



SERFF Tracking Number: AMLC-126370732 State: Arkansas  
 Filing Company: Liberty National Life Insurance Company State Tracking Number: 44212  
 Company Tracking Number: LSHXC  
 TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical  
 Hospital/Surgical/Medical Expense Expense  
 Product Name: Limited Benefit Hospital, Surgical and Medical Expense Policy  
 Project Name/Number: Limited Benefit Hospital, Surgical and Medical Expense Policy/LSHXC

The policy will be offered as an individual plan as well as a family plan to person's age 0 through 63. This product will be marketed to individuals through licensed agents.

The Actuarial Memorandum and rates for policy form LSHXC are also enclosed.

I hereby certify that I have carefully reviewed these forms and determined:

1. The forms conform to all insurance statutes and Department requirements of your jurisdiction.
2. The forms contain no provisions previously disapproved by your department.
3. The forms do not contain any unusual or unorthodox provisions and wording.
4. The forms are being filed in Nebraska, our state of domicile, and other jurisdictions in which we are licensed to do business.

## Company and Contact

### Filing Contact Information

Tom Cao, Compliance Analyst tcao@torchmarkcorp.com  
 3700 S. Stonebridge Drive 214-544-5389 [Phone]  
 McKinney, TX 75070 972-569-3728 [FAX]

### Filing Company Information

Liberty National Life Insurance Company CoCode: 65331 State of Domicile: Nebraska  
 2001 Third Avenue South Group Code: 290 Company Type: Life and Health  
 Birmingham, AL 35233 Group Name: Liberty National Life State ID Number:  
 (800) 288-2722 ext. 2912[Phone] FEIN Number: 63-0124600

-----

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$100.00  
 Retaliatory? No  
 Fee Explanation: \$50 for policy form filing with application  
 \$50 for rate filing.  
 Per Company: No

SERFF Tracking Number: AMLC-126370732 State: Arkansas  
Filing Company: Liberty National Life Insurance Company State Tracking Number: 44212  
Company Tracking Number: LSHXC  
TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical  
Hospital/Surgical/Medical Expense Expense  
Product Name: Limited Benefit Hospital, Surgical and Medical Expense Policy  
Project Name/Number: Limited Benefit Hospital, Surgical and Medical Expense Policy/LSHXC

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Liberty National Life Insurance Company	\$100.00	12/01/2009	32384673

SERFF Tracking Number: AMLC-126370732 State: Arkansas  
Filing Company: Liberty National Life Insurance Company State Tracking Number: 44212  
Company Tracking Number: LSHXC  
TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical  
Hospital/Surgical/Medical Expense Expense  
Product Name: Limited Benefit Hospital, Surgical and Medical Expense Policy  
Project Name/Number: Limited Benefit Hospital, Surgical and Medical Expense Policy/LSHXC

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/03/2009	12/03/2009



SERFF Tracking Number: AMLC-126370732 State: Arkansas  
 Filing Company: Liberty National Life Insurance Company State Tracking Number: 44212  
 Company Tracking Number: LSHXC  
 TOI: H151 Individual Health - Hospital/Surgical/Medical Expense Sub-TOI: H151.001 Health - Hospital/Surgical/Medical Expense  
 Product Name: Limited Benefit Hospital, Surgical and Medical Expense Policy  
 Project Name/Number: Limited Benefit Hospital, Surgical and Medical Expense Policy/LSHXC

<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	No
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Form</b>	Limited Benefit Hospital, Surgical and Medical Expense Policy	Approved-Closed	Yes
<b>Form</b>	Application for Insurance	Approved-Closed	Yes
<b>Rate</b>	Proposed Annual Premium Rates	Approved-Closed	Yes

SERFF Tracking Number: AMLC-126370732 State: Arkansas  
 Filing Company: Liberty National Life Insurance Company State Tracking Number: 44212  
 Company Tracking Number: LSHXC  
 TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical  
 Hospital/Surgical/Medical Expense Expense  
 Product Name: Limited Benefit Hospital, Surgical and Medical Expense Policy  
 Project Name/Number: Limited Benefit Hospital, Surgical and Medical Expense Policy/LSHXC

## Form Schedule

### Lead Form Number: LSHXC

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 12/03/2009	LSHXC	Policy/Contract/Fraternal Hospital, Surgical and Medical Expense Certificate Policy	Initial		54.000	LSHXC - AR.pdf
Approved-Closed 12/03/2009	LHA-1-AP(03)	Application/Enrollment Form	Initial		52.000	LHA-1-AP(03).pdf

LIMITED BENEFIT HOSPITAL, SURGICAL AND MEDICAL 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.

**LIBERTY NATIONAL LIFE INSURANCE COMPANY**  
 P. O. BOX 8080, MCKINNEY, TEXAS 75070 (972) 529-5085  
 A Legal Reserve Stock Company \* Administrative Offices: McKinney, Texas

**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. WE have the right to change the renewal premiums for this policy when WE change, and in accordance with, OUR table of premium rates applicable to all policies of this form and class. Class is based on benefit amounts, persons covered under the policy, state of issue, age at issue, gender, underwriting group and geographic rating area. WE also have the right to change the renewal premiums for this policy when the persons covered under the policy change, in accordance with the table of premium rates applicable to all policies of this form and class.

**BENEFIT SCHEDULE**

PART 1 Daily Hospital Room and Board Benefit . . up to \$ [100.00]	PART 4 Surgeon Benefit Limit . . . . . up to \$ [1,000.00]
PART 2 Daily Intensive Care Benefit . . . . . up to \$ [200.00]	Surgery Conversion Factor . . . . . [18]
PART 3 Misc. Hospital Expense Benefit . . . . . 80% up to \$ [2,000.00]	PART 5 Ambulance Benefit . . . . . up to \$ [100.00]
	PART 6 Outpatient Expense Benefit . . . . . 80% up to \$ [200.00]
	{Outpatient Deductible Amount . . . . . \$ [ 50.00]}

**POLICY SCHEDULE**

INSURED	POLICY NUMBER	EFFECTIVE DATE	INITIAL TERM EXPIRES ON	INITIAL PREMIUM
[John Doe]	12345678	04-01-09	05-01-09	\$100.00]

**ADDITIONAL BENEFIT RIDERS**

[Critical Illness Rider], [Accident Rider], [Cancer Rider]

---

The Policy Schedule includes premiums for additional benefit riders, if any, unless provided to the contrary in the rider(s).

---

## INSURING CLAUSE

The COMPANY insures YOU against specified losses incurred by a COVERED PERSON. Benefits payable under this policy, subject to all of its provisions, limitations and exclusions, will be paid to YOU or, at OUR option, to the HOSPITAL, PHYSICIAN, or person providing any care, treatment, service, or supply covered by this policy. For the purpose of determining benefits payable for a particular SICKNESS of a COVERED PERSON after the applicable benefit limits for that SICKNESS have been paid by the COMPANY, it shall be considered a new SICKNESS, which is then again covered under this policy, if the COVERED PERSON goes without a PHYSICIAN'S advice or treatment for that particular SICKNESS for a period of 24 consecutive months. OUR obligation to make payment under this policy for any particular SICKNESS or INJURY shall not exceed the amounts disclosed in the Benefit Schedule or described elsewhere in this policy. A benefit will only be due and payable when a COVERED PERSON is obligated to pay a charge that is incurred for any covered care, treatment, service, or supply, or combination thereof, provided to or for a COVERED PERSON while this policy is in force. An expense or charge is incurred on the date the care, treatment, service, or supply is provided.

