

SERFF Tracking Number: AMLC-125732353 State: Arkansas
 Filing Company: Globe Life and Accident Insurance Company State Tracking Number: 39609
 Company Tracking Number: G-GSPA
 TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical
 Hospital/Surgical/Medical Expense Expense
 Product Name: Limited Benefit Hospital and Surgical Expense Policy
 Project Name/Number: Limited Benefit Hospital and Surgical Expense Policy/G-GSPA

Company and Contact

Filing Contact Information

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Filing Company Information

Globe Life and Accident Insurance Company CoCode: 91472 State of Domicile: Nebraska
 204 North Robinson Avenue Group Code: 290 Company Type: Life and Health
 Oklahoma City, OK 73102 Group Name: Liberty National State ID Number:
 (405) 270-1400 ext. [Phone] FEIN Number: 63-0782739

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
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 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Globe Life and Accident Insurance Company	\$50.00	07/14/2008	21390909

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/14/2008	07/14/2008

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Correspondence	Approved-Closed	Yes
Supporting Document	Readability Certification	Approved-Closed	Yes
Form	Limited Benefit Hospital and Surgical Expense Policy	Approved-Closed	Yes
Rate	Rates	Approved-Closed	Yes

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Form Schedule

Lead Form Number: G-GSPA

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	G-GSPA	Policy/Contract	Limited Benefit Hospital and Surgical Expense Policy Certificate	Initial		57	G-GSPA_AR_.pdf

LIMITED BENEFIT HOSPITAL AND SURGICAL EXPENSE POLICY
GUARANTEED RENEWABLE FOR YOU AND EACH COVERED FAMILY MEMBER AS STATED IN THE RENEWAL AGREEMENT. COMPANY CANNOT CANCEL POLICY. COMPANY MAY CHANGE PREMIUM RATES BY CLASS.

GLOBE LIFE AND ACCIDENT INSURANCE COMPANY
GLOBE LIFE CENTER * OKLAHOMA CITY, OKLAHOMA 73184 (800) 478-3291
A Legal Reserve Stock Company

30 DAY RIGHT TO EXAMINE POLICY

If You are not satisfied with this policy for any reason, return it to Our Administrative Offices or to the agent within 30 days after You receive it. Any premium You paid will be refunded. The policy will be void from the beginning. It will be as if no policy had been issued.

RENEWAL AGREEMENT

You can continue this policy in force for successive renewal terms of 1 month, 3 months, 6 months, or 12 months by paying appropriate renewal premiums before the end of the grace period. The appropriate renewal premiums will be those under Our applicable table of premium rates that is in effect on the respective due dates of the premiums. Your premiums will change on each policy anniversary solely because of Your age change. Your premiums may also change due to increasing health care costs for all policies of this form and class. Class is based on state of issue, age, gender, underwriting group, benefit amounts, and geographic rating area where You resided at issue.

BENEFIT SCHEDULE

PART 1		PART 4	
Deductible Amount	\$ 500.00	Inpatient Physician Expense Benefit	\$ 50.00
Primary Daily Hospital Expense Benefit	\$ 4,000.00	Inpatient Physician Expense Maximum	\$ 2,000.00
Secondary Daily Hospital Expense Benefit	\$ 2,000.00	PART 5	
Maximum Hospital Expense Benefit	\$100,000.00	Outpatient Physician Expense Benefit	\$ 50.00
Additional Daily Intensive Care Benefit	\$ 1,000.00	Physical Exam Benefit	\$ 100.00
Maximum Intensive Care Benefit	\$ 10,000.00	Outpatient Physician Expense Maximum	\$ 500.00
PART 2		PART 6	
Maximum Outpatient Benefit	\$ 500.00	Registered Nurse Benefit	\$ 100.00
PART 3		PART 7	
Surgical Benefit Percentage	133% of Schedule	Ambulance Benefit	\$ 200.00
Surgical Benefit Maximum	\$ 10,000.00		

POLICY SCHEDULE

INSURED	POLICY NUMBER	EFFECTIVE DATE	INITIAL TERM EXPIRES ON	INITIAL PREMIUM
[John Doe]	123456789	01-01-07	02-01-07	\$100.00]

ADDITIONAL BENEFITS

- [Refund of Premium Benefit]
- [Accidental Death Benefit]
- [Accident Benefit]

The Policy Schedule includes premiums for additional benefits, if any.

THE INSURING CLAUSE

The Company insures You against specified losses incurred by You or a Family Member. Benefits stated in this policy, subject to all its provisions, limitations and exclusions, will be paid for such losses which are incurred while this policy is in force.

PRE-EXISTING CONDITION LIMITATION

This policy does not insure You against loss incurred during the twelve (12) months immediately after the effective date of this policy if that loss results from a Pre-Existing Condition. In addition, any Pre-Existing Condition listed on the application is not covered for the first twelve (12) months after the policy effective date.

