

SERFF Tracking Number: AMLC-126111229 State: Arkansas  
Filing Company: Liberty National Life Insurance Company State Tracking Number: 42141  
Company Tracking Number: LMSA06  
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
Standard Plans  
Product Name: Medicare Supplement Policy Forms  
Project Name/Number: LMSA06/LMSA06

## Filing at a Glance

Company: Liberty National Life Insurance Company

Product Name: Medicare Supplement Policy SERFF Tr Num: AMLC-126111229 State: ArkansasLH  
Forms

TOI: MS051 Individual Medicare Supplement - SERFF Status: Closed State Tr Num: 42141  
Standard Plans

Sub-TOI: MS051.001 Plan A

Co Tr Num: LMSA06

State Status: Approved-Closed

Filing Type: Form/Rate

Co Status:

Reviewer(s): Stephanie Fowler

Author: Phylis Ballard

Disposition Date: 06/23/2009

Date Submitted: 04/20/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: LMSA06

Status of Filing in Domicile: Pending

Project Number: LMSA06

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Filed on this day

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 06/23/2009

Explanation for Other Group Market Type:

State Status Changed: 06/23/2009

Deemer Date:

Corresponding Filing Tracking Number:  
LMSA06

Filing Description:

RE: Medicare Supplement Policy Forms LMSA06, LMSB06, LMSF06, LMSHDF06 and LDMSB06

Outline of Coverage Forms DS-LMS2006(03) and DS-LDMS2006(03)

Application Forms LMA14(03) and LDMA14(03)

Replacement Notice Form LREPMSM

SERFF Tracking Number: AMLC-126111229 State: Arkansas  
Filing Company: Liberty National Life Insurance Company State Tracking Number: 42141  
Company Tracking Number: LMSA06  
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
Standard Plans  
Product Name: Medicare Supplement Policy Forms  
Project Name/Number: LMSA06/LMSA06

Actuarial Memorandums and Rates  
Readability Certification Form S-1351(03)

We are submitting for your review and approval copies of the subject Medicare Supplement Policies and related forms. These forms are being submitted as a new filing and do not replace any previously approved forms. Policy Forms LMSA06, LMSB06, LMSF06 and LMSHDF06 are intended to provide coverage to Medicare recipients. Policy Form LDMSB06 is intended to provide coverage to individuals under age 65 who are on Medicare by reason of disability. They will be marketed to individuals through licensed agents. The policies are completed in John Doe fashion.

The forms do not contain any unusual or unorthodox provisions and wording. The Readability Certification form is enclosed.

I hereby certify that I have carefully reviewed the forms and to the best of my knowledge and ability find:

- 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 have been filed in Nebraska, our state of domicile, and have been filed in all jurisdictions where the company operates.

The Outlines of Coverage, standard Form DS-LMS2006(03) and disability Form DS-LDMS2006(03) will be provided to the applicant at the time of application.

The applications to be used with these policies are standard Application Form LMA14(03) and disability Application Form LDMA14(03), which are being filed for general use with our Medicare Supplement portfolio.

The Replacement Notice, Form LREPMSM, will be provided to the applicant at the time of application, if the applicant has indicated on the application that this policy is intended to replace previous coverage.

The required Buyer's Guide will be provided to the applicant at the time of application.

Copies of the Actuarial Memorandums and rates are also enclosed.

SERFF Tracking Number: AMLC-126111229 State: Arkansas  
 Filing Company: Liberty National Life Insurance Company State Tracking Number: 42141  
 Company Tracking Number: LMSA06  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans  
 Product Name: Medicare Supplement Policy Forms  
 Project Name/Number: LMSA06/LMSA06

Your early review and approval of this filing would be greatly appreciated. If you have any questions, please feel free to contact me collect at (972) 569-3748, or by e-mail at pballard@torchmarkcorp.com.

Sincerely,

Phylis Ballard  
 Regulatory Compliance

## Company and Contact

### Filing Contact Information

Phylis Ballard, Compliance Analyst pballard@torchmarkcorp.com  
 3700 S. Stonebridge Drive (972) 569-3748 [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: \$750.00  
 Retaliatory? No  
 Fee Explanation: 10 forms x \$50.00 = \$500.00  
 5 rates x \$50.00 = \$250.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Liberty National Life Insurance Company	\$750.00	04/20/2009	27268953

SERFF Tracking Number: AMLC-126111229 State: Arkansas  
 Filing Company: Liberty National Life Insurance Company State Tracking Number: 42141  
 Company Tracking Number: LMSA06  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans  
 Product Name: Medicare Supplement Policy Forms  
 Project Name/Number: LMSA06/LMSA06

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	06/23/2009	06/23/2009

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Stephanie Fowler	06/17/2009	06/17/2009	Phylis Ballard	06/18/2009	06/18/2009
Pending Industry Response	Stephanie Fowler	05/14/2009	05/14/2009	Phylis Ballard	05/21/2009	05/21/2009

### Amendments

Item	Schedule	Created By	Created On	Date Submitted
LMA14(03)	Form	Phylis Ballard	05/20/2009	06/23/2009
LDMA14(03)	Form	Phylis Ballard	05/20/2009	06/23/2009



SERFF Tracking Number: AMLC-126111229 State: Arkansas  
 Filing Company: Liberty National Life Insurance Company State Tracking Number: 42141  
 Company Tracking Number: LMSA06  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans  
 Product Name: Medicare Supplement Policy Forms  
 Project Name/Number: LMSA06/LMSA06

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification	Accepted for Informational Purposes	No
Supporting Document	Outline of Coverage	Accepted for Informational Purposes	Yes
Form	LREPMSM	Approved	Yes
Form	LMA14(03)	Approved	Yes
Form	LDMA14(03)	Approved	Yes
Form (revised)	LMSA06	Approved	Yes
Form	LMSA06		Yes
Form (revised)	LMSB06	Approved	Yes
Form	LMSA06		Yes
Form (revised)	LMSF06	Approved	Yes
Form	LMSF06		Yes
Form (revised)	LMSHDF06	Approved	Yes
Form	LMSHDF06		Yes
Form (revised)	LDMSB06	Approved	Yes
Form	LDMSB06		Yes
Rate	LMSA06 Rates	Approved	Yes
Rate	LMSB06 Rates	Approved	Yes
Rate	LMSF06 Rates	Approved	Yes
Rate	LMSHDF06 Rates	Approved	Yes
Rate	LDMSB06 Rates	Approved	Yes

SERFF Tracking Number: AMLC-126111229 State: Arkansas  
Filing Company: Liberty National Life Insurance Company State Tracking Number: 42141  
Company Tracking Number: LMSA06  
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
Standard Plans  
Product Name: Medicare Supplement Policy Forms  
Project Name/Number: LMSA06/LMSA06

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 06/17/2009  
Submitted Date 06/17/2009  
Respond By Date 07/17/2009

Dear Phylis Ballard,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Application (Supporting Document)

Comment: The Tobacco Use question is an underwriting question and should either be moved to the health question portion of both applications or should include the disclosure outlined in R&R 27, Sec. 11.D.

Also, the applications need to be moved to the Form Schedule so that they can be included in the Disposition, once we reach that point.

Please feel free to contact me if you have questions.

Sincerely,

Stephanie Fowler

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 06/18/2009  
Submitted Date 06/18/2009

Dear Stephanie Fowler,

### Comments:

This is in response to your objection on June 17, 2009.

### Response 1

Comments: The tobacco questions has been removed from the application.

### Related Objection 1



SERFF Tracking Number: AMLC-126111229 State: Arkansas  
Filing Company: Liberty National Life Insurance Company State Tracking Number: 42141  
Company Tracking Number: LMSA06  
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
Standard Plans  
Product Name: Medicare Supplement Policy Forms  
Project Name/Number: LMSA06/LMSA06

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 05/14/2009  
Submitted Date 05/14/2009  
Respond By Date 06/15/2009

Dear Phylis Ballard,

This will acknowledge receipt of the captioned filing.

### Objection 1

- LMSA06 (Form)
- LMSA06 (Form)
- LMSF06 (Form)
- LMSHDF06 (Form)
- LDMSB06 (Form)

Comment: Page one, next to the last sentence; "Your premium may..." needs to be removed. Premiums can only be increased on the policy's anniversary date, this statement makes it sound like the premiums can be raised at any time.

Page two, first sentence of the second paragraph; "If You have a Pre-Existing Condition..."; please revise this sentence to replace the "and" with "or". This sentence should read, "If You have a Pre-Existing Condition and qualify for open enrollment or have had a continuous period of creditable coverage for at least 6 months, We cannot exclude coverage based on the Pre-Existing Condition." If the policyholder was enrolled during his or her open enrollment, it would not matter if they had continuous coverage or not.

### Objection 2

- Application (Supporting Document)

Comment: These comments apply to both application. When responding to this objection, please attach the applications to the forms schedule.

R&R 27, Sec. 11 prohibits discrimination of pricing during Open Enrollment. The Tobacco Use question is an underwriting question and should be moved to be included with the other health related questions.

R&R 27, Sec. 11.D requires a statement above health questions on the application that "Under Open Enrollment, health questions are not required to be answered." Please add this statement above the health question portions of Part II.

Please explain the relevancy behind Part III. This information seems to be covered in the first section of Part II.

SERFF Tracking Number: AMLC-126111229 State: Arkansas  
Filing Company: Liberty National Life Insurance Company State Tracking Number: 42141  
Company Tracking Number: LMSA06  
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
Standard Plans  
Product Name: Medicare Supplement Policy Forms  
Project Name/Number: LMSA06/LMSA06

Please feel free to contact me if you have questions.

Sincerely,  
Stephanie Fowler

## Response Letter

Response Letter Status	Submitted to State
Response Letter Date	05/21/2009
Submitted Date	05/21/2009

Dear Stephanie Fowler,

### Comments:

We have revised the policies as requested.

### Response 1

Comments: We revised the policies and have attached them.

### Related Objection 1

Applies To:

- LMSA06 (Form)
- LMSA06 (Form)
- LMSF06 (Form)
- LMSHDF06 (Form)
- LDMSB06 (Form)

Comment:

Page one, next to the last sentence; "Your premium may..." needs to be removed. Premiums can only be increased on the policy's anniversary date, this statement makes it sound like the premiums can be raised at any time.

Page two, first sentence of the second paragraph; "If You have a Pre-Existing Condition..."; please revise this sentence to replace the "and" with "or". This sentence should read, "If You have a Pre-Existing Condition and qualify for open enrollment or have had a continuous period of creditable coverage for at least 6 months, We cannot exclude coverage based on the Pre-Existing Condition." If the policyholder was enrolled during his or her open enrollment, it would not matter if they had continuous coverage or not.

SERFF Tracking Number: AMLC-126111229 State: Arkansas  
 Filing Company: Liberty National Life Insurance Company State Tracking Number: 42141  
 Company Tracking Number: LMSA06  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans  
 Product Name: Medicare Supplement Policy Forms  
 Project Name/Number: LMSA06/LMSA06

**Changed Items:**

No Supporting Documents changed.

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
LMSA06	LMSA06		Policy/Contract/Fraternal Certificate	Initial		68	LMSA06ar.pdf
<b>Previous Version</b>							
LMSA06	LMSA06		Policy/Contract/Fraternal Certificate	Initial		68	LMSA06ar.pdf
LMSB06	LMSB06		Policy/Contract/Fraternal Certificate	Initial		56	LMSB06ar.pdf
<b>Previous Version</b>							
LMSA06	LMSB06		Policy/Contract/Fraternal Certificate	Initial		56	LMSB06ar.pdf
LMSF06	LMSF06		Policy/Contract/Fraternal Certificate	Initial		60	LMSF06ar.pdf
<b>Previous Version</b>							
LMSF06	LMSF06		Policy/Contract/Fraternal Certificate	Initial		60	LMSF06ar.pdf
LMSHDF06	LMSHDF06		Policy/Contract/Fraternal Certificate	Initial		58	LMSHDF06ar.pdf
<b>Previous Version</b>							
LMSHDF06	LMSHDF06		Policy/Contract/Fraternal Certificate	Initial		58	LMSHDF06ar.pdf
LDMSB06	LDMSB06		Policy/Contract/Fraternal Certificate	Initial		56	LDMSB06ar.pdf
<b>Previous Version</b>							
LDMSB06	LDMSB06		Policy/Contract/Fraternal Certificate	Initial		56	LDMSB06ar.pdf

SERFF Tracking Number: AMLC-126111229 State: Arkansas  
Filing Company: Liberty National Life Insurance Company State Tracking Number: 42141  
Company Tracking Number: LMSA06  
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
Standard Plans  
Product Name: Medicare Supplement Policy Forms  
Project Name/Number: LMSA06/LMSA06

No Rate/Rule Schedule items changed.

## Response 2

Comments: According to R&R 27, Sec. 11 prohibits discrimination of pricing during Open Enrollment. The tobacco questions is not an underwriting question, it is just to determine if they use tobacco or not. They will not be declined if the answer is yes. But the rates will be higher as stated on the rate page.

As for as health questions on the application question 6 on page 2 has this sentence "Are you within 6 month of your enrollment in Medicare Part B or otherwise qualified for open enrollment? (Questions 7-18 not required if the answer to question 6 is "YES". Its telling them that if they qualify for open enrollment not to answer the health questions.

The relevancy to Part II is to obtain additional information for eligibiltiy. New guideline came out in 2007 concerning creditable coverage and this additional information will help with eligibility. This has been on the United American applications for years.

### Related Objection 1

Applies To:

- Application (Supporting Document)

Comment:

These comments apply to both application. When responding to this objection, please attach the applications to the forms schedule.

R&R 27, Sec. 11 prohibits discrimination of pricing during Open Enrollment. The Tobacco Use question is an underwriting question and should be moved to be included with the other health related questions.

R&R 27, Sec. 11.D requires a statement above health questions on the application that "Under Open Enrollment, health questions are not required to be answered." Please add this statement above the health question portions of Part II.

Please explain the relevancy behind Part III. This information seems to be covered in the first section of Part II.

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.



