits for:

- (a) expense incurred while this Policy is not in force, except as provided in the Extension of Benefits section;
- (b) Hospital or skilled nursing facility confinement incurred during a Medicare Part A Benefit Period that begins while this Policy is not in force.
- (c) that portion of any expense incurred which is paid for by Medicare;
- (d) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take home drugs and eye refractions;
- (e) services for which a charge is not normally made in the absence of insurance; or
- (f) loss or expense that is payable under any other Medicare Supplement Insurance Policy or certificate.

## GENERAL POLICY PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This Policy, including the endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the two (2) year period.

**GRACE PERIOD:** A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Policy shall continue in force.

**REINSTATEMENT:** If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after that date. In all other respects We and You shall have the same rights thereunder as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

**NOTICE OF CLAIMS:** We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on behalf of You to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

**CLAIM FORMS:** When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

**PROOF OF LOSS:** We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

**TIME OF PAYMENT OF CLAIMS:** All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

**PAYMENT OF CLAIMS:** Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

## GENERAL POLICY PROVISIONS CONTINUED

**OTHER INSURANCE WITH US:** You can be insured under only one of Our Medicare Supplement Policies at any one time. If You are insured under more than one such Policy, You can select the one that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return all premiums paid (less any claims paid) for any Policy that does not remain in effect.

**PHYSICAL EXAMINATIONS:** At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

**LEGAL ACTION:** No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

**UNPAID PREMIUM:** Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

**CONFORMITY WITH STATE LAWS:** Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

**ASSIGNMENT:** No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408.

**CLERICAL ERROR:** Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

**PRO RATA REFUND:** If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after the Policy month that death occurs.

**CANCELLATION BY INSURED:** You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

**This Policy is signed for Family Life Insurance Company by its President.**



President



Secretary

Gross Annual Premiums

**Family Life Insurance Company**

Medicare Supplement Policy  
Standardized Plan A

Issue Age	Preferred	Standard
All	1,186	1,318

There is no modal loading.  
The rates above do not include a one time \$25 policy fee.  
A discount factor of 0.93 is applied for married applicants.

Area Factors:

<u>Arkansas</u>	
722.....	1.00
72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113- 72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199.....	1.00
All other zip codes beginning with 720 and 721.....	0.95
Rest of State.....	0.85

Gross Annual Premiums

**Family Life Insurance Company**

Medicare Supplement Policy  
Standardized Plan B

Issue Age	Preferred	Standard
All	1,444	1,604

There is no modal loading.

The rates above do not include a one time \$25 policy fee.

A discount factor of 0.93 is applied for married applicants.

Area Factors:

<u>Arkansas</u>	
722.....	1.00
72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113- 72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199.....	1.00
All other zip codes beginning with 720 and 721.....	0.95
Rest of State.....	0.85

Gross Annual Premiums

**Family Life Insurance Company**

Medicare Supplement Policy  
Standardized Plan C

Issue Age	Preferred	Standard
All	1,658	1,842

There is no modal loading.

The rates above do not include a one time \$25 policy fee.

A discount factor of 0.93 is applied for married applicants.

Area Factors:

<u>Arkansas</u>	
722.....	1.00
72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113- 72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199.....	1.00
All other zip codes beginning with 720 and 721.....	0.95
Rest of State.....	0.85

Gross Annual Premiums

**Family Life Insurance Company**

Medicare Supplement Policy  
Standardized Plan D

Issue Age	Preferred	Standard
All	1,514	1,681

There is no modal loading.  
The rates above do not include a one time \$25 policy fee.  
A discount factor of 0.93 is applied for married applicants.

Area Factors:

<u>Arkansas</u>	
722.....	1.00
72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113- 72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199.....	1.00
All other zip codes beginning with 720 and 721.....	0.95
Rest of State.....	0.85

Gross Annual Premiums

**Family Life Insurance Company**

Medicare Supplement Policy  
Standardized Plan E

Issue Age	Preferred	Standard
All	1,519	1,688

There is no modal loading.  
The rates above do not include a one time \$25 policy fee.  
A discount factor of 0.93 is applied for married applicants.

Area Factors:

<u>Arkansas</u>	
722.....	1.00
72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113- 72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199.....	1.00
All other zip codes beginning with 720 and 721.....	0.95
Rest of State.....	0.85

Gross Annual Premiums

**Family Life Insurance Company**

Medicare Supplement Policy  
Standardized Plan F

Issue Age	Preferred	Standard
All	1,696	1,885

There is no modal loading.

The rates above do not include a one time \$25 policy fee.

A discount factor of 0.93 is applied for married applicants.

Area Factors:

<u>Arkansas</u>	
722.....	1.00
72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113- 72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199.....	1.00
All other zip codes beginning with 720 and 721.....	0.95
Rest of State.....	0.85

Gross Annual Premiums

**Family Life Insurance Company**

Medicare Supplement Policy  
Standardized Plan G

Issue Age	Preferred	Standard
All	1,521	1,691

There is no modal loading.  
The rates above do not include a one time \$25 policy fee.  
A discount factor of 0.93 is applied for married applicants.

Area Factors:

<u>Arkansas</u>	
722.....	1.00
72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113- 72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199.....	1.00
All other zip codes beginning with 720 and 721.....	0.95
Rest of State.....	0.85

**FAMILY LIFE INSURANCE COMPANY**

P.O. Box 924408, Houston, Texas 77292-4408

**MEDICARE SUPPLEMENT INSURANCE POLICY - PLAN B**

**THIS IS A LEGAL CONTRACT BETWEEN YOU AND US**

**READ YOUR POLICY CAREFULLY**

This Policy provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Policy. In this Policy, "You" and "Your" means the Insured named on the application and shown on the Policy Schedule. "We", "Our" and "Us" means Family Life Insurance Company.

**NOTICE TO BUYER. THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

**IMPORTANT NOTICE:** Issuance of this Medicare Supplement Insurance Policy is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Policy to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Our Office at:

**P.O. Box 924408  
Houston, Texas 77292-4408  
800-877-7705**

**POLICY EFFECTIVE DATE AND CONSIDERATION**

We have issued this Policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Policy. The term of this Policy begins at twelve (12:00) o'clock, midnight, Standard Time, at the place where You reside on the Policy Effective Date shown on the Policy Schedule. It ends at twelve (12:00) o'clock, midnight, the same Standard Time, on the date Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Policy is shown on the Policy Schedule. An annual premium will maintain the Policy in force for twelve (12) months, semi-annual for six (6) months, quarterly for three (3) months and monthly for one (1) month.

**THIRTY DAY RIGHT TO EXAMINE AND RETURN POLICY**

Please read Your Policy carefully. If, for any reason, You are not satisfied, You may return Your Policy to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded, less any claims paid.

**GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE**

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. Premiums are based on Your issue age. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as issue age, underwriting class, state and zip code of residence. We will give You the advance written notice required by Your state prior to any premium change.

**THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION**

**CAUTION**

**POLICY BENEFITS ARE LIMITED TO THOSE APPROVED BY MEDICARE FOR PAYMENT**

**THIS IS A NON-PARTICIPATING POLICY**

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**APPLICATION ... Attached**

**POLICY SCHEDULE**

**INSURED:** [John Doe]

**POLICY EFFECTIVE DATE:** [01/01/2009]

**POLICY NUMBER:** [123456]

**ISSUE AGE:** [65]

**SEX:** [Male]

**STATE OF ISSUE:** [Arizona]

**MODE AT ISSUE:** [Annual]

**MODAL PREMIUM:** [\$XXXX]

**PREMIUM TERM:** [Annual]

**UNDERWRITING CLASS:** [Preferred]

**SPOUSE DISCOUNT:** [No]

**TYPE OF COVERAGE:** MEDICARE SUPPLEMENT POLICY PLAN B

## DEFINITIONS

**Benefit Period** means the period as determined by Medicare which begins on the date You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

**Calendar Year** means the period of time beginning on January 1 and ending on December 31 of that same year.

**Coinsurance Amount** means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

**Hospital** means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

**Hospitalized or Hospitalization** means being confined in a Hospital on an inpatient basis.

**Immediate Family** means Your spouse, parents, grandparents, children, or siblings, and their spouses.

**Injury** means a bodily injury which is the direct result of an accident and independent of all other causes.

**Lifetime Inpatient Reserve Days** means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

**Medicaid** means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

**Medically Necessary** means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards or medical practice; and (4) not solely for the convenience of You or the Physician.

**Medicare** means 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** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

**Medicare Part A Initial Deductible** means the fixed amount Medicare does not pay during the first sixty (60) days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

**Physician** means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

**Policy Effective Date** means the effective date of this Policy and is shown on the Policy Schedule. The Policy Effective Date is not the date You signed the application for coverage.

**Sickness** means illness or disease which first manifests itself after the Policy Effective Date and while this Policy is in force.

**Skilled Nursing Facility** means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

## **BENEFIT PROVISIONS**

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

**The benefits paid under this Policy will not duplicate benefits paid by Medicare.**

### **Basic (Core) Benefits**

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first (61<sup>st</sup>) day through the ninetieth (90<sup>th</sup>) day in any Medicare Benefit Period;

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;

Upon exhaustion of Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A Eligible Expenses for Hospitalization paid at applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days.

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;

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 For Plan "B"**

**Medicare Part A Deductible:** Coverage for all of the Medicare Part A Initial Deductible amount per Benefit Period.

## **GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS**

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **PREMIUMS SUBJECT TO CHANGE** provision on page 1.

### **EXTENSION OF BENEFITS**

Termination of this Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

### **MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN**

Benefits and premiums under this Policy are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Policy is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this Policy shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstatement of Your coverage provides for:

1. Coverage equivalent to coverage in effect before the date of suspension; and
2. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, and You enrolled in Medicare Part D while the Policy was suspended, the reinstated policy for Medicare Part D enrollees will not have outpatient prescription drug coverage, but will be substantially equivalent to Your coverage before the date of suspension.

### **EXCLUSIONS**

We will not pay benefits for:

- (a) expense incurred while this Policy is not in force, except as provided in the Extension of Benefits section;
- (b) Hospital or skilled nursing facility confinement incurred during a Medicare Part A Benefit Period that begins while this Policy is not in force.
- (c) that portion of any expense incurred which is paid for by Medicare;
- (d) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take home drugs and eye refractions;
- (e) services for which a charge is not normally made in the absence of insurance; or
- (f) loss or expense that is payable under any other Medicare Supplement Insurance Policy or certificate.

## GENERAL POLICY PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This Policy, including the endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the two (2) year period.

**GRACE PERIOD:** A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Policy shall continue in force.

**REINSTATEMENT:** If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after that date. In all other respects We and You shall have the same rights thereunder as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

**NOTICE OF CLAIMS:** We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on behalf of You to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

**CLAIM FORMS:** When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

**PROOF OF LOSS:** We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

**TIME OF PAYMENT OF CLAIMS:** All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

**PAYMENT OF CLAIMS:** Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

## GENERAL POLICY PROVISIONS CONTINUED

**OTHER INSURANCE WITH US:** You can be insured under only one of Our Medicare Supplement Policies at any one time. If You are insured under more than one such Policy, You can select the one that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return all premiums paid (less any claims paid) for any Policy that does not remain in effect.

**PHYSICAL EXAMINATIONS:** At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

**LEGAL ACTION:** No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

**UNPAID PREMIUM:** Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

**CONFORMITY WITH STATE LAWS:** Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

**ASSIGNMENT:** No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408.

**CLERICAL ERROR:** Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

**PRO RATA REFUND:** If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after the Policy month that death occurs.

**CANCELLATION BY INSURED:** You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

**This Policy is signed for Family Life Insurance Company by its President.**



President



Secretary

**FAMILY LIFE INSURANCE COMPANY**

P.O. Box 924408, Houston, Texas 77292-4408

**MEDICARE SUPPLEMENT INSURANCE POLICY - PLAN C**

**THIS IS A LEGAL CONTRACT BETWEEN YOU AND US**

**READ YOUR POLICY CAREFULLY**

This Policy provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Policy. In this Policy, "You" and "Your" means the Insured named on the application and shown on the Policy Schedule. "We", "Our" and "Us" means Family Life Insurance Company.

