Retain This Outline For Your Records

BANKERS FIDELITY LIFE INSURANCE COMPANY®
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OUTLINE OF COVERAGE FOR CANCER INSURANCE POLICY

Policy Form B 21904-CR VA

READ YOUR POLICY CAREFULLY

This Outline of Coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in details the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

SPECIFIED DISEASE COVERAGE

Policies of this category are designed to provide, to persons insured, limited coverage paying benefits ONLY when certain losses occur as a result of specified diseases, subject to any limitations and waiting periods set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If you are eligible for Medicare, review the *Buyer's Guide to Health Insurance for People with Medicare* available from the insurance company. Bankers Fidelity Life Insurance Company® does not represent Medicare, the federal government or any state government.

THE POLICY IS A LIMITED BENEFIT SUPPLEMENTAL HEALTH INSURANCE PRODUCT AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICALCOVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT DUE WITH YOUR TAXES.

BENEFITS

The policy contains a 30-day Waiting Period - Benefits are not payable for any Loss incurred within the first 30 days after the Effective Date of the Policy or any attached Rider.

The following is a brief description of the benefits, additional options and optional riders that are available with the Policy. All benefits are subject to the conditions, definitions, exclusions, limitations and provisions of the actual Policy and applicable Rider, **including the 30-day Waiting Period**.

CANCER INSURANCE BENEFIT

A Lump Sum Cancer Benefit will be payable upon receipt of due proof of the Insured's Diagnosis with Invasive Cancer or Carcinoma In Situ. Benefits for Carcinoma In Situ may be elected at levels of 100% or/are payable at an amount equal to 25% of the benefit amount payable for Invasive Cancer. Benefits for Skin Cancer are payable in the amount applied for. Payment of the Skin Cancer Benefit will be one (1) time per Diagnosis, even if Skin Cancer is Diagnosed in multiple locations on the same occasion. Benefits are payable for subsequent Skin Cancer upon receipt of due proof satisfactory to Us that: 1) at least twenty-four (24) consecutive months have elapsed since a Diagnosis of Skin Cancer; and 2) the Covered Person has not received Treatment for any Skin Cancer for a period of at least twenty-four (24) consecutive months. There is no lifetime maximum to the Skin Cancer Benefit.

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OPTIONAL ADDITIONAL BENEFIT RIDERS – *May select as many as desired*

Additional Occurrence Benefit Rider (Form B 21904 CAO R9 VA) –

Requested: ☐ Yes ☐ No

If requested and included in the Policy, benefits will be payable for additional occurrences of a Covered Cancer in accordance with the schedule below, if: 1) at least six (6) consecutive months or more have elapsed since the Covered Persons' Diagnosis with Cancer; and 2) the Covered Person has been free of Treatment for a period of at least six (6) consecutive months:

Time Period That Has Elapsed Since the Date of the Last Diagnosis of a Covered Cancer Condition or	Restoration Percentage
Less than 6 months	0%
At least 6 months or more	100%

In addition to the Exclusions included in the Policy, no Benefits are provided for the following, nor will We pay any benefits for any Loss arising from or otherwise related to, directly or indirectly, any condition or disease which was not a Loss for which a valid benefit was previously paid under the Policy to which this Rider is attached. This includes a Loss for which a benefit was previously paid but was later determined to have been paid erroneously.

Benefit Builder Rider (Form B 21904 CBB R2 VA) – Applied for: ☐ Yes ☐ No

If, after the 30-day Waiting Period and while the Rider is In Force, We pay a Lump Sum Benefit under the Policy for Cancer , We will pay a benefit under the Rider subject to the conditions, definitions, exclusions and limitations of the Rider and the Policy equal to: 1) the Benefit Amount shown in the chart below for the corresponding number of complete Rider Years the Rider was In Force on the Date of Diagnosis of the first Cancer ; *multiplied by* 2) the Number of Units elected and shown in the Rider; *multiplied by* 3) the percentage payable for Cancer shown in the Policy.

Rider Years:	Benefit Amount Per Unit:	Rider Years:	Benefit Amount Per Unit:	Rider Years:	Benefit Amount Per Unit:
1	$100.00	8	$800.00	15	$1,500.00
2	$200.00	9	$900.00	16	$1,600.00
3	$300.00	10	$1,000.00	17	$1,700.00
4	$400.00	11	$1,100.00	18	$1,800.00
5	$500.00	12	$1,200.00	19	$1,900.00
6	$600.00	13	$1,300.00	20	$2,000.00
7	$700.00	14	$1,400.00		

In addition to the Exclusions included in the Policy, no Benefits are provided for the following, nor will We pay any benefits for any Loss arising from or otherwise related to, directly or indirectly, any condition or disease which was not a Loss for which a valid benefit was previously paid under the Policy to which this Rider is attached. This includes a Loss for which a benefit was previously paid but was later determined to have been paid erroneously.