SERFF Tracking Number: AMLC-126111229 State: Arkansas  
 Filing Company: Liberty National Life Insurance Company State Tracking Number: 42141  
 Company Tracking Number: LMSA06  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans  
 Product Name: Medicare Supplement Policy Forms  
 Project Name/Number: LMSA06/LMSA06

**Amendment Letter**

Amendment Date:  
 Submitted Date: 06/23/2009

**Comments:**

Attached are the applications.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
LMA14(03)	Application/ELMA14(03)	Initial nrollment Form					66	LMA14(03).pdf

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
LDMA14(03)	Application/ELDMA14(03)	Initial nrollment Form					66	LDMA14(03).pdf

SERFF Tracking Number: AMLC-126111229 State: Arkansas  
 Filing Company: Liberty National Life Insurance Company State Tracking Number: 42141  
 Company Tracking Number: LMSA06  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans  
 Product Name: Medicare Supplement Policy Forms  
 Project Name/Number: LMSA06/LMSA06

## Form Schedule

Lead Form Number: LMSA06

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved	LREPMSM	Other	LREPMSM	Initial			LREPMSM.pdf
Approved	LMA14(03)	Application/Enrollment Form	LMA14(03)	Initial		66	LMA14(03).pdf
Approved	LDMA14(03)	Application/Enrollment Form	LDMA14(03)	Initial		66	LDMA14(03).pdf
Approved	LMSA06	Policy/Contract/Fraternal Certificate	LMSA06	Initial		68	LMSA06ar.pdf
Approved	LMSB06	Policy/Contract/Fraternal Certificate	LMSB06	Initial		56	LMSB06ar.pdf
Approved	LMSF06	Policy/Contract/Fraternal Certificate	LMSF06	Initial		60	LMSF06ar.pdf
Approved	LMSHDF06	Policy/Contract/Fraternal Certificate	LMSHDF06	Initial		58	LMSHDF06ar.pdf
Approved	LDMSB06	Policy/Contract/Fraternal Certificate	LDMSB06	Initial		56	LDMSB06ar.pdf

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered YES, this form must be dated, signed by the applicant and by the Agent, and submitted with the application, AND a copy of this form must be left with the applicant.

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

LIBERTY NATIONAL LIFE INSURANCE COMPANY

3700 S. STONEBRIDGE DRIVE, P.O. BOX 8080, MCKINNEY, TEXAS 75070 (972) 529-5085

A Legal Reserve Stock Company \* Administrative Offices: McKinney, Texas

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

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

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

STATEMENT TO APPLICANT BY ISSUER OR AGENT:

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

- Additional benefits.
No change in benefits, but lower premiums.
Fewer benefits and lower premiums.
My plan has outpatient prescription drug coverage and I am enrolling in Part D.
Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

Other. (please specify)

- (1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
(2) State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
(3) If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. FAILURE TO INCLUDE ALL REQUESTED MATERIAL MEDICAL INFORMATION ON AN APPLICATION MAY PROVIDE A BASIS FOR THE COMPANY TO DENY ANY FUTURE CLAIMS AND TO REFUND YOUR PREMIUM AS THOUGH YOUR POLICY HAD NEVER BEEN IN FORCE. After the application has been completed and before you sign it, review it carefully to be certain that all requested information has been properly recorded.

DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

\*\*\*\*\*

(Agent's Signature)

(Applicant's Signature)

Type or print name & address of Agent or Broker

(Date)

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

**PART I: APPLICANT INFORMATION**

<b>Plan Code</b> <input style="width:40px; height:20px;" type="text"/> <small>(Refer to Rate Card)</small>	<b>Effective Date Requested (mm-dd-yyyy)</b> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/>	<b>Mode of Premium</b> <input type="radio"/> Annual <input type="radio"/> Semi-Annual <input type="radio"/> Quarterly <input type="radio"/> Monthly	<b>Method of Payment</b> <input type="radio"/> Send Premium Notices <input type="radio"/> Automatic Payment Plan	<b>Draft Date</b> Day (01-28) of the Month to Draft Bank Account <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/>
<b>Select Plan Applying for:</b> <input type="radio"/> A <input type="radio"/> B <input type="radio"/> F <input checked="" type="radio"/> HDF				

Applicant's First Name

Last Name

M.I.

**Applicant's Mailing Address:**

Street or Route

City  State

Zip Code  County

**If Applicant's Residence Address is different from Mailing Address, show below:**

Street or Route

City  State

Zip Code  County

Social Security Number  -  -

Date of Birth (mm-dd-yyyy)  -  -  -  -  -

Height (ft. in.)

Weight (lbs.)

Age Last Birthday

Sex  Male  Female

E-mail Address of Proposed Insured

<b>Application Verification Information</b>	A recorded interview may be necessary as part of the underwriting of your application for insurance. The most convenient time and place for the interview is:	<input type="radio"/> 8 AM - Noon <input type="radio"/> Noon - 6 PM <input type="radio"/> 6 PM - 9 PM	Home Phone No. <input style="width:30px; height:25px;" type="text"/> - <input style="width:30px; height:25px;" type="text"/> - <input style="width:30px; height:25px;" type="text"/> Work Phone No. <input style="width:30px; height:25px;" type="text"/> - <input style="width:30px; height:25px;" type="text"/> - <input style="width:30px; height:25px;" type="text"/>
---	---	---	--

**PART II: ELIGIBILITY QUESTIONS**

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS.**

**TO THE BEST OF YOUR KNOWLEDGE:**

**Yes No**

1. (a) Did you turn age 65 in the last six (6) months? -----

(b) Did you enroll in Medicare Part B in the last six (6) months? -----

(c) If "YES", what is the effective date? (mm-dd-yyyy)      -   -

(d) What is your Medicare Claim Number?        -   -       -    
(exactly as shown on your Medicare card)

2. Are you covered for medical assistance through the state Medicaid program?

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

If you answered "YES":

(a) Will Medicaid pay your premiums for this Medicare Supplement policy? -----

(b) Do you receive any benefits from Medicaid OTHER THAN payment towards your Medicare Part B premium? -----

3. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END Date" blank.

START Date (mm-dd-yyyy)      -   -        END Date (mm-dd-yyyy)      -   -

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? -----

(c) Was this your first time in this type of Medicare plan? -----

(d) Did you drop a Medicare Supplement policy to enroll in the Medicare plan? -----

4. (a) Do you have another Medicare Supplement policy in force? -----

(b) If so, with what company, and what plan do you have? \_\_\_\_\_

(c) If so, do you intend to replace your current Medicare Supplement policy with this policy? -----

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

(a) If so, with what company and what kind of policy?  
\_\_\_\_\_  
\_\_\_\_\_

(b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END Date" blank.)

START Date (mm-dd-yyyy)      -   -        END Date (mm-dd-yyyy)      -   -

**Yes No**

6. Are you within 6 months of your enrollment in Medicare Part B or otherwise qualified for open enrollment? -----    
(Questions 7-17 not required if the answer to question 6 is "YES".)



**PART II: ELIGIBILITY QUESTIONS (continued)**

**IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES," THE APPLICANT IS NOT ELIGIBLE FOR COVERAGE:**

- |  |  |
|--|--|
| 7. Are you currently hospitalized, confined to a nursing facility or receiving Medicare approved home health care, or have you been hospitalized or received Medicare approved home health care 2 or more times in the past 12 months? -----   | <b>Yes No</b><br><input type="radio"/> <input type="radio"/> |
| 8. Do you have emphysema, Chronic Obstructive Pulmonary Disease (COPD), or pulmonary fibrosis? -----   | <input type="radio"/> <input type="radio"/>                  |
| 9. Are you bedridden or do you use a wheelchair for any daily activity, or have you been diagnosed with Gaucher's Disease or any other type of lysosomal storage disorder, or have you had any type of amputation caused by disease? -----   | <input type="radio"/> <input type="radio"/>                  |
| 10. Have you been advised that surgery may be required within the next twelve months for cataracts? -----  | <input type="radio"/> <input type="radio"/>                  |
| 11. Have you been diagnosed or treated for Parkinson's disease, Multiple or Lateral Sclerosis, Alzheimer's disease, senile dementia, or organic brain disorder? -----  | <input type="radio"/> <input type="radio"/>                  |
| 12. Have you been treated, diagnosed or tested positive as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or ever tested positive for antibodies for the AIDS (HIV) virus? -----  | <input type="radio"/> <input type="radio"/>                  |
| 13. Do you have diabetes requiring more than 50 units of insulin daily? -----  | <input type="radio"/> <input type="radio"/>                  |
| 14. Within the past 2 years, have you been diagnosed or treated for internal cancer, melanoma, leukemia, alcoholism or drug abuse, cirrhosis, mental or nervous disorder requiring psychiatric care, or have you been advised to have kidney dialysis? -----                             | <input type="radio"/> <input type="radio"/>                  |
| 15. Within the past 2 years, have you been diagnosed or treated for heart attack, peripheral vascular disease, congestive heart failure, heart valve disorder, stroke, or transient ischemic attacks (TIA)? -----  | <input type="radio"/> <input type="radio"/>                  |
| 16. Within the past 2 years, have you been diagnosed or treated for rheumatoid arthritis or crippling arthritis? -----   | <input type="radio"/> <input type="radio"/>                  |
| 17. Within the past year, have you been fed intravenously or through a tube, have you been medically advised to have surgery for joint replacement or for a heart condition, but not had such surgery, or have you been advised to have other surgery that has not been performed? ----- | <input type="radio"/> <input type="radio"/>                  |

**PART III**

**I. INVOLUNTARY TERMINATION OF COVERAGE:**

If your previous coverage was terminated involuntarily, please provide a copy of the notice of termination of coverage and attach it to this form.

What type of coverage was terminated? \_\_\_\_\_

Date of termination?   -   -     Reason for termination? \_\_\_\_\_

**II. VOLUNTARY TERMINATION OF COVERAGE:**

If you voluntarily terminated your present coverage, please attach evidence of previous coverage to this form.

What type of coverage was terminated? \_\_\_\_\_

Date of termination?   -   -     Reason for termination? \_\_\_\_\_

If you voluntarily terminated coverage under a Medicare Advantage plan\* or Medicare Select policy, please answer the following questions: **Yes No**

- |   |   |
|---|---|
| 1. Was this the first time you were ever enrolled in a Medicare Advantage plan or purchased a Medicare Select policy? -----   | <input type="radio"/> <input type="radio"/> |
| If so, did you have the Medicare Advantage plan or Medicare Select policy for less than 12 months? -----                      | <input type="radio"/> <input type="radio"/> |
| 2. Did you have a Medicare Supplement policy before applying for the Medicare Advantage plan or Medicare Select policy? ----- | <input type="radio"/> <input type="radio"/> |
| If "YES", with which Company and which Medicare Supplement plan? _____  |   |
| Is that Company still offering that Medicare Supplement plan? -----   | <input type="radio"/> <input type="radio"/> |

\* Medicare Advantage plan means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; (2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and (3) Medicare Advantage private fee-for-service plans.



PART V: AGENT CERTIFICATION

The undersigned Agent certifies that he/she has personally met with the Applicant and that the Applicant has read, or had read to him/her, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

**AGENT COMPLETES** (Attach separate sheet, if necessary.)

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

---

---

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

---

---

I certify: (1) I have accurately recorded the information supplied by the Applicant, (2) I have given an outline of coverage for the policy applied for and a Medicare Supplement Buyers Guide to the Applicant.

Last Name

--	--	--	--	--	--	--	--

Agent No.

--	--	--	--	--	--	--	--

Agent's Signature

LMA14(03)

MAIL POLICY TO:  Agent  Insured (The Policy will be sent to Insured unless otherwise instructed.)

SPECIMEN

Initials of Proposed Insured 

--	--	--



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

**PART I: APPLICANT INFORMATION**

<b>Plan Code</b> <input style="width:30px; height:20px;" type="text"/> <small>(Refer to Rate Card)</small>	<b>Effective Date Requested (mm-dd-yyyy)</b> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/> <input style="width:30px; height:20px;" type="text"/>	<b>Mode of Premium</b> <input type="radio"/> Annual <input type="radio"/> Semi-Annual <input type="radio"/> Quarterly <input type="radio"/> Monthly	<b>Method of Payment</b> <input type="radio"/> Send Premium Notices <input type="radio"/> Automatic Payment Plan	<b>Draft Date</b> Day (01-28) of the Month to Draft Bank Account <input style="width:30px; height:20px;" type="text"/>
<b>Select Plan Applying for</b> <input type="radio"/> A <input checked="" type="radio"/> B				

Applicant's First Name

Last Name

M.I.

**Applicant's Mailing Address:**

Street or Route

City  State

Zip Code  County

**If Applicant's Residence Address is different from Mailing Address, show below:**

Street or Route

City  State

Zip Code  County

Social Security Number  -  -

Date of Birth (mm-dd-yyyy)  -  -

Height (ft. in.)

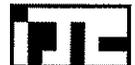
Weight (lbs.)

Age Last Birthday

Sex  Male  Female

E-mail Address of Proposed Insured

<b>Application Verification Information</b>	A recorded interview may be necessary as part of the underwriting of your application for insurance. The most convenient time and place for the interview is:	<input type="radio"/> 8 AM - Noon <input type="radio"/> Noon - 6 PM <input type="radio"/> 6 PM - 9 PM	Home Phone No. <input style="width:30px; height:20px;" type="text"/> - <input style="width:30px; height:20px;" type="text"/> - <input style="width:30px; height:20px;" type="text"/> Work Phone No. <input style="width:30px; height:20px;" type="text"/> - <input style="width:30px; height:20px;" type="text"/> - <input style="width:30px; height:20px;" type="text"/>
---	---	---	--



**PART II: ELIGIBILITY QUESTIONS**

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS.**

**TO THE BEST OF YOUR KNOWLEDGE:**

**Yes No**

1. (a) Did you turn age 65 in the last six (6) months? -----
- (b) Did you enroll in Medicare Part B in the last six (6) months? -----

(c) If "YES", what is the effective date? (mm-dd-yyyy)   -   -

(d) What is your Medicare Claim Number?     -   -       -

(exactly as shown on your Medicare card)

2. Are you covered for medical assistance through the state Medicaid program? -----
- NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question. -----

If you answered "YES":

- (a) Will Medicaid pay your premiums for this Medicare Supplement policy? -----
- (b) Do you receive any benefits from Medicaid OTHER THAN payment towards your Medicare Part B premium? -----

3. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END Date" blank.

START Date (mm-dd-yyyy)   -   -          END Date (mm-dd-yyyy)   -   -

**Yes No**

- (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? -----
- (c) Was this your first time in this type of Medicare plan? -----
- (d) Did you drop a Medicare Supplement policy to enroll in the Medicare plan? -----

4. (a) Do you have another Medicare Supplement policy in force? -----
- (b) If so, with what company, and what plan do you have? \_\_\_\_\_
- (c) If so, do you intend to replace your current Medicare Supplement policy with this policy? -----

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)
- (a) If so, with what company and what kind of policy? \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

(b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END Date" blank.)

START Date (mm-dd-yyyy)   -   -          END Date (mm-dd-yyyy)   -   -

**Yes No**

6. Are you within 6 months of your enrollment in Medicare Part B or otherwise qualified for open enrollment? -----
- (Questions 7-18 not required if the answer to question 6 is "YES".)