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DEFINITIONS

Where used in this policy:

FAMILY MEMBER means a person who is named in the application for this policy or has been added in accordance with the ELIGIBILITY AND INSURED'S TERMINATION provision.

HOSPITAL means a medical facility operated pursuant to law which: (1) is primarily and continuously engaged in providing medical and diagnostic care for the treatment of sick or injured persons on an acute care inpatient basis under the supervision of one or more licensed physicians for which a charge is made; and (2) provides 24-hour nursing service by or under the supervision of a Registered Nurse (R.N.). "Hospital" does not mean: a facility or special unit of a facility primarily operated as; (a) a convalescent, skilled nursing, swing bed, or other nursing facility; (b) a facility or special unit of a facility primarily affording rehabilitative care; or (c) a facility or special unit of a facility primarily affording care or treatment for the aged, chemical dependency, alcohol abuse or mental or nervous disorder.

HOSPITAL DAYS means the total number of days of confinement for all Hospital Stays for the same Injury or Sickness. Each outpatient surgical occurrence performed in a Hospital or ambulatory surgical center setting for which a benefit is payable under PART 3 of this Policy will be considered one (1) day confinement.

HOSPITAL STAY means one day or more of confinement within a Hospital, as a resident patient and under the care of a Physician, due to an Injury or Sickness.

INJURY means accidental bodily injury which is sustained while this policy is in force and includes all injuries resulting from one accident.

INTENSIVE CARE means care which is provided within a separate area or unit of a Hospital that has been set aside for care of the critically ill or injured. The area or unit must have special monitoring equipment for the use of Physicians, nurses or other medical specialists assisting in these units. Intensive Care does not include: step down, Isolation, Telemetry, or Post Intensive Care units of a hospital.

PHYSICIAN means a person legally licensed to treat Injury or Sickness, other than You or any member of Your immediate family.

PRE-EXISTING CONDITION means any condition for which symptoms existed which would cause an ordinary prudent person to seek diagnosis, care or treatment within the 12 month period immediately prior to the effective date of You or the Family Member's coverage under this policy. It also means any condition for which the Family Member did receive treatment or medical advice during the 12 month period immediately prior to Your or the Family Member's effective date of coverage under this policy.

SICKNESS means a health condition, illness; disease or disorder requiring medical diagnosis, care, advice or treatment which first manifests itself after the Effective Date of the policy and while this policy is in force. After 24 calendar months without treatment for a particular Sickness, subsequent treatment for that Sickness will be counted as a new Sickness for purposes of determining benefits payable under the policy.

WE, US, OUR and **COMPANY** mean Globe Life And Accident Insurance Company.

YOU, YOUR, YOURS and **INSURED** means the Insured whose name is shown in the **POLICY SCHEDULE**.

PART 1 HOSPITAL EXPENSE BENEFIT

We will pay benefits at the rate of 80% of the expenses incurred in excess of the Deductible Amount that are incurred for Hospital room charges, services and supplies furnished by a Hospital to You or a Family Member during a Hospital Stay or in connection with an outpatient surgical occurrence performed in a Hospital or ambulatory surgical center setting for which a benefit is payable under PART 3 of this policy. Benefits under this PART 1 for all such expenses incurred for the same Injury or Sickness will not exceed the lesser of (A) or (B), where:

(A) is the Primary Daily Hospital Expense Benefit times the number of Hospital Days, but not greater than 10 Hospital Days, plus:

The Secondary Daily Hospital Expense Benefit times the number of Hospital Days in excess of 10, but not greater than 30 such additional Hospital Days; and

(B) is the Maximum Hospital Expense Benefit.

For each day of the first 10 days of Intensive Care confinement during a Hospital Stay the Primary or Secondary Daily Hospital Expense Benefit will be increased by the Additional Intensive Care Benefit and the Maximum Hospital Expense Benefit will be increased by the Additional Intensive Care Benefit but the Maximum Hospital Expense Benefit will never be increased more than one Maximum Intensive Care Benefit.

We will not include any expenses incurred for Physician's charges (including professional charges) in determining benefits under this PART 1. We will pay the larger of the Hospital Expense Benefit or the Outpatient Benefit, but not both, for surgery performed in a Hospital on an outpatient basis.

In addition to the above benefits based on eligible expenses, We will also pay \$100 for each Hospital Stay by You or a Family Member. This \$100 benefit is not assignable.

PART 2 OUTPATIENT BENEFIT

We will pay benefits at the rate of 80% of expenses incurred due to Injury or Sickness for Outpatient Services which You or a Family Member receives. Outpatient Services Include:

1. Outpatient hospital expense,
2. Diagnostic imaging; and,
3. Radiological treatment by a licensed Radiologist or Pathologist.

Outpatient Services do not include interpretation of imaging or radiological or pathological tests. We will not pay in excess of the Maximum Outpatient Benefit for all such expenses incurred in relation to any one Injury or Sickness. If a benefit is provided elsewhere in the policy for such expenses incurred, the larger benefit shall be payable.