## PRE-EXISTING CONDITION LIMITATION

This policy does not insure YOU against loss incurred by YOU or a covered FAMILY MEMBER during the 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 12 months after the policy effective date. Conditions, illnesses, diseases, disorders, or injuries specifically excluded by rider are never covered.

---

## TABLE OF CONTENTS

	Page		Page
30-Day Right To Examine Policy .....	1	Miscellaneous Hospital Expense Benefit .....	4
Renewal Agreement .....	1	Surgical Procedure Benefits .....	5
Insuring Clause .....	2	Ambulance Benefit .....	5
Pre-Existing Condition Limitation .....	2	Outpatient Expense Benefit .....	5
Definitions .....	2	Other Benefits .....	6
Daily Hospital Room And Board Benefit.....	4	Limitations and Exclusions .....	8
Daily Intensive Care Benefit.....	4	Policy Provisions .....	9

---

## DEFINITIONS

Where used in this policy:

**ACCIDENT** and **ACCIDENTAL** means that which happens by chance or fortuitously, without intention or design, and which is unexpected, unusual and unforeseen.

**AMBULATORY SURGICAL CENTER** means a freestanding facility, other than a PHYSICIAN'S office, where surgical and diagnostic services are provided on an ambulatory basis.

**CHILD PREVENTIVE HEALTH CARE SERVICES** means PHYSICIAN-delivered or PHYSICIAN-supervised services for covered dependents from birth through eighteen (18) years of age that are provided for PERIODIC PREVENTIVE CARE VISITS, including medical history, physical examination, developmental assessment, anticipatory guidance and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards.

**COVERED PERSON** means YOU or any covered FAMILY MEMBER.

**DIABETES SELF-MANAGEMENT TRAINING** means instruction in an inpatient or outpatient setting which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications. Such instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

**FAMILY MEMBER** means a person who is named in the application for coverage under this policy, other than the Proposed Insured, or a person who 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, or for chemical dependency, alcohol abuse, or mental or nervous disorder.

**HOSPITAL STAY** means one day or more of inpatient confinement within a HOSPITAL, and under the care of a PHYSICIAN, for which a charge for room and board is incurred due to an INJURY or SICKNESS.

**INHERITED METABOLIC DISEASE** means a disease caused by an inherited abnormality of body chemistry.

**INJURY** means ACCIDENTAL bodily injury sustained by a COVERED PERSON which is the direct cause independently of disease, bodily infirmity or other cause of the loss and occurs while the insurance is in force.

**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 the unit. INTENSIVE CARE does not include: step-down, isolation, telemetry, or post-intensive care units of a HOSPITAL.

**LOW PROTEIN MODIFIED FOOD PRODUCT** means a food product that is:

1. Specially formulated to have less than one (1) gram of protein per serving; and
2. Intended to be used under the direction of a PHYSICIAN for the dietary treatment of an INHERITED METABOLIC DISEASE.

**MASTECTOMY** means the removal of all or part of the breast for MEDICALLY NECESSARY reasons as determined by a PHYSICIAN who is licensed as a medical doctor or doctor of osteopathy.

**MEDICALLY NECESSARY** means:

1. consistent with the symptoms or diagnosis and treatment of YOUR or a covered FAMILY MEMBER'S SICKNESS or INJURY; and
2. appropriate with regard to the standards of good medical practice; and
3. the most appropriate level of service that can be safely provided to YOU or a covered FAMILY MEMBER.

In order to determine that care is MEDICALLY NECESSARY, WE reserve the right to obtain, at OUR expense, a second opinion from a PHYSICIAN who (a) is not an employee or owner of a facility or agency from which YOU or a covered FAMILY MEMBER receive care, and (b) specializes in the condition that is the subject of YOUR claim.

**MENTAL ILLNESS** means psychosis, neurosis or an emotional disorder.

**PERIODIC PREVENTIVE CARE VISITS** means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

**PHYSICIAN** and **DOCTOR** mean a person duly licensed in the United States and duly qualified to provide care, treatment, services, or supplies for the INJURY or SICKNESS that is the subject of YOUR claim, or for the additional conditions or disorders, or diagnostic services, which are specifically covered under PART 7 of this policy. PHYSICIAN or DOCTOR does not include YOU or any member of YOUR household or immediate family. Primary Care Physician (PCP) means a PHYSICIAN who provides basic diagnosis and treatment of common illnesses and medical conditions. A Specialist means a PHYSICIAN who provides diagnosis and treatment for a specific specialty of medicine for which he or she has received additional education, training and experience.

**PRE-EXISTING CONDITION** means any medical condition, illness, disease, disorder, or injury for which symptoms existed that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment within the 12-month period immediately prior to the effective date of YOUR or the covered FAMILY MEMBER'S coverage under this policy. It also means any medical condition, illness, disease, disorder, or injury for which YOU or the covered FAMILY MEMBER did receive treatment or medical advice during the 12-month period immediately prior to YOUR or the covered FAMILY MEMBER'S effective date of coverage under this policy. PRE-EXISTING CONDITION will include any medical condition, illness, disease, disorder, or injury listed on YOUR application for YOU or a covered FAMILY MEMBER, which occurred within the 12-month period immediately prior to the effective date of YOUR or the covered FAMILY MEMBER'S coverage under this policy, irrespective of whether a rider has been issued. It also means a pregnancy existing at any time prior to, and which continues to exist as of, the effective date of YOUR or the covered FAMILY MEMBER'S coverage under this policy.

**RELATIVE VALUE UNITS** means the total unit value of the service, including all three components: PHYSICIAN work, facility practice expense, and professional liability expense, as contained in the national RESOURCE-BASED RELATIVE VALUE SCHEDULE (RBRVS).

**RESOURCE-BASED RELATIVE VALUE SCHEDULE (RBRVS)** means the scale of relative values for medical and surgical procedures that is maintained and updated by the Centers for Medicare and Medicaid Services with input from the AMA/Specialty Society Relative Value Scale Committee (RUC).

**SICKNESS** means a medical condition, illness, disease, or disorder which first manifests itself more than 30 days after the effective date of the policy and while this policy is in force. A medical condition, illness, disease, or disorder is "manifested" when it is diagnosed by a PHYSICIAN, or whenever the COVERED PERSON begins experiencing any symptom or sign of the medical condition, illness, disease, or disorder. SICKNESS includes continuations and reoccurrences of the medical condition, illness, disease, or disorder, and all general conditions associated with, related to, or caused by the medical condition, illness, disease, or disorder.

**SURGICAL PROCEDURE** means the performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, endoscopic examinations, and any one procedure designated by Current Procedural Terminology codes as surgery, except that venipuncture for the collection of blood for the purpose of performing a test shall not be considered a surgery. **SURGICAL PROCEDURE** shall also include all post-operative care for the 90-day period following surgery.