**PART II: ELIGIBILITY QUESTIONS (continued)**

**IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES," THE APPLICANT IS NOT ELIGIBLE FOR COVERAGE:**

- |  | <b>Yes</b>            | <b>No</b>             |
|--|-----------------------|-----------------------|
| 7. Are you currently hospitalized, confined to a nursing facility or receiving Medicare approved home health care, or have you been hospitalized or received Medicare approved home health care 2 or more times in the past 12 months? -----   | <input type="radio"/> | <input type="radio"/> |
| 8. Do you have emphysema, Chronic Obstructive Pulmonary Disease (COPD), or pulmonary fibrosis? -----   | <input type="radio"/> | <input type="radio"/> |
| 9. Are you bedridden or do you use a wheelchair for any daily activity, or have you been diagnosed with Gaucher's Disease or any other type of lysosomal storage disorder, or have you had any type of amputation caused by disease? -----   | <input type="radio"/> | <input type="radio"/> |
| 10. Have you been advised that surgery may be required within the next twelve months for cataracts? -----  | <input type="radio"/> | <input type="radio"/> |
| 11. Have you been diagnosed or treated for Parkinson's disease, Multiple or Lateral Sclerosis, Cerebral Palsy, Alzheimer's disease, senile dementia, or organic brain disorder? -----  | <input type="radio"/> | <input type="radio"/> |
| 12. Have you been treated, diagnosed or tested positive as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or ever tested positive for antibodies for the AIDS (HIV) virus? -----  | <input type="radio"/> | <input type="radio"/> |
| 13. Have you had or been medically treated for or been advised to have a bone marrow or organ transplant? -----  | <input type="radio"/> | <input type="radio"/> |
| 14. Do you have diabetes requiring more than 50 units of insulin daily? -----  | <input type="radio"/> | <input type="radio"/> |
| 15. Within the past 2 years, have you been diagnosed or treated for internal cancer, melanoma, leukemia, alcoholism or drug abuse, cirrhosis, schizophrenia or bipolar disorder requiring psychiatric care, or have you been advised to have kidney dialysis? -----                      | <input type="radio"/> | <input type="radio"/> |
| 16. Within the past 2 years, have you been diagnosed or treated for heart attack, peripheral vascular disease, congestive heart failure, heart valve disorder, stroke, or transient ischemic attacks (TIA)? -----  | <input type="radio"/> | <input type="radio"/> |
| 17. Within the past 2 years, have you been diagnosed or treated for rheumatoid arthritis or crippling arthritis? -----   | <input type="radio"/> | <input type="radio"/> |
| 18. Within the past year, have you been fed intravenously or through a tube, have you been medically advised to have surgery for joint replacement or for a heart condition, but not had such surgery, or have you been advised to have other surgery that has not been performed? ----- | <input type="radio"/> | <input type="radio"/> |

**PART III**

**I. INVOLUNTARY TERMINATION OF COVERAGE:**

If your previous coverage was terminated involuntarily, please provide a copy of the notice of termination of coverage and attach it to this form.

What type of coverage was terminated? \_\_\_\_\_

Date of termination?   -     Reason for termination? \_\_\_\_\_

**II. VOLUNTARY TERMINATION OF COVERAGE:**

If you voluntarily terminated your present coverage, please attach evidence of previous coverage to this form.

What type of coverage was terminated? \_\_\_\_\_

Date of termination?   -     Reason for termination? \_\_\_\_\_

If you voluntarily terminated coverage under a Medicare Advantage plan\* or Medicare Select policy, please answer the following questions: **Yes No**

- |   |                       |                       |
|---|-----------------------|-----------------------|
| 1. Was this the first time you were ever enrolled in a Medicare Advantage plan or purchased a Medicare Select policy? -----   | <input type="radio"/> | <input type="radio"/> |
| If so, did you have the Medicare Advantage plan or Medicare Select policy for less than 12 months? -----                      | <input type="radio"/> | <input type="radio"/> |
| 2. Did you have a Medicare Supplement policy before applying for the Medicare Advantage plan or Medicare Select policy? ----- | <input type="radio"/> | <input type="radio"/> |
| If "YES", with which Company and which Medicare Supplement plan? _____  |                       |                       |
| Is that Company still offering that Medicare Supplement plan? -----   | <input type="radio"/> | <input type="radio"/> |

\* Medicare Advantage plan means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; (2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and (3) Medicare Advantage private fee-for-service plans.



PART V: AGENT CERTIFICATION

The undersigned Agent certifies that he/she has personally met with the applicant and that the Applicant has read, or had read to him/her, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

AGENT COMPLETES (Attach separate sheet, if necessary.)

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

---

---

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

---

---

I certify: (1) I have accurately recorded the information supplied by the Applicant, (2) I have given an outline of coverage for the policy applied for and a Medicare Supplement Buyers Guide to the Applicant.

Last Name

--	--	--	--	--	--	--	--

Agent No.

--	--	--	--	--	--	--	--

Agent's Signature

LDMA14(03)

MAIL POLICY TO:  Agent  Insured (The Policy will be sent to Insured unless otherwise instructed.)

SPECIMEN

Initials of Proposed Insured 

--	--	--



**NOTICE TO BUYER:** This policy may not cover all of Your medical expenses.

**MEDICARE SUPPLEMENT POLICY**

**BENEFIT PLAN A**

**GUARANTEED RENEWABLE FOR LIFE. COMPANY CANNOT CANCEL POLICY. COMPANY MAY CHANGE PREMIUM RATES BY CLASS AND AS MEDICARE BENEFITS CHANGE AS PROVIDED IN THE GUARANTEED RENEWAL PROVISION.**

**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.

**GUARANTEED RENEWAL PROVISION**

You can renew and continue this policy in force during Your lifetime, for successive renewal terms 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 such 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 year of issue, area of the state in which You resided at issue, and underwriting group at issue for policyholders of this form in Your state.

The benefits provided by this policy which are designed to cover cost sharing amounts under Medicare will change automatically to coincide with any applicable changes in the deductible and/or Coinsurance amounts which You are required to pay under Medicare. The renewal premiums for this policy may change on the renewal date following the effective date of any such applicable change. Any such premium change will be based on the actuarial computations which We then use to determine the renewal premium.

---

**POLICY SCHEDULE**

---

<b>INSURED</b>	<b>POLICY NUMBER</b>	<b>EFFECTIVE DATE</b>	<b>INITIAL TERM EXPIRES ON</b>	<b>INITIAL PREMIUM</b>
[John Doe]	[0000000]	[01-01-09]	[01-01-10]	[\$0]

If this policy is a replacement of an existing policy the “PRE-EXISTING CONDITIONS LIMITATIONS PROVISION” does not apply.

---

## TABLE OF CONTENTS

	Page
30 Day Right to Examine Policy .....	1
Guaranteed Renewal Provision.....	1
Pre-Existing Conditions Limitations Provision.....	2
Insuring Clause.....	2
Extended Benefit Provision .....	2
Definitions .....	2
Benefits For Hospital Stays - Medicare Part A.....	4
Medicare Blood Deductible Benefit .....	4
Benefits for Medical Expense - Medicare Part B .....	4
Limitations and Exclusions .....	4
Policy Provisions .....	4
Policy Provisions - Claims .....	6

---

### PRE-EXISTING CONDITIONS LIMITATIONS PROVISION

Loss due to a Pre-Existing Condition is not covered unless the loss is incurred more than 60 days after the policy effective date.

If You have a Pre-Existing Condition and qualify for open enrollment or have had a continuous period of creditable coverage for at least 6 months, We cannot exclude coverage based on the Pre-Existing Condition. If the period of creditable coverage is less than 6 months, We will give credit for the amount of time of creditable coverage You have had towards fulfilling the Pre-Existing Condition exclusion period.

If You are an Eligible Person who applied to enroll under this Medicare supplement policy not later than 63 days after the date of the termination or disenrollment, and who submitted evidence of the date of termination or disenrollment with the application, the Pre-Existing Conditions Limitations Provision will not apply.

### THE INSURING CLAUSE

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

### EXTENDED BENEFIT PROVISION

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

### DEFINITIONS

Where used in this policy:

**BENEFIT PERIOD** means the unit of time used in the Medicare program to measure use of services and availability of services under Medicare Part A hospital insurance.

**CALENDAR YEAR** means the period beginning on each January 1 and ending on the following December 31.

**COINSURANCE AMOUNTS** means the portion of Medicare approved expense You are obligated to pay but not including the Medicare Part A inpatient hospital deductible or Part B Calendar Year deductible.

**CONTINUOUS PERIOD OF CREDITABLE COVERAGE** means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

**CREDITABLE COVERAGE** means coverage of an individual provided by any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;
5. Chapter 55 of Title 10 United States Code (CHAMPUS);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);
9. A public health plan as defined in federal regulation; and
10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

**ELIGIBLE PERSON** means a person who submits evidence of the date of termination, disenrollment, or Medicare Part D enrollment as applies under the following plans: (1) Employee Welfare Benefit Plan; (2) Medicare Advantage plan; (3) Medicare Select Plan, Medicare Risk or Cost Plan, or Medicare HMO plan; or (4) Medicare supplement policy.

**HOSPITAL** means a lawfully operated hospital which has been accredited by the Joint Commission on Accreditation of Hospitals.

**HOSPITAL STAY** means one day or more of confinement within a hospital, as a resident patient under the care of a Physician, due to 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.

**MEDICARE** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

**MEDICARE ADVANTAGE PLAN** means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; (2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and (3) Medicare Advantage private fee-for-service plans.

**MEDICARE ELIGIBLE EXPENSES** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

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

**PRE-EXISTING CONDITION** means an Injury sustained or Sickness first manifesting itself prior to the policy effective date for which medical advice or treatment was recommended or given by a Physician within 6 months prior to the policy effective date.

**SICKNESS** means illness or disease of an insured person which first manifests itself after the effective date of insurance and while this policy is in force.

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

**YOU, YOUR, YOURS and INSURED** mean the person whose name is shown in the Policy Schedule.

## **BASIC CORE BENEFITS**

### **PART 1 BENEFITS FOR HOSPITAL STAYS - MEDICARE PART A**

We will pay the following benefits when You have a Hospital Stay for which benefits are paid by Medicare Part A:

- 1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
- 2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime reserve day used; and
- 3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

### **PART 2 MEDICARE BLOOD DEDUCTIBLE BENEFIT**

We will pay the expense You incur for coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations), unless replaced in accordance with Federal regulations.

### **PART 3 BENEFITS FOR MEDICAL EXPENSE - MEDICARE PART B**

If You incur a medical expense that is eligible under Medicare Part B, We will pay the following benefit for the Medicare approved charge:

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

Under this PART 3 of this policy, We will not pay benefits for (a) the Medicare Part B blood deductible for which benefits are paid under PART 2 of this policy, or (b) any portion of the Medicare Part B Calendar Year deductible.

### **PART 4 LIMITATIONS AND EXCLUSIONS**

We will not pay benefits under this policy for:

- 1) Any expense which You are not legally obligated to pay; or
- 2) Any services that are not medically necessary as determined by Medicare or are not furnished at the direction of and under the supervision of a Physician; or
- 3) Any portion of any expense for which payment is made by Medicare; or
- 4) Custodial or intermediate level care, or rest cures; or
- 5) Any type of expense not eligible for coverage under Medicare.

## **POLICY PROVISIONS**

**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 on 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.

Upon Your death, We will refund any premiums paid in Your behalf, for any period beyond the ending of the policy month the death occurred, within 30 days after We receive proof of death.

If death is due to Injury and this policy provides for the refund of premiums for death due to Injury, only one benefit will be paid, the largest.

**ENTIRE CONTRACT; CHANGES:** This policy, with the application and attached papers, is the entire contract between You and Us. No change in this policy will 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 60 days from the effective date will be reduced or denied because a Sickness or physical condition had existed before the effective date of this policy.

**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 (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.

**SUSPENSION OF COVERAGE WHILE ENTITLED TO MEDICAID:** By written notice to Us, You may request that benefits and premiums for You under this policy be suspended for the period in which You have been determined to be entitled to Medicaid. Written notice must be received by Us within 90 days after the date You become entitled to Medicaid. After We have received such notice, We will return to You any portion of premiums paid for the period of suspension less any claims paid. The suspension period shall not exceed 24 months.

If Your entitlement to Medicaid ends, You must send Us written notice of the loss of such entitlement within 90 days and pay the premium attributable to the period, effective as of the date of termination of entitlement. We will reinstate Your benefits and premiums under this policy as of the date Your entitlement ended. The reinstated coverage shall be the same as if no suspension has occurred.

**SUSPENSION OF COVERAGE WHILE ENTITLED TO BENEFITS UNDER A GROUP HEALTH PLAN:** By written notice to Us, You may request that benefits and premiums for You under this policy be suspended (for any period that may be provided by federal regulation) if You are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). Written notice must be received by Us within 90 days after the date You become entitled to coverage under the group health plan. After We have received such notice, We will return to You any portion of premiums paid for the period of suspension less any claims paid.

If Your entitlement to coverage under the group health plan ends, You must send Us written notice of the loss of such entitlement within 90 days and pay the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan. We will reinstitute Your benefits and premiums under this policy as of the date Your entitlement ended. The reinstated coverage shall be the same as if no suspension had occurred.

**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 any required forms for filing proof of loss, if applicable. 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 Your loss.

**PROOF OF LOSS:** You must give written proof of loss to Us within 6 months 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 will pay all benefits then due for such loss.

**PAYMENT OF CLAIMS:** Any benefits unpaid at Your death may be paid, at Our option, either to Your beneficiary or Your estate. All other benefits will be paid to You.

If benefits are payable to Your estate or a beneficiary who cannot execute a valid release, We can pay benefits up to \$1,000.00 to someone related to You or the beneficiary 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 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.