PART 3 BENEFITS FOR SURGICAL OPERATIONS

We will pay benefits for expense incurred due to an Injury or Sickness for a surgical operation performed by a Physician on You or a Family Member. Benefits will be equal to the fee charged by a Physician for the operation, but not to exceed the amount resulting from multiplying the Surgical Benefit Percentage by the amount set opposite the name of the operation listed below. If the operation is not listed below, benefits will be paid up to the amount that would be payable for the most comparable operation in severity and gravity that is listed below but not more than the Surgical Benefit Maximum.

We will not pay more than one benefit (the largest applicable) under this PART 3 for all operations performed on account of any one Injury or Sickness.

SCHEDULE FOR SURGICAL OPERATIONS AND ADMINISTRATION OF ANESTHETIC

ABDOMEN

Incision and drainage of appendicular abscess, transabdominal.....	\$ 1125.00
Appendectomy	1500.00
Cholecystectomy	2250.00
Colectomy, total, with ileostomy or ileoproctostomy	4125.00
Total gastrectomy	3750.00
Hemiotomy, inguinal, unilateral.....	1315.00
Recurrent.....	1500.00
Exploratory laparotomy; exploratory celiotomy	1500.00
Pancreatectomy, total.....	5250.00

CHEST

Lobectomy, total, subtotal or segmental	3750.00
with concomitant decortication	4690.00
Wedge resection, single or multiple	3000.00
Pulmonary resection with concomitant thoracoplasty	5625.00
Thoracotomy, exploratory, including biopsy.....	1875.00
With open drainage of empyema cavity by rib resection (independent procedure)	1500.00
With closed drainage of empyema cavity; tube drainage with negative pressure (independent procedure), in hospital.....	190.00

CYSTS AND TUMORS

Incision and drainage of infected or non-infected sebaceous cyst.....	75.00
(second lesion fifty percent; each additional lesion twenty-five percent)	
Drainage of pilonidal cyst	75.00
Excision of pilonidal cyst or sinus.....	1125.00
Excision (including simple closure) of benign cicatricial, fibrous, inflammatory, congenital, cystic, etc., lesions of skin, subcutaneous tissue or mucous membrane, one	
Lesion diameter up to one-fourth inch.....	150.00
Lesion diameter one-fourth inch to one-half inch.....	190.00
Lesion diameter one-half inch to three-fourths inch	225.00
Thyroid gland	
Local excision of small cyst or adenoma of thyroid.....	1500.00
Thyroidectomy, total or complete	2625.00
Subtotal or partial	2250.00
Total or subtotal for malignancy with radical neck dissection	3750.00
Total or subtotal for malignancy with limited neck dissection	3000.00
Secondary, unilateral.....	2250.00
Bilateral.....	2625.00

EYE, EAR, NOSE AND THROAT

Extraction of lens, intra capsular, extracapsular or linear, unilateral	3000.00
Reattachment of retina, electrocoagulation, scleral resection, buckling or partial tubing.....	3750.00
Any type of muscle operation involving one or more muscles in one or both eyes done in one stage.....	2250.00
Removal of foreign body from surface of cornea.....	75.00
From surface of conjunctiva	40.00
Fenestration of semicircular canal	3750.00
Stapes mobilization, primary or secondary	2625.00
Excision of nasal polyp(s), one or more, unilateral or bilateral, one or more stages, office	265.00
Complicated, requiring hospitalization	750.00
Submucous resection, classic, nasal septum ..	1125.00
Tonsillectomy, with or without adenoidectomy, under eighteen years of age.....	565.00
Eighteen years or over	750.00
Laryngectomy, without neck dissection.....	3750.00
With neck dissection.....	5250.00

GENERAL

Biopsy; excision of skin, subcutaneous tissue or mucous membrane for biopsy (including simple closure) (independent procedure)	115.00
Muscle biopsy, superficial	190.00
Deep	375.00
Biopsy of salivary gland.....	190.00

Breast

Excision of cyst, fibroadenoma or other benign tumor, aberrant breast tissue, duct lesion, (including gynecomastia) or nipple lesion (including any other partial mastectomy), male or female	
Unilateral	565.00
Bilateral.....	940.00
Complete (simple) mastectomy.....	1125.00
Radical mastectomy, including breast, pectoral muscles and axillary lymph nodes.....	2625.00
Bronchoscopy, diagnostic	565.00
With biopsy.....	750.00
With removal of foreign body.....	940.00
With excision of tumor	940.00