**WE, US, OUR** and **COMPANY** mean Liberty National Life Insurance Company.

**YOU, YOUR, YOURS** and **INSURED** mean the COVERED PERSON whose name is shown in the POLICY SCHEDULE as the INSURED.

#### **PART 1 DAILY HOSPITAL ROOM AND BOARD BENEFIT**

WE will pay a benefit for **MEDICALLY NECESSARY HOSPITAL** room expenses incurred by **YOU** or a covered **FAMILY MEMBER** during a necessary **HOSPITAL STAY**. Such **HOSPITAL** room expenses incurred must be the result of an **INJURY** or **SICKNESS**. The benefit payable shall not exceed the Daily Hospital Room and Board Benefit stated in the Benefit Schedule for each day of the **HOSPITAL STAY**, and shall not be for more than 2 years for any one **INJURY** or **SICKNESS**.

#### **PART 2 DAILY INTENSIVE CARE BENEFIT**

WE will pay a benefit for **MEDICALLY NECESSARY INTENSIVE CARE** expenses incurred by **YOU** or a covered **FAMILY MEMBER** during a necessary **HOSPITAL STAY**. Such **INTENSIVE CARE** admission and expenses incurred must be the result of an **INJURY** or **SICKNESS**. The benefit payable shall not exceed the Daily Intensive Care Benefit stated in the Benefit Schedule for each day of **INTENSIVE CARE**, and shall not be for more than 90 days for any one **INJURY** or **SICKNESS**.

The benefit payable under this **PART 2** for any day of **INTENSIVE CARE** is in lieu of the Daily Hospital Room and Board Benefit provided under **PART 1** of this policy.

#### **PART 3 MISCELLANEOUS HOSPITAL EXPENSE BENEFIT**

WE will pay a benefit at the rate of 80% of the expenses incurred by **YOU** or a covered **FAMILY MEMBER** for **MEDICALLY NECESSARY** care, treatment, services, and supplies provided by a **HOSPITAL** to or for **YOU** or a covered **FAMILY MEMBER** during a necessary **HOSPITAL STAY**, or for **MEDICALLY NECESSARY** care, treatment, services, and supplies provided by a **HOSPITAL** or **AMBULATORY SURGICAL CENTER** to or for **YOU** or a covered **FAMILY MEMBER** during a necessary outpatient admission for a **SURGICAL PROCEDURE** payable under **PART 4** of this policy. Such care, treatment, services, and supplies and expenses incurred during a **HOSPITAL STAY** or an outpatient surgical admission must be the result of an **INJURY** or **SICKNESS**. We will pay benefits for such expenses if the **HOSPITAL STAY** occurs prior to the 65<sup>th</sup> birthday of the **FAMILY MEMBER**.

The benefit under this **PART 3** will not exceed the amount of the Miscellaneous Hospital Expense Benefit stated in the Benefit Schedule for all such expenses incurred during a necessary **HOSPITAL STAY** or a necessary outpatient surgical admission, or for any one **INJURY** or **SICKNESS**, irrespective of the number of necessary **HOSPITAL STAYS** or outpatient surgical admissions. Only one benefit is payable for a **HOSPITAL STAY** or outpatient surgical admission even if the **COVERED PERSON'S** care, treatment, services, and supplies are for multiple **INJURIES** or **SICKNESSES** during any **HOSPITAL STAY** or outpatient surgical admission.

No benefits will be paid under this **PART 3** for a **HOSPITAL STAY** for a **FAMILY MEMBER** who is 65 years old or older, unless the **HOSPITAL STAY** began prior to the 65<sup>th</sup> birthday.

In determining the benefit payable under this **PART 3**, WE will not include expenses incurred for: (1) **PHYSICIAN** charges (including professional charges); (2) **HOSPITAL** room charges; (3) **INTENSIVE CARE** charges; or (4) charges for which coverage is provided or any benefit is payable under any other **PART** of this policy.

WE will pay the larger of either the Miscellaneous Hospital Expense Benefit payable under this **PART 3** or the Outpatient Expense Benefit payable under **PART 6**, but not both, where surgery is performed in a **HOSPITAL** or **AMBULATORY SURGICAL CENTER** on an outpatient basis.

## **PART 4**

## **SURGICAL PROCEDURE BENEFITS**

### **1. SURGEON BENEFIT**

WE will pay a benefit for expenses incurred by YOU or a covered FAMILY MEMBER for one PHYSICIAN performing a MEDICALLY NECESSARY SURGICAL PROCEDURE on YOU or a covered FAMILY MEMBER. Such SURGICAL PROCEDURE and expenses incurred must be the result of an INJURY or SICKNESS. The benefit will be equal to the fee charged by the PHYSICIAN for the SURGICAL PROCEDURE, but, in no event will the benefit payable be more than the lesser of either: (a) an amount equal to the Surgery Conversion Factor stated in the Benefit Schedule times the RELATIVE VALUE UNITS for that procedure as contained in the national RESOURCE-BASED RELATIVE VALUE SCHEDULE (RBRVS) last published and effective before the date of the SURGICAL PROCEDURE; or (b) the Surgeon Benefit Limit amount stated in the Benefit Schedule. If the SURGICAL PROCEDURE is not contained in the RBRVS, the benefit payable will be the lesser of: (a) the fee charged by the PHYSICIAN for the SURGICAL PROCEDURE; (b) the amount that would be payable for the most comparable SURGICAL PROCEDURE in severity and gravity; or (c) the Surgeon Benefit Limit amount stated in the Benefit Schedule. In the event that the RBRVS is discontinued, WE shall thereafter have the right to continue to use the RELATIVE VALUE UNITS contained in the last published RBRVS or, at OUR option and upon reasonable written notice to YOU, WE may designate an alternative, generally accepted, method to be used for determining relative values from the date specified in OUR notice.

WE will not pay a benefit for more than one SURGICAL PROCEDURE (the largest applicable) under this PART 4 for all SURGICAL PROCEDURES performed as a result of any one INJURY or SICKNESS.

### **2. ASSISTANT SURGEON BENEFIT**

WE will pay a benefit for expenses incurred by YOU or a covered FAMILY MEMBER for one PHYSICIAN providing MEDICALLY NECESSARY assistance to the primary PHYSICIAN during a SURGICAL PROCEDURE for which a Surgeon Benefit is payable under this PART 4. Such surgical assistance and expenses incurred must be the result of an INJURY or SICKNESS. The benefits will not exceed 20% of the amount payable for the Surgeon Benefit.

### **3. ADMINISTRATION OF ANESTHETIC BENEFIT**

WE will pay a benefit for expenses incurred by YOU or a covered FAMILY MEMBER for one PHYSICIAN providing MEDICALLY NECESSARY administration of anesthetic to YOU or a covered FAMILY MEMBER during a SURGICAL PROCEDURE for which a Surgeon Benefit is payable under this PART 4. Such anesthetic administration and expenses incurred must be the result of an INJURY or SICKNESS. The administration of anesthetic must be by a PHYSICIAN or a legally qualified anesthetist. The benefits will not exceed 25% of the amount payable for the Surgeon Benefit. WE will not pay any benefit for the administration of anesthetic by the primary PHYSICIAN or the assistant surgeon.