**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.



Secretary



President

Countersigned:

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

**IMPORTANT NOTICE**

This notice is to advise You that, should any problems arise concerning this insurance, You may contact the following:

**Consumer Service Department  
Liberty National Life Insurance Company  
P. O. Box 8080  
McKinney, Texas 75070  
Telephone: (972) 529-5085**

**Arkansas Insurance Department  
Consumer Services Division  
1200 West 3<sup>rd</sup> Street  
Little Rock, Arkansas 72201  
Telephone: (800) 852-5494 or  
(501) 371-2640**

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

**Agent's Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

\_\_\_\_\_

**NOTICE TO BUYER: This policy may not cover all of Your medical expenses.**

**MEDICARE SUPPLEMENT POLICY**

**BENEFIT PLAN B**

**GUARANTEED RENEWABLE FOR LIFE. COMPANY CANNOT CANCEL POLICY. COMPANY MAY CHANGE PREMIUM RATES BY CLASS AND AS MEDICARE BENEFITS CHANGE AS PROVIDED IN THE GUARANTEED RENEWAL PROVISION.**

**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.**

**GUARANTEED RENEWAL PROVISION**

**You can renew and continue this policy in force during Your lifetime, for successive renewal terms 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 such 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 year of issue, area of the state in which You resided at issue, and underwriting group at issue for policyholders of this form in Your state.**

**The benefits provided by this policy which are designed to cover cost sharing amounts under Medicare will change automatically to coincide with any applicable changes in the deductible and/or Coinsurance amounts which You are required to pay under Medicare. The renewal premiums for this policy may change on the renewal date following the effective date of any such applicable change. Any such premium change will be based on the actuarial computations which We then use to determine the renewal premium.**

---

**POLICY SCHEDULE**

---

<b>INSURED</b>	<b>POLICY NUMBER</b>	<b>EFFECTIVE DATE</b>	<b>INITIAL TERM EXPIRES ON</b>	<b>INITIAL PREMIUM</b>
[John Doe]	[0000000]	[01-01-09]	[01-01-10]	[\$0]

**If this policy is a replacement of an existing policy the “PRE-EXISTING CONDITIONS LIMITATIONS PROVISION” does not apply.**

---

## TABLE OF CONTENTS

	Page
30 Day Right to Examine Policy .....	1
Guaranteed Renewal Provision.....	1
Pre-Existing Conditions Limitations Provision.....	2
Insuring Clause.....	2
Extended Benefit Provision .....	2
Definitions .....	2
Benefits For Hospital Stays - Medicare Part A.....	4
Medicare Blood Deductible Benefit .....	4
Benefits for Medical Expense - Medicare Part B .....	4
Medicare Part A Deductible Benefit .....	4
Limitations and Exclusions .....	4
Policy Provisions .....	4
Policy Provisions - Claims .....	6

---

### PRE-EXISTING CONDITIONS LIMITATIONS PROVISION

Loss due to a Pre-Existing Condition is not covered unless the loss is incurred more than 60 days after the policy effective date.

If You have a Pre-Existing Condition and qualify for open enrollment or have had a continuous period of creditable coverage for at least 6 months, We cannot exclude coverage based on the Pre-Existing Condition. If the period of creditable coverage is less than 6 months, We will give credit for the amount of time of creditable coverage You have had towards fulfilling the Pre-Existing Condition exclusion period.

If You are an Eligible Person who applied to enroll under this Medicare supplement policy not later than 63 days after the date of the termination or disenrollment, and who submitted evidence of the date of termination or disenrollment with the application, the Pre-Existing Conditions Limitations Provision will not apply.

### THE INSURING CLAUSE

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

### EXTENDED BENEFIT PROVISION

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

### DEFINITIONS

Where used in this policy:

**BENEFIT PERIOD** means the unit of time used in the Medicare program to measure use of services and availability of services under Medicare Part A hospital insurance.

**CALENDAR YEAR** means the period beginning on each January 1 and ending on the following December 31.

**COINSURANCE AMOUNTS** means the portion of Medicare approved expense You are obligated to pay but not including the Medicare Part A inpatient hospital deductible or Part B Calendar Year deductible.

**CONTINUOUS PERIOD OF CREDITABLE COVERAGE** means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

**CREDITABLE COVERAGE** means coverage of an individual provided by any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;
5. Chapter 55 of Title 10 United States Code (CHAMPUS);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);
9. A public health plan as defined in federal regulation; and
10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

**ELIGIBLE PERSON** means a person who submits evidence of the date of termination, disenrollment, or Medicare Part D enrollment as applies under the following plans: (1) Employee Welfare Benefit Plan; (2) Medicare Advantage plan; (3) Medicare Select Plan, Medicare Risk or Cost Plan, or Medicare HMO plan; or (4) Medicare supplement policy.

**HOSPITAL** means a lawfully operated hospital which has been accredited by the Joint Commission on Accreditation of Hospitals.

**HOSPITAL STAY** means one day or more of confinement within a hospital, as a resident patient under the care of a Physician, due to 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.

**MEDICARE** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

**MEDICARE ADVANTAGE PLAN** means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; (2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and (3) Medicare Advantage private fee-for-service plans.

**MEDICARE ELIGIBLE EXPENSES** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

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

**PRE-EXISTING CONDITION** means an Injury sustained or Sickness first manifesting itself prior to the policy effective date for which medical advice or treatment was recommended or given by a Physician within 6 months prior to the policy effective date.

**SICKNESS** means illness or disease of an insured person which first manifests itself after the effective date of insurance and while this policy is in force.

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

**YOU, YOUR, YOURS and INSURED** mean the person whose name is shown in the Policy Schedule.

## **BASIC CORE BENEFITS**

### **PART 1                    BENEFITS FOR HOSPITAL STAYS - MEDICARE PART A**

We will pay the following benefits when You have a Hospital Stay for which benefits are paid by Medicare Part A:

- 1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
- 2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime reserve day used; and
- 3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

### **PART 2                    MEDICARE BLOOD DEDUCTIBLE BENEFIT**

We will pay the expense You incur for coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations), unless replaced in accordance with Federal regulations.

### **PART 3                    BENEFITS FOR MEDICAL EXPENSE - MEDICARE PART B**

If You incur a medical expense that is eligible under Medicare Part B, We will pay the following benefit for the Medicare approved charge:

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

Under this PART 3 of this policy, We will not pay benefits for (a) the Medicare Part B blood deductible for which benefits are paid under PART 2 of this policy, or (b) any portion of the Medicare Part B Calendar Year deductible.

## **ADDITIONAL BENEFITS**

### **PART 4                    MEDICARE PART A DEDUCTIBLE BENEFIT**

We will pay the expense You incur for all of the Medicare Part A Inpatient hospital deductible amount per Benefit Period.

### **PART 5                    LIMITATIONS AND EXCLUSIONS**

We will not pay benefits under this policy for:

- 1) Any expense which You are not legally obligated to pay; or
- 2) Any services that are not medically necessary as determined by Medicare or are not furnished at the direction of and under the supervision of a Physician; or
- 3) Any portion of any expense for which payment is made by Medicare; or
- 4) Custodial or intermediate level care, or rest cures; or
- 5) Any type of expense not eligible for coverage under Medicare.

## **POLICY PROVISIONS**

**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 on 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.

Upon Your death, We will refund any premiums paid in Your behalf, for any period beyond the ending of the policy month the death occurred, within 30 days after We receive proof of death.

If death is due to Injury and this policy provides for the refund of premiums for death due to Injury, only one benefit will be paid, the largest.

**ENTIRE CONTRACT; CHANGES:** This policy, with the application and attached papers, is the entire contract between You and Us. No change in this policy will 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 60 days from the effective date will be reduced or denied because a Sickness or physical condition had existed before the effective date of this policy.

**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 (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.

**SUSPENSION OF COVERAGE WHILE ENTITLED TO MEDICAID:** By written notice to Us, You may request that benefits and premiums for You under this policy be suspended for the period in which You have been determined to be entitled to Medicaid. Written notice must be received by Us within 90 days after the date You become entitled to Medicaid. After We have received such notice, We will return to You any portion of premiums paid for the period of suspension less any claims paid. The suspension period shall not exceed 24 months.

If Your entitlement to Medicaid ends, You must send Us written notice of the loss of such entitlement within 90 days and pay the premium attributable to the period, effective as of the date of termination of entitlement. We will reinstate Your benefits and premiums under this policy as of the date Your entitlement ended. The reinstated coverage shall be the same as if no suspension has occurred.

**SUSPENSION OF COVERAGE WHILE ENTITLED TO BENEFITS UNDER A GROUP HEALTH PLAN:** By written notice to Us, You may request that benefits and premiums for You under this policy be suspended (for any period that may be provided by federal regulation) if You are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). Written notice must be received by Us within 90 days after the date You become entitled to coverage under the group health plan. After We have received such notice, We will return to You any portion of premiums paid for the period of suspension less any claims paid.

If Your entitlement to coverage under the group health plan ends, You must send Us written notice of the loss of such entitlement within 90 days and pay the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan. We will reinstitute Your benefits and premiums under this policy as of the date Your entitlement ended. The reinstated coverage shall be the same as if no suspension had occurred.

**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 any required forms for filing proof of loss, if applicable. 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 Your loss.

**PROOF OF LOSS:** You must give written proof of loss to Us within 6 months 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 will pay all benefits then due for such loss.

**PAYMENT OF CLAIMS:** Any benefits unpaid at Your death may be paid, at Our option, either to Your beneficiary or Your estate. All other benefits will be paid to You.

If benefits are payable to Your estate or a beneficiary who cannot execute a valid release, We can pay benefits up to \$1,000.00 to someone related to You or the beneficiary 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 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.

**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.



Secretary



President

Countersigned:

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

**IMPORTANT NOTICE**

**This notice is to advise You that, should any problems arise concerning this insurance, You may contact the following:**

**Consumer Service Department  
Liberty National Life Insurance Company  
P. O. Box 8080  
McKinney, Texas 75070  
Telephone: (972) 529-5085**

**Arkansas Insurance Department  
Consumer Services Division  
1200 West 3<sup>rd</sup> Street  
Little Rock, Arkansas 72201  
Telephone: (800) 852-5494 or  
(501) 371-2640**

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

**Agent's Address: \_\_\_\_\_**

**Telephone: \_\_\_\_\_**

\_\_\_\_\_

**NOTICE TO BUYER:** This policy may not cover all of Your medical expenses.

**MEDICARE SUPPLEMENT POLICY**

**BENEFIT PLAN F**

**GUARANTEED RENEWABLE FOR LIFE. COMPANY CANNOT CANCEL POLICY. COMPANY MAY CHANGE PREMIUM RATES BY CLASS AND AS MEDICARE BENEFITS CHANGE AS PROVIDED IN THE GUARANTEED RENEWAL PROVISION.**

**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.

**GUARANTEED RENEWAL PROVISION**

You can renew and continue this policy in force during Your lifetime, for successive renewal terms 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 such 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 year of issue, area of the state in which You resided at issue, and underwriting group at issue for policyholders of this form in Your state.

The benefits provided by this policy which are designed to cover cost sharing amounts under Medicare will change automatically to coincide with any applicable changes in the deductible and/or Coinsurance amounts which You are required to pay under Medicare. The renewal premiums for this policy may change on the renewal date following the effective date of any such applicable change. Any such premium change will be based on the actuarial computations which We then use to determine the renewal premium.

---

**POLICY SCHEDULE**

---

<b>INSURED</b>	<b>POLICY NUMBER</b>	<b>EFFECTIVE DATE</b>	<b>INITIAL TERM EXPIRES ON</b>	<b>INITIAL PREMIUM</b>
[John Doe]	[0000000]	[01-01-09]	[01-01-10]	[\$0]

If this policy is a replacement of an existing policy the “PRE-EXISTING CONDITIONS LIMITATIONS PROVISION” does not apply.

---

## TABLE OF CONTENTS

	Page
30 Day Right to Examine Policy .....	1
Guaranteed Renewal Provision.....	1
Pre-Existing Conditions Limitations Provision.....	2
Insuring Clause.....	2
Extended Benefit Provision .....	2
Definitions .....	2
Benefits For Hospital Stays - Medicare Part A.....	4
Medicare Blood Deductible Benefit .....	4
Benefits for Medical Expense - Medicare Part B .....	4
Medicare Part A Deductible Benefit .....	5
Benefits For Skilled Nursing Facility Stays - Medicare Part A.....	5
Medicare Part B Deductible Benefit .....	5
100% Excess Expense Benefit - Medicare Part B .....	5
Medically Necessary Emergency Care In A Foreign Country .....	5
Limitations and Exclusions .....	5
Policy Provisions .....	5
Policy Provisions - Claims .....	7

---

### PRE-EXISTING CONDITIONS LIMITATIONS PROVISION

Loss due to a Pre-Existing Condition is not covered unless the loss is incurred more than 60 days after the policy effective date.

If You have a Pre-Existing Condition and qualify for open enrollment or have had a continuous period of creditable coverage for at least 6 months, We cannot exclude coverage based on the Pre-Existing Condition. If the period of creditable coverage is less than 6 months, We will give credit for the amount of time of creditable coverage You have had towards fulfilling the Pre-Existing Condition exclusion period.

If You are an Eligible Person who applied to enroll under this Medicare supplement policy not later than 63 days after the date of the termination or disenrollment, and who submitted evidence of the date of termination or disenrollment with the application, the Pre-Existing Conditions Limitations Provision will not apply.

### THE INSURING CLAUSE

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

### EXTENDED BENEFIT PROVISION

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

### DEFINITIONS

Where used in this policy:

**BENEFIT PERIOD** means the unit of time used in the Medicare program to measure use of services and availability of services under Medicare Part A hospital insurance.

**CALENDAR YEAR** means the period beginning on each January 1 and ending on the following December 31.

**COINSURANCE AMOUNTS** means the portion of Medicare approved expense You are obligated to pay but not including the Medicare Part A inpatient hospital deductible or Part B Calendar Year deductible.

**CONTINUOUS PERIOD OF CREDITABLE COVERAGE** means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

**CREDITABLE COVERAGE** means coverage of an individual provided by any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;
5. Chapter 55 of Title 10 United States Code (CHAMPUS);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);
9. A public health plan as defined in federal regulation; and
10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

**ELIGIBLE PERSON** means a person who submits evidence of the date of termination, disenrollment, or Medicare Part D enrollment as applies under the following plans: (1) Employee Welfare Benefit Plan; (2) Medicare Advantage plan; (3) Medicare Select Plan, Medicare Risk or Cost Plan, or Medicare HMO plan; or (4) Medicare supplement policy.

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

**HOSPITAL** means a lawfully operated hospital which has been accredited by the Joint Commission on Accreditation of Hospitals.

**HOSPITAL STAY** means one day or more of confinement within a hospital, as a resident patient under the care of a Physician, due to 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.

**MEDICARE** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

**MEDICARE ADVANTAGE PLAN** means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; (2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and (3) Medicare Advantage private fee-for-service plans.

**MEDICARE ELIGIBLE EXPENSES** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

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

**PRE-EXISTING CONDITION** means an Injury sustained or Sickness first manifesting itself prior to the policy effective date for which medical advice or treatment was recommended or given by a Physician within 6 months prior to the policy effective date.

**SICKNESS** means illness or disease of an insured person which first manifests itself after the effective date of insurance and while this policy is in force.