**NOTICE TO BUYER. THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

**IMPORTANT NOTICE:** Issuance of this Medicare Supplement Insurance Policy is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Policy to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Our Office at:

**P.O. Box 924408  
Houston, Texas 77292-4408  
800-877-7705**

**POLICY EFFECTIVE DATE AND CONSIDERATION**

We have issued this Policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Policy. The term of this Policy begins at twelve (12:00) o'clock, midnight, Standard Time, at the place where You reside on the Policy Effective Date shown on the Policy Schedule. It ends at twelve (12:00) o'clock, midnight, the same Standard Time, on the date Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Policy is shown on the Policy Schedule. An annual premium will maintain the Policy in force for twelve (12) months, semi-annual for six (6) months, quarterly for three (3) months and monthly for one (1) month.

**THIRTY DAY RIGHT TO EXAMINE AND RETURN POLICY**

Please read Your Policy carefully. If, for any reason, You are not satisfied, You may return Your Policy to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded, less any claims paid.

**GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE**

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. Premiums are based on Your issue age. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as issue age, underwriting class, state and zip code of residence. We will give You the advance written notice required by Your state prior to any premium change.

**THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION**

**CAUTION**

**POLICY BENEFITS ARE LIMITED TO THOSE APPROVED BY MEDICARE FOR PAYMENT**

**THIS IS A NON-PARTICIPATING POLICY**

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**POLICY SCHEDULE**

**INSURED:** [John Doe]

**POLICY EFFECTIVE DATE:** [01/01/2009]

**POLICY NUMBER:** [123456]

**ISSUE AGE:** [65]

**SEX:** [Male]

**STATE OF ISSUE:** [Arizona]

**MODE AT ISSUE:** [Annual]

**MODAL PREMIUM:** [\$XXXX]

**PREMIUM TERM:** [Annual]

**UNDERWRITING CLASS:** [Preferred]

**SPOUSE DISCOUNT:** [No]

**TYPE OF COVERAGE:** MEDICARE SUPPLEMENT POLICY PLAN C

## DEFINITIONS

**Benefit Period** means the period as determined by Medicare which begins on the date You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

**Calendar Year** means the period of time beginning on January 1 and ending on December 31 of that same year.

**Coinsurance Amount** means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

**Emergency Care** means care needed immediately because of an Injury or an illness of sudden and unexpected onset.

**Hospital** means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

**Hospitalized** or **Hospitalization** means being confined in a Hospital on an inpatient basis.

**Immediate Family** means Your spouse, parents, grandparents, children, or siblings, and their spouses.

**Injury** means a bodily injury which is the direct result of an accident and independent of all other causes.

**Lifetime Inpatient Reserve Days** means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

**Medicaid** means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

**Medically Necessary** means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards or medical practice; and (4) not solely for the convenience of You or the Physician.

**Medicare** means 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** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

**Medicare Part A Initial Deductible** means the fixed amount Medicare does not pay during the first 60 days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

**Medicare Part B Deductible** means the fixed amount You must pay each Calendar Year before Medicare starts paying Part B expenses. This amount is set each year by Medicare. Medicare does not pay this amount.

**Physician** means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

**Policy Effective Date** means the effective date of this Policy and is shown on the Policy Schedule. The Policy Effective Date is not the date You signed the application for coverage.

**Sickness** means illness or disease which first manifests itself after the Policy Effective Date and while this Policy is in force.

**Skilled Nursing Facility** means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

## BENEFIT PROVISIONS

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

**The benefits paid under this Policy will not duplicate benefits paid by Medicare.**

### Basic (Core) Benefits

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first (61<sup>st</sup>) day through the ninetieth (90<sup>th</sup>) day in any Medicare Benefit Period;

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;

Upon exhaustion of Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A Eligible Expenses for Hospitalization paid at applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days;

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;

Coverage for the Coinsurance Amount, or in the case of hospital outpatient department services paid under a prospective payment plan, the copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B deductible.

### Additional Benefits For Plan "C"

**Medicare Part A Deductible:** Coverage for all of the Medicare Part A Initial Deductible amount per Benefit Period.

**Skilled Nursing Facility Care:** Coverage for the actual billed charges up to the Coinsurance Amount from the twenty first (21<sup>st</sup>) day through the one hundredth (100<sup>th</sup>) day in a Medicare Benefit Period for posthospital Skilled Nursing Facility care eligible under Medicare Part A.

**Medicare Part B Deductible:** Coverage for all of the Medicare Part B Deductible amount per Calendar Year regardless of Hospital confinement.

**Medically Necessary Emergency Care in a Foreign Country:** 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).

## **GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS**

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **PREMIUMS SUBJECT TO CHANGE** provision on page 1.

## **EXTENSION OF BENEFITS**

Termination of this Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

## **MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN**

Benefits and premiums under this Policy are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Policy is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this Policy shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstatement of Your coverage provides for:

1. Coverage equivalent to coverage in effect before the date of suspension; and
2. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, and You enrolled in Medicare Part D while the Policy was suspended, the reinstated policy for Medicare Part D enrollees will not have outpatient prescription drug coverage, but will be substantially equivalent to Your coverage before the date of suspension.

## **EXCLUSIONS**

We will not pay benefits for:

- (a) expense incurred while this Policy is not in force, except as provided in the Extension of Benefits section;
- (b) Hospital or skilled nursing facility confinement incurred during a Medicare Part A Benefit Period that begins while this Policy is not in force.
- (c) that portion of any expense incurred which is paid for by Medicare;
- (d) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take home drugs and eye refractions;
- (e) services for which a charge is not normally made in the absence of insurance; or loss or expense that is payable under any other Medicare Supplement Insurance Policy or certificate.

## GENERAL POLICY PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This Policy, including the endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the two (2) year period.

**GRACE PERIOD:** A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Policy shall continue in force.

**REINSTATEMENT:** If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after that date. In all other respects We and You shall have the same rights thereunder as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

**NOTICE OF CLAIMS:** We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on behalf of You to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

**CLAIM FORMS:** When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

**PROOF OF LOSS:** We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

**TIME OF PAYMENT OF CLAIMS:** All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

**PAYMENT OF CLAIMS:** Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

**GENERAL POLICY PROVISIONS CONTINUED**

**OTHER INSURANCE WITH US:** You can be insured under only one of Our Medicare Supplement Policies at any one time. If You are insured under more than one such Policy, You can select the one that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return all premiums paid (less any claims paid) for any Policy that does not remain in effect.

**PHYSICAL EXAMINATIONS:** At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

**LEGAL ACTION:** No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

**UNPAID PREMIUM:** Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

**CONFORMITY WITH STATE LAWS:** Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

**ASSIGNMENT:** No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408.

**CLERICAL ERROR:** Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

**PRO RATA REFUND:** If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after the Policy month that death occurs.

**CANCELLATION BY INSURED:** You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

**This Policy is signed for Family Life Insurance Company by its President.**



President



Secretary

**FAMILY LIFE INSURANCE COMPANY**

P.O. Box 924408, Houston, Texas 77292-4408

**MEDICARE SUPPLEMENT INSURANCE POLICY - PLAN D**

**THIS IS A LEGAL CONTRACT BETWEEN YOU AND US**

**READ YOUR POLICY CAREFULLY**

This Policy provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Policy. In this Policy, "You" and "Your" means the Insured named on the application and shown on the Policy Schedule. "We", "Our" and "Us" means Family Life Insurance Company.

**NOTICE TO BUYER. THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

**IMPORTANT NOTICE:** Issuance of this Medicare Supplement Insurance Policy is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Policy to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Our Office at:

**P.O. Box 924408  
Houston, Texas 77292-4408  
800-877-7705**

**POLICY EFFECTIVE DATE AND CONSIDERATION**

We have issued this Policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Policy. The term of this Policy begins at twelve (12:00) o'clock, midnight, Standard Time, at the place where You reside on the Policy Effective Date shown on the Policy Schedule. It ends at twelve (12:00) o'clock, midnight, the same Standard Time, on the date Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Policy is shown on the Policy Schedule. An annual premium will maintain the Policy in force for twelve (12) months, semi-annual for six (6) months, quarterly for three (3) months and monthly for one (1) month.

**THIRTY DAY RIGHT TO EXAMINE AND RETURN POLICY**

Please read Your Policy carefully. If, for any reason, You are not satisfied, You may return Your Policy to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded, less any claims paid.

**GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE**

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. Premiums are based on Your issue age. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as issue age, underwriting class, state and zip code of residence. We will give You the advance written notice required by Your state prior to any premium change.

**THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION**

**CAUTION**

**POLICY BENEFITS ARE LIMITED TO THOSE APPROVED BY MEDICARE FOR PAYMENT**

**THIS IS A NON-PARTICIPATING POLICY**

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**POLICY SCHEDULE**

**INSURED:** [John Doe]

**POLICY EFFECTIVE DATE:** [01/01/2009]

**POLICY NUMBER:** [123456]

**ISSUE AGE:** [65]

**SEX:** [Male]

**STATE OF ISSUE:** [Arizona]

**MODE AT ISSUE:** [Annual]

**MODAL PREMIUM:** [\$XXXX]

**PREMIUM TERM:** [Annual]

**UNDERWRITING CLASS:** [Preferred]

**SPOUSE DISCOUNT:** [No]

**TYPE OF COVERAGE:** MEDICARE SUPPLEMENT POLICY PLAN D

## DEFINITIONS

**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.

**At-Home Recovery Visit** means 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-hour period of services provided by a Care Provider is one visit.

**Benefit Period** means the period as determined by Medicare which begins on the date You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

**Calendar Year** means the period of time beginning on January 1 and ending on December 31 of that same year.

**Care Provider** means a duly qualified or licensed home health aide or 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.

**Coinsurance Amount** means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

**Emergency Care** means care needed immediately because of an Injury or illness of sudden and unexpected onset.

**Home** shall mean any place used by the Insured as a place of residence, provided that the 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.

**Hospital** means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

**Hospitalized or Hospitalization** means being confined in a Hospital on an inpatient basis.

**Immediate Family** means Your spouse, parents, grandparents, children, or siblings, and their spouses.

**Injury** means a bodily injury which is the direct result of an accident and independent of all other causes.

**Lifetime Inpatient Reserve Days** means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

**Medicaid** means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

**Medically Necessary** means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards or medical practice; and (4) not solely for the convenience of You or the Physician.

## DEFINITIONS CONTINUED

**Medicare** means 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** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

**Medicare Part A Initial Deductible** means the fixed amount Medicare does not pay during the first sixty (60) days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

**Physician** means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

**Policy Effective Date** means the effective date of this Policy and is shown on the Policy Schedule. The Policy Effective Date is not the date You signed the application for coverage.

**Sickness** means illness or disease which first manifests itself after the Policy Effective Date and while this Policy is in force.

**Skilled Nursing Facility** means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

## BENEFIT PROVISIONS

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

**The benefits paid under this Policy will not duplicate benefits paid by Medicare.**

### Basic (Core) Benefits

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first ( 61<sup>st</sup> ) day through the ninetieth (90<sup>th</sup>) day in any Medicare Benefit Period;

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;

Upon exhaustion of Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A Eligible Expenses for Hospitalization paid at applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days;

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;

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 For Plan "D"**

**Medicare Part A Deductible:** Coverage for all of the Medicare Part A Initial Deductible amount per Benefit Period.

**Skilled Nursing Facility Care:** Coverage for the actual billed charges up to the Coinsurance Amount from the twenty first (21<sup>st</sup>) day through the one hundredth (100<sup>th</sup>) day in a Medicare Benefit Period for posthospital Skilled Nursing Facility care eligible under Medicare Part A.