GYNECOLOGY

Excision of Bartholin's gland or cyst.....	750.00
Excision of fulguration of Skene's glands.....	265.00
Incision and drainage of Bartholin's gland abscess, unilateral.....	190.00
Anterior colporrhaphy, repair of cystocele,	

with or without repair of urethrocele (independent procedure).....	1315.00
Posterior colporrhaphy, repair of rectocele (independent procedure).....	1125.00
With perineoplasty or perineorrhaphy	1315.00
Combined anterior-posterior colporrhaphy	1875.00
Dilation and curettement of cervical canal	565.00
Cauterization of cervix, office	115.00
Total hysterectomy (corpus and cervix) with or without tubes, and/or ovaries, one or both	2250.00
Supracervical hysterectomy: Subtotal hysterectomy with or without tubes, and/or ovaries, or both.....	2065.00
Radical hysterectomy for cancer, including regional lymph nodes	3750.00
Salpingectomy, complete or partial, unilateral or bilateral (independent procedure).....	1690.00
Salpingo-oophorectomy, complete or partial unilateral or bilateral (independent procedure)	1690.00
HEART AND BLOOD VESSELS	
Aortic valve, valvotomy (commissurotomy) (closed).....	5625.00
Valvuloplasty for stenosis or insufficiency (open)	7500.00
Pulmonic valve, valvotomy (commissurotomy) (closed).....	5625.00
Valvotomy; infundibular stenosis (open)	7500.00
Mitral valve, valvotomy (commissurotomy) (closed).....	5250.00
Valvuloplasty for stenosis or insufficiency (open)	7500.00
Atrial septal defect (secundum type; endocardial cushion defect) (open).....	6750.00
Insertion internal pacemaker with myocardial electrodes, initial.....	3750.00
Replacement or repair.....	1125.00
Ligation and division and complete stripping of long or short saphenous veins	
Unilateral	1125.00
Bilateral.....	1875.00
Long and short saphenous veins	
Unilateral	1500.00
Bilateral.....	2250.00
MUSCULOSKELETAL	
Amputations	
Digit (finger or thumb), any joint or phalanx, one, with or without split or Wolfe's graft, or skinplasty and/or tenodesis, with or without resection of digital nerves	565.00
Toe, one, with or without split or Wolfe's graft, or skinplasty and or tenodesis, with or without resection of digital nerves	375.00
More than one	565.00
Thigh, through femur, including supracondylar.....	2250.00
Open (guillotine)	1875.00
Joints	
Anthrotomy or capsulotomy with exploration, drainage or removal of loose body,	

e.g. osteochondritis or foreign body		
Elbow		1875.00
Hip		2625.00
Knee		1875.00
Toe, great		565.00
Other.....		375.00
Dislocations		
Elbow, simple, closed reduction.....		190.00
Compound with uncomplicated soft tissue closure		940.00
Simple or compound, open reduction		2065.00
Shoulder (humerus), simple, closed.....		190.00
Reduction with anesthetic		190.00
Simple or compound, open reduction		2065.00
Fractures		
	Simple Closed Reduction	Simple or Compound Open Reduction
Ankle, bimalleolar (including Pott's)	940.00	1875.00
Fibula, distal end, malleolus	565.00	1500.00
Clavical	565.00	1500.00
Femur, neck.....	1875.00	3000.00
Phalanx or phalanges, finger, proximal middle or thumb	280.00	750.00
Phalanx or phalanges, great toe	190.00	565.00
Other than great toe	190.00	470.00
Humerus, surgical neck.....	1125.00	1875.00
Fibula, shaft		1125.00
Tibia and fibula, shafts	1125.00	2250.00
Radius, distal end (e.g. Colles' type)	565.00	1500.00
With severe comminution and impaction, closed reduction.....	750.00	
Radius and ulna, shafts.....	940.00	1875.00
Tibia, shaft.....	940.00	1875.00
Ulna, shaft	750.00	1500.00
Removal or metal band, plate, screws or nails		565.00
Mandible, simple or compound, closed reduction and wiring of teeth		1125.00
Tendons - Excision of lesion of tendon or fibrous sheath, or ganglion, digits only		375.00
In other locations		565.00
NEUROSURGERY		
Craniotomy Following Trauma		
Evacuation of hematoma, subdural, extradural or intracerebral by burr holes only.....		3375.00
Requiring craniotomy		3750.00
Craniotomy for Nontraumatic Causes		
Craniotomy for lobotomy		
Unilateral		1500.00
Bilateral.....		2250.00
Osteopathic craniotomy for excision of brain tumor, abscess or cyst, supratentorial		4690.00

Suboccipital craniectomy for brain tumor.....	5625.00
Excision of intervertebral disc	3375.00
Laminotomy for removal of intervertebral discs, cervical	3375.00

Spinal fusion with removal of intervertebral disc, cervical region, posterior technique	4500.00
Lumbar or thoracic region, posterior, posterolateral or posterior interbody technique	4500.00
Sympathectomy	
Cervical, unilateral.....	2250.00
Bilateral.....	3000.00
Lumbar, unilateral.....	2065.00
Bilateral.....	2815.00
Spinal puncture, lumbar, simple (independent procedure).....	75.00
Injection procedure for myelography.....	375.00
For discography.....	375.00

We will pay additional benefits for the expense incurred due to an Injury or Sickness for charges by a Physician for assisting the surgeon during a surgical operation for which benefits are covered under this PART 3. The additional benefits will not exceed 20% of those payable for the surgeon's fee.