**SKILLED NURSING FACILITY** means a facility certified by Medicare as a Skilled Nursing Facility.

**SKILLED NURSING FACILITY STAY** means one day or more of confinement within a Skilled Nursing Facility, as a resident patient under the care of a Physician, following a Hospital Stay of at least 3 days. The Skilled Nursing Facility Stay must be for further treatment of the Injury or Sickness requiring the Hospital Stay and begin within 30 days of hospital discharge.

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

**YOU, YOUR, YOURS and INSURED** mean the person whose name is shown in the Policy Schedule.

## **BASIC CORE BENEFITS**

### **PART 1 BENEFITS FOR HOSPITAL STAYS - MEDICARE PART A**

We will pay the following benefits when You have a Hospital Stay for which benefits are paid by Medicare Part A:

- 1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
- 2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime reserve day used; and
- 3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

### **PART 2 MEDICARE BLOOD DEDUCTIBLE BENEFIT**

We will pay the expense You incur for coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations), unless replaced in accordance with Federal regulations.

### **PART 3 BENEFITS FOR MEDICAL EXPENSE - MEDICARE PART B**

If You incur a medical expense that is eligible under Medicare Part B, We will pay the following benefit for the Medicare approved charge:

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

Under this PART 3 of this policy, We will not pay benefits for (a) the Medicare Part B blood deductible for which benefits are paid under PART 2 of this policy, or (b) any portion of the Medicare Part B Calendar Year deductible.

## **ADDITIONAL BENEFITS**

### **PART 4 MEDICARE PART A DEDUCTIBLE BENEFIT**

We will pay the expense You incur for all of the Medicare Part A Inpatient hospital deductible amount per Benefit Period.

### **PART 5 BENEFITS FOR SKILLED NURSING FACILITY STAYS - MEDICARE PART A**

When You have a posthospital Skilled Nursing Facility Stay which is eligible under Medicare Part A, We will pay the following benefit:

Coverage for the actual billed charges up to the Coinsurance Amount from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital Skilled Nursing Facility care eligible under Medicare Part A .

### **PART 6 MEDICARE PART B DEDUCTIBLE BENEFIT**

We will pay the expense You incur for all of the Medicare Part B deductible amount per Calendar Year regardless of Hospital confinement.

### **PART 7 100% EXCESS EXPENSE BENEFIT - MEDICARE PART B**

We will pay 100% of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

### **PART 8 MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY**

We will pay benefits for coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare Eligible Expenses for Medically Necessary Emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which began during the first 60 consecutive days of each trip outside of the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000.

For the purposes of this benefit, "Emergency Care" shall mean care needed immediately because of an Injury or an illness of sudden and unexpected onset.

### **PART 9 LIMITATIONS AND EXCLUSIONS**

We will not pay benefits under this policy for:

- 1) Any expense which You are not legally obligated to pay; or
- 2) Any services that are not medically necessary as determined by Medicare or are not furnished at the direction of and under the supervision of a Physician; or
- 3) Any portion of any expense for which payment is made by Medicare; or
- 4) Custodial or intermediate level care, or rest cures; or
- 5) Any type of expense not eligible for coverage under Medicare, except as provided under Part 8.

## **POLICY PROVISIONS**

**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 on 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.

**Upon Your death, We will refund any premiums paid in Your behalf, for any period beyond the ending of the policy month the death occurred, within 30 days after We receive proof of death.**

**If death is due to Injury and this policy provides for the refund of premiums for death due to Injury, only one benefit will be paid, the largest.**

**ENTIRE CONTRACT; CHANGES:** This policy, with the application and attached papers, is the entire contract between You and Us. No change in this policy will 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 60 days from the effective date will be reduced or denied because a Sickness or physical condition had existed before the effective date of this policy.**

**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 (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.**

**SUSPENSION OF COVERAGE WHILE ENTITLED TO MEDICAID:** By written notice to Us, You may request that benefits and premiums for You under this policy be suspended for the period in which You have been determined to be entitled to Medicaid. Written notice must be received by Us within 90 days after the date You become entitled to Medicaid. After We have received such notice, We will return to You any portion of premiums paid for the period of suspension less any claims paid. The suspension period shall not exceed 24 months.

**If Your entitlement to Medicaid ends, You must send Us written notice of the loss of such entitlement within 90 days and pay the premium attributable to the period, effective as of the date of termination of entitlement. We will reinstate Your benefits and premiums under this policy as of the date Your entitlement ended. The reinstated coverage shall be the same as if no suspension has occurred.**

**SUSPENSION OF COVERAGE WHILE ENTITLED TO BENEFITS UNDER A GROUP HEALTH PLAN:** By written notice to Us, You may request that benefits and premiums for You under this policy be suspended (for any period that may be provided by federal regulation) if You are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). Written notice must be received by Us within 90 days after the date You become entitled to coverage under the group health plan. After We have received such notice, We will return to You any portion of premiums paid for the period of suspension less any claims paid.

If Your entitlement to coverage under the group health plan ends, You must send Us written notice of the loss of such entitlement within 90 days and pay the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan. We will reinstitute Your benefits and premiums under this policy as of the date Your entitlement ended. The reinstated coverage shall be the same as if no suspension had occurred.

**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 any required forms for filing proof of loss, if applicable. 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 Your loss.

**PROOF OF LOSS:** You must give written proof of loss to Us within 6 months 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 will pay all benefits then due for such loss.

**PAYMENT OF CLAIMS:** Any benefits unpaid at Your death may be paid, at Our option, either to Your beneficiary or Your estate. All other benefits will be paid to You.

If benefits are payable to Your estate or a beneficiary who cannot execute a valid release, We can pay benefits up to \$1,000.00 to someone related to You or the beneficiary 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 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.

**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.



Secretary



President

Countersigned:

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

**IMPORTANT NOTICE**

This notice is to advise You that, should any problems arise concerning this insurance, You may contact the following:

**Consumer Service Department  
Liberty National Life Insurance Company  
P. O. Box 8080  
McKinney, Texas 75070  
Telephone: (972) 529-5085**

**Arkansas Insurance Department  
Consumer Services Division  
1200 West 3<sup>rd</sup> Street  
Little Rock, Arkansas 72201  
Telephone: (800) 852-5494 or  
(501) 371-2640**

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

**Agent's Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

\_\_\_\_\_

**NOTICE TO BUYER:** This policy may not cover all of Your medical expenses.

**MEDICARE SUPPLEMENT POLICY**

**HIGH DEDUCTIBLE BENEFIT PLAN F**

**GUARANTEED RENEWABLE FOR LIFE. COMPANY CANNOT CANCEL POLICY.  
COMPANY MAY CHANGE PREMIUM RATES BY CLASS AND AS MEDICARE BENEFITS  
CHANGE AS PROVIDED IN THE GUARANTEED RENEWAL PROVISION.**

**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.

**GUARANTEED RENEWAL PROVISION**

You can renew and continue this policy in force during Your lifetime, for successive renewal terms 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 such 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 year of issue, area of the state in which You resided at issue, and underwriting group at issue for policyholders of this form in Your state.

The benefits provided by this policy which are designed to cover cost sharing amounts under Medicare will change automatically to coincide with any applicable changes in the deductible and/or Coinsurance amounts which You are required to pay under Medicare. The renewal premiums for this policy may change on the renewal date following the effective date of any such applicable change. Any such premium change will be based on the actuarial computations which We then use to determine the renewal premium.

---

**POLICY SCHEDULE**

---

<b>INSURED</b>	<b>POLICY NUMBER</b>	<b>EFFECTIVE DATE</b>	<b>INITIAL TERM EXPIRES ON</b>	<b>INITIAL PREMIUM</b>	<b>ANNUAL HIGH DEDUCTIBLE</b>
[John Doe]	[0000000]	[01-01-09]	[01-01-10]	[\$0]	[\$2,000]

This policy contains an annual high deductible as shown in the policy schedule above. This deductible will be adjusted for inflation each Calendar Year.

If this policy is a replacement of an existing policy the "PRE-EXISTING CONDITIONS LIMITATIONS PROVISION" does not apply.

---

## TABLE OF CONTENTS

	Page
30 Day Right to Examine Policy .....	1
Guaranteed Renewal Provision.....	1
Pre-Existing Conditions Limitations Provision.....	2
Insuring Clause.....	2
Extended Benefit Provision .....	2
Definitions .....	2
Benefits For Hospital Stays - Medicare Part A.....	4
Medicare Blood Deductible Benefit .....	4
Benefits for Medical Expense - Medicare Part B .....	5
Medicare Part A Deductible Benefit .....	5
Benefits For Skilled Nursing Facility Stays - Medicare Part A.....	5
Medicare Part B Deductible Benefit .....	5
100% Excess Expense Benefit - Medicare Part B .....	5
Medically Necessary Emergency Care In A Foreign Country .....	5
Limitations and Exclusions .....	6
Policy Provisions .....	6
Policy Provisions - Claims .....	7

---

### PRE-EXISTING CONDITIONS LIMITATIONS PROVISION

Loss due to a Pre-Existing Condition is not covered unless the loss is incurred more than 60 days after the policy effective date.

If You have a Pre-Existing Condition and qualify for open enrollment or have had a continuous period of creditable coverage for at least 6 months, We cannot exclude coverage based on the Pre-Existing Condition. If the period of creditable coverage is less than 6 months, We will give credit for the amount of time of creditable coverage You have had towards fulfilling the Pre-Existing Condition exclusion period.

If You are an Eligible Person who applied to enroll under this Medicare supplement policy not later than 63 days after the date of the termination or disenrollment, and who submitted evidence of the date of termination or disenrollment with the application, the Pre-Existing Conditions Limitations Provision will not apply.

### THE INSURING CLAUSE

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

### EXTENDED BENEFIT PROVISION

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

### DEFINITIONS

Where used in this policy:

**BENEFIT PERIOD** means the unit of time used in the Medicare program to measure use of services and availability of services under Medicare Part A hospital insurance.

**CALENDAR YEAR** means the period beginning on each January 1 and ending on the following December 31.

**COINSURANCE AMOUNTS** means the portion of Medicare approved expense You are obligated to pay but not including the Medicare Part A inpatient hospital deductible or Part B Calendar Year deductible.

**CONTINUOUS PERIOD OF CREDITABLE COVERAGE** means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

**CREDITABLE COVERAGE** means coverage of an individual provided by any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;
5. Chapter 55 of Title 10 United States Code (CHAMPUS);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);
9. A public health plan as defined in federal regulation; and
10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

**ELIGIBLE PERSON** means a person who submits evidence of the date of termination, disenrollment, or Medicare Part D enrollment as applies under the following plans: (1) Employee Welfare Benefit Plan; (2) Medicare Advantage plan; (3) Medicare Select Plan, Medicare Risk or Cost Plan, or Medicare HMO plan; or (4) Medicare supplement policy.

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

**HOSPITAL** means a lawfully operated hospital which has been accredited by the Joint Commission on Accreditation of Hospitals.

**HOSPITAL STAY** means one day or more of confinement within a hospital, as a resident patient under the care of a Physician, due to 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.

**MEDICARE** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

**MEDICARE ADVANTAGE PLAN** means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; (2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and (3) Medicare Advantage private fee-for-service plans.

**MEDICARE ELIGIBLE EXPENSES** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

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

**PRE-EXISTING CONDITION** means an Injury sustained or Sickness first manifesting itself prior to the policy effective date for which medical advice or treatment was recommended or given by a Physician within 6 months prior to the policy effective date.

**SICKNESS** means illness or disease of an insured person which first manifests itself after the effective date of insurance and while this policy is in force.

**SKILLED NURSING FACILITY** means a facility certified by Medicare as a Skilled Nursing Facility.

**SKILLED NURSING FACILITY STAY** means one day or more of confinement within a Skilled Nursing Facility, as a resident patient under the care of a Physician, following a Hospital Stay of at least 3 days. The Skilled Nursing Facility Stay must be for further treatment of the Injury or Sickness requiring the Hospital Stay and begin within 30 days of hospital discharge.

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

**YOU, YOUR, YOURS and INSURED** mean the person whose name is shown in the Policy Schedule.

### **BASIC CORE BENEFITS**

**ANNUAL HIGH DEDUCTIBLE:** We will pay the following benefits after You pay the annual high deductible each Calendar Year. The annual high deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by this policy, and shall be in addition to any other specific benefit deductibles. Expenses incurred prior to the effective date of Your policy will not be applied to this deductible. The annual high deductible amount is shown in the policy schedule and shall be adjusted annually.

#### **PART 1 BENEFITS FOR HOSPITAL STAYS - MEDICARE PART A**

We will pay the following benefits when You have a Hospital Stay for which benefits are paid by Medicare Part A:

- 1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
- 2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime reserve day used; and
- 3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

#### **PART 2 MEDICARE BLOOD DEDUCTIBLE BENEFIT**

We will pay the expense You incur for coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations), unless replaced in accordance with Federal regulations.

### **PART 3 BENEFITS FOR MEDICAL EXPENSE - MEDICARE PART B**

If You incur a medical expense that is eligible under Medicare Part B, We will pay the following benefit for the Medicare approved charge:

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

Under this PART 3 of this policy, We will not pay benefits for (a) the Medicare Part B blood deductible for which benefits are paid under PART 2 of this policy, or (b) any portion of the Medicare Part B Calendar Year deductible.

### **ADDITIONAL BENEFITS**

**ANNUAL HIGH DEDUCTIBLE:** We will pay the following benefits after You pay the annual high deductible each Calendar Year. The annual high deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by this policy, and shall be in addition to any other specific benefit deductibles. Expenses incurred prior to the effective date of Your policy will not be applied to this deductible. The annual high deductible amount is shown in the policy schedule and shall be adjusted annually.

### **PART 4 MEDICARE PART A DEDUCTIBLE BENEFIT**

We will pay the expense You incur for all of the Medicare Part A Inpatient hospital deductible amount per Benefit Period.

### **PART 5 BENEFITS FOR SKILLED NURSING FACILITY STAYS - MEDICARE PART A**

When You have a posthospital Skilled Nursing Facility Stay which is eligible under Medicare Part A, We will pay the following benefit:

Coverage for the actual billed charges up to the Coinsurance Amount from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital Skilled Nursing Facility care eligible under Medicare Part A .

### **PART 6 MEDICARE PART B DEDUCTIBLE BENEFIT**

We will pay the expense You incur for all of the Medicare Part B deductible amount per Calendar Year regardless of Hospital confinement.

### **PART 7 100% EXCESS EXPENSE BENEFIT - MEDICARE PART B**

We will pay 100% of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

### **PART 8 MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY**

We will pay benefits for coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare Eligible Expenses for Medically Necessary Emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which began during the first 60 consecutive days of each trip outside of the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000.