**Medically Necessary Emergency Care in a Foreign Country:** 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).

**At-Home Recovery Benefit:** Coverage for services to provide short term, at-home assistance with Activities of Daily Living for those recovering from an illness, Injury or surgery.

### **Coverage Requirements and Limitations**

At-home recovery services provided must be primarily services which assist in Activities of Daily Living.

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.

#### **Coverage is limited to:**

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;

The actual charges for each visit up to a maximum reimbursement of \$40 per visit;

\$1,600 per calendar year;

Seven (7) visits in any one week;

Care furnished on a visiting basis in the Insured's Home;

Services provided by a Care Provider as defined in this Policy;

At-Home Recovery Visits while the Insured is covered under the Policy and not otherwise excluded;

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:**

Home care visits paid for by Medicare or other government programs; and

Care provided by family members, unpaid volunteers or providers who are not Care Providers.

## **GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS**

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **PREMIUMS SUBJECT TO CHANGE** provision on page 1.

### **EXTENSION OF BENEFITS**

Termination of this Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

### **MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN**

Benefits and premiums under this Policy are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Policy is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this Policy shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstatement of Your coverage provides for:

1. Coverage equivalent to coverage in effect before the date of suspension; and
2. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, and You enrolled in Medicare Part D while the Policy was suspended, the reinstated policy for Medicare Part D enrollees will not have outpatient prescription drug coverage, but will be substantially equivalent to Your coverage before the date of suspension.

### **EXCLUSIONS**

We will not pay benefits for:

- (a) expense incurred while this Policy is not in force, except as provided in the Extension of Benefits section;
- (b) Hospital or skilled nursing facility confinement incurred during a Medicare Part A Benefit Period that begins while this Policy is not in force.
- (c) that portion of any expense incurred which is paid for by Medicare;
- (d) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take home drugs and eye refractions;
- (e) services for which a charge is not normally made in the absence of insurance; or
- (f) loss or expense that is payable under any other Medicare Supplement Insurance Policy or certificate.

## GENERAL POLICY PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This Policy, including the endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the two (2) year period.

**GRACE PERIOD:** A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Policy shall continue in force.

**REINSTATEMENT:** If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after that date. In all other respects We and You shall have the same rights thereunder as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

**NOTICE OF CLAIMS:** We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on behalf of You to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

**CLAIM FORMS:** When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

**PROOF OF LOSS:** We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

**TIME OF PAYMENT OF CLAIMS:** All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

**PAYMENT OF CLAIMS:** Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

## GENERAL POLICY PROVISIONS CONTINUED

**OTHER INSURANCE WITH US:** You can be insured under only one of Our Medicare Supplement Policies at any one time. If You are insured under more than one such Policy, You can select the one that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return all premiums paid (less any claims paid) for any Policy that does not remain in effect.

**PHYSICAL EXAMINATIONS:** At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

**LEGAL ACTION:** No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

**UNPAID PREMIUM:** Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

**CONFORMITY WITH STATE LAWS:** Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

**ASSIGNMENT:** No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408.

**CLERICAL ERROR:** Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

**PRO RATA REFUND:** If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after the Policy month that death occurs.

**CANCELLATION BY INSURED:** You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

**This Policy is signed for Family Life Insurance Company by its President.**



President



Secretary

**FAMILY LIFE INSURANCE COMPANY**

P.O. Box 924408, Houston, Texas 77292-4408

**MEDICARE SUPPLEMENT INSURANCE POLICY - PLAN E**

**THIS IS A LEGAL CONTRACT BETWEEN YOU AND US**

**READ YOUR POLICY CAREFULLY**

This Policy provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Policy. In this Policy, "You" and "Your" means the Insured named on the application and shown on the Policy Schedule. "We", "Our" and "Us" means Family Life Insurance Company.

**NOTICE TO BUYER. THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

**IMPORTANT NOTICE:** Issuance of this Medicare Supplement Insurance Policy is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Policy to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Our Office at:

**P.O. Box 924408  
Houston, Texas 77292-4408  
800-877-7705**

**POLICY EFFECTIVE DATE AND CONSIDERATION**

We have issued this Policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Policy. The term of this Policy begins at twelve (12:00) o'clock, midnight, Standard Time, at the place where You reside on the Policy Effective Date shown on the Policy Schedule. It ends at twelve (12:00) o'clock, midnight, the same Standard Time, on the date Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Policy is shown on the Policy Schedule. An annual premium will maintain the Policy in force for twelve (12) months, semi-annual for six (6) months, quarterly for three (3) months and monthly for one (1) month.

**THIRTY DAY RIGHT TO EXAMINE AND RETURN POLICY**

Please read Your Policy carefully. If, for any reason, You are not satisfied, You may return Your Policy to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded, less any claims paid.

**GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE**

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. Premiums are based on Your issue age. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as issue age, underwriting class, state and zip code of residence. We will give You the advance written notice required by Your state prior to any premium change.

**THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION**

**CAUTION**

**POLICY BENEFITS ARE LIMITED TO THOSE APPROVED BY MEDICARE FOR PAYMENT**

**THIS IS A NON-PARTICIPATING POLICY**

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**APPLICATION ... Attached**

**POLICY SCHEDULE**

**INSURED:** [John Doe]

**POLICY EFFECTIVE DATE:** [01/01/2009]

**POLICY NUMBER:** [123456]

**ISSUE AGE:** [65]

**SEX:** [Male]

**STATE OF ISSUE:** [Arizona]

**MODE AT ISSUE:** [Annual]

**MODAL PREMIUM:** [\$XXXX]

**PREMIUM TERM:** [Annual]

**UNDERWRITING CLASS:** [Preferred]

**SPOUSE DISCOUNT:** [No]

**TYPE OF COVERAGE:** MEDICARE SUPPLEMENT POLICY PLAN E

## DEFINITIONS

**Benefit Period** means the period as determined by Medicare which begins on the date You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

**Calendar Year** means the period of time beginning on January 1 and ending on December 31 of that same year.

**Coinsurance Amount** means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

**Emergency Care** means care needed immediately because of an Injury or illness of sudden and unexpected onset.

**Hospital** means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

**Hospitalized or Hospitalization** means being confined in a Hospital on an inpatient basis.

**Immediate Family** means Your spouse, parents, grandparents, children, or siblings, and their spouses.

**Injury** means a bodily injury which is the direct result of an accident and independent of all other causes.

**Lifetime Inpatient Reserve Days** means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

**Medicaid** means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

**Medically Necessary** means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards or medical practice; and (4) not solely for the convenience of You or the Physician.

**Medicare** means 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** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

**Medicare Part A Initial Deductible** means the fixed amount Medicare does not pay during the first sixty (60) days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

**Physician** means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

**Policy Effective Date** means the effective date of this Policy and is shown on the Policy Schedule. The Policy Effective Date is not the date You signed the application for coverage.

**Sickness** means illness or disease which first manifests itself after the Policy Effective Date and while this Policy is in force.

**Skilled Nursing Facility** means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

## BENEFIT PROVISIONS

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

**The benefits paid under this Policy will not duplicate benefits paid by Medicare.**

### Basic (Core) Benefits

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first ( 61<sup>st</sup> ) day through the ninetieth (90<sup>th</sup>) day in any Medicare Benefit Period;

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;

Upon exhaustion of Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A Eligible Expenses for Hospitalization paid at applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days;

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;

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 For Plan "E"

**Medicare Part A Deductible:** Coverage for all of the Medicare Part A Initial Deductible amount per Benefit Period.

**Skilled Nursing Facility Care:** Coverage for the actual billed charges up to the Coinsurance Amount from the twenty first ( 21<sup>st</sup> ) day through the one hundredth ( 100<sup>th</sup> ) day in a Medicare Benefit Period for posthospital Skilled Nursing Facility care eligible under Medicare Part A.

**Medically Necessary Emergency Care in a Foreign Country:** 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).

**Preventive Care:** Coverage for the following preventive health services **not** covered by Medicare:

- (a) An annual clinical preventive medical history and physical examination that may include tests and services listed below and patient education to address preventive health care measures;
- (b) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

Reimbursement shall be for the actual charges up to 100% of the Medicare approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of \$120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

## **GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS**

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **PREMIUMS SUBJECT TO CHANGE** provision on page 1.

### **EXTENSION OF BENEFITS**

Termination of this Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

### **MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN**

Benefits and premiums under this Policy are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Policy is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this Policy shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstatement of Your coverage provides for:

1. Coverage equivalent to coverage in effect before the date of suspension; and
2. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, and You enrolled in Medicare Part D while the Policy was suspended, the reinstated policy for Medicare Part D enrollees will not have outpatient prescription drug coverage, but will be substantially equivalent to Your coverage before the date of suspension.

## **EXCLUSIONS**

We will not pay benefits for:

- (a) expense incurred while this Policy is not in force, except as provided in the Extension of Benefits section;
- (b) Hospital or skilled nursing facility confinement incurred during a Medicare Part A Benefit Period that begins while this Policy is not in force.
- (c) that portion of any expense incurred which is paid for by Medicare;
- (d) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take home drugs and eye refractions;
- (e) services for which a charge is not normally made in the absence of insurance; or
- (f) loss or expense that is payable under any other Medicare Supplement Insurance Policy or certificate.

## GENERAL POLICY PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This Policy, including the endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the two (2) year period.

**GRACE PERIOD:** A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Policy shall continue in force.

**REINSTATEMENT:** If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after that date. In all other respects We and You shall have the same rights thereunder as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

**NOTICE OF CLAIMS:** We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on behalf of You to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

**CLAIM FORMS:** When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

**PROOF OF LOSS:** We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

**TIME OF PAYMENT OF CLAIMS:** All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

**PAYMENT OF CLAIMS:** Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

## GENERAL POLICY PROVISIONS CONTINUED

**OTHER INSURANCE WITH US:** You can be insured under only one of Our Medicare Supplement Policies at any one time. If You are insured under more than one such Policy, You can select the one that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return all premiums paid (less any claims paid) for any Policy that does not remain in effect.

**PHYSICAL EXAMINATIONS:** At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

**LEGAL ACTION:** No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

**UNPAID PREMIUM:** Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

**CONFORMITY WITH STATE LAWS:** Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

**ASSIGNMENT:** No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408.

**CLERICAL ERROR:** Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

**PRO RATA REFUND:** If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after the Policy month that death occurs.

**CANCELLATION BY INSURED:** You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

**This Policy is signed for Family Life Insurance Company by its President.**



President



Secretary

**FAMILY LIFE INSURANCE COMPANY**

P.O. Box 924408, Houston, Texas 77292-4408

**MEDICARE SUPPLEMENT INSURANCE POLICY - PLAN F**

**THIS IS A LEGAL CONTRACT BETWEEN YOU AND US**

**READ YOUR POLICY CAREFULLY**

This Policy provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Policy. In this Policy, "You" and "Your" means the Insured named on the application and shown on the Policy Schedule. "We", "Our" and "Us" means Family Life Insurance Company.

**NOTICE TO BUYER. THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

**IMPORTANT NOTICE:** Issuance of this Medicare Supplement Insurance Policy is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Policy to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Our Office at:

**P.O. Box 924408  
Houston, Texas 77292-4408  
800-877-7705**

**POLICY EFFECTIVE DATE AND CONSIDERATION**

We have issued this Policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Policy. The term of this Policy begins at twelve (12:00) o'clock, midnight, Standard Time, at the place where You reside on the Policy Effective Date shown on the Policy Schedule. It ends at twelve (12:00) o'clock, midnight, the same Standard Time, on the date Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Policy is shown on the Policy Schedule. An annual premium will maintain the Policy in force for twelve (12) months, semi-annual for six (6) months, quarterly for three (3) months and monthly for one (1) month.

**THIRTY DAY RIGHT TO EXAMINE AND RETURN POLICY**

Please read Your Policy carefully. If, for any reason, You are not satisfied, You may return Your Policy to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded, less any claims paid.

**GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE**

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. Premiums are based on Your issue age. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as issue age, underwriting class, state and zip code of residence. We will give You the advance written notice required by Your state prior to any premium change.

**THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION**

**CAUTION**

**POLICY BENEFITS ARE LIMITED TO THOSE APPROVED BY MEDICARE FOR PAYMENT**

**THIS IS A NON-PARTICIPATING POLICY**

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**POLICY SCHEDULE**

**INSURED:** [John Doe]

**POLICY EFFECTIVE DATE:** [01/01/2009]

**POLICY NUMBER:** [123456]

**ISSUE AGE:** [65]

**SEX:** [Male]

**STATE OF ISSUE:** [Arizona]

**MODE AT ISSUE:** [Annual]

**MODAL PREMIUM:** [\$XXXX]

**PREMIUM TERM:** [Annual]

**UNDERWRITING CLASS:** [Preferred]

**SPOUSE DISCOUNT:** [No]

**TYPE OF COVERAGE:** MEDICARE SUPPLEMENT POLICY PLAN F

## DEFINITIONS

**Benefit Period** means the period as determined by Medicare which begins on the date You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

**Calendar Year** means the period of time beginning on January 1 and ending on December 31 of that same year.

**Coinsurance Amount** means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

**Emergency Care** means care needed immediately because of an Injury or an illness of sudden and unexpected onset.

**Hospital** means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

**Hospitalized or Hospitalization** means being confined in a Hospital on an inpatient basis.

**Immediate Family** means Your spouse, parents, grandparents, children, or siblings, and their spouses.

**Injury** means a bodily injury which is the direct result of an accident and independent of all other causes.

**Lifetime Inpatient Reserve Days** means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

**Medicaid** means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

**Medically Necessary** means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards or medical practice; and (4) not solely for the convenience of You or the Physician.

**Medicare** means 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** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

**Medicare Part A Initial Deductible** means the fixed amount Medicare does not pay during the first sixty (60) days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

**Medicare Part B Deductible** means the fixed amount You must pay each Calendar Year before Medicare starts paying Part B expenses. This amount is set each year by Medicare. Medicare does not pay this amount.

**Physician** means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

## DEFINITIONS CONTINUED

**Policy Effective Date** means the effective date of this Policy and is shown on the Policy Schedule. The Policy Effective Date is not the date You signed the application for coverage.

**Sickness** means illness or disease which first manifests itself after the Policy Effective Date and while this Policy is in force.

**Skilled Nursing Facility** means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

## BENEFIT PROVISIONS

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

**The benefits paid under this Policy will not duplicate benefits paid by Medicare.**

### Basic (Core) Benefits

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first (61<sup>st</sup>) day through the ninetieth (90<sup>th</sup>) day in any Medicare Benefit Period;

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;

Upon exhaustion of Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A Eligible Expenses for Hospitalization paid at applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days;

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;

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 For Plan "F"

**Medicare Part A Deductible:** Coverage for all of the Medicare Part A Initial Deductible amount per Benefit Period.

**Skilled Nursing Facility Care:** Coverage for the actual billed charges up to the Coinsurance Amount from the twenty first (21<sup>st</sup>) day through the one hundredth (100<sup>th</sup>) day in a Medicare benefit period for posthospital Skilled Nursing Facility care eligible under Medicare Part A.

**Medicare Part B Deductible:** Coverage for all of the Medicare Part B Deductible amount per Calendar Year regardless of Hospital confinement.

### **Additional Benefits For Plan "F" Continued**

**One Hundred Percent (100%) of the Medicare Part B Excess Charges:** Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

**Medically Necessary Emergency Care in a Foreign Country:** 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).

### **GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS**

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **PREMIUMS SUBJECT TO CHANGE** provision on page 1.

### **EXTENSION OF BENEFITS**

Termination of this Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

### **MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN**

Benefits and premiums under this Policy are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Policy is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this Policy shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862 (b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstatement of Your coverage provides for:

1. Coverage equivalent to coverage in effect before the date of suspension; and
2. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, and You enrolled in Medicare Part D while the Policy was suspended, the reinstated policy for Medicare Part D enrollees will not have outpatient prescription drug coverage, but will be substantially equivalent to Your coverage before the date of suspension.

## EXCLUSIONS

We will not pay benefits for:

- (a) expense incurred while this Policy is not in force, except as provided in the Extension of Benefits section;
- (b) Hospital or skilled nursing facility confinement incurred during a Medicare Part A Benefit Period that begins while this Policy is not in force.
- (c) that portion of any expense incurred which is paid for by Medicare;
- (d) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take home drugs and eye refractions;
- (e) services for which a charge is not normally made in the absence of insurance; or
- (f) loss or expense that is payable under any other Medicare Supplement Insurance Policy or certificate.

## GENERAL POLICY PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This Policy, including the endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the two (2) year period.

**GRACE PERIOD:** A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Policy shall continue in force.

**REINSTATEMENT:** If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after that date. In all other respects We and You shall have the same rights thereunder as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

**NOTICE OF CLAIMS:** We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on behalf of You to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

**CLAIM FORMS:** When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

**PROOF OF LOSS:** We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

**TIME OF PAYMENT OF CLAIMS:** All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

**PAYMENT OF CLAIMS:** Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

## GENERAL PROVISIONS CONTINUED

**OTHER INSURANCE WITH US:** You can be insured under only one of Our Medicare Supplement Policies at any one time. If You are insured under more than one such Policy, You can select the one that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return all premiums paid (less any claims paid) for any Policy that does not remain in effect.

**PHYSICAL EXAMINATIONS:** At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

**LEGAL ACTION:** No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

**UNPAID PREMIUM:** Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

**CONFORMITY WITH STATE LAWS:** Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

**ASSIGNMENT:** No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408.

**CLERICAL ERROR:** Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

**PRO RATA REFUND:** If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after the Policy month that death occurs.

**CANCELLATION BY INSURED:** You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

**This Policy is signed for Family Life Insurance Company by its President.**



President



Secretary

**FAMILY LIFE INSURANCE COMPANY**

P.O. Box 924408, Houston, Texas 77292-4408

**MEDICARE SUPPLEMENT INSURANCE POLICY - PLAN G**

**THIS IS A LEGAL CONTRACT BETWEEN YOU AND US**

**READ YOUR POLICY CAREFULLY**

This Policy provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Policy. In this Policy, "You" and "Your" means the Insured named on the application and shown on the Policy Schedule. "We", "Our" and "Us" means Family Life Insurance Company.

**NOTICE TO BUYER. THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

**IMPORTANT NOTICE:** Issuance of this Medicare Supplement Insurance Policy is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Policy to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Our Office at:

**P.O. Box 924408  
Houston, Texas 77292-4408  
800-877-7705**

**POLICY EFFECTIVE DATE AND CONSIDERATION**

We have issued this Policy in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Policy. The term of this Policy begins at twelve (12:00) o'clock, midnight, Standard Time, at the place where You reside on the Policy Effective Date shown on the Policy Schedule. It ends at twelve (12:00) o'clock, midnight, the same Standard Time, on the date Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Policy is shown on the Policy Schedule. An annual premium will maintain the Policy in force for twelve (12) months, semi-annual for six (6) months, quarterly for three (3) months and monthly for one (1) month.

**THIRTY DAY RIGHT TO EXAMINE AND RETURN POLICY**

Please read Your Policy carefully. If, for any reason, You are not satisfied, You may return Your Policy to Us within thirty (30) days after receiving it. If returned, the Policy will be void from its beginning and any premium paid will be refunded.

**GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE**

This Policy is renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage. Premiums are based on Your issue age. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as issue age, underwriting class, state and zip code of residence. You will be notified at least thirty (30) days in advance before any change in the table of rates.

**THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION**

**CAUTION**

**POLICY BENEFITS ARE LIMITED TO THOSE APPROVED BY MEDICARE FOR PAYMENT**

**THIS IS A NON-PARTICIPATING POLICY**

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**POLICY SCHEDULE**

**INSURED:** [John Doe]

**POLICY EFFECTIVE DATE:** [01/01/2009]

**POLICY NUMBER:** [123456]

**ISSUE AGE:** [65]

**SEX:** [Male]

**STATE OF ISSUE:** [Arizona]

**MODE AT ISSUE:** [Annual]

**MODAL PREMIUM:** [\$XXXX]

**PREMIUM TERM:** [Annual]

**UNDERWRITING CLASS:** [Preferred]

**SPOUSE DISCOUNT:** [No]

**TYPE OF COVERAGE:** MEDICARE SUPPLEMENT POLICY PLAN G

## DEFINITIONS

**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.

**At-Home Recovery Visit** means 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-hour period of services provided by a Care Provider is one visit.

**Benefit Period** means the period as determined by Medicare which begins on the date You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

**Calendar Year** means the period of time beginning on January 1 and ending on December 31 of that same year.

**Care Provider** means a duly qualified or licensed home health aide or 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.

**Coinsurance Amount** means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

**Emergency Care** means care needed immediately because of an Injury or illness of sudden and unexpected onset.

**Home** shall mean any place used by the Insured as a place of residence, provided that the 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.

**Hospital** means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

**Hospitalized or Hospitalization** means being confined in a Hospital on an inpatient basis.

**Immediate Family** means Your spouse, parents, grandparents, children, or siblings, and their spouses.

**Injury** means a bodily injury which is the direct result of an accident and independent of all other causes.

**Lifetime Inpatient Reserve Days** means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

**Medicaid** means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

**Medically Necessary** means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards or medical practice; and (4) not solely for the convenience of You or the Physician.

## DEFINITIONS CONTINUED

**Medicare** means 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** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

**Medicare Part A Initial Deductible** means the fixed amount Medicare does not pay during the first sixty (60) days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

**Physician** means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

**Policy Effective Date** means the effective date of this Policy and is shown on the Policy Schedule. The Policy Effective Date is not the date You signed the application for coverage.

**Sickness** means illness or disease which first manifests itself after the Policy Effective Date and while this Policy is in force.

**Skilled Nursing Facility** means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

## BENEFIT PROVISIONS

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

**The benefits paid under this Policy will not duplicate benefits paid by Medicare.**

### Basic (Core) Benefits

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first ( 61<sup>st</sup> ) day through the ninetieth (90<sup>th</sup>) day in any Medicare Benefit Period;

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;

Upon exhaustion of Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A Eligible Expenses for Hospitalization paid at applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days;

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;

Coverage for the Coinsurance Amount, or in the case of 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 For Plan "G"**

**Medicare Part A Deductible:** Coverage for all of the Medicare Part A Initial Deductible amount per Benefit Period.

**Skilled Nursing Facility Care:** Coverage for the actual billed charges up to the Coinsurance Amount from the twenty first (21<sup>st</sup>) day through the one hundredth (100<sup>th</sup>) day in a Medicare Benefit Period for posthospital Skilled Nursing Facility care eligible under Medicare Part A.

**Eighty Percent (80%) of the Medicare Part B Excess Charges:** Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

**Medically Necessary Emergency Care in a Foreign Country:** 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).

**At-Home Recovery Benefit:** Coverage for services to provide short term, at-home assistance with Activities of Daily Living for those recovering from an illness, Injury or surgery.

### **Coverage Requirements and Limitations**

At-home recovery services provided must be primarily services which assist in Activities of Daily Living.

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.

### **Coverage is limited to:**

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;

The actual charges for each visit up to a maximum reimbursement of \$40 per visit;

\$1,600 per calendar year;

Seven (7) visits in any one week;

Care furnished on a visiting basis in the Insured's Home;

Services provided by a Care Provider as defined in this Policy;

At-Home Recovery Visits while the Insured is covered under the Policy and not otherwise excluded;

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:**

Home care visits paid for by Medicare or other government programs; and

Care provided by family members, unpaid volunteers or providers who are not Care Providers.

## **GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS**

We guarantee that the benefits and payment schedule of this Policy will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Policy which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **PREMIUMS SUBJECT TO CHANGE** provision on page 1.

### **EXTENSION OF BENEFITS**

Termination of this Policy shall be without prejudice to any continuous loss which commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned upon Your continuous total disability, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

### **MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN**

Benefits and premiums under this Policy are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Policy is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Policy is effective as of the date of termination of such entitlement.