## **PART 5**

## **AMBULANCE BENEFIT**

WE will pay a benefit for expenses incurred by YOU or a covered FAMILY MEMBER for MEDICALLY NECESSARY ambulance service for YOU or a covered FAMILY MEMBER. Such ambulance service and expenses incurred must be the result of an INJURY or SICKNESS. The ambulance service must be to or from a HOSPITAL. WE will not pay more than the Ambulance Benefit stated in the Benefit Schedule for any one INJURY or SICKNESS, regardless of the frequency that ambulance service is required because of that INJURY or SICKNESS. Only one benefit will be payable for any one trip.

## **PART 6**

## **OUTPATIENT EXPENSE BENEFIT**

WE will pay a benefit at the rate of 80% of expenses incurred by YOU or a covered FAMILY MEMBER, in excess of the Outpatient Deductible Amount stated in the Benefit Schedule, for MEDICALLY NECESSARY outpatient care, treatment, and services provided to or for YOU or a covered FAMILY MEMBER. Such outpatient care, treatment, and services and expenses incurred must be the result of an INJURY or SICKNESS. Outpatient care, treatment, and services include:

1. Outpatient HOSPITAL expense;
2. Diagnostic imaging performed at other duly licensed locations; and
3. Laboratory tests performed at other duly licensed locations, including pathology tests.

WE will not pay in excess of the Outpatient Expense Benefit stated in the Benefit Schedule for expenses incurred for outpatient care, treatment, and services resulting from any one INJURY or SICKNESS.

If a benefit or benefits are payable under any other PART of this policy for an incurred expense also payable under this PART 6, only one benefit, the largest, will be payable for such expense.

## **PART 7**

## **OTHER BENEFITS**

On the condition that a benefit for expenses incurred for the following care, treatment, services, and supplies is not elsewhere provided in this policy, WE will pay benefits for expenses incurred for the following care, treatment, services, and supplies provided to a COVERED PERSON while this policy is in force according to the terms, dollar amounts and maximums set forth below in this PART 7 with respect to such covered care, treatment, services, and supplies. ALL BENEFITS PAYABLE UNDER THIS PART 7 SHALL BE SUBJECT TO ALL POLICY PROVISIONS, LIMITATIONS AND EXCLUSIONS, DEDUCTIBLES, CO-PAYS, CO-INSURANCE, AND DOLLAR-LIMIT PROVISIONS OF THIS POLICY, EXCEPT AS OTHERWISE SPECIFICALLY PROVIDED IN THIS PART 7. A benefit payable under this PART 7 shall not duplicate any benefit or benefits payable under any other PART or PARTS of this policy. The total benefit payable for care, treatment, services, and supplies covered under this PART 7 of the policy, together with benefits paid under any other policy or policies issued by US to YOU or a covered FAMILY MEMBER, will never exceed the total expense incurred by YOU or the covered FAMILY MEMBER for such care, treatment, services, and supplies.

### **1. MATERNITY BENEFITS, MINIMUM HOSPITAL STAYS**

As described in PART 8(1), this policy does not provide benefits for normal pregnancy. However, for a HOSPITAL STAY for which benefits are otherwise provided under this policy to a COVERED PERSON for a distinct complication of pregnancy, WE will provide a benefit for expenses incurred due to a distinct complication of pregnancy by any COVERED PERSON for a HOSPITAL STAY and inpatient care for a minimum of forty-eight (48) hours of inpatient care following vaginal delivery and a minimum of ninety-six (96) hours of inpatient care following a cesarean section for a mother, her newly born child, or both, in a HOSPITAL or any other health care facility licensed to provide obstetrical care, when that HOSPITAL STAY is deemed MEDICALLY NECESSARY by the attending PHYSICIAN, who is a medical doctor.

### **2. BREAST RECONSTRUCTIVE SURGERY AND PROSTHETIC DEVICE BENEFIT**

WE will provide a benefit for the following expenses incurred by YOU or a covered FAMILY MEMBER for prosthetic devices, breast reconstructive surgery, or both, for a COVERED PERSON incident to a MASTECTOMY covered under this policy, including:

- 1) Reconstruction of the breast on which the MEDICALLY NECESSARY MASTECTOMY has been performed;
- 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- 3) Prostheses and physical complications from all stages of MASTECTOMY, including lymphedemas.

To be covered, breast reconstructive surgery must be in the manner chosen by the affected COVERED PERSON'S treating PHYSICIAN, who is a licensed medical doctor or doctor of osteopathy, consistent with prevailing medical standards, and in consultation with the affected COVERED PERSON.

A benefit for prosthetic devices and breast reconstructive surgery covered under this subpart of PART 7 will be paid as follows:

- a. For prosthetic devices and breast reconstructive surgery not covered under PARTS 1-6 of this policy because such care is not being provided in relation to a SICKNESS, or because maximum policy benefits have been paid previously for the SICKNESS that resulted in the MEDICALLY NECESSARY MASTECTOMY, WE will consider all that COVERED PERSON'S prosthetic devices and breast reconstructive surgery(ies) collectively, as though they were for a single SICKNESS (separate from the SICKNESS that resulted in the MEDICALLY NECESSARY MASTECTOMY) under this policy.
- b. For prosthetic devices and breast reconstructive surgery not covered under PARTS 1-6 of this policy, nor brought within the scope of coverage based on (a) above, WE will pay a sum equal to 80% of the incurred expenses, but not to exceed a maximum benefit of \$500 for prosthetic devices and breast reconstructive surgery for any one COVERED PERSON.

### **3. DIABETES BENEFIT**

WE will provide a benefit for expenses incurred by a COVERED PERSON for medically appropriate and necessary equipment, supplies, diabetes outpatient self-management training and educational services, or any combination thereof, used in the management and treatment of diabetes for persons with gestational, type I or type II diabetes, if the COVERED PERSON'S treating PHYSICIAN or a PHYSICIAN who specializes in the treatment of diabetes certifies that such services are necessary.

The diabetes outpatient self-management training and educational services must be provided under the direct supervision of a certified diabetes educator or a board-certified endocrinologist. Any nutrition counseling must be provided by a licensed dietician.

For equipment, supplies, treatment, service, training, or any combination thereof, for diabetes covered under this subpart of PART 7, and not otherwise covered under another PART of this policy, WE will pay a sum of money equal to 80% of the incurred charge not to exceed a maximum benefit of \$1,500 during any policy year for all equipment, supplies, treatment, service, or training for diabetes provided that COVERED PERSON.

#### **4. ANESTHESIA AND HOSPITALIZATION FOR DENTAL PROCEDURES BENEFIT**

WE will provide a benefit for general anesthesia, hospital charges, or both, for dental care charges incurred in a HOSPITAL or AMBULATORY SURGICAL CENTER when the procedure is performed by (i) a fully accredited specialist in pediatric dentistry or other dentist fully accredited in a recognized dental specialty for which HOSPITAL or AMBULATORY SURGICAL CENTER privileges are granted; (ii) a dentist who is certified by virtue of completion of an accredited program of postgraduate training to be granted HOSPITAL or AMBULATORY SURGICAL CENTER privileges; or (iii) a dentist who has not yet satisfied certification requirements but has been granted HOSPITAL or AMBULATORY SURGICAL CENTER privileges; and when the COVERED PERSON receiving such treatment:

- 1) is younger than 7 years of age;
- 2) has a serious mental or physical condition; or
- 3) has significant behavioral problems.

This benefit does not cover routine dental care, including the diagnosis or treatment of disease or other dental conditions and procedures not specifically covered under this subpart of PART 7.