For the purposes of this benefit, "Emergency Care" shall mean care needed immediately because of an Injury or an illness of sudden and unexpected onset.

## **PART 9**

## **LIMITATIONS AND EXCLUSIONS**

We will not pay benefits under this policy for:

- 1) Any expense which You are not legally obligated to pay; or
- 2) Any services that are not medically necessary as determined by Medicare or are not furnished at the direction of and under the supervision of a Physician; or
- 3) Any portion of any expense for which payment is made by Medicare; or
- 4) Custodial or intermediate level care, or rest cures; or
- 5) Any type of expense not eligible for coverage under Medicare, except as provided under Part 8.

## **POLICY PROVISIONS**

**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 on 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.

Upon Your death, We will refund any premiums paid in Your behalf, for any period beyond the ending of the policy month the death occurred, within 30 days after We receive proof of death.

If death is due to Injury and this policy provides for the refund of premiums for death due to Injury, only one benefit will be paid, the largest.

**ENTIRE CONTRACT; CHANGES:** This policy, with the application and attached papers, is the entire contract between You and Us. No change in this policy will 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 60 days from the effective date will be reduced or denied because a Sickness or physical condition had existed before the effective date of this policy.

**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 (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.

**SUSPENSION OF COVERAGE WHILE ENTITLED TO MEDICAID:** By written notice to Us, You may request that benefits and premiums for You under this policy be suspended for the period in which You have been determined to be entitled to Medicaid. Written notice must be received by Us within 90 days after the date You become entitled to Medicaid. After We have received such notice, We will return to You any portion of premiums paid for the period of suspension less any claims paid. The suspension period shall not exceed 24 months.

If Your entitlement to Medicaid ends, You must send Us written notice of the loss of such entitlement within 90 days and pay the premium attributable to the period, effective as of the date of termination of entitlement. We will reinstate Your benefits and premiums under this policy as of the date Your entitlement ended. The reinstated coverage shall be the same as if no suspension has occurred.

**SUSPENSION OF COVERAGE WHILE ENTITLED TO BENEFITS UNDER A GROUP HEALTH PLAN:** By written notice to Us, You may request that benefits and premiums for You under this policy be suspended (for any period that may be provided by federal regulation) if You are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). Written notice must be received by Us within 90 days after the date You become entitled to coverage under the group health plan. After We have received such notice, We will return to You any portion of premiums paid for the period of suspension less any claims paid.

If Your entitlement to coverage under the group health plan ends, You must send Us written notice of the loss of such entitlement within 90 days and pay the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan. We will reinstate Your benefits and premiums under this policy as of the date Your entitlement ended. The reinstated coverage shall be the same as if no suspension had occurred.

**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 any required forms for filing proof of loss, if applicable. 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 Your loss.

**PROOF OF LOSS:** You must give written proof of loss to Us within 6 months 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 will pay all benefits then due for such loss.

**PAYMENT OF CLAIMS:** Any benefits unpaid at Your death may be paid, at Our option, either to Your beneficiary or Your estate. All other benefits will be paid to You.

If benefits are payable to Your estate or a beneficiary who cannot execute a valid release, We can pay benefits up to \$1,000.00 to someone related to You or the beneficiary 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 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.

**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.



Secretary



President

Countersigned:

Licensed Resident Agent where required by law.

**IMPORTANT NOTICE**

This notice is to advise You that, should any problems arise concerning this insurance, You may contact the following:

Consumer Service Department  
Liberty National Life Insurance Company  
P. O. Box 8080  
McKinney, Texas 75070  
Telephone: (972) 529-5085

Arkansas Insurance Department  
Consumer Services Division  
1200 West 3<sup>rd</sup> Street  
Little Rock, Arkansas 72201  
Telephone: (800) 852-5494 or  
(501) 371-2640

Agent's Name: \_\_\_\_\_

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

Telephone: \_\_\_\_\_

\_\_\_\_\_

**NOTICE TO BUYER:** This policy may not cover all of Your medical expenses.

**MEDICARE SUPPLEMENT POLICY**

**BENEFIT PLAN B**

**GUARANTEED RENEWABLE FOR LIFE. COMPANY CANNOT CANCEL POLICY.  
COMPANY MAY CHANGE PREMIUM RATES BY CLASS AND AS MEDICARE BENEFITS  
CHANGE AS PROVIDED IN THE GUARANTEED RENEWAL PROVISION.**

**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.

**GUARANTEED RENEWAL PROVISION**

You can renew and continue this policy in force during Your lifetime, for successive renewal terms 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 such 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 year of issue, area of the state in which You resided at issue, and underwriting group at issue for policyholders of this form in Your state.

The benefits provided by this policy which are designed to cover cost sharing amounts under Medicare will change automatically to coincide with any applicable changes in the deductible and/or Coinsurance amounts which You are required to pay under Medicare. The renewal premiums for this policy may change on the renewal date following the effective date of any such applicable change. Any such premium change will be based on the actuarial computations which We then use to determine the renewal premium.

---

**POLICY SCHEDULE**

---

<b>INSURED</b>	<b>POLICY NUMBER</b>	<b>EFFECTIVE DATE</b>	<b>INITIAL TERM EXPIRES ON</b>	<b>INITIAL PREMIUM</b>
[John Doe]	[0000000]	[01-01-09]	[01-01-10]	[\$0]

If this policy is a replacement of an existing policy the "PRE-EXISTING CONDITIONS LIMITATIONS PROVISION" does not apply.

---

## TABLE OF CONTENTS

	Page
30 Day Right to Examine Policy .....	1
Guaranteed Renewal Provision.....	1
Pre-Existing Conditions Limitations Provision.....	2
Insuring Clause.....	2
Extended Benefit Provision .....	2
Definitions .....	2
Benefits For Hospital Stays - Medicare Part A.....	4
Medicare Blood Deductible Benefit .....	4
Benefits for Medical Expense - Medicare Part B .....	4
Medicare Part A Deductible Benefit .....	4
Limitations and Exclusions .....	4
Policy Provisions .....	4
Policy Provisions - Claims .....	6

---

### PRE-EXISTING CONDITIONS LIMITATIONS PROVISION

Loss due to a Pre-Existing Condition is not covered unless the loss is incurred more than 6 months after the policy effective date.

If You have a Pre-Existing Condition and qualify for open enrollment or have had a continuous period of creditable coverage for at least 6 months, We cannot exclude coverage based on the Pre-Existing Condition. If the period of creditable coverage is less than 6 months, We will give credit for the amount of time of creditable coverage You have had towards fulfilling the Pre-Existing Condition exclusion period.

If You are an Eligible Person who applied to enroll under this Medicare supplement policy not later than 63 days after the date of the termination or disenrollment, and who submitted evidence of the date of termination or disenrollment with the application, the Pre-Existing Conditions Limitations Provision will not apply.

### THE INSURING CLAUSE

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

### EXTENDED BENEFIT PROVISION

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

### DEFINITIONS

Where used in this policy:

**BENEFIT PERIOD** means the unit of time used in the Medicare program to measure use of services and availability of services under Medicare Part A hospital insurance.

**CALENDAR YEAR** means the period beginning on each January 1 and ending on the following December 31.

**COINSURANCE AMOUNTS** means the portion of Medicare approved expense You are obligated to pay but not including the Medicare Part A inpatient hospital deductible or Part B Calendar Year deductible.

**CONTINUOUS PERIOD OF CREDITABLE COVERAGE** means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

**CREDITABLE COVERAGE** means coverage of an individual provided by any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;
5. Chapter 55 of Title 10 United States Code (CHAMPUS);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);
9. A public health plan as defined in federal regulation; and
10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

**ELIGIBLE PERSON** means a person who submits evidence of the date of termination, disenrollment, or Medicare Part D enrollment as applies under the following plans: (1) Employee Welfare Benefit Plan; (2) Medicare Advantage plan; (3) Medicare Select Plan, Medicare Risk or Cost Plan, or Medicare HMO plan; or (4) Medicare supplement policy.

**HOSPITAL** means a lawfully operated hospital which has been accredited by the Joint Commission on Accreditation of Hospitals.

**HOSPITAL STAY** means one day or more of confinement within a hospital, as a resident patient under the care of a Physician, due to 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.

**MEDICARE** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

**MEDICARE ADVANTAGE PLAN** means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; (2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and (3) Medicare Advantage private fee-for-service plans.

**MEDICARE ELIGIBLE EXPENSES** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

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

**PRE-EXISTING CONDITION** means an Injury sustained or Sickness first manifesting itself prior to the policy effective date for which medical advice or treatment was recommended or given by a Physician within 6 months prior to the policy effective date.

**SICKNESS** means illness or disease of an insured person which first manifests itself after the effective date of insurance and while this policy is in force.

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

**YOU, YOUR, YOURS and INSURED** mean the person whose name is shown in the Policy Schedule.

## **BASIC CORE BENEFITS**

### **PART 1                    BENEFITS FOR HOSPITAL STAYS - MEDICARE PART A**

We will pay the following benefits when You have a Hospital Stay for which benefits are paid by Medicare Part A:

- 1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
- 2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime reserve day used; and
- 3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

### **PART 2                    MEDICARE BLOOD DEDUCTIBLE BENEFIT**

We will pay the expense You incur for coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations), unless replaced in accordance with Federal regulations.

### **PART 3                    BENEFITS FOR MEDICAL EXPENSE - MEDICARE PART B**

If You incur a medical expense that is eligible under Medicare Part B, We will pay the following benefit for the Medicare approved charge:

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

Under this PART 3 of this policy, We will not pay benefits for (a) the Medicare Part B blood deductible for which benefits are paid under PART 2 of this policy, or (b) any portion of the Medicare Part B Calendar Year deductible.

## **ADDITIONAL BENEFITS**

### **PART 4                    MEDICARE PART A DEDUCTIBLE BENEFIT**

We will pay the expense You incur for all of the Medicare Part A Inpatient hospital deductible amount per Benefit Period.

### **PART 5                    LIMITATIONS AND EXCLUSIONS**

We will not pay benefits under this policy for:

- 1) Any expense which You are not legally obligated to pay; or
- 2) Any services that are not medically necessary as determined by Medicare or are not furnished at the direction of and under the supervision of a Physician; or
- 3) Any portion of any expense for which payment is made by Medicare; or
- 4) Custodial or intermediate level care, or rest cures; or
- 5) Any type of expense not eligible for coverage under Medicare.

## **POLICY PROVISIONS**

**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 on 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.

Upon Your death, We will refund any premiums paid in Your behalf, for any period beyond the ending of the policy month the death occurred, within 30 days after We receive proof of death.

If death is due to Injury and this policy provides for the refund of premiums for death due to Injury, only one benefit will be paid, the largest.

**ENTIRE CONTRACT; CHANGES:** This policy, with the application and attached papers, is the entire contract between You and Us. No change in this policy will 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 6 months from the effective date will be reduced or denied because a Sickness or physical condition had existed before the effective date of this policy.

**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 (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.

**SUSPENSION OF COVERAGE WHILE ENTITLED TO MEDICAID:** By written notice to Us, You may request that benefits and premiums for You under this policy be suspended for the period in which You have been determined to be entitled to Medicaid. Written notice must be received by Us within 90 days after the date You become entitled to Medicaid. After We have received such notice, We will return to You any portion of premiums paid for the period of suspension less any claims paid. The suspension period shall not exceed 24 months.

If Your entitlement to Medicaid ends, You must send Us written notice of the loss of such entitlement within 90 days and pay the premium attributable to the period, effective as of the date of termination of entitlement. We will reinstate Your benefits and premiums under this policy as of the date Your entitlement ended. The reinstated coverage shall be the same as if no suspension has occurred.

**SUSPENSION OF COVERAGE WHILE ENTITLED TO BENEFITS UNDER A GROUP HEALTH PLAN:** By written notice to Us, You may request that benefits and premiums for You under this policy be suspended (for any period that may be provided by federal regulation) if You are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). Written notice must be received by Us within 90 days after the date You become entitled to coverage under the group health plan. After We have received such notice, We will return to You any portion of premiums paid for the period of suspension less any claims paid.

If Your entitlement to coverage under the group health plan ends, You must send Us written notice of the loss of such entitlement within 90 days and pay the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan. We will reinstitute Your benefits and premiums under this policy as of the date Your entitlement ended. The reinstated coverage shall be the same as if no suspension had occurred.

**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 any required forms for filing proof of loss, if applicable. 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 Your loss.

**PROOF OF LOSS:** You must give written proof of loss to Us within 6 months 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 will pay all benefits then due for such loss.

**PAYMENT OF CLAIMS:** Any benefits unpaid at Your death may be paid, at Our option, either to Your beneficiary or Your estate. All other benefits will be paid to You.

If benefits are payable to Your estate or a beneficiary who cannot execute a valid release, We can pay benefits up to \$1,000.00 to someone related to You or the beneficiary 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 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.