Benefits and premiums under this Policy shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstatement of Your coverage provides for:

1. Coverage equivalent to coverage in effect before the date of suspension; and
2. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended.

If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, and You enrolled in Medicare Part D while the Policy was suspended, the reinstated policy for Medicare Part D enrollees will not have outpatient prescription drug coverage, but will be substantially equivalent to Your coverage before the date of suspension.

### **EXCLUSIONS**

We will not pay benefits for:

- (a) expense incurred while this Policy is not in force, except as provided in the Extension of Benefits section;
- (b) Hospital or skilled nursing facility confinement incurred during a Medicare Part A Benefit Period that begins while this Policy is not in force.
- (c) that portion of any expense incurred which is paid for by Medicare;
- (d) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take home drugs and eye refractions;
- (e) services for which a charge is not normally made in the absence of insurance; or
- (f) loss or expense that is payable under any other Medicare Supplement Insurance Policy or certificate.

## GENERAL POLICY PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This Policy, including the endorsements and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the two (2) year period.

**GRACE PERIOD:** A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Policy shall continue in force.

**REINSTATEMENT:** If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after that date. In all other respects We and You shall have the same rights thereunder as We and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

**NOTICE OF CLAIMS:** We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice given by or on behalf of You to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

**CLAIM FORMS:** When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

**PROOF OF LOSS:** We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

**TIME OF PAYMENT OF CLAIMS:** All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

**PAYMENT OF CLAIMS:** Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

## GENERAL POLICY PROVISIONS CONTINUED

**OTHER INSURANCE WITH US:** You can be insured under only one of Our Medicare Supplement Policies at any one time. If You are insured under more than one such Policy, You can select the one that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return all premiums paid (less any claims paid) for any Policy that does not remain in effect.

**PHYSICAL EXAMINATIONS:** At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

**LEGAL ACTION:** No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

**UNPAID PREMIUM:** Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

**CONFORMITY WITH STATE LAWS:** Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

**ASSIGNMENT:** No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Family Life Insurance Company, P.O. Box 924408, Houston, Texas 77292-4408.

**CLERICAL ERROR:** Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied, documenting any clerical errors.

**PRO RATA REFUND:** If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after the Policy month that death occurs.

**CANCELLATION BY INSURED:** You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

**This Policy is signed for Family Life Insurance Company by its President.**



President



Secretary

**FAMILY LIFE INSURANCE COMPANY**

Home Office: Houston, TX

Medicare Supplement Administrative Office: P. O. Box 924408, Houston, TX 77292-4408

**APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE**

<b>APPLICATION #:</b>	
<b>APPLICANT</b>	<b>RESIDENCE ADDRESS</b>
<i>Last</i> _____ <i>First</i> _____ <i>MI</i> _____	<i>Street:</i> _____
<b>Check the Medicare Supplement Plan You Prefer:</b>	<i>City:</i> _____
<input type="checkbox"/> Standardized Plan A <input type="checkbox"/> Standardized Plan E	<i>State:</i> _____ <i>Zip Code:</i> _____
<input type="checkbox"/> Standardized Plan B <input type="checkbox"/> Standardized Plan F	
<input type="checkbox"/> Standardized Plan C <input type="checkbox"/> Standardized Plan G	
<input type="checkbox"/> Standardized Plan D	

<b>MEDICARE INFORMATION</b>	<b>MAILING ADDRESS</b>
Date first enrolled in Medicare Part B: _____	<i>Street:</i> _____
Medicare Claim Number: _____	<i>City:</i> _____
	<i>State:</i> _____ <i>Zip Code:</i> _____

<b>AGE</b>	<b>DATE OF BIRTH</b>			<b>SEX</b>	<b>AREA CODE</b>	<b>TELEPHONE NUMBER</b>
	<i>Month</i>	<i>Day</i>	<i>Year</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female		
<b>SOCIAL SECURITY NUMBER</b>					<b>HEIGHT</b>	
					<b>Feet</b>	<b>Inches</b>
					<b>WEIGHT</b>	
					<b>Lbs.</b>	
<i>Effective Date:</i> _____			<i>Special Requests:</i> _____			

<b>UNDERWRITING RISK CLASSIFICATION QUESTION</b> Have you used any form of tobacco in the past five years? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(You do not have to answer this question if you are applying during open enrollment or a guaranteed issue period.)</i>	<b>MODAL PREMIUM:</b> \$ _____ <b>SPOUSAL DISCOUNT:</b> \$ _____ <b>(IF APPLICABLE)</b> <b>POLICY FEE:</b> \$ <u>25.00</u> <b>TOTAL INITIAL PREMIUM:</b> \$ _____
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**PLEASE SELECT THE METHOD OF PAYMENT YOU WANT**

Bank Draft     Annual     Semiannual     Quarterly     Monthly Bank Draft

**PART I – HEALTH QUESTIONS**

**YOU ARE NOT REQUIRED TO ANSWER HEALTH QUESTIONS 1-14 IF YOU ARE IN OPEN ENROLLMENT OR A GUARANTEED ISSUE PERIOD. PLEASE SEE PAGE FOUR FOR AN EXPLANATION OF OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION.**

**IF YOU ANSWER “YES” TO ANY OF THE HEALTH QUESTIONS 1-11, YOU ARE NOT ELIGIBLE FOR COVERAGE.**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. Are you bedridden or confined to a wheelchair or require the assistance of a motorized mobility aid; or in the past two years have you suffered two or more falls within a six month period? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Are you currently hospitalized or confined to a nursing facility; or have you been hospitalized two or more times within the past year?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. In the past two years, has surgery or tests been advised by a physician but not performed?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Is surgery anticipated in the next twelve months?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Within the past two years have you had an amputation caused by disease?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Do you have now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for any of the following:                       |                              |                             |
| a. Parkinson’s Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Muscular Dystrophy, Alzheimer’s Disease, or any other cognitive disorder?                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**PART I – HEALTH QUESTIONS CONTINUED**

- b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human immunodeficiency virus (HIV) infection?  Yes  No
- c. Diabetes that has required more than 50 units of insulin daily or more than two medications (insulin or oral), Chronic Kidney Disease or Insufficiency, or Renal Failure requiring dialysis?  Yes  No
- d. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any Chronic Pulmonary condition?  Yes  No
- e. Internal Cancer, Leukemia, Malignant Melanoma, Hodgkin's Disease, or Lymphoma?  Yes  No
- f. Congestive Heart Failure (CHF), heart attack, Coronary or Carotid Artery Disease, Peripheral Vascular Disease, Stroke or Transient Ischemic Attack (TIA)?  Yes  No
- 7. Within the past two years have you had atrial fibrillation, heart valve surgery, cardiac pacemaker replaced or implanted, or been treated with a heart defibrillating device?  Yes  No
- 8. Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Cirrhosis of the Liver, Hepatitis, Alcohol or Drug Abuse, or Systemic Lupus?  Yes  No
- 9. Have you had an organ transplant or been advised to have an organ transplant?  Yes  No
- 10. Are you currently using the services of a home health care agency?  Yes  No
- 11. Do you require or receive any assistance with any of your activities of daily living such as transferring, bathing, toileting, eating, dressing, or continence?  Yes  No
- 12. Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Disabling Arthritis, Paget's Disease of the bone, or Rheumatoid Arthritis?  Yes  No
- 13. Do you now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for Osteoporosis with fracture?  Yes  No
- 14. Are you a non-insulin dependent diabetic, and if so do you have or have you been treated for any of the following conditions: diabetic retinopathy, peripheral vascular disease, kidney disease, kidney failure, neuropathy, stroke, congestive heart failure, heart condition, or high blood pressure treated with three or more medications?  Yes  No

Do you take prescription medications? If yes, please list below all the prescription medications you are currently taking. Attach an additional sheet if necessary.  Yes  No

Prescription Medication Name	Date Originally Prescribed	Frequency and Dosage	**Diagnosis/Condition

**\*\* PLEASE DO NOT LIST WATER PILL, WATER RETENTION, FLUID RETENTION OR BLOOD THINNER AS THESE ARE NOT MEDICAL CONDITIONS.**

**Primary Physician Information**

**Name:**

---

**Address:**

---

**Telephone:**

---

Did you turn age 65 in the last 6 months?  Yes  No

Did you enroll in Medicare Part B in the last 6 months?  Yes  No If yes, what is the effective date? \_\_\_\_\_

## PART II – MEDICAL COVERAGE REPLACEMENT (MUST BE COMPLETED)

**If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement policy, or that you had certain rights to buy such a policy you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with our application. PLEASE ANSWER ALL QUESTIONS. Please Mark Yes or No with an "X."**

To the best of your knowledge:

1. Are you covered for medical assistance through the state Medicaid program?  Yes  No

NOTE TO APPLICANT: If you are participating in a "Spend-Down" program and have not met your "Share of Cost," please answer NO to this question.

**IF YES,**

(a) Will Medicaid pay your premiums for this Medicare Supplement policy?  Yes  No

(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?  Yes  No

2. (a) If you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates. START END  
/ / / /

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?  Yes  No

(c) Was this your first time in this type of Medicare plan?  Yes  No

(d) Did you drop a Medicare Supplement plan to enroll in the Medicare plan?  Yes  No

3. (a) Do you have another Medicare Supplement policy in force?  Yes  No

(b) If so, with which company: \_\_\_\_\_

with which plan: \_\_\_\_\_

and what paid-to-date do you have? \_\_\_\_\_

(c) If so, do you intend to replace your current Medicare Supplement policy with this policy?  Yes  No

4. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)?  Yes  No

(a) If yes, with what company, what kind of policy and reason for termination?

\_\_\_\_\_  
(b) What are your dates of coverage under the other policy? START END  
/ / / /

## IMPORTANT STATEMENTS TO BE READ AND SIGNED BY THE APPLICANT

- (1) You do not need more than one Medicare Supplement Insurance Policy.
- (2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- (3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance Policy.
- (4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance Policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- (5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing your employer or union based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- (6) Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

## OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

**Open Enrollment:** You are eligible for Open Enrollment and will not need to answer Health Questions 1-14 on Pages 1 and 2 of this application if (a) you are within six months of purchasing Medicare Part B coverage for the first time; or (b) you were eligible for early Medicare and you are within six months of turning age 65.

**Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997:** The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

- (a) Enrolled under an employee welfare benefit plan that either: (1) supplements Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits; or (2) is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan; or
- (b) Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (d) Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency or other involuntary termination of coverage under the policy, substantial violation of a material policy provision, or material misrepresentation; or
- (e) Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage plan, a risk or cost contract, a Medicare Select plan, or a PACE provider, and then the insured person terminates coverage within 12 months of enrollment; or
- (f) Upon *first* becoming eligible for benefits under Part A at age 65, you enrolled in a Medicare Advantage plan or PACE provider and then you disenroll within 12 months; or
- (g) Lost eligibility for health benefits under Medicaid.

**Documentation of these events must be submitted with the application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.**

## AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person including Medicare, that has any records or knowledge of me or my health or having any non-medical information concerning me to give Family Life Insurance Company, or its reinsurers, any such information. I understand that I am authorizing Family Life Insurance Company to receive my health information, prescription drug usage history and my non-medical information. I understand that prescription drug usage may be used to verify the presence of certain medical conditions and that such history will not be used to decline coverage. These medical conditions will be confirmed by a telephone interview prior to being used in the underwriting process. The released information received by Family Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Medical information will not be used to decline coverage if you are applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Family Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Family Life Insurance Company *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying Family Life Insurance Company in writing at their Medicare Supplement Administrative Office: P.O. Box 924408, Houston, Texas 77292-4408. I understand that such revocation will not have any effect on actions Family Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be treated in the same manner as the original.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part.

**WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for Insurance is guilty of a crime and may be subject to fines and confinement in prison.**

I acknowledge receiving: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed At: \_\_\_\_\_  
(City /State)

Dated: \_\_\_\_\_ Applicant's Signature: \_\_\_\_\_  
(Month/Day/Year)

**AGENT'S CERTIFICATION**

The undersigned Agent certifies that the Applicant has read, or had read to the Applicant, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

**TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)**

1. List any other health insurance policy you have sold to the Applicant that is still in force.

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2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

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I certify that:

1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for and a Guide To Health Insurance for People With Medicare to the Applicant.

\_\_\_\_\_  
**Agent's Signature:**

\_\_\_\_\_  
**Date:**

\_\_\_\_\_  
**Agent's Printed Name:**

\_\_\_\_\_  
**Agent No.:**

AUTHORIZATION	<b>IN FAVOR OF:</b> <b>Family Life Insurance Company</b> <b>Administrative office</b> <b>P.O. Box 924408, Houston, Texas 77292-4408</b>	
	<b>Name of Bank Customer:</b>	<b>Policy Numbers</b>
	<b>Insured's Name:</b>	
	<b>Account Number :</b>	<b>Routing Number:</b>
	<b>To (Name of Bank):</b> _____ <b>Address of Bank:</b> _____	
<p>You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Company indicated above, (hereinafter referred to as THE COMPANY), on my account by and payable to the order of The Company for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Company shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or other orders drawn by The Company. I further agree that if any such checks or other orders drawn by The Company be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.</p>		
<b>Date</b>	<b>Signature of Depositor</b>	
<b>Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.</b>		
<b>To:    The Bank above</b>		
<p>In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our order, we agree:</p> <ul style="list-style-type: none"> <li>➤ To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.</li> <li>➤ In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.</li> <li>➤ To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.</li> </ul>		

AUTHORIZATION

(Attach Voided Check)

### AUTHORITY TO HONOR PREMIUM CHECKS

**FAMILY LIFE INSURANCE COMPANY**  
**Outline of Medicare Supplement Coverage-Cover Page 1 of 2**  
**Benefit Plans A, B, C, D, E, F AND G**

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. Family Life Insurance Company offers seven of the fourteen plans available.

**See Outlines of Coverage sections for details about ALL plans**

**Basic Benefits for Plans A-J:**

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.

Blood: First three pints of blood each year.

<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>F</b>	<b>F*</b>	<b>G</b>	<b>H</b>	<b>I</b>	<b>J</b>	<b>J*</b>
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance				
	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	

\*Plans 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 benefits as Plans F and J after one has paid a calendar year \$2000 deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed \$2000. 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 do not include the plan's separate foreign travel emergency deductible.

**FAMILY LIFE INSURANCE COMPANY**  
**Outline of Medicare Supplement Coverage-Cover Page 2 of 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.**

<b>J</b>	<b>K**</b>	<b>L**</b>
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 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		
Preventative Care NOT covered by Medicare		
	\$4620 Out of Pocket Annual Limit***	\$2310 Out of Policy 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 plans pays 100% of the Medicare copayments, 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.**

**See Outlines of Coverage for details and exceptions.**

**FAMILY LIFE INSURANCE COMPANY OF AMERICA**

**PREFERRED PREMIUM RATES  
FOR USE IN ARKANSAS ZIP CODES**

**722, 72002, 72053, 72065, 72076, 72078, 72099, 72103, 722113-72120, 72124,  
72135, 72142, 72164, 72180, 72190, 72198, 72199**

**ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[1186]	[1444]	[1658]	[1514]	[1519]	[1696]	[1521]

**SEMI-ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[593]	[722]	[829]	[757]	[760]	[848]	[761]

**QUARTERLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[297]	[361]	[415]	[379]	[380]	[424]	[380]

**MONTHLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[99]	[120]	[138]	[126]	[127]	[141]	[127]

**Spousal Discount Factor: .93  
There is a one time \$25 policy fee**

**FAMILY LIFE INSURANCE COMPANY OF AMERICA**

**STANDARD PREMIUM RATES  
FOR USE IN ARKANSAS ZIP CODES**

**722, 72002, 72053, 72065, 72076, 72078, 72099, 72103, 722113-72120, 72124,  
72135, 72142, 72164, 72180, 72190, 72198, 72199**

**ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	<b>[1318]</b>	<b>[1604]</b>	<b>[1842]</b>	<b>[1681]</b>	<b>[1688]</b>	<b>[1885]</b>	<b>[1691]</b>

**SEMI-ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	<b>[659]</b>	<b>[802]</b>	<b>[921]</b>	<b>[841]</b>	<b>[844]</b>	<b>[943]</b>	<b>[846]</b>

**QUARTERLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	<b>[330]</b>	<b>[401]</b>	<b>[461]</b>	<b>[420]</b>	<b>[422]</b>	<b>[471]</b>	<b>[423]</b>

**MONTHLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	<b>[110]</b>	<b>[134]</b>	<b>[154]</b>	<b>[140]</b>	<b>[141]</b>	<b>[157]</b>	<b>[141]</b>

**Spousal Discount Factor: .93  
There is a one time \$25 policy fee**

**FAMILY LIFE INSURANCE COMPANY OF AMERICA**

**PREFERRED PREMIUM RATES**

**FOR USE IN ALL ARKANSAS ZIP CODES BEGINNING WITH 720 and 721 EXCEPT  
72002, 72053, 72065, 72076, 72078, 72099, 72103, 722113-72120, 72124,  
72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199**

**ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[1127]	[1372]	[1575]	[1438]	[1443]	[1611]	[1445]

**SEMI-ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[564]	[686]	[788]	[719]	[722]	[806]	[723]

**QUARTERLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[282]	[343]	[394]	[360]	[361]	[403]	[361]

**MONTHLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[94]	[114]	[131]	[120]	[120]	[134]	[120]

**Spousal Discount Factor: .93  
There is a one time \$25 policy fee**

**FAMILY LIFE INSURANCE COMPANY OF AMERICA**

**STANDARD PREMIUM RATES**

**FOR USE IN ALL ARKANSAS ZIP CODES BEGINNING WITH 720 and 721 EXCEPT  
72002, 72053, 72065, 72076, 72078, 72099, 72103, 722113-72120, 72124,  
72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199**

**ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	<b>[1252]</b>	<b>[1524]</b>	<b>[1750]</b>	<b>[1597]</b>	<b>[1604]</b>	<b>[1791]</b>	<b>[1606]</b>

**SEMI-ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	<b>[626]</b>	<b>[762]</b>	<b>[875]</b>	<b>[799]</b>	<b>[802]</b>	<b>[896]</b>	<b>[803]</b>

**QUARTERLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	<b>[313]</b>	<b>[381]</b>	<b>[438]</b>	<b>[399]</b>	<b>[401]</b>	<b>[448]</b>	<b>[402]</b>

**MONTHLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	<b>[104]</b>	<b>[127]</b>	<b>[146]</b>	<b>[133]</b>	<b>[134]</b>	<b>[149]</b>	<b>[134]</b>

**Spousal Discount Factor: .93  
There is a one time \$25 policy fee  
Effective 01-01-2009**

**FAMILY LIFE INSURANCE COMPANY OF AMERICA**

**PREFERRED PREMIUM RATES  
FOR USE IN ALL ARKANSAS ZIP CODES  
EXCEPT 720-722**

**ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[1008]	[1227]	[1409]	[1287]	[1291]	[1442]	[1293]

**SEMI-ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[504]	[614]	[705]	[644]	[646]	[721]	[647]

**QUARTERLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[252]	[307]	[352]	[322]	[323]	[361]	[323]

**MONTHLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[84]	[102]	[117]	[107]	[108]	[120]	[108]

**Spousal Discount Factor: .93  
There is a one time \$25 policy fee**

**FAMILY LIFE INSURANCE COMPANY OF AMERICA**

**STANDARD PREMIUM RATES  
FOR USE IN ALL ARKANSAS ZIP CODES  
EXCEPT 720-722**

**ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[1120]	[1363]	[1566]	[1429]	[1435]	[1602]	[1437]

**SEMI-ANNUAL**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[560]	[682]	[783]	[715]	[718]	[801]	[719]

**QUARTERLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[280]	[341]	[392]	[357]	[359]	[401]	[359]

**MONTHLY**

<b>Issue Age</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F</b>	<b>Plan G</b>
<b>All Ages</b>	[93]	[114]	[131]	[119]	[120]	[134]	[120]

**Spousal Discount Factor: .93  
There is a one time \$25 policy fee**

### **PREMIUM INFORMATION**

Family Life Insurance Company may change your premium if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class on the date of change. Class is defined as Issue age, underwriting class, state and zip code of residence.

Premiums are based on your Issue age.

### **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 Family Life Insurance Company.

#### **RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to our Medicare Supplement Administrative Office at P. O. Box 924408, Houston, Texas 77292-4408. If you send the policy back to us within 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**

This policy may not fully cover all of your medical costs. Neither Family Life Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

#### **LIMITATIONS AND EXCLUSIONS**

This policy does not contain a pre-existing condition limitation and this policy does not pay benefits for (a) Expenses incurred while this policy is not in force except as provided in the Extension of Benefits section; (b) Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force; (c) That portion of any expense incurred which is paid for by Medicare; (d) Services for non-Medicare Eligible Expenses unless specifically covered in the policy, including, but not limited to, routine exams, take-home drugs and eye refractions; (e) Services for which a charge is not normally made in the absence of insurance; or (f) Loss or expense that is payable under any other Medicare Supplement insurance policy or certificate.

#### **REFUND OF PREMIUMS**

The Policy does contain a Pro-Rata Refund provision which provides for the partial refund of premium upon death.

The Policy does contain a Cancellation By Insured provision which provides for a refund of premium upon surrender of the Policy.

#### **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.**

**Please refer to your policy for details.**

**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 60 days in a row.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61<sup>st</sup> thru 90<sup>th</sup> day 91<sup>st</sup> day and after:</p> <ul style="list-style-type: none"> <li>— While using 60 lifetime reserve days</li> <li>— Once lifetime reserve days are used:                             <ul style="list-style-type: none"> <li>— Additional 365 days</li> <li>— Beyond the additional 365 days</li> </ul> </li> </ul>	<p>All but [\$1068] All but [\$267] a day</p> <p>All but [\$534] a day</p> <p>\$0</p> <p>\$0</p>	<p>\$0 [\$267] a day</p> <p>[\$534] a day</p> <p>100% of Medicare eligible expenses</p> <p>\$0</p>	<p>[\$1068] (Part A deductible) \$0**</p> <p>\$0**</p> <p>\$0**</p> <p>All costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> 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 21<sup>st</sup> thru 100<sup>th</sup> day 101<sup>st</sup> day and after</p>	<p>All approved amounts All but [\$133.50] a day \$0</p>	<p>\$0 \$0 \$0</p>	<p>\$0** Up to [\$133.50] a day All costs</p>
<p><b>BLOOD</b> First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0** \$0**</p>
<p><b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN A**

**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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES –</b> 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	\$0 Generally 80%	\$0 Generally 20%	[\$135] (Part B deductible) \$0**
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> 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**
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0**

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> 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**

**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 60 days in a row.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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 [\$1068] All but [\$267] a day  All but [\$534] a day  \$0  \$0	[\$1068] (Part A deductible) [\$267] a day  [\$534] a day  100% of Medicare eligible expenses  \$0	\$0** \$0**  \$0**  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day  101 <sup>st</sup> day and after	All approved amounts All but [\$133.50] a day  \$0	\$0 \$0  \$0	\$0** Up to [\$133.50] a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0** \$0**
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN B**

**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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES –</b> 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	\$0  Generally 80%	\$0  Generally 20%	[\$135] (Part B deductible)  \$0**
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> 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**
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0**

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> 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**

**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 60 days in a row.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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 [\$1068] All but [\$267] a day  All but [\$534] a day  \$0  \$0	[\$1068] (Part A deductible) [\$267] a day  [\$534] a day  100% of Medicare eligible expenses  \$0	\$0** \$0**  \$0**  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$133.50] a day \$0	\$0** \$0** All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0** \$0**
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN C**

**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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES –</b> 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	\$0 Generally 80%	[\$135] (Part B deductible) Generally 20%	\$0** \$0**
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> 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**
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0**

**PARTS A & B**

<b>HOME HEALTH CARE</b> 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**

<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA 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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**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 60 days in a row.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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 [\$1068] All but [\$267] a day All but [\$534] a day \$0 \$0	[\$1068] (Part A deductible) [\$267] a day [\$534] a day 100% of Medicare eligible expenses \$0	\$0** \$0** \$0** \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$133.50] a day \$0	\$0** \$0** All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0** \$0**
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN D**

**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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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	 \$0 Generally 80%	 \$0 Generally 20%	 [\$135] (Part B deductible) \$0**
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> 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**
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0**

(continued)

**PLAN D**

**PARTS A & B**

\*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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b>			
<b>MEDICARE APPROVED SERVICES</b>			
— 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**
<b>AT HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE</b>			
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	\$0	Actual charges to [\$40] a visit	Balance
— Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	Balance
— Calendar Year maximum	\$0	[\$1,600]	Balance

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	[\$250]
Remainder of charges	\$0	80% to a lifetime maximum benefit of [\$50,000].	20% and amounts over the [\$50,000] lifetime maximum.