A benefit for anesthesia or facility charges for dental care covered under this subpart of PART 7 will be paid as follows:

- a. For anesthesia or facility charges for dental care not otherwise eligible for coverage under this policy, WE will consider that COVERED PERSON'S incurred expenses for anesthesia and facility charges for dental care as though they were eligible for coverage under PARTS 1-4 and PART 6 of the policy.
- b. For anesthesia or facility charges for dental care not covered under PARTS 1-6 of this policy, or brought within the scope of coverage based on (a) above, WE will pay a sum equal to 80% of the incurred expenses, but not to exceed a maximum benefit of \$100 for all anesthesia and facility charges for dental care provided to any one COVERED PERSON.

#### **6. MEDICAL FOODS AND LOW PROTEIN MODIFIED FOOD PRODUCTS BENEFIT**

WE will provide a benefit for the expense incurred for MEDICAL FOODS, LOW PROTEIN MODIFIED FOOD PRODUCTS, amino acid modified preparations and any other special dietary products and formulas for the treatment of INHERITED METABOLIC DISEASES if the MEDICAL FOODS, LOW PROTEIN MODIFIED FOOD PRODUCTS, amino acid modified preparations and other special dietary products and formulas are prescribed as MEDICALLY NECESSARY for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias and disorders of amino acid metabolism, and administered under the direction of a PHYSICIAN.

For benefits for MEDICAL FOODS and LOW PROTEIN MODIFIED FOOD PRODUCTS covered under this subpart of PART 7 that are not otherwise covered under another PART of this policy, WE will pay a sum of money equal to 80% of the incurred charge, but not to exceed a maximum benefit of \$2,400 for each COVERED PERSON during any one policy year as provided under the Income Tax Act of 1929.

#### **7. COLORECTAL CANCER SCREENING BENEFIT**

WE will provide a benefit for the expense incurred for colorectal cancer examinations and laboratory tests for a COVERED PERSON who is 50 years of age or older, at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005, or experiencing the symptoms of colorectal cancer as determined by a PHYSICIAN licensed under the Arkansas Medical Practices Act, §17-95-201 et seq., §17-95-301 et seq., and §17-95-401 et seq., including bleeding from the rectum or blood in the stool, or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool that lasts more than five (5) days. The colorectal screening shall involve an examination of the entire colon, and WE will provide a benefit for colorectal cancer screening for any one of the following options:

- 1) An annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;
- 2) A double-contrast barium enema every five (5) years; or
- 3) A colonoscopy every ten (10) years, and follow-ups based on the following schedule:
  - i. If the initial colonoscopy is normal, a follow-up is covered once every ten (10) years;
  - ii. For individuals with one (1) or more neoplastic polyps, adenomatous polyps, and the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps was performed, a follow-up will be covered after three (3) years;
  - iii. If single tubular adenoma of less than one centimeter (1 cm) is found, a follow-up will be covered after five (5) years; and
  - iv. For patients with large sessile adenomas greater than three centimeters (3 cm), a follow-up will be covered after six (6) months, or continuously until complete polyp removal is verified by colonoscopy.
- 4) Any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health determined in consultation with appropriate health care organizations.

Benefits for colorectal cancer screening covered under this subpart of PART 7 will be paid as follows:

- a. For colorectal cancer screening not covered under PARTS 1-6 of this policy because such treatment or service is not being provided in relation to a covered SICKNESS, WE will consider that COVERED PERSON'S colorectal cancer testing as though it was for a covered SICKNESS under PART 6 of this policy.
- b. For colorectal cancer screening not covered under PARTS 1-6 of this policy, nor brought within the scope of coverage based on (a) above, WE will pay a sum of money equal to 80% of the incurred charge, but not to exceed a maximum benefit of \$50 for each screening provided a COVERED PERSON.

## **8. MENTAL ILLNESS BENEFIT**

WE will provide a benefit for expenses incurred for a COVERED PERSON for the treatment of MENTAL ILLNESS on an inpatient or outpatient basis. Benefits will be provided to the same extent as any other physical illness covered under this policy.

## **9. TEMPOROMANDIBULAR JOINT DISORDER AND CRANIOMANDIBULAR JAW DISORDER BENEFIT**

WE will provide coverage for the treatment and care provided to or for a COVERED PERSON for the diagnostic procedure and surgical treatment of temporomandibular and craniomandibular disorder if, under accepted medical standards, such diagnostic procedure or surgery is MEDICALLY NECESSARY to treat conditions caused by a congenital or developmental deformity, disease, disorder, or INJURY. A temporomandibular and craniomandibular disorder shall be considered to be a SICKNESS under this policy, and benefits will be paid under PARTS 1-6 as applicable. However, this policy does not include coverage for orthodontic appliances and treatment, crowns, bridges and dentures unless the disorder is trauma related.

## **PART 8**

### **LIMITATIONS AND EXCLUSIONS**

Except to the extent specifically and directly provided elsewhere in this policy to the contrary, 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. Any charges for (1) usual and customary routine nursery care; or (2) well-baby care, immunizations, medical examinations or tests of any kind; or (3) 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 (except where specified under Part 7 and all subsections); or
3. Convalescent or skilled nursing care in a facility other than a HOSPITAL; educational care; or for nervous or mental disorders; or
4. Any dental treatment (except as necessitated by INJURY), hearing aids, or eye refractive exams, surgery or treatment; or
5. Any HOSPITAL STAY, INTENSIVE CARE unit admission, or other care, treatment, services, or supplies for which YOU or a covered FAMILY MEMBER do not incur a charge; or
6. Any HOSPITAL STAY, INTENSIVE CARE unit admission, or other care, treatment, services, or supplies that are not MEDICALLY NECESSARY for diagnosis of or for care, treatment, or services resulting from an INJURY or SICKNESS; or
7. Any cosmetic or elective procedures and any related complications; or
8. Any expense incurred in excess of the usual, customary, and reasonable charges for any care, treatment, service, or supply in the geographic area where furnished; or
9. Professional radiological, pathological or EKG interpretations during a HOSPITAL STAY; or
10. Any rehabilitative care services received at a facility not meeting the definition of a HOSPITAL; or
11. Any care, treatment, services, or supplies received outside of the U.S. boundaries or territories; or
12. Any Infertility care, treatment or services; or sterilization or reversal of sterilization procedures; or
13. Any medical condition, illness, disease, or disorder that first manifests itself before the effective date of the policy; or
14. Any care, treatment, services, or supplies for obesity or morbid obesity, including but not limited to, gastric banding ("lapband"), vertical banded gastroplasty, Roux-en-Y gastric bypass, DISTAL gastric bypass (duodenal switch, biliopancreatic diversion), or stomach stapling procedures, even if the COVERED PERSON has a health condition or conditions that might be benefited thereby; or
15. Any care, treatment, services, or supplies for drug abuse or addiction, including alcoholism or overdose of drugs, narcotics, or hallucinogens, unless taken as prescribed by a PHYSICIAN; or any loss caused directly or indirectly, wholly or partially, or contributed to by or as a result of any COVERED PERSON being under the influence of an intoxicant or a narcotic; or
16. Suicide, or treatment of an attempted suicide, or any intentionally self-inflicted injury, while sane or insane.