**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.



Secretary



President

Countersigned:

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

**IMPORTANT NOTICE**

This notice is to advise You that, should any problems arise concerning this insurance, You may contact the following:

**Consumer Service Department  
Liberty National Life Insurance Company  
P. O. Box 8080  
McKinney, Texas 75070  
Telephone: (972) 529-5085**

**Arkansas Insurance Department  
Consumer Services Division  
1200 West 3<sup>rd</sup> Street  
Little Rock, Arkansas 72201  
Telephone: (800) 852-5494 or  
(501) 371-2640**

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

**Agent's Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

\_\_\_\_\_



SERFF Tracking Number: AMLC-126111229 State: Arkansas  
 Filing Company: Liberty National Life Insurance Company State Tracking Number: 42141  
 Company Tracking Number: LMSA06  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans  
 Product Name: Medicare Supplement Policy Forms  
 Project Name/Number: LMSA06/LMSA06

## Rate/Rule Schedule

Review Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved	LMSA06 Rates	LMSA06	New		09 AR LMSA06 Rate Page.pdf
Approved	LMSB06 Rates	LMSB06	New		09 AR LMSB06 Rate Page.pdf
Approved	LMSF06 Rates	LMSF06	New		09 AR LMSF06 Rate Page.pdf
Approved	LMSHDF06 Rates	LDMSB06	New		09 AR LMSHDF06 Rate Page.pdf
Approved	LDMSB06 Rates	LMSHDF06	New		09 AR LDMSB06 Rate Page.pdf

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

Policy Form LMSA06

2009 New Product Filing

ARKANSAS

**Proposed Annual Premium Rates**  
**For Policies Issued with Issue Age Rates**

---

Issue Age	Proposed Annual Rate
65 and Over	\$1,660

---

Modal Premium Formulas:

Semi-Annual = Annual / 2 (rounded to near dollar)

Quarterly = Annual / 4 (rounded to near dollar)

Monthly = Annual / 12 (rounded to near dollar)

---

For Company Use: Plan Code XXX

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

Policy Form LMSB06

2009 New Product Filing

ARKANSAS

**Proposed Annual Premium Rates  
For Policies Issued with Issue Age Rates**

---

Issue Age	Proposed Annual Rate
65 and Over	\$2,430

---

Modal Premium Formulas:

Semi-Annual = Annual / 2 (rounded to near dollar)

Quarterly = Annual / 4 (rounded to near dollar)

Monthly = Annual / 12 (rounded to near dollar)

---

For Company Use: Plan Code XXX

**LIBERTY NATIONAL LIFE INSURANCE COMPANY**

McKinney, Texas

Policy Form LMSF06

2009 New Product Filing

ARKANSAS

**Proposed Annual Premium Rates  
For Policies Issued with Issue Age Rates**

---

Issue Age	Proposed Annual Rate
65 and Over	\$2,798

---

Modal Premium Formulas:

Semi-Annual = Annual / 2 (rounded to near dollar)

Quarterly = Annual / 4 (rounded to near dollar)

Monthly = Annual / 12 (rounded to near dollar)

---

For Company Use: Plan Code XXX

# LIBERTY NATIONAL LIFE INSURANCE COMPANY

McKinney, Texas

Policy Form LMSHDF06

2009 New Product Filing

ARKANSAS

## Proposed Annual Premium Rates For Policies Issued with Issue Age Rates

Issue Age	Proposed Annual Rate
65 and Over	\$1,000

### Modal Premium Formulas:

Semi-Annual = Annual / 2 (rounded to near dollar)  
Quarterly = Annual / 4 (rounded to near dollar)  
Monthly = Annual / 12 (rounded to near dollar)

For Company Use: Plan Code XXX

**LIBERTY NATIONAL LIFE INSURANCE COMPANY**

McKinney, Texas

Policy Form LDMSB06

2009 New Product Filing

**ARKANSAS**

Proposed Annual Premium Rates  
For Policies Issued with Issue Age Rates

---

Issue Age	Proposed Annual Rate
64 and Under	\$4,380

---

Modal Premium Formulas:

Semi-Annual = Annual / 2 (rounded to near dollar)

Quarterly = Annual / 4 (rounded to near dollar)

Monthly = Annual / 12 (rounded to near dollar)

---

For Company Use: Plan Code XXX

SERFF Tracking Number: AMLC-126111229 State: Arkansas  
Filing Company: Liberty National Life Insurance Company State Tracking Number: 42141  
Company Tracking Number: LMSA06  
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
Standard Plans  
Product Name: Medicare Supplement Policy Forms  
Project Name/Number: LMSA06/LMSA06

## Supporting Document Schedules

**Satisfied -Name:** Flesch Certification **Review Status:** Accepted for Informational 06/23/2009  
Purposes

**Comments:**  
**Attachment:**  
S-1351(03).pdf

**Satisfied -Name:** Application **Review Status:** 04/13/2009

**Comments:**  
**Attachments:**  
LMA14(03).pdf  
LDMA14(03).pdf

**Satisfied -Name:** Outline of Coverage **Review Status:** Accepted for Informational 06/23/2009  
Purposes

**Comments:**  
**Attachments:**  
DS-LDMS2006(03).pdf  
DS-LMS2006(03).pdf

CERTIFICATION

This is to certify that the attached Policy Form see below

has achieved Flesch Reading Ease Score of \_\_\_\_\_\* and complies with the requirements of Arkansas Stat. Ann. SS66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.



Michael J. Gaisbauer, Vice President

<u>SUPPLEMENTAL FORMS</u>	<u>SCORE</u>
Medicare Supplement Policy Form LMSA06	67.87
Medicare Supplement Policy Form LMSB06	56.35
Medicare Supplement Policy Form LMSF06	60.06
Medicare Supplement Policy Form LMSHDF06	57.83
Medicare Supplement Policy Form LDMSB06	56.35
Application Form LMA14(03)	66.02
Application Form LDMA14(03)	66.25

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

**PART I: APPLICANT INFORMATION**

<b>Plan Code</b> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <small>(Refer to Rate Card)</small>	<b>Effective Date Requested (mm-dd-yyyy)</b> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/>	<b>Mode of Premium</b> <input type="radio"/> Annual <input type="radio"/> Semi-Annual <input type="radio"/> Quarterly <input type="radio"/> Monthly	<b>Method of Payment</b> <input type="radio"/> Send Premium Notices <input type="radio"/> Automatic Payment Plan	<b>Draft Date</b> Day (01-28) of the Month to Draft Bank Account <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/>
<b>Select Plan Applying for</b> <input type="radio"/> A <input type="radio"/> B <input type="radio"/> F <input type="radio"/> HDF				

Applicant's First Name    
 Last Name    
 M.I.

**Applicant's Mailing Address:**

Street or Route

City  State

Zip Code  County

**If Applicant's Residence Address is different from Mailing Address, show below:**

Street or Route

City  State

Zip Code  County

Social Security Number   -

Date of Birth (mm-dd-yyyy)  -  -

Age Last Birthday

Height (ft. in.)

Weight (lbs.)

Sex  Male  Female

Have you used tobacco in any form in the past 12 months?  Yes  No

E-mail Address of Proposed Insured

<b>Application Verification Information</b>	A recorded interview may be necessary as part of the underwriting of your application for insurance. The most convenient time and place for the interview is:	<input type="radio"/> 8 AM - Noon <input type="radio"/> Noon - 6 PM <input type="radio"/> 6 PM - 9 PM	Home Phone No. <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> - <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> - <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> Work Phone No. <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> - <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> - <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/>
---	---	---	--

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

**PART II: ELIGIBILITY QUESTIONS**

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS.**

**TO THE BEST OF YOUR KNOWLEDGE:**

**Yes No**

1. (a) Did you turn age 65 in the last six (6) months? .....
- (b) Did you enroll in Medicare Part B in the last six (6) months? .....
- (c) If "YES", what is the effective date? (mm-dd-yyyy)      -   -
- (d) What is your Medicare Claim Number?        -   -       -
- (exactly as shown on your Medicare card)

2. Are you covered for medical assistance through the state Medicaid program?  
NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question. **Yes No**  
If you answered "YES": .....
- (a) Will Medicaid pay your premiums for this Medicare Supplement policy? .....
- (b) Do you receive any benefits from Medicaid OTHER THAN payment towards your Medicare Part B premium? .....

3. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END Date" blank.  
START Date (mm-dd-yyyy)   -   -        END Date (mm-dd-yyyy)   -   -
- (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? .....   **Yes No**
- (c) Was this your first time in this type of Medicare plan? .....
- (d) Did you drop a Medicare Supplement policy to enroll in the Medicare plan? .....

4. (a) Do you have another Medicare Supplement policy in force? .....
- (b) If so, with what company, and what plan do you have? \_\_\_\_\_
- (c) If so, do you intend to replace your current Medicare Supplement policy with this policy? .....

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)
- (a) If so, with what company and what kind of policy?  
\_\_\_\_\_  
\_\_\_\_\_

- (b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END Date" blank.)  
START Date (mm-dd-yyyy)   -   -        END Date (mm-dd-yyyy)   -   -

**Yes No**

6. Are you within 6 months of your enrollment in Medicare Part B or otherwise qualified for open enrollment? .....    
(Questions 7-17 not required if the answer to question 6 is "YES".)

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

**PART II: ELIGIBILITY QUESTIONS (continued)**

**IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES," THE APPLICANT IS NOT ELIGIBLE FOR COVERAGE:**

- |  | <b>Yes</b>                  | <b>No</b>                   |
|--|-----------------------------|-----------------------------|
| 7. Are you currently hospitalized, confined to a nursing facility or receiving Medicare approved home health care, or have you been hospitalized or received Medicare approved home health care 2 or more times in the past 12 months?   | ..... <input type="radio"/> | ..... <input type="radio"/> |
| 8. Do you have emphysema, Chronic Obstructive Pulmonary Disease (COPD), or pulmonary fibrosis?   | ..... <input type="radio"/> | ..... <input type="radio"/> |
| 9. Are you bedridden or do you use a wheelchair for any daily activity, or have you been diagnosed with Gaucher's Disease or any other type of lysosomal storage disorder, or have you had any type of amputation caused by disease?   | ..... <input type="radio"/> | ..... <input type="radio"/> |
| 10. Have you been advised that surgery may be required within the next twelve months for cataracts?  | ..... <input type="radio"/> | ..... <input type="radio"/> |
| 11. Have you been diagnosed or treated for Parkinson's disease, Multiple or Lateral Sclerosis, Alzheimer's disease, senile dementia, or organic brain disorder?  | ..... <input type="radio"/> | ..... <input type="radio"/> |
| 12. Have you been treated, diagnosed or tested positive as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or ever tested positive for antibodies for the AIDS (HIV) virus?  | ..... <input type="radio"/> | ..... <input type="radio"/> |
| 13. Do you have diabetes requiring more than 50 units of insulin daily?  | ..... <input type="radio"/> | ..... <input type="radio"/> |
| 14. Within the past 2 years, have you been diagnosed or treated for internal cancer, melanoma, leukemia, alcoholism or drug abuse, cirrhosis, mental or nervous disorder requiring psychiatric care, or have you been advised to have kidney dialysis?                             | ..... <input type="radio"/> | ..... <input type="radio"/> |
| 15. Within the past 2 years, have you been diagnosed or treated for heart attack, peripheral vascular disease, congestive heart failure, heart valve disorder, stroke, or transient ischemic attacks (TIA)?  | ..... <input type="radio"/> | ..... <input type="radio"/> |
| 16. Within the past 2 years, have you been diagnosed or treated for rheumatoid arthritis or crippling arthritis?   | ..... <input type="radio"/> | ..... <input type="radio"/> |
| 17. Within the past year, have you been fed intravenously or through a tube, have you been medically advised to have surgery for joint replacement or for a heart condition, but not had such surgery, or have you been advised to have other surgery that has not been performed? | ..... <input type="radio"/> | ..... <input type="radio"/> |

**PART III**

**I. INVOLUNTARY TERMINATION OF COVERAGE:**

If your previous coverage was terminated involuntarily, please provide a copy of the notice of termination of coverage and attach it to this form.

What type of coverage was terminated? \_\_\_\_\_

Date of termination?   -     Reason for termination? \_\_\_\_\_  
(mm-dd-yyyy)

**II. VOLUNTARY TERMINATION OF COVERAGE:**

If you voluntarily terminated your present coverage, please attach evidence of previous coverage to this form.

What type of coverage was terminated? \_\_\_\_\_

Date of termination?   -   -     Reason for termination? \_\_\_\_\_  
(mm-dd-yyyy)

If you voluntarily terminated coverage under a Medicare Advantage plan\* or Medicare Select policy, please answer the following questions: **Yes No**

- Was this the first time you were ever enrolled in a Medicare Advantage plan or purchased a Medicare Select policy? .....    
If so, did you have the Medicare Advantage plan or Medicare Select policy for less than 12 months? .....
- Did you have a Medicare Supplement policy before applying for the Medicare Advantage plan or Medicare Select policy? .....    
If "YES", with which Company and which Medicare Supplement plan?  
.....

\* Medicare Advantage plan means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; (2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and (3) Medicare Advantage private fee-for-service plans.

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

**PART IV: APPLICANT AUTHORIZATION**

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

I hereby apply to Liberty National Life Insurance Company for a policy to be issued in reliance on my written answers to the above questions. The answers are, to the best of my knowledge and belief, true. I agree the policy shall not be effective unless it has actually been issued. I have received an outline of coverage for the policy applied for and a Medicare Supplement Buyers Guide.

I understand that loss due to injury or sickness for which medical advice was received or treatment was recommended or given by a physician within 6 months prior to the policy effective date is not covered unless the loss is incurred more than 60 days after the policy effective date, subject to the Time Limit on Certain Defenses provision and legal proceedings.

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 organizations 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 or an authorized representative 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](http://www.mib.com).

No agent may bind, alter, change or waive any underwriting requirements or other provisions of the application or policy. Final acceptance is made by the Underwriting Department of the Company.

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.

Application Signed at City  State  On this Date (mm-dd-yyyy)  -  -

Amount paid with application: \$  ,  .

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

for first  months premiums.

Initials of Proposed Insured

*(Application Continued)*



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

PART V: AGENT CERTIFICATION

The undersigned Agent certifies that he/she has personally met with the Applicant and that the Applicant has read, or had read to him/her, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

AGENT COMPLETES (Attach separate sheet, if necessary.)

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

---

---

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

---

---

I certify: (1) I have accurately recorded the information supplied by the Applicant, (2) I have given an outline of coverage for the policy applied for and a Medicare Supplement Buyers Guide to the Applicant.

Last Name

Agent No.

--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--

Agent's Signature

LMA14(03)

MAIL POLICY TO:  Agent  Insured (The Policy will be sent to Insured unless otherwise instructed.)

SPECIMEN

Initials of Proposed Insured 

--	--	--	--

55846

Pg 5





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

**PART II: ELIGIBILITY QUESTIONS**

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS.**

**TO THE BEST OF YOUR KNOWLEDGE:**

**Yes No**

1. (a) Did you turn age 65 in the last six (6) months? .....  Yes  No  
 (b) Did you enroll in Medicare Part B in the last six (6) months? .....  Yes  No

(c) If "YES", what is the effective date? (mm-dd-yyyy)   -   -

(d) What is your Medicare Claim Number?     -   -       -    
 (exactly as shown on your Medicare card)

2. Are you covered for medical assistance through the state Medicaid program? .....  Yes  No  
 NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.

If you answered "YES":

- (a) Will Medicaid pay your premiums for this Medicare Supplement policy? .....  Yes  No  
 (b) Do you receive any benefits from Medicaid OTHER THAN payment towards your Medicare Part B premium? .....  Yes  No

3. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END Date" blank.

START Date (mm-dd-yyyy)   -   -          END Date (mm-dd-yyyy)   -   -

- (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? .....  Yes  No  
 (c) Was this your first time in this type of Medicare plan? .....  Yes  No  
 (d) Did you drop a Medicare Supplement policy to enroll in the Medicare plan? .....  Yes  No

4. (a) Do you have another Medicare Supplement policy in force? .....  Yes  No  
 (b) If so, with what company, and what plan do you have? \_\_\_\_\_  
 (c) If so, do you intend to replace your current Medicare Supplement policy with this policy? .....  Yes  No

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) .....  Yes  No  
 (a) If so, with what company and what kind of policy?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END Date" blank.)