**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 60 days in a row.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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 [\$1068]  All but [\$267] a day  All but [\$534] a day  \$0  \$0	[\$1068] (Part A deductible) [\$267] a day  [\$534] a day  100% of Medicare eligible expenses  \$0	\$0**  \$0**  \$0**  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$133.50] a day \$0	\$0** \$0** All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0** \$0**
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN E**

**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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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	\$0  Generally 80%	\$0  Generally 20%	  [\$135] (Part B deductible)  \$0**
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> 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**
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0**

**PARTS A & B**

<b>HOME HEALTH CARE</b> 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**
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(continued)

**PLAN E**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

\*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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA 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.
<b>†PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE</b> Some annual physical and preventive tests and services 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

†Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

**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 60 days in a row.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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 [\$1068]  All but [\$267] a day  All but [\$534] a day  \$0  \$0	[\$1068] (Part A deductible) [\$267] a day  [\$534] a day  100% of Medicare eligible expenses  \$0	\$0**  \$0**  \$0**  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$133.50] a day \$0	\$0** \$0** All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0** \$0**
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN F**

**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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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*	\$0	[\$135] (Part B deductible)	\$0**
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0**
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0**
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0**
Next \$135 of Medicare Approved amounts*	\$0	[\$135] (Part B deductible)	\$0**
Remainder of Medicare Approved amounts	80%	20%	\$0**
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0**

(continued)

**PLAN F**  
**PARTS A & B**

\*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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b>			
MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0**
— Durable medical equipment			
First \$135 of Medicare Approved Amounts*	\$0	[\$135] (Part B deductible)	\$0**
Remainder of Medicare Approved Amounts	80%	20%	\$0**

**OTHER SERVICES – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	[\$250]
Remainder of charges	\$0	80% to a lifetime maximum benefit of [\$50,000]	20% and amounts over the [\$50,000] lifetime maximum

**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 60 days in a row.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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 [\$1068] All but [\$267] a day  All but [\$534] a day  \$0  \$0	[\$1068] (Part A deductible) [\$267] a day  [\$534] a day  100% of Medicare eligible expenses  \$0	\$0** \$0**  \$0**  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$133.50] a day \$0	\$0** \$0** All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0** \$0**
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN G**

**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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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*	\$0	\$0	[\$135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0**
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	80%	20%
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0**
Next \$135 of Medicare Approved Amounts*	\$0	\$0	[\$135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0**
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0**

(continued)

**PLAN G  
PARTS A & B**

\*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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
— 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**
<b>AT HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE</b>			
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	\$0	Actual charges to [\$40] a visit	Balance
— Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	Balance
— Calendar Year maximum	\$0	[\$1600]	Balance

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	[\$250]
Remainder of Charges	\$0	80% to a lifetime maximum benefit of [\$50,000].	20% and amounts over the [\$50,000] lifetime maximum



## Medicare Supplement Insurance Plans

*“Insuring your tomorrow  
with star treatment today.”*

# Family Life Medicare Supplements

## Protection from the Bills Medicare Doesn't Pay

Medicare was never meant to cover all of your doctor and hospital bills. Many people do not realize this and expect them to pay all. Reliance on Medicare in this situation can mean financial difficulty with out-of-pocket expenses.

## Family Life Offers 7 Standardized Insurance Plans

Family Life insurance plans are designed to give you choices. Choices you need to help cover health care costs today! Our plans allow you to choose a Medicare Supplement to suit your life's situation, budget and needs. All plans may not be available in all states.

## Initial Hospital Deductible

Medicare Part A hospital deductibles have risen [\$984] since 1968 - just [40] years!

[\$1024]

[2 0 0 8]

\$ 40  
1 9 6 8

## All Medicare Supplement Plans Offer These Benefits:

**Part A Co-Insurance** pays if you are confined to a hospital. Should you require more than 60 continuous days hospitalization, Family Life will pay the co-insurance amounts up to the 150th day of confinement and also for the first 3 pints of blood each year. Additionally, if you use your lifetime reserve days, Family Life will provide coverage for up to an additional 365 days.

**Part B Co-Insurance** pays the Medicare Part B coinsurance amount, reducing your out-of-pocket expenses when you require medical services.

**FAMILY LIFE**  
INSURANCE COMPANY

# Your Benefits

## Medicare Part A Hospital Coverage

**Deductible** - Medicare Supplement Plans B, C, D, E, F and G all pay the [\$1024] inpatient hospital deductible for each benefit period.

**First 60 Days** - After the Part A deductible, Medicare pays all eligible expenses for services from your first through 60th day of hospital confinement. Services include semiprivate room and board, general nursing and miscellaneous hospital services and supplies.

**Coinsurance** - All Medicare Supplement Plans pay up to [\$256] a day when you're hospitalized from the 61st through the 90th day. And when you're in the hospital from the 91st through 150th day, Medicare Supplement Plans pay you up to [\$512] a day for each Lifetime Reserve day used.

**Extended Hospital Coverage** - When you're in the hospital longer than 150 days during a Benefit Period, and you've exhausted your 60 Medicare Lifetime Reserve days, all Medicare Supplement Plans pay the Part A Medicare eligible expenses for hospitalization, paid at the Prospective Payment System (PPS) rate or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days.

**Benefit for Blood** - Medicare has one calendar-year deductible for blood that is the cost of the first three pints needed. All Medicare Supplement Plans pay this deductible.

### Skilled Nursing Facility Care

**First 20 Days** - Medicare pays all eligible expenses.

**Coinsurance** - Medicare Supplement Plans C, D, E, F and G pay up to [\$128] a day from the 21st through the 100th day during which you receive skilled nursing care. You must enter a Medicare-certified skilled nursing facility within 30 days of being hospitalized for at least three days.

## Medicare Part B Physician's Services and Supplies

**Deductible** - Medicare Supplement Plans C and F pay the [\$135] calendar year deductible.

**Coinsurance** - After the Part B deductible, All Medicare Supplement Plans generally pay 20% of Medicare Eligible Expenses for physician's services, hospital outpatient services and supplies, physical and speech therapy, and ambulance service.

**Excess Benefits** - Your bill for Part B services and supplies may exceed the Medicare Eligible Expense. When that occurs, Medicare Supplement Plan F pays 100% of the difference, up to the charge limitation established by Medicare. Medicare Supplement Plan G Pays 80% of the difference, up to the charge limitation established by Medicare.

**Benefit for Blood** - Medicare has one calendar year deductible for blood that is the cost of the first three pints needed. All Medicare Supplement Plans pay this deductible.

### Additional Benefits

**Emergency Care Received Outside the U.S.** - After you pay a [\$250] calendar-year deductible, Medicare Supplement Plans C, D, E, F and G pay you 80% of eligible expenses incurred during the first 60 days for emergency care received outside the U.S. up to a lifetime maximum of \$50,000. Benefits are payable for emergency health care you need immediately because of a covered injury or illness of sudden and unexpected onset.

**At-Home Recovery Visits** - Medicare Supplement Plans D and G pay for seven visits a week, up to \$40 a visit up to a maximum of \$1,600 a year for assistance with activities of daily living. Benefits are payable for services necessary for your recovery from an illness, injury or surgery in your home by a Medicare approved provider.

**Preventive Care Benefit** - Medicare Supplement Plan E pays \$120 per year for some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.

# Your Plan; The Facts

**Family Life** helps pay some eligible expenses not paid for by Medicare Part A and Medicare Part B. **There may be charges above what Medicare and Family Life pay.**

**Medicare Part A Eligible Expenses for Hospital/Skilled Nursing Facility Care** include expenses for semiprivate room and board, general nursing, miscellaneous services and supplies.

**Medicare Part B Eligible Expenses for Medical Services** include expenses for physician's services, hospital outpatient services and supplies, physical and speech therapy, and ambulance service.

**"Medicare Eligible Expenses"** means expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

**A Benefit Period** begins the first full day you are hospitalized and ends when you have not been in a hospital or skilled nursing facility for 60 days in a row.

**Coinsurance** is the portion of the Medicare Eligible Expense you have to pay. It does not include Part A and B deductible amounts not paid by Medicare.

**As Medicare deductibles and coinsurance increase**, your Medicare Supplement benefits will automatically increase. Medicare Supplement benefits will not duplicate benefits paid by Medicare.

**Benefits are paid to you** or to your hospital or doctor.

**You have 31 days from your renewal date to pay your premium.** Your policy will stay in force during this 31 day grace period.

**Your policy is guaranteed renewable.** Your policy cannot be cancelled. It will be renewed as long as

Premium rate adjustments may be made based on current health care cost experience for benefits paid. Family Life reserves the right to establish new premium rates for all insureds based on a class basis, but only after giving you advance notice. **However, we will not increase premiums based on your own claims.**

**You're covered immediately.** There is no waiting period for pre-existing conditions. Benefits will be paid from the time your policy is in force.

**Family Life Medicare Supplements will not pay for:**

- Expenses incurred while the policy is not in force except as provided in the Extension of Benefits section;
- Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while the policy is not in force;
- That portion of any expense incurred which is paid for by Medicare;
- Services for non-Medicare Eligible Expenses unless specifically covered in the policy, including, but not limited to, routine exams, take-home drugs and eye refractions;
- Services for which a charge is not normally made in the absence of insurance; or
- Loss or expense that is payable under any other Medicare Supplement insurance policy or certificate.