## POLICY PROVISIONS

**ELIGIBILITY AND INSURED'S TERMINATION:** YOU, as the INSURED, are the beneficiary of YOUR covered FAMILY MEMBERS. Every transaction relating to this policy shall be between US and YOU.

A new family member (including husband, wife, or any children under the age of 19 at the time the policy is issued) will be covered; each new member must be named 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 automatically be a COVERED PERSON from the moment of birth or adoption if 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 21<sup>st</sup> 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 21<sup>st</sup> 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 covered FAMILY MEMBER), or (2) YOUR eldest remaining covered 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 covered 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 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 that the initial term expires.

The effective date of this policy, the first premium, and the date the initial term expires are stated 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 an officer of 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.

After 2 years from the date of an endorsement adding a FAMILY MEMBER, other than a newborn or newly adopted child, only fraudulent misstatements in the application may be used to void the endorsement or deny any claim for loss incurred after the 2-year period.

**GRACE PERIOD:** This policy has 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 without requiring an application for reinstatement will reinstate this policy.

If WE require 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 to YOU of its disapproval.

The reinstated policy will cover only loss that results from an INJURY sustained after the date of reinstatement or a SICKNESS that manifests itself 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 or as soon as reasonably possible. The notice can be given to US at OUR Administrative Offices in McKinney, Texas 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 may 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 set forth below.

**PROOFS OF LOSS:** YOU must give US written proof of loss to OUR satisfaction 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 proper written proof of loss satisfactory to US, WE will pay to YOU, or at OUR option to the HOSPITAL, DOCTOR, or person rendering services covered by this policy, all benefits then due for such loss.

**PAYMENT OF CLAIMS:** Benefits will be paid, after receiving a claim form and proper written proof of loss satisfactory to US, to YOU, or at OUR option to the HOSPITAL, DOCTOR, or person providing care, treatment, services, or supplies covered by this policy. Any benefit unpaid at death may 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 covered FAMILY MEMBER examined as often as reasonably necessary while a claim is pending.

**NONDUPLICATION OF COVERAGE:** The benefits payable under this policy shall be excess over benefits paid or payable or required to be provided:

1. under any workers' compensation, occupational disease, employers' liability or similar law;
2. under any motor vehicle no-fault plan or coverage or similar law; and
3. under any national, state, or other governmental plan not limited to governmental employees or their families, such as Medicare or Medicaid.

**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.

**SUBROGATION; REIMBURSEMENT:** YOU agree that, to the extent of the benefits paid under this policy, WE shall be subrogated to all YOUR rights to damages or recovery for any INJURY or SICKNESS, or any care, treatment, services, or supplies provided, for which a third party or parties, or their insurance carrier(s), are or may be liable or responsible. YOU agree to repay US first out of any monies YOU receive or recover by settlement, judgment or otherwise, regardless of whether YOU are fully compensated for YOUR losses and damages. In the event that WE retain OUR own attorney to represent OUR subrogation interest, WE will not be responsible for paying a portion of YOUR attorney fees or costs.

YOU assign to US YOUR claims and rights against all liable or responsible third party or parties and their insurance carrier(s) to the extent of OUR payments, and shall do nothing after the loss to prejudice OUR subrogation rights. Entering into a settlement or compromise arrangement with a third party or parties, or their insurance carrier(s), without OUR prior written consent, shall be deemed to prejudice OUR subrogation rights. YOU shall promptly advise US in writing whenever a claim or demand against a third party or parties, or their insurance carrier(s), is made, and shall further provide to US such additional information and execute and deliver such instruments or papers as are reasonably requested by US to secure OUR subrogation rights. YOU agree to fully cooperate in protecting OUR subrogation rights against the liable or responsible third party or parties, and their insurance carrier(s).

**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 the expiration of the applicable statute of limitations from the time written proof of the claim is required to be given.

**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 written assignment (or a copy thereof) is on file at OUR Administrative Offices. At OUR option, WE may waive this requirement. WE do not assume any responsibility for the validity of any assignment.

sThis policy is signed for US by OUR President and Secretary.

*Sandy M. [Signature]*  
SPECIMEN

Secretary

*[Signature]*  
SPECIMEN

President

Countersigned:

\_\_\_\_\_  
Licensed Resident Agent where required by law.

**APPLICATION FOR INSURANCE**  
**LIBERTY NATIONAL LIFE INSURANCE COMPANY**  
**A LEGAL RESERVE STOCK COMPANY**

Applicant's Telephone # ( )  
 POLICY FORM [LSHXC]  
 Daily Room Benefit \$50 \$75 \$100

1. Full Name(s) of Family Member(s) to be Insured	Sex	Date of Birth			Age Last Birthday	(HOME OFFICE USE ONLY)
		Mo.	Day	Year		
(a) (Applicant)						
(b) (Spouse)						
(c) (Child)						
(d) (Child)						
(e) (Child)						
(f) (Child)						

2. **PRINT** — Where should Premium Notices be sent?

Name \_\_\_\_\_  
 No. & St. or Rt. No. \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_  
 E-Mail Address \_\_\_\_\_

3. Do any of you have any existing (or pending applications for) hospital, medical or surgical insurance?  
 Yes  No

Company \_\_\_\_\_  
 Describe Coverage \_\_\_\_\_

4. Will this policy replace any existing coverage?  
 Yes  No

If so, what coverage? \_\_\_\_\_

**IF A CONDITION LISTED IN QUESTIONS 5, 6 OR 7 EXISTS, THE APPLICABLE FAMILY MEMBER IS NOT ELIGIBLE FOR COVERAGE.**

5. Indicate any family member who has had or been treated for any of the following within the past 2 years:  
 Alcoholism, drug abuse, Alzheimer's, amputation due to disease, chronic muscle disorder, sickle cell or aplastic anemia, Down's syndrome, quadriplegia, mental retardation, kidney failure, dialysis, chronic brain syndrome, diabetic neuropathy, liver cirrhosis, hospitalized 4 or more times, advised to have surgery but not yet done so.

1(a) Applicant	1(b) Spouse	1(c) Child	1(d) Child	1(e) Child	1(f) Child
<input type="checkbox"/>					

6. Indicate any family member who is currently: pregnant, totally disabled, bedridden, hospitalized or confined to a nursing facility or who has had or been treated for internal cancer in the last 6 months.

1(a) Applicant	1(b) Spouse	1(c) Child	1(d) Child	1(e) Child	1(f) Child
<input type="checkbox"/>					

7. Indicate any family member who has ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or immune deficiency related disorders or tested positive for antibodies to the HIV virus.