We will pay additional benefits for the expense incurred due to an Injury or Sickness for charges by a Physician for administration of anesthetic to You or a Family Member during a surgical operation for which benefits are payable under this PART 3. The administration of anesthetic must be by a Physician or a legally qualified anesthetist. The additional benefits will not exceed 25% of those payable for the surgeon's fee. We will not pay benefits for the administration of anesthetic by the operating surgeon or the assistant surgeon.

PART 4 INPATIENT PHYSICIAN EXPENSE BENEFIT

We will pay benefits for expenses incurred due to Injury or Sickness for Physician's treatment of You or a Family Member during a Hospital Stay.

1. For any Hospital Stay which does not involve a surgical occurrence for which a benefit is payable under PART 3 of this policy: Benefits will be paid at the rate of 80% of the fee charged by the Physician, not to exceed the Inpatient Physician Expense Benefit for each Physician's treatment and for not more than one Physician's treatment per day, and not to exceed the Inpatient Physician Expense Maximum for any one Injury or Sickness; and
2. For any Hospital Stay involving a surgical occurrence for which a benefit is payable under PART 3 of this policy: The benefit provided in (1) above or the Benefit For Surgical Operations in PART 3, whichever is greater.

PART 5 OUTPATIENT PHYSICIAN EXPENSE BENEFIT

We will pay benefits for expenses incurred due to injury or Sickness for outpatient treatment by a Physician of You or a Family Member at the Physician's office, clinic, a hospital (on an outpatient basis), or at home.

1. For treatment because of Injury or Sickness which does not require a surgical operation: Benefits will be paid at the rate of 80% of the fee charged by the Physician, not to exceed the Outpatient Physician Expense Benefit for each Physician's treatment and for not more than one Physician's treatment per day, and not to exceed the Outpatient Physician Expense Maximum for any one Injury or Sickness; and
2. For a physical exam, benefits will be equal to 80% of the fee charged by the Physician, not to exceed the Physical Exam Benefit and not more than one physical exam per year.

The total of (1) and (2) are not to exceed the Outpatient Physician Expense Maximum during any policy year.

For treatment because of Injury or Sickness which requires a surgical operation, We will pay the benefit provided in (1) above or the Benefits For Surgical Operations in PART 3, whichever is greater.

PART 6 **BENEFIT FOR IN-HOSPITAL REGISTERED NURSE**

We will pay benefits at the rate of 80% of expenses incurred by You or a Family Member during a Hospital Stay for the full-time care and attendance of a Registered Nurse. We will pay up to Registered Nurse Benefit per 8 hour shift, but not for more than 3 nursing shifts per day and not for more than 90 days total because of any one Injury or Sickness.

We will not pay benefits for services provided by You or a member of Your immediate household or family.

PART 7 **BENEFIT FOR AMBULANCE SERVICE**

We will pay benefits at the rate of 80% of expenses incurred due to Injury or Sickness for Ambulance Service which You or a Family Member receives. The ambulance service must be to or from a Hospital. We will not pay more than an amount equal to the Ambulance Benefit for all such expenses incurred because of any one Injury or Sickness.

PART 8 **LIMITATIONS AND EXCLUSIONS**

We will not pay benefits under this policy for:

1. Normal pregnancy (including childbirth, false labor, occasional spotting, physician-prescribed rest, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with a difficult pregnancy which do not constitute a distinct complication of pregnancy) or voluntary termination of pregnancy; or
2. Usual and customary routine nursery care, or well-baby care or immunizations, except as provided under PART 5 of this policy; or any other usual and customary routine care and treatment following full term or premature birth, not incident and necessary to the treatment of Injury or Sickness; or
3. Convalescent, skilled nursing, educational care or for nervous or mental disorders; or
4. Dental treatment, hearing aids or eye refractive exams, surgery or treatment; or
5. Any Hospital Stay or other service for which You or a Family Member do not incur a charge; or
6. Any loss covered by any Workmen's Compensation or Employers' Liability Law; or
7. Any Hospital Stay or other service that is not medically necessary, or is cosmetic in nature; or
8. Any expense incurred in excess of the usual, customary and regular charges for any service or materials in the geographic area where furnished; or
9. Charges incurred for professional radiological, pathological or EKG interpretations; or
10. Rehabilitative care services received at a facility not meeting the definition of a Hospital; or
11. Treatment or services incurred outside of the U.S. boundaries; or
12. Infertility or sterilization treatment procedures.

POLICY PROVISIONS

ELIGIBILITY AND INSURED'S TERMINATION: You, as the Insured, are the beneficiary of Your Family Members. Every transaction relating to this policy shall be between Us and You.