**THIS IS A BRIEF DESCRIPTION** of your coverage. For complete information on benefits, exceptions and limitations, **PLEASE READ YOUR ACCOMPANYING OUTLINE OF COVERAGE.**

**Neither Family Life nor its agents** are connected in any way with the Federal or state Government or Medicare.

# A Plan to Meet Your Every Need

	Medicare Pays	Plan A Pays	Plan B Pays	Plan C Pays	Plan D Pays	Plan E Pays	Plan F Pays	Plan G Pays
<b>Medicare Part A Hospital Coverage</b>								
Deductible	All but [\$1024]	-	[\$1024]	[\$1024]	[\$1024]	[\$1024]	[\$1024]	[\$1024]
First 60 days	100%	-	-	-	-	-	-	-
Coinsurance 61-90 days	All but [\$256]	Up to [\$256]	Up to [\$256]	Up to [\$256]	Up to [\$256]	Up to [\$256]	Up to [\$256]	Up to [\$256]
Coinsurance 91-150 days	All but [\$512]	Up to [\$512]	Up to [\$512]	Up to [\$512]	Up to [\$512]	Up to [\$512]	Up to [\$512]	Up to [\$512]
Extended Hospital Coverage (up to an additional 365 days in your lifetime)	-	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses
Benefit for Blood First Three Pints	\$0	Three pints	Three pints	Three pints	Three pints	Three pints	Three pints	Three pints
Addtl. Amounts	100%	-	-	-	-	-	-	-
<b>Skilled Nursing Facility Care</b>								
First 20 days	100%	-	-	-	-	-	-	-
Coinsurance 21-100 days	All but [\$128] A day	-	-	Up to [\$128] A day	Up to [\$128] A day	Up to [\$128] A day	Up to [\$128] A day	Up to [\$128] A day
<b>Medicare Part B Physician's Services And Supplies</b>								
Deductible	-	-	-	[\$135]	-	-	[\$135]	-
Coinsurance	Generally 80%	Generally 20%	Generally 20%	Generally 20%	Generally 20%	Generally 20%	Generally 20%	Generally 20%
Excess Benefits	-	-	-	-	-	-	100% up to Medicare's Limit	80% up to Medicare's Limit
Benefit for Blood First Three Pints	\$0	Three pints	Three pints	Three pints	Three pints	Three pints	Three pints	Three pints
Addtl. Amounts	100%	-	-	-	-	-	-	-
<b>Additional Benefits</b>								
Emergency Care Received Outside The U.S.	-	-	-	Up to \$50,000	Up to \$50,000	Up to \$50,000	Up to \$50,000	Up to \$50,000
At-home Recovery Visits	-	-	-	-	Up to \$1,600 Per Year	-	-	Up to \$1,600 Per Year
Preventive Care Benefit	-	-	-	-	-	\$120 Per Year	-	-

**FOR CLAIMS, PLEASE CALL:  
1-800-877-7705**

**This brochure is an illustration, not a contract. Consult your outline of coverage for a complete description of benefits available to you.**

RECEIPT

Received of \_\_\_\_\_

this \_\_\_\_\_ day of \_\_\_\_\_ the sum of \$ \_\_\_\_\_

being the payment of \_\_\_\_\_ Premium.

This insurance applied for shall not take effect until the effective date of the policy and the payment of the first premium. In the event the application is declined, any payments made by the Applicant will be returned.

\_\_\_\_\_  
Agent's Signature

Underwritten by:  
**Family Life  
Insurance Company**  
PO Box 924408  
Houston, Texas 77292-4408  
1-800-987-1593

Make checks payable to Family Life Insurance Company.  
Do not make payable to agent or leave payee blank.

**FAMILY LIFE**  
INSURANCE COMPANY



## Medicare Supplement Insurance Plans

*“Insuring your tomorrow  
With star treatment today.”*

# Family Life Medicare Supplements

## Protection from the Bills Medicare Doesn't Pay

Medicare was never meant to cover all of your doctor and hospital bills. Many people do not realize this and expect them to pay all. Reliance on Medicare in this situation can mean financial difficulty with out-of-pocket expenses.

## Family Life Offers 7 Standardized Insurance Plans

Family Life insurance plans are designed to give you choices. Choices you need to help cover health care costs today! Our plans allow you to choose a Medicare Supplement to suit your life's situation, budget and needs. All plans may not be available in all states.

## Initial Hospital Deductible

Medicare Part A hospital deductibles have risen [\$984] since 1968 - just [40] years!

[\$1024]

[2 0 0 8]

\$ 40  
1 9 6 8

## All Medicare Supplement Plans Offer These Benefits:

**Part A Co-Insurance** pays if you are confined to a hospital. Should you require more than 60 continuous days hospitalization, Family Life will pay the co-insurance amounts up to the 150th day of confinement and also for the first 3 pints of blood each year. Additionally, if you use your lifetime reserve days, Family Life will provide coverage for up to an additional 365 days.

**Part B Co-Insurance** pays the Medicare Part B coinsurance amount, reducing your out-of-pocket expenses when you require medical services.



# Your FamilyLife Benefits

## Medicare Part A Hospital Coverage

**Deductible** - Family Life Plans B, C, D, E, F and G all pay the [\$1024] inpatient hospital deductible for each benefit period.

**First 60 Days** - After the Part A deductible, Medicare pays all eligible expenses for services from your first through 60th day of hospital confinement. Services include semiprivate room and board, general nursing and miscellaneous hospital services and supplies.

**Coinsurance** - All Family Life Plans pay up to [\$256] a day when you're hospitalized from the 61st through the 90th day. And when you're in the hospital from the 91st through 150th day, Family Life Plans pay you up to [\$512] a day for each Lifetime Reserve day used.

**Extended Hospital Coverage** - When you're in the hospital longer than 150 days during a Benefit Period, and you've exhausted your 60 Medicare Lifetime Reserve days, all Family Life Plans pay the Part A Medicare eligible expenses for hospitalization, paid at the Prospective Payment System (PPS) rate or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days.

**Benefit for Blood** - Medicare has one calendar-year deductible for blood that is the cost of the first three pints needed. All Family Life Plans pay this deductible.

### Skilled Nursing Facility Care

**First 20 Days** - Medicare pays all eligible expenses.

**Coinsurance** - Family Life Plans C, D, E, F and G pay up to [\$128] a day from the 21st through the 100th day during which you receive skilled nursing care. You must enter a Medicare-certified skilled nursing facility within 30 days of being hospitalized for at least three days.

## Medicare Part B Physician's Services and Supplies

**Deductible** - Family Life Plans C and F pay the [\$135] calendar year deductible.

**Coinsurance** - After the Part B deductible, All Family Life Plans generally pay 20% of Medicare Eligible Expenses for physician's services, hospital outpatient services and supplies, physical and speech therapy, and ambulance service.

**Excess Benefits** - Your bill for Part B services and supplies may exceed the Medicare Eligible Expense. When that occurs, Family Life Plan F pays 100% of the difference, up to the charge limitation established by Medicare. Family Life Plan G Pays 80% of the difference, up to the charge limitation established by Medicare.

**Benefit for Blood** - Medicare has one calendar year deductible for blood that is the cost of the first three pints needed. All Family Life Plans pay this deductible.

### Additional Benefits

#### Emergency Care Received Outside the U.S. -

After you pay a [\$250] calendar-year deductible, Family Life Plans C, D, E, F and G pay you 80% of eligible expenses incurred during the first 60 days for emergency care received outside the U.S. up to a lifetime maximum of \$50,000. Benefits are payable for emergency health care you need immediately because of a covered injury or illness of sudden and unexpected onset.

#### At-Home Recovery Visits -

Family Life Plans D and G pay for seven visits a week, up to \$40 a visit up to a maximum of \$1,600 a year for assistance with activities of daily living. Benefits are payable for services necessary for your recovery from an illness, injury or surgery in your home by a Medicare approved provider.

**Preventive Care Benefit** - Family Life Plan E pays \$120 per year for some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.

# Your Plan; The Facts

**Family Life** helps pay some eligible expenses not paid for by Medicare Part A and Medicare Part B. **There may be charges above what Medicare and Family Life pay.**

**Medicare Part A Eligible Expenses for Hospital/Skilled Nursing Facility Care** include expenses for semiprivate room and board, general nursing, miscellaneous services and supplies.

**Medicare Part B Eligible Expenses for Medical Services** include expenses for physician's services, hospital outpatient services and supplies, physical and speech therapy, and ambulance service.

**"Medicare Eligible Expenses"** means expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

**A Benefit Period** begins the first full day you are hospitalized and ends when you have not been in a hospital or skilled nursing facility for 60 days in a row.

**Coinsurance** is the portion of the Medicare Eligible Expense you have to pay. It does not include Part A and B deductible amounts not paid by Medicare.

**As Medicare deductibles and coinsurance increase,** your Family Life benefits will automatically increase. Family Life benefits will not duplicate benefits paid by Medicare.

**Benefits are paid to you** or to your hospital or doctor.

**You have 31 days from your renewal date to pay your premium.** Your policy will stay in force during this 31 day grace period.

**Your policy is guaranteed renewable.** Your policy cannot be cancelled. It will be renewed as long as the premiums are paid on time.

**Rates are based on your age** and your premiums will increase automatically on each policy anniversary date, based on the age you attain. Premium rate adjustments may also be made based on current health care cost experience for benefits paid. Family Life reserves the right to establish new premium rates for all insureds based on a class basis, but only after giving you advance notice. **However, we will not increase premiums based on your own claims.**

**You're covered immediately.** There is no waiting period for pre-existing conditions. Benefits will be paid from the time your policy is in force.

**Family Life Medicare Supplements will not pay for:**

- Expenses incurred while the policy is not in force except as provided in the Extension of Benefits section;
- Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while the policy is not in force;
- That portion of any expense incurred which is paid for by Medicare;
- Services for non-Medicare Eligible Expenses unless specifically covered in the policy, including, but not limited to, routine exams, take-home drugs and eye refractions;
- Services for which a charge is not normally made in the absence of insurance; or
- Loss or expense that is payable under any other Medicare Supplement insurance policy or certificate.

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# A Plan to Meet Your Every Need

	Medicare Pays	Plan A Pays	Plan B Pays	Plan C Pays	Plan D Pays	Plan E Pays	Plan F Pays	Plan G Pays
<b>Medicare Part A Hospital Coverage</b>								
Deductible	All but [\$1024]	-	[\$1024]	[\$1024]	[\$1024]	[\$1024]	[\$1024]	[\$1024]
First 60 days	100%	-	-	-	-	-	-	-
Coinsurance 61-90 days	All but [\$256]	Up to [\$256]	Up to [\$256]	Up to [\$256]	Up to [\$256]	Up to [\$256]	Up to [\$256]	Up to [\$256]
Coinsurance 91-150 days	All but [\$512]	Up to [\$512]	Up to [\$512]	Up to [\$512]	Up to [\$512]	Up to [\$512]	Up to [\$512]	Up to [\$512]
Extended Hospital Coverage (up to an additional 365 days in your lifetime)	-	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses
Benefit for Blood First Three Pints	\$0	Three pints	Three pints	Three pints	Three pints	Three pints	Three pints	Three pints
Addtl. Amounts	100%	-	-	-	-	-	-	-
<b>Skilled Nursing Facility Care</b>								
First 20 days	100%	-	-	-	-	-	-	-
Coinsurance 21-100 days	All but [\$128] A day	-	-	Up to [\$128] A day	Up to [\$128] A day	Up to [\$128] A day	Up to [\$128] A day	Up to [\$128] A day
<b>Medicare Part B Physician's Services And Supplies</b>								
Deductible	-	-	-	[\$135]	-	-	[\$135]	-
Coinsurance	Generally 80%	Generally 20%	Generally 20%	Generally 20%	Generally 20%	Generally 20%	Generally 20%	Generally 20%
Excess Benefits	-	-	-	-	-	-	100% up to Medicare's Limit	80% up to Medicare's Limit
Benefit for Blood First Three Pints	\$0	Three pints	Three pints	Three pints	Three pints	Three pints	Three pints	Three pints
Addtl. Amounts	100%	-	-	-	-	-	-	-
<b>Additional Benefits</b>								
Emergency Care Received Outside The U.S.	-	-	-	Up to \$50,000	Up to \$50,000	Up to \$50,000	Up to \$50,000	Up to \$50,000
At-home Recovery Visits	-	-	-	-	Up to \$1,600 Per Year	-	-	Up to \$1,600 Per Year
Preventive Care Benefit	-	-	-	-	-	\$120 Per Year	-	-

**FOR CLAIMS, PLEASE CALL:  
1-800-877-7705**

**This brochure is an illustration, not a contract. Consult your outline of coverage for a complete description of benefits available to you.**

RECEIPT

Received of \_\_\_\_\_

this \_\_\_\_\_ day of \_\_\_\_\_ the sum of \$ \_\_\_\_\_

being the payment of \_\_\_\_\_ Premium.

This insurance applied for shall not take effect until the effective date of the policy and the payment of the first premium. In the event the application is declined, any payments made by the Applicant will be returned.

\_\_\_\_\_  
Agent's Signature

Underwritten by:  
**Family Life  
Insurance Company**  
PO Box 924408  
Houston, Texas 77292-4408  
1-800-987-1593

Make checks payable to Family Life Insurance Company.  
Do not make payable to agent or leave payee blank.