1(a) Applicant	1(b) Spouse	1(c) Child	1(d) Child	1(e) Child	1(f) Child
<input type="checkbox"/>					

**QUESTIONS 8 THRU 10 ARE TO BE COMPLETED ONLY FOR THOSE FAMILY MEMBERS NOT INDICATED IN QUESTIONS 5, 6 OR 7.**

8. Indicate any family member who has had or been treated for any of the following in the past 2 years:

	1(a) Applicant	1(b) Spouse	1(c) Child	1(d) Child	1(e) Child	1(f) Child
Breast or reproductive organ disorder, eye disorder . . . . .	<input type="checkbox"/>					
Skin cancer, hernia (unoperated) . . . . .	<input type="checkbox"/>					
Gallbladder disease (unoperated), stomach ulcers . . . . .	<input type="checkbox"/>					
Colitis, hepatitis . . . . .	<input type="checkbox"/>					
Recurrent urinary tract disorders, diverticulitis . . . . .	<input type="checkbox"/>					

**MULTIPLY THE NUMBER OF BOXES CHECKED BY 2 =**

<input type="checkbox"/>						
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

9. Indicate any family member who has had or been treated for any of the following in the past 2 years:

	1(a) Applicant	1(b) Spouse	1(c) Child	1(d) Child	1(e) Child	1(f) Child
Heart or circulatory disorder but no surgery, cystic fibrosis . . . . .	<input type="checkbox"/>					
Chronic obstructive lung disease, Bright's disease . . . . .	<input type="checkbox"/>					
Diabetes, Crohn's disease . . . . .	<input type="checkbox"/>					
Ulcerative colitis, lupus, high blood pressure (hospitalized) . . . . .	<input type="checkbox"/>					
Paraplegia, internal cancer (no treatment in last 6 months) . . . . .	<input type="checkbox"/>					
Back, joint or bone disorder, convulsions . . . . .	<input type="checkbox"/>					

**MULTIPLY THE NUMBER OF BOXES CHECKED BY 3 =**

<input type="checkbox"/>						
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

10. Indicate any family member who has had or been treated for any of the following in the past 2 years:

	1(a) Applicant	1(b) Spouse	1(c) Child	1(d) Child	1(e) Child	1(f) Child
Congenital disorders . . . . .	<input type="checkbox"/>					
Peripheral blood vessel disease . . . . .	<input type="checkbox"/>					
Parkinson's disease . . . . .	<input type="checkbox"/>					
Heart/Cardiovascular surgery . . . . .	<input type="checkbox"/>					
Polycythemia . . . . .	<input type="checkbox"/>					
Hemophilia . . . . .	<input type="checkbox"/>					

**MULTIPLY THE NUMBER OF BOXES CHECKED BY 5 =**

<input type="checkbox"/>						
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

**ADD TOTAL POINTS FROM QUESTIONS 8, 9 & 10. REFER TO RATE CHART FOR APPROPRIATE CLASSIFICATION AND PREMIUM.**

<input type="checkbox"/>						
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

**APPLICATION FOR INSURANCE  
LIBERTY NATIONAL LIFE INSURANCE COMPANY  
A LEGAL RESERVE STOCK COMPANY**

**AGREEMENT:** I hereby apply to Liberty National Life Insurance Company ("Company") for a policy to be issued in reliance on my written answers to all questions. The applicant(s) represent(s) to the Company that the agent asked each and every question that appears on the application and that all the answers are true, correct and complete. I agree the policy shall not be effective unless it has actually been issued by the Company. I acknowledge that no agent has the authority to make, alter, modify or discharge any policy or any of its provisions for or on behalf of the Company; nor is the Company bound by any statement or representation made to any agent unless the statement or representation is included in this application.

I authorize the MIB, Inc., any insurance company, hospital, physician or other practitioner having any information available as to my diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, to disclose such information to Liberty National Life Insurance Company for the purpose of determining my eligibility for insurance and eligibility for benefits under this policy. I understand that any information obtained will not be released to any person or organization except to the MIB, Inc., reinsuring companies or other persons or organization performing business or legal services in connection with this application, with a claim or as may be otherwise lawfully required. I agree that a copy of this authorization is to be acceptable. This authorization will remain in effect for a period of 24 months from the date signed. I understand that I may request a copy of this authorization. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Information for consumers about MIB may be obtained on its website at www.mib.com.

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 certify: (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 to the applicant.

Dated at \_\_\_\_\_  
City and State                      Month                      Day                      Year

X \_\_\_\_\_  
Agent's Signature                      Agent No.

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

Agent's Address \_\_\_\_\_

Amount paid to agent \$ \_\_\_\_\_ for first \_\_\_\_\_ month's premiums.

Mail policy to     Applicant     Agent

**SPECIMEN**

SERFF Tracking Number: AMLC-126370732 State: Arkansas  
 Filing Company: Liberty National Life Insurance Company State Tracking Number: 44212  
 Company Tracking Number: LSHXC  
 TOI: H151 Individual Health - Hospital/Surgical/Medical Expense Sub-TOI: H151.001 Health - Hospital/Surgical/Medical Expense  
 Product Name: Limited Benefit Hospital, Surgical and Medical Expense Policy  
 Project Name/Number: Limited Benefit Hospital, Surgical and Medical Expense Policy/LSHXC

## Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 12/03/2009	Proposed Annual Premium Rates	LSHXC	New		LNL LSHXC Rate Page - 55% (AR).pdf

**LIBERTY NATIONAL LIFE INSURANCE COMPANY**  
**McKinney, Texas**

**Policy Form LSHXC**  
**Limited Benefit Hospital, Surgical and Medical Expense Policy**

**New Product Filing**

**Proposed Annual Premium Rates**

SEX / AGE		DAILY ROOM BENEFIT AMOUNT		
		\$50	\$75	\$100
Children	0-17	\$209	\$264	\$319
Male	18-45	\$374	\$462	\$539
Male	46-63	\$594	\$770	\$924
Female	18-45	\$407	\$506	\$594
Female	46-63	\$495	\$649	\$781

**Modal Premium Factors:**

Semiannual	=	Annual Premium *	0.520	( rounded to near cent )
Quarterly	=	Annual Premium *	0.265	( rounded to near cent )
Monthly	=	Annual Premium /	11	( rounded to near cent )

SERFF Tracking Number: AMLC-126370732 State: Arkansas  
 Filing Company: Liberty National Life Insurance Company State Tracking Number: 44212  
 Company Tracking Number: LSHXC  
 TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical  
 Hospital/Surgical/Medical Expense Expense  
 Product Name: Limited Benefit Hospital, Surgical and Medical Expense Policy  
 Project Name/Number: Limited Benefit Hospital, Surgical and Medical Expense Policy/LSHXC

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> AR Readability Certification.pdf	Approved-Closed	12/03/2009

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> The application is being filed under the Form Schedule. <b>Comments:</b>	Approved-Closed	12/03/2009

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Outline of Coverage <b>Comments:</b> <b>Attachment:</b> DS-LSHXC(03).pdf	Approved-Closed	12/03/2009

LIBERTY NATIONAL LIFE INSURANCE COMPANY  
McKinney, Texas

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, Surgical and Medical Expense Policy LSHXC	54
Application for Life Insurance Form LHA-1-AP(03)	52

Date: November 13, 2009



Michael J. Gaisbauer, Vice President

FORM S-1351

**LIBERTY NATIONAL LIFE INSURANCE COMPANY**  
P. O. BOX 8080, MCKINNEY, TEXAS 75070 (972) 529-5085  
A Legal Reserve Stock Company \* Administrative Offices: McKinney, Texas

**OUTLINE OF COVERAGE - POLICY FORM LSHXC**  
Retain This Form For Your Records.  
**LIMITED BENEFIT SURGICAL AND MEDICAL EXPENSE COVERAGE**

**Read Your Policy Carefully** - This outline of coverage provides a very brief description of the important features of the policy for which You, as the proposed insured designated in the application, are applying. This outline of coverage is not the insurance contract and does not alter or modify the terms of the policy. The policy itself will set forth, in detail, the rights and obligations of the parties if Your application is accepted. It is, therefore, important that You **READ YOUR POLICY CAREFULLY** when it is delivered to You!