A new Family Member, (including husband, wife, any children under the age of 19, on the Policy Date. To be covered, each existing member must be name in the application. Stepchildren and legally adopted children can be included if listed in the application.

Any newborn or newly adopted children of the Primary Insured will be automatically be a Covered Person from the moment of birth or adoption is such birth or adoption occurs after the Effective Date of the policy. This will also cover children You have filed a petition to adopt.

You may apply for coverage on other dependents acquired after the Effective Date of the policy, subject to Our approval. Coverage on Your children terminate when they marry. It also terminates on the policy anniversary date following their 21st birthday, unless they are still dependent on You due to a physical or mental handicap, or because they are a full-time student under age 23. However, if a dependent child is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and if such disability occurred prior to the first policy anniversary following the child's 21st birthday, then the child will continue to be a Covered Person for as long as such disability continues. Proof of such incapacity or disability must be furnished upon Our request, but not more often than annually.

In the event of Your death or other termination of Your coverage, the following shall successively become the Insured: (1) Your spouse (if Your spouse is a Family Member); or (2) Your eldest remaining Family Member.

RIGHTS OF A SPOUSE: Should You and Your spouse dissolve Your marriage by a valid decree of dissolution of marriage and the spouse was a Family Member, the spouse can apply for and receive without evidence of insurability, a policy providing coverage not greater than the terminated coverage. To obtain the policy, the spouse must make application to the Company within sixty (60) days following the entry of the decree of dissolution of marriage and pay the appropriate premium for the policy. No waiting or probationary period is required except to the extent that such period has not been met under the prior policy.

PREMIUM PAYMENT: This policy is issued based on the application and the payment of the first premium. A copy of the application is a part of this policy. This policy takes effect at 12 o'clock noon, Standard Time of the place where You reside, and remains in effect until the same hour on the date which the initial term expires.

The effective date of this policy, the first premium and the date the initial term expires are shown in the POLICY SCHEDULE. All premiums, except the first premium, shall be due and payable at our Administrative Offices.

ENTIRE CONTRACT; CHANGES: This policy, with the application and attached papers, is the entire contract between You and Us. No change in this policy shall be effective until approved by Us. This approval must be noted on or attached to this policy.

No agent may change this policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After 2 years from the effective date only fraudulent misstatements in the application may be used to void this policy or deny any claim for loss incurred after the 2 year period.

No claim for loss incurred after 2 years from the effective date will be reduced or denied because a Sickness or physical condition not excluded from coverage by name or specific description on the date of loss had existed before the effective date of this policy.

GRACE PERIOD: This policy had a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, this policy will stay in force.

REINSTATEMENT: If the renewal premium is not paid before the grace period ends, this policy will lapse. Later acceptance of the premium by Us (or by Our agent authorized to accept payment) without requiring an application for reinstatement will reinstate this policy.

If We or Our agent requires an application, this policy will be reinstated when We approve the application, or on the 45th day after We receive it unless We have previously written You of its disapproval.

The reinstated policy will cover only loss that results from an Injury sustained after the date of reinstatement or Sickness that starts more than 10 days after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM: Written notice of claim must be given to Us within 20 days after a covered loss starts as soon as reasonably possible. The notice can be given to Us at Our Administrative Offices in Oklahoma City, Oklahoma or to Our agent.

Notice should include Your name and Your policy number.

CLAIM FORMS: When We receive the Notice of Claim, We will send You forms for filing proof of loss. If these forms are not given to You within 15 days, You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the PROOFS OF LOSS Provision.

PROOFS OF LOSS: You must give written proof of loss to Us within 90 days after the date of such loss. If it was not reasonably possible to give written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than 1 year from the time specified unless You were legally incapacitated.

TIME OF PAYMENT OF CLAIMS: After receiving written proof of loss, We immediately will pay all benefits then due for such loss.

PAYMENT OF CLAIMS: Benefits will be paid to you unless you assign them to the doctor or hospital. Any benefit unpaid at death will be paid to your named beneficiary or, at our option, to your estate. If benefits are payable to your estate, we can pay benefits up to \$3,000 to someone related to you by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATIONS: We, at Our expense, have the right to have You or a Family Member examined as often as reasonably necessary while a claim is pending.

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

REFUND OF UNEARNED PREMIUMS ON DEATH: Upon the death of a Family Member Insured under this policy, We will refund any premiums paid in behalf of the member, for any period beyond the ending of the policy month the death occurred, within 30 days after We receive proof of death.

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which You reside on that date is amended to conform to the minimum requirements of such laws.

ASSIGNMENT: No assignment under this policy shall be binding upon Us unless the original (or a copy of it) is on file at Our Administrative Offices. We do not assume any responsibility for the validity of any assignment.

This policy is signed for Us by Our President and Secretary.

Garry M. Hutchison

Secretary

Charles F. Hudson

President

Countersigned:

Licensed Resident Agent where required by law.