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Second Opinion and Travel Benefit Rider (Form B 21904 TRVL R7) – Applied for: ☐ Yes ☐ No

We will pay the following benefits, subject to the conditions, definitions, exclusions and limitations of the Rider and the Policy, when a Covered Person incurs a Loss due to Cancer. No benefits are payable under the Rider for the treatment of a Cancer except those expressly stated.

Second Opinion Benefit – We will pay $500.00 when a Covered Person is recommended by a Physician to have surgery or Treatment for Cancer, and the Covered Person chooses to obtain the second opinion of a second Physician, who is at least a board-certified Oncologist. This second opinion must be: 1) rendered prior to surgery or Treatment being performed; and 2) obtained from a Physician not in practice with the Physician rendering the original recommendation. This benefit is payable only once per Covered Person, per Cancer.

Transportation Benefit – We will pay $0.50 per mile when a Covered Person is transported by motor vehicle or common carrier (bus, rail, air) to and from a Hospital or other medical facility if the Covered Person must travel more than 100 miles away from their primary residence to receive Specialized Cancer Treatment. Mileage is measured from the Covered Person's primary residence to the nearest facility. Benefits are not payable for transportation by ambulance or any other type of licensed medical transport vehicle. This benefit is limited to a Maximum of seven hundred (700) miles per trip. There is no lifetime maximum to this benefit.

Lodging Benefit – We will pay $100.00 for each night a Covered Person incurs a charge for Lodging in order to receive Specialized Cancer Treatment at a medical facility that is located more than one hundred (100) miles from the Covered Persons' primary residence. This benefit is limited to a Maximum of thirty (30) nights per Covered Person, per Policy Year. There is no lifetime maximum to this benefit.

In addition to the Exclusions included in the Policy, no Benefits are provided for the following, nor will We pay any benefits for any Loss arising from or otherwise related to, directly or indirectly: 1) Skin Cancer; or 2) any condition or disease which was not a Loss for which a valid benefit was previously paid under the Policy to which this Rider is attached. This includes a Loss for which a benefit was previously paid but was later determined to have been paid erroneously.

PRE-EXISTING CONDITIONS LIMITATION

For benefits payable under the Policy, benefits are not payable during the first 12 months the Policy is In Force for Losses incurred due to a Pre-Existing Condition. For benefits payable under any optional benefit rider attached to the Policy, benefits are not payable during the first 12 months the rider is In Force for Losses incurred due to a Pre-Existing Condition.

EXCLUSIONS AND LIMITATIONS

The Policy does not provide any benefits for any Loss arising from or otherwise related to, directly or indirectly, any: 1) illness, disease, condition not specifically and exclusively a Diagnosis of a Covered Cancer or Heart-Stroke Condition and as defined within the Policy; 2) Your attempted suicide or intentionally self-inflicted injury; or 3) Loss resulting from the Insured's being drunk, or under the influence of any narcotic unless prescribed by or taken under the direction of a Physician.

In addition to any exclusions noted in the description of the Riders, the Riders also do not provide benefits for any Loss arising from or otherwise related to, directly or indirectly, any Diagnosis that is made or Loss that begins: 1) prior to the Effective Date of the Rider; 2) while the Rider is not In Force for the Covered Person; or 3) during the Rider's thirty (30) day Waiting Period.

RENEWAL CONDITIONS

The Policy is guaranteed renewable for life, as long as renewal premiums are paid on time, either in advance or during the Grace Period. However, the Policy will Terminate on the earliest of the following events: 1) at the end of the Grace Period in which a renewal premium remains unpaid; 2) on the date that all Covered Persons have exhausted all benefits under this Policy and any attached riders; or 3) on the date of death of the Insured. Coverage under the Policy will end for a Covered Person on the date that: 1) the Covered Person has exhausted all their benefits under the Policy and any attached riders, 2) the date the Policy Terminates, 3) the date of death of that Covered Person.

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PREMIUMS SUBJECT TO CHANGE

The premium rates may be changed. A change will apply to all policies with the same form number, issue age group, tobacco status and state of issue as the Policy issued to the Insured. A minimum of 30 days advance written notice will be given. A change will apply on the next premium due date after notification is given. Each premium will be computed by the issue age and tobacco status shown in the application. We will not change the rates because of the Insured's physical condition or on account of any claims paid.