**Limited Benefit Hospital, Surgical and Medical Expense Coverage** - Policies of this category are designed to provide, to persons insured, coverage for certain hospital and surgical expenses incurred as a result of a covered Injury or Sickness as defined in the policy. Coverage is provided for Hospital outpatient services, surgical services, anesthesia services, and other medical services, subject to any limitations, exclusions, deductibles, co-insurance and co-payment requirements set forth in the policy. Benefits provided under this policy are limited, and coverage is not provided for all Hospital, surgical or medical expenses.

**BENEFITS - Eligible Surgical and Medical Expenses. Benefits listed below are subject to the applicable deductibles, coinsurance and copays, and benefit amounts shown in Your policy Benefit Schedule.**

- 1. Daily Hospital Room and Board Benefit..... [\$50.00, \$75.00 or \$100.00]**  
A benefit is payable for Medically Necessary Hospital room expenses incurred by a Covered Person during a necessary Hospital Stay for any one covered Injury or Sickness up to the Daily Hospital Room and Board Benefit, for up to 2 years.
- 2. Daily Intensive Care Benefit, up to ..... [\$200.00]**  
Benefits are payable for intensive care up to 2 times the Daily Hospital Room Benefit beginning with the first day of confinement in an intensive care unit of a hospital for a maximum of 90 days for each covered injury or sickness. This benefit payable is in lieu of the Daily Hospital Room and Board Benefit.
- 3. Miscellaneous Hospital Expense Benefit, up to ..... [\$2,000.00]**  
Benefits are payable for 80% of the expenses incurred up to 20 times the Daily Room Benefit for Medically Necessary Miscellaneous Hospital Services and supplies during a hospital confinement prior to the Insured's 65<sup>th</sup> birthday. There is no deductible.
- 4. Surgeon Benefit, up to ..... [\$1,000.00]**  
Benefits are payable for one Medically Necessary Surgical Procedure due to a covered Injury or Sickness. Benefits are payable for expenses incurred up to the lesser of the Surgery Conversion Factor stated in the Benefit Schedule multiplied by the Relative Value Units for such procedure or the Surgeon Benefit Limit. The policy pays up to 20% of the Surgeon Benefit for one Assistant Surgeon and up to 25% of the Surgeon Benefit for one anesthesiologist.
- 5. Ambulance Benefit ..... [\$100.00] Maximum**  
A benefit is payable for expenses incurred by a Covered Person for Medically Necessary ambulance service to or from a Hospital due to a covered Injury or Sickness, not to exceed [\$100.00]. Only one benefit will be payable for any one Injury or Sickness.
- 6. Outpatient Expense Benefit, up to ..... [\$50.00] Deductible [\$200.00] Annual Maximum**  
We will pay a benefit at the rate of 80% of expenses incurred by a Covered Person (in excess of the Outpatient Deductible Amount stated in the Benefit Schedule) for Medically Necessary outpatient services and treatment including outpatient Hospital expense, diagnostic imaging and laboratory tests, due to a covered Injury or Sickness. We will not pay more than the Outpatient Expense Benefit shown in the Benefit Schedule for all such expenses incurred in relation to any one Injury or Sickness.
- 7. Optional Riders** – Available with the LSHXC are a Cancer Rider, a Critical Illness Rider and an Accident Rider.

**YOUR POLICY MAY CONTAIN OTHER BENEFITS MANDATED BY YOUR STATE. REFER TO PART 5 OF YOUR POLICY.**

**PRE-EXISTING CONDITION LIMITATION**

Any medical condition, illness, disease, disorder, or injury for which a Covered Person received treatment or medical advice, or for which symptoms existed that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment, within the 12-month period prior to the policy effective date will not be covered for the first 12 months following the policy effective date. A pregnancy existing at any time prior to, and which continues to exist as of, the Effective Date of such Covered Person's coverage under the policy, or any medical condition, illness, disease, disorder, or injury listed on Your application which occurred within the 12-month period prior to the policy effective date, will not be covered for the first 12 months following the policy effective date.

**LIMITATIONS AND EXCLUSIONS**

Except to the extent specifically and directly provided elsewhere in this policy to the contrary, 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. Any charges for (1) usual and customary routine nursery care; or (2) well-baby care, immunizations, medical examinations or tests of any kind; or (3) 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 (except where specified under Part 7 and all subsections); or
3. Convalescent or skilled nursing care in a facility other than a HOSPITAL; educational care; or for nervous or mental disorders; or
4. Any dental treatment (except as necessitated by INJURY), hearing aids, or eye refractive exams, surgery or treatment; or
5. Any HOSPITAL STAY, INTENSIVE CARE unit admission, or other care, treatment, services, or supplies for which YOU or a covered FAMILY MEMBER do not incur a charge; or
6. Any HOSPITAL STAY, INTENSIVE CARE unit admission, or other care, treatment, services, or supplies that are not MEDICALLY NECESSARY for diagnosis of or for care, treatment, or services resulting from an INJURY or SICKNESS; or
7. Any cosmetic or elective procedures and any related complications; or
8. Any expense incurred in excess of the usual, customary, and reasonable charges for any care, treatment, service, or supply in the geographic area where furnished; or
9. Professional radiological, pathological or EKG interpretations during a HOSPITAL STAY; or
10. Any rehabilitative care services received at a facility not meeting the definition of a HOSPITAL; or
11. Any care, treatment, services, or supplies received outside of the U.S. boundaries or territories; or
12. Any Infertility care, treatment or services; or sterilization or reversal of sterilization procedures; or
13. Any medical condition, illness, disease, or disorder that first manifests itself before the effective date of the policy; or
14. Any care, treatment, services, or supplies for obesity or morbid obesity, including but not limited to, gastric banding ("lapband"), vertical banded gastroplasty, Roux-en-Y gastric bypass, DISTAL gastric bypass (duodenal switch, biliopancreatic diversion), or stomach stapling procedures, even if the COVERED PERSON has a health condition or conditions that might be benefited thereby; or
15. Any care, treatment, services, or supplies for drug abuse or addiction, including alcoholism or overdose of drugs, narcotics, or hallucinogens, unless taken as prescribed by a PHYSICIAN; or any loss caused directly or indirectly, wholly or partially, or contributed to by or as a result of any COVERED PERSON being under the influence of an intoxicant or a narcotic; or
16. Suicide, or treatment of an attempted suicide, or any intentionally self-inflicted injury, while sane or insane.

**TERMINATION OF COVERAGE FOR CHILDREN**

Coverage on YOUR children terminate when they marry. It also terminates on the policy anniversary date following their 21<sup>st</sup> 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 21<sup>st</sup> 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.

**RENEWAL AGREEMENT**

You can continue the 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. We have the right to change the renewal premiums for the policy when We change, and in accordance with, Our table of premium rates applicable to all policies of this form and class. Class is based on benefit amounts, persons covered under the policy, state of issue, age at issue, gender, underwriting group and geographic rating area. We also have the right to change the renewal premiums for this policy when the persons covered under the policy change, in accordance with the table of premium rates applicable to all policies of this form and class.

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 \$ \_\_\_\_\_ .