SPECIMEN

SERFF Tracking Number: AMLC-125732353 State: Arkansas
 Filing Company: Globe Life and Accident Insurance Company State Tracking Number: 39609
 Company Tracking Number: G-GSPA
 TOI: H151 Individual Health - Hospital/Surgical/Medical Expense Sub-TOI: H151.001 Health - Hospital/Surgical/Medical Expense
 Product Name: Limited Benefit Hospital and Surgical Expense Policy
 Project Name/Number: Limited Benefit Hospital and Surgical Expense Policy/G-GSPA

Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 07/14/2008
Comments:
Attachment:
 CertificationAR.pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 07/14/2008
Comments:
 Previously approved application to be used with this filing: form GLHA(03) approved on 09/19/2007 under serff filing number:AMLC-125286837

Satisfied -Name: Outline of Coverage **Review Status:** Approved-Closed 07/14/2008
Comments:
Attachment:
 DS-G-GSPA.pdf

Satisfied -Name: Correspondence **Review Status:** Approved-Closed 07/14/2008
Comments:
Attachment:
 G-GSPA Letter AR.pdf

Satisfied -Name: Readability Certification **Review Status:** Approved-Closed 07/14/2008
Comments:
Attachment:
 Readability Cert G-GSPA .xls.pdf

ARKANSAS

COMPANY NAME: LIBERTY NATIONAL LIFE INSURANCE COMPANY

RE: LSPDA02

I hereby certify that I have reviewed the filing being submitted and find, to the best of my knowledge and belief, that each form is consistent and complies with the requirements of the Standard Valuation and Nonforfeiture Laws as outlined in Arkansas Regulation 19s10B.

I further certify that I am duly authorized to execute this certification on behalf of the Company.

05/20/ 2008

Date



Michael J. Gaisbauer, Vice President

C-AR1

**GLOBE LIFE AND ACCIDENT INSURANCE COMPANY
GLOBE LIFE CENTER * OKLAHOMA CITY, OKLAHOMA 73184
A LEGAL RESERVE STOCK COMPANY**

**OUTLINE OF COVERAGE - Retain This Form For Your Records.
LIMITED BENEFIT HOSPITAL AND SURGICAL EXPENSE COVERAGE**

POLICY FORM G-GSPA

Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of Your policy. This outline of coverage is not the insurance contract and only the actual policy provisions will control Your benefits. The policy itself sets forth, in detail, the rights and obligations of both You and Your insurance company. It is, therefore, important that You **READ YOUR POLICY CAREFULLY!**

Limited Benefit Hospital and Surgical Expense Coverage - Policies of this category are designed to provide, to persons insured, coverage for hospital and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital outpatient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical surgical expenses.

BENEFITS - Eligible Hospital and Surgical Expenses

- Hospital Expense Benefit** - Benefits at the rate of 80% of the expenses incurred in excess of the Deductible Amount (\$500.00) for Hospital room charges, services and supplies furnished by the Hospital to You or a Family Member during a Hospital Stay or in connection with an outpatient surgical occurrence performed in a Hospital. **This benefit is subject to the applicable limitations below.**

G-GSPA - (25)	G-GSPA - (50)	G-GSPA - (100)
Up to \$1,000 per day first 10 days	Up to \$2,000 per day first 10 days	Up to \$4,000 per day first 10 days
Up to \$500 per day next 30 days	Up to \$1,000 per day next 30 days	Up to \$2,000 per day next 30 days
Not to exceed \$25,000 Maximum benefit for any one Injury or sickness	Not to exceed \$50,000 Maximum benefit for any one Injury or sickness	Not to exceed \$100,000 Maximum benefit for any one Injury or sickness

- Outpatient Benefit** - Benefits at the rate of 80% of expenses incurred due to Injury or Sickness for Outpatient Services which You or a Family Member receives. **This benefit is subject to the applicable limitation below.**

G-GSPA - (25)	G-GSPA - (50)	G-GSPA - (100)
Up to \$200 for any one injury or sickness	Up to \$300 for any one injury or sickness	Up to \$500 for any one injury or sickness

- Surgical Expense Benefit** - Benefits are payable for one surgical operation due to each covered injury or sickness per schedule. Policy pays up to 20% of surgical benefit for Assistant Surgeon and 25% of surgical benefit for Anesthesiologist. **This benefit is subject to the applicable limitation below.**

G-GSPA - (25)	G-GSPA - (50)	G-GSPA - (100)
100% of benefit amount listed in surgical schedule up to \$5,000	100% of benefit amount listed in surgical schedule up to \$7,500	100% of benefit amount listed in surgical schedule up to \$10,000

- Inpatient Physician Expense Benefit, up to\$2,000.00**
Benefits at the rate of 80% of expenses incurred **up to \$50 per Physician's treatment** during a Hospital Stay, one treatment each day, for each Injury or Sickness not requiring surgery.