$_____ Annual $_____ Semi-Annual $_____ Quarterly

$_____ Monthly Bank Draft $_____ Monthly Credit Card

IMPORTANT TERMS

When we use the following terms from the Policy, this is what we mean:

CARCINOMA IN SITU – for the purposes of the Policy, means a pre-malignant neoplasm limited to the epithelium which has not invaded the basement membrane. It is a group of abnormal cells that show cytological characteristics of cancer and has the potential to become cancer, but has so far stayed in place where it began and has not spread to surrounding tissues. "Carcinoma In Situ" may be referred to as "Stage 0" cancer and includes: 1) early prostate Cancer Diagnosed as T1N0M0 or equivalent staging; and 2) melanoma not invading the dermis. Carcinoma In Situ does not include: 1) other skin malignancies; 2) pre-malignant lesions (such as intraepithelial neoplasia); or 3) benign tumors or polyps.

DIAGNOSIS; DIAGNOSED; DATE OF DIAGNOSIS – the definitive establishment of a specified condition through the use of clinical and/or laboratory findings. The Diagnosis must be made: 1) after both the: a) Effective Date of the Policy; and b) the thirty (30) days Waiting Period; 2) during the lifetime of the Covered Person and while the Policy is in force; 2) by a Physician who is a board-certified specialist where required under the Policy.

The Date Of Diagnosis is the earliest of: 1) the date the specimen used to Diagnose a condition was taken; 2) the date any test was run that was used to establish the Diagnosis of a condition; or 3) the date a condition was positively Diagnosed. Diagnosis of any condition will be considered to have been made prior to the Effective Date of the Policy if medical advice or Treatment received prior to the Effective Date results in a Diagnosis of that condition.

In addition, Diagnosis of Invasive Cancer or Carcinoma In Situ must be: 1) made by a Physician who is board certified by the American Board of Pathology to practice Pathologic Anatomy, or by Physician who is a board-certified Osteopathic Pathologist; and 2) established by Pathological Diagnosis. The Physician establishing the Diagnosis shall base his or her judgment solely on the criteria of malignancy as accepted by the American Board of Pathology or Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen. A Clinical Diagnosis will be accepted only if: 1) a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; 2) there is medical evidence to support the Diagnosis; and 3) a Physician is treating the Insured for Invasive Cancer or Carcinoma In Situ.

Diagnosis of Invasive Cancer or Carcinoma In Situ includes a Diagnosis of a recurrence of an Invasive Cancer or Carcinoma In Situ that was previously Diagnosed before the Effective Date of the Policy if, after the previous Diagnosis and before the date of Diagnosis of the recurrence, the Covered Person is free of any symptoms and treatment of the Invasive Cancer or Carcinoma In Situ for the twelve (12) months immediately preceding the Effective Date of coverage or any twelve (12) months thereafter

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INVASIVE CANCER – 1) a disease manifested by the presence of a malignant neoplasm characterized by the uncontrolled growth and spread of malignant cells, the invasion of tissue; 2) Carcinoma, Hodgkin's Disease, Leukemia, Lymphoma, Multiple Myeloma, and Sarcoma. "Invasive Cancer" does not include: 1) pre-malignant tumors or polyps; 2) pre-malignant lesions, Carcinoma In Situ, or 3) any skin cancer (except invasive malignant melanoma in the dermis or deeper skin malignancies that have become metastatic).

Invasive Cancer must be Diagnosed pursuant to Pathological Diagnosis. A Clinical Diagnosis will be accepted only if: 1) a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; 2) there is medical evidence to support the Diagnosis; and 3) a Physician is treating the Covered Person for Invasive Cancer.

TREATMENT – care or services provided by a Physician or other member of the medical profession, acting within the scope of his or her license, including: 1) surgery; 2) therapeutic measures; or 3) diagnostic x rays and the diagnostic procedure or laboratory tests directly or indirectly related to a surgical procedure.

For purposes of this benefit, "Treatment" does not include maintenance drug therapy, cardiac medications, immunosuppressant (anti-rejection) drugs, or routine follow-up office visits to verify if a condition has returned. "Maintenance drug therapy" means ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer due to primary treatment, meant to decrease the risk of cancer recurrence rather than the palliation or suppression of a cancer that is still present. "Immunosuppressant (anti-rejection) drugs" are drugs that prevent your immune system from attacking or rejecting the donor organ and typically must be taken for the lifetime of the transplanted organ. For purposes of the Policy, "immunosuppressant (anti-rejection) drugs" include any drug that must be taken in conjunction with the immunosuppressant (anti-rejection) drugs to aid them or control their side effects.

WAITING PERIOD – the first 30 days after the Effective Date of the Policy or a Rider during which if a Loss is incurred, benefits are not payable.

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