- Outpatient Physician Expense Benefitper year.....\$500.00**
Benefits at the rate of 80% of expenses incurred **up to \$50 per visit** for outpatient treatment due to Injury or Sickness by a Physician for You or a Family Member at the Physician's office, clinic, a hospital (on an outpatient basis), or at home.

6. **In-Hospital Registered Nurse Benefit, up to**.....**\$100.00**
 Benefits at the rate of 80% of expenses incurred by You or a Family Member during a Hospital Stay for the Full-time care and attendance of a Registered Nurse.
7. **Ambulance Service Benefit, up to****\$200.00**
 Benefits at the rate of 80% of expenses incurred due to Injury or Sickness for Ambulance Service which You or a Family Member receives.

LIMITATIONS AND EXCLUSIONS

We will not pay benefits under this policy for:

1. Normal pregnancy (including childbirth, false labor, occasional spotting, physician-prescribed rest, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with a difficult pregnancy which do not constitute a distinct complication of pregnancy) or voluntary termination of pregnancy; or
2. Usual and customary routine nursery care, or well-baby care or immunizations, except as provided under Part 5 of this policy; or any other usual and customary routine care and treatment following full term or premature birth, not incident and necessary to the treatment of Injury or Sickness; or
3. Convalescent, skilled nursing, educational care or for nervous or mental disorders; or
4. Dental treatment, hearing aids or eye refractive exams, surgery or treatment; or
5. Any Hospital Stay or other service for which You or a Family Member do not incur a charge; or
6. Any loss covered by paid Workmen’s Compensation or Employers’ Liability Law; or
7. Any Hospital Stay or other service that is not medically necessary, or is cosmetic in nature; or
8. Any expense incurred in excess of the usual, customary and regular charges for any service or materials in the geographic area where furnished; or
9. Charges incurred for professional radiological, pathological or EKG interpretations; or
10. Rehabilitative care services received at a facility not meeting the definition of a Hospital; or
11. Treatment or services incurred outside of the U.S. boundaries; or
12. Infertility or sterilization treatment procedures.

RENEWAL AGREEMENT

You can continue this policy in force for successive renewal terms of 1 month, 3 months, 6 months, or 12 months by paying appropriate renewal premiums before the end of the grace period. The appropriate renewal premiums will be those under Our applicable table of premium rates that is in effect on the respective due dates of the premiums. Your premiums will change on each policy anniversary solely because of Your age change. Your premiums may also change due to increasing health care cost for all policies of this form and class. Class is based on state of issue, age, gender, underwriting group, benefit amounts, and geographic rating area where You resided at issue.

A grace period of 31 days will be granted for the payment of each renewal premium. The policy will stay in force during the grace period.

PREMIUM

Your premium for the policy is monthly \$_____, quarterly \$_____, semi-annually \$_____, or annually \$_____. You pay a one time policy fee of \$_____.



July 14, 2008

Honorable Julie Benafield Bowman
Commissioner of Insurance
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, AR 72201-1904

ATTN: Mr. Joe Musgrove

FEIN #63-0782739

NAIC #290-91472

RE: G-GSPA - Limited Benefit Hospital and Surgical Expense Policy - G-GSPA
Actuarial Memorandum
DS-G-GSPA

Dear Mr. Joe Musgrove :

Enclosed for your review and approval is the above captioned Limited Benefit Hospital and Surgical Expense Policy G-GSPA. This policy is being submitted as a replacement to the previously approved policy G-GSP. The G-GSP policy was approved by your department on 9/19/2007, AMLC-125286837.

The only change to the previously approved policy form is on page one regarding the Renewal Agreement section and the change therein is being implemented to correct an inadvertent divergence between the approved rate schedule and the language of the policy.

We hope to receive an expedited approval to correct the inadvertent divergence between the rates and the language in the policy.

The corrected Actuarial Memorandum and rate schedule are also enclosed. Please be advised that rates being submitted are the same rates that were filed with the original filing G-GSP only the form number has changed to accommodate this filing submission.

If you have any questions or concerns, please feel free to contact me by phone, collect if necessary: (214) 544-5335 or by e-mail: mjohnson@torchmarkcorp.com.

Sincerely,

A handwritten signature in cursive script that reads 'Mary A. Johnson' with a long horizontal flourish extending to the right.

Mary A. Johnson
Compliance Analyst

/maj
Enclosures

GLOBE LIFE AND ACCIDENT INSURANCE COMPANY

Oklahoma City, Oklahoma

READABILITY CERTIFICATION

We hereby certify we have carefully reviewed the form(s) listed below and to the best of our knowledge and ability determine the Flesch scale analysis readability test score to be as shown:

<u>FORM</u>		<u>SCORE</u>
Limited Benefit Hospital and Surgical Policy	G-GSPA	56.7

July 14, 2008

Date



Michael J. Gaisbauer, Vice President