START Date (mm-dd-yyyy)   -   -          END Date (mm-dd-yyyy)   -   -

**Yes No**

6. Are you within 6 months of your enrollment in Medicare Part B or otherwise qualified for open enrollment? .....  Yes  No  
 (Questions 7-18 not required if the answer to question 6 is "YES".)



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

**PART II: ELIGIBILITY QUESTIONS (continued)**

**IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES," THE APPLICANT IS NOT ELIGIBLE FOR COVERAGE:**

- |  |               |
|--|---------------|
| 7. Are you currently hospitalized, confined to a nursing facility or receiving Medicare approved home health care, or have you been hospitalized or received Medicare approved home health care 2 or more times in the past 12 months?   | <b>Yes No</b> |
| 8. Do you have emphysema, Chronic Obstructive Pulmonary Disease (COPD), or pulmonary fibrosis?   | ○ ○           |
| 9. Are you bedridden or do you use a wheelchair for any daily activity, or have you been diagnosed with Gaucher's Disease or any other type of lysosomal storage disorder, or have you had any type of amputation caused by disease?   | ○ ○           |
| 10. Have you been advised that surgery may be required within the next twelve months for cataracts?  | ○ ○           |
| 11. Have you been diagnosed or treated for Parkinson's disease, Multiple or Lateral Sclerosis, Cerebral Palsy, Alzheimer's disease, senile dementia, or organic brain disorder?  | ○ ○           |
| 12. Have you been treated, diagnosed or tested positive as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or ever tested positive for antibodies for the AIDS (HIV) virus?  | ○ ○           |
| 13. Have you had or been medically treated for or been advised to have a bone or organ transplant?   | ○ ○           |
| 14. Do you have diabetes requiring more than 50 units of insulin daily?  | ○ ○           |
| 15. Within the past 2 years, have you been diagnosed or treated for internal cancer, melanoma, leukemia, alcoholism or drug abuse, cirrhosis, schizophrenia or bipolar disorder requiring psychiatric care, or have you been advised to have kidney dialysis?                      | ○ ○           |
| 16. Within the past 2 years, have you been diagnosed or treated for heart attack, peripheral vascular disease, congestive heart failure, heart valve disorder, stroke, or transient ischemic attacks (TIA)?  | ○ ○           |
| 17. Within the past 2 years, have you been diagnosed or treated for rheumatoid arthritis or crippling arthritis?   | ○ ○           |
| 18. Within the past year, have you been fed intravenously or through a tube, have you been medically advised to have surgery for joint replacement or for a heart condition, but not had such surgery, or have you been advised to have other surgery that has not been performed? | ○ ○           |

**PART III**

**I. INVOLUNTARY TERMINATION OF COVERAGE:**

If your previous coverage was terminated involuntarily, please provide a copy of the notice of termination of coverage and attach it to this form.

What type of coverage was terminated? \_\_\_\_\_

Date of termination?   -   -     Reason for termination? \_\_\_\_\_

(mm-dd-yyyy)

**II. VOLUNTARY TERMINATION OF COVERAGE:**

If you voluntarily terminated your present coverage, please attach evidence of previous coverage to this form.

What type of coverage was terminated? \_\_\_\_\_

Date of termination?   -   -     Reason for termination? \_\_\_\_\_

(mm-dd-yyyy)

If you voluntarily terminated coverage under a Medicare Advantage plan\* or Medicare Select policy, please answer the following questions: **Yes No**

- |   |     |
|---|-----|
| 1. Was this the first time you were ever enrolled in a Medicare Advantage plan or purchased a Medicare Select policy?   | ○ ○ |
| If so, did you have the Medicare Advantage plan or Medicare Select policy for less than 12 months?                      | ○ ○ |
| 2. Did you have a Medicare Supplement policy before applying for the Medicare Advantage plan or Medicare Select policy? | ○ ○ |
| If "YES", with which Company and which Medicare Supplement plan?  |     |
| _____   |     |
| Is that Company still offering that Medicare Supplement plan?   | ○ ○ |

\* Medicare Advantage plan means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; (2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and (3) Medicare Advantage private fee-for-service plans.



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

PART V: AGENT CERTIFICATION

The undersigned Agent certifies that he/she has personally met with the applicant and that the Applicant has read, or had read to him/her, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

AGENT COMPLETES (Attach separate sheet, if necessary.)

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

---

---

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

---

---

I certify: (1) I have accurately recorded the information supplied by the Applicant, (2) I have given an outline of coverage for the policy applied for and a Medicare Supplement Buyers Guide to the Applicant.

Last Name

--	--	--	--	--	--

Agent No.

--	--	--	--	--	--	--	--

Agent's Signature

LDMA14(03)

MAIL POLICY TO:  Agent  Insured (The Policy will be sent to Insured unless otherwise instructed.)

SPECIMEN

Initials of Proposed Insured 

--	--	--



**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 Medicare Supplement Coverage - Cover Page: 1 of 2

Benefit Plan B

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

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

BASIC BENEFITS for Plans A - J.

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

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

Blood: First three pints of blood each year.

<b>A</b>	<b>B*</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>F</b>	<b>F**</b>	<b>G</b>	<b>H</b>	<b>I</b>	<b>J</b>	<b>J**</b>
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible						Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)			Part B Excess (100%)	Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	At-Home Recovery
				Preventive Care NOT Covered by Medicare							Preventive Care NOT Covered by Medicare

\* Denotes plans available by Liberty National Life Insurance Company.

\*\* Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year [\$2000] deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are [\$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

**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 Medicare Supplement Coverage - Cover Page 2

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

<b>J</b>	<b>K **</b>	<b>L **</b>
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	[\$4620]Out-of-Pocket Annual Limit***	[\$2310] Out-of-Pocket Annual Limit***

\* Denotes plans available by Liberty National Life Insurance Company.

\*\* Plans K and L provide for different cost-sharing for items and services than Plans A - J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

\*\*\* The out-of-pocket annual limit will increase each year for inflation. See Outlines of Coverage for details and exceptions.

## **PREMIUM INFORMATION**

We, Liberty National Life Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this State.

## **DISCLOSURES**

Use this Outline to compare benefits and premiums among policies.

## **READ YOUR POLICY VERY CAREFULLY**

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

## **RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to Liberty National Life Insurance Company, P.O. Box 8080, McKinney, Texas 75070. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

## **POLICY REPLACEMENT**

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

## **NOTICE**

This policy may not fully cover all your medical cost.

Neither Liberty National Life Insurance Company nor its agents are connected with Medicare.

This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

## **COMPLETE ANSWERS ARE VERY IMPORTANT**

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

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

## **RENEWABILITY**

This policy is guaranteed renewable for life. We have the right to change the renewal premiums for this policy in accordance with our table of premium rates applicable to all policies of this form and class. This policy provides a 31-day grace period.

## Liberty National Life Insurance Company Medicare Supplement Rates

[Rates are for representation purposes, final rates will be placed in this outline when approved].

<b>PLAN B</b>			
<b>Plan Code [LN2]</b>			
<b>Annual</b>	<b>Semi Annual</b>	<b>Quarterly</b>	<b>Monthly</b>
[1873]	[955]	[487]	[165]
<b>COMMUNITY</b>	<b>Effective Date: [07-01-09]</b>		

**PLAN B**  
**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION *</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1068]	[\$1068] (Part A Deductible)	\$0
61st thru 90th day	All but [\$267] a day	[\$267] a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but [\$534] a day	[\$534] a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0 **
– Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE *</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but [\$133.50] a day	\$0	Up to [\$133.50] a day
101st day and after	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			

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

**PLAN B**  
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First [\$135] of Medicare Approved Amounts*	\$0	\$0	[\$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next [\$135] of Medicare Approved Amounts*	\$0	\$0	[\$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	\$0	\$0
– Durable medical equipment			
First [\$135] of Medicare Approved Amounts*	\$0	\$0	[\$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**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 Medicare Supplement Coverage - Cover Page: 1 of 2

Benefit Plans A, B, F, HDF

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

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

BASIC BENEFITS for Plans A - J.

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

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

Blood: First three pints of blood each year.

<b>A*</b>	<b>B*</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>F*</b>	<b>F**</b>	<b>G</b>	<b>H</b>	<b>I</b>	<b>J</b>	<b>J**</b>
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits				
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance				
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible				
		Part B Deductible			Part B Deductible						Part B Deductible
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency				
			At-Home Recovery				At-Home Recovery		At-Home Recovery		At-Home Recovery
				Preventive Care NOT Covered by Medicare							Preventive Care NOT Covered by Medicare

\* Denotes plans available by Liberty National Life Insurance Company.

\*\* Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year [\$2000] deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are [\$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

**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 Medicare Supplement Coverage - Cover Page 2

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

<b>J</b>	<b>K **</b>	<b>L **</b>
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	[\$4620] Out-of-Pocket Annual Limit***	[\$2310] Out-of-Pocket Annual Limit***

\* Denotes plans available by Liberty National Life Insurance Company.

\*\* Plans K and L provide for different cost-sharing for items and services than Plans A - J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

\*\*\* The out-of-pocket annual limit will increase each year for inflation. See Outlines of Coverage for details and exceptions.

### **PREMIUM INFORMATION**

We, Liberty National Life Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this State.

### **DISCLOSURES**

Use this Outline to compare benefits and premiums among policies.

### **READ YOUR POLICY VERY CAREFULLY**

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

### **RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to Liberty National Life Insurance Company, P.O. Box 8080, McKinney, Texas 75070. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

### **POLICY REPLACEMENT**

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

### **NOTICE**

This policy may not fully cover all your medical cost.

Neither Liberty National Life Insurance Company nor its agents are connected with Medicare.

This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

### **COMPLETE ANSWERS ARE VERY IMPORTANT**

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

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

### **RENEWABILITY**

This policy is guaranteed renewable for life. We have the right to change the renewal premiums for this policy in accordance with our table of premium rates applicable to all policies of this form and class. This policy provides a 31-day grace period.

<b>PLAN A</b>			
<b>Plan Code [LN1]</b>			
<b>Annual</b>	<b>Semi Annual</b>	<b>Quarterly</b>	<b>Monthly</b>
[1873]	[955]	[487]	[165]
<b>COMMUNITY</b>	<b>Effective Date: [07-01-09]</b>		

<b>PLAN B</b>			
<b>Plan Code [LN2]</b>			
<b>Annual</b>	<b>Semi Annual</b>	<b>Quarterly</b>	<b>Monthly</b>
[1873]	[955]	[487]	[165]
<b>COMMUNITY</b>	<b>Effective Date: [07-01-09]</b>		

<b>PLAN F</b>			
<b>Plan Code [LN3]</b>			
<b>Annual</b>	<b>Semi Annual</b>	<b>Quarterly</b>	<b>Monthly</b>
[1873]	[955]	[487]	[165]
<b>COMMUNITY</b>	<b>Effective Date: [07-01-09]</b>		

<b>HIGH DEDUCTIBLE PLAN F</b>			
<b>Plan Code [LN4]</b>			
<b>Annual</b>	<b>Semi Annual</b>	<b>Quarterly</b>	<b>Monthly</b>
[1873]	[955]	[487]	[165]
<b>COMMUNITY</b>	<b>Effective Date: [07-01-09]</b>		

**PLAN A**  
**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION *</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1068]	\$0	[\$1068] (Part A Deductible)
61st thru 90th day	All but [\$267] a day	[\$267] a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but [\$534] a day	[\$534] a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0 **
– Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE *</b>			
You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but [\$133.50] a day	\$0	Up to [\$133.50] a day
101st day and after	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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

**PLAN A**  
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First [\$135] of Medicare Approved Amounts*	\$0	\$0	[\$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next [\$135] of Medicare Approved Amounts*	\$0	\$0	[\$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	\$0	\$0
– Durable medical equipment			
First [\$135] of Medicare Approved Amounts*	\$0	\$0	[\$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**PLAN B**  
**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION *</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1068]	[\$1068] (Part A Deductible)	\$0
61st thru 90th day	All but [\$267] a day	[\$267] a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but [\$534] a day	[\$534] a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0 **
– Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE *</b>			
You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but [\$133.50] a day	\$0	Up to [\$133.50] a day
101st day and after	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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

**PLAN B**  
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First [\$135] of Medicare Approved Amounts*	\$0	\$0	[\$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next [\$135] of Medicare Approved Amounts*	\$0	\$0	[\$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	\$0	\$0
– Durable medical equipment			
First [\$135] of Medicare Approved Amounts*	\$0	\$0	[\$135] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**PLAN F or HIGH DEDUCTIBLE PLAN F  
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

- \* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
- \*\* This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$2000] DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO [\$2000] DEDUCTIBLE, ** YOU PAY
<b>HOSPITALIZATION *</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1068]	[\$1068] (Part A Deductible)	\$0
61st thru 90th day	All but [\$267] a day	[\$267] a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but [\$534] a day	[\$534] a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0 ***
– Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE *</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but [\$133.50] a day	Up to [\$133.50] a day	\$0
101st day and after	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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

**PLAN F or HIGH DEDUCTIBLE PLAN F  
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

- \* Once you have been billed [\$135] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.
- \*\* This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$2000] DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO [\$2000] DEDUCTIBLE, ** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First [\$135] of Medicare Approved Amounts*	\$0	[\$135] (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next [\$135] of Medicare Approved Amounts*	\$0	[\$135] (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	\$0	\$0
– Durable medical equipment			
First [\$135] of Medicare Approved Amounts*	\$0	[\$135] (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

SERFF Tracking Number: AMLC-126111229 State: Arkansas  
 Filing Company: Liberty National Life Insurance Company State Tracking Number: 42141  
 Company Tracking Number: LMSA06  
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
 Standard Plans  
 Product Name: Medicare Supplement Policy Forms  
 Project Name/Number: LMSA06/LMSA06

## Superseded Attachments

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

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	LMSA06	04/13/2009	LMSA06ar.pdf
No original date	Form	LMSA06	04/13/2009	LMSB06ar.pdf
No original date	Form	LMSF06	04/13/2009	LMSF06ar.pdf
No original date	Form	LMSHDF06	04/13/2009	LMSHDF06ar.pdf
No original date	Form	LDMSB06	04/14/2009	LDMSB06ar.pdf

**NOTICE TO BUYER:** This policy may not cover all of Your medical expenses.

**MEDICARE SUPPLEMENT POLICY**

**BENEFIT PLAN A**

**GUARANTEED RENEWABLE FOR LIFE. COMPANY CANNOT CANCEL POLICY. COMPANY MAY CHANGE PREMIUM RATES BY CLASS AND AS MEDICARE BENEFITS CHANGE AS PROVIDED IN THE GUARANTEED RENEWAL PROVISION.**

**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.

**GUARANTEED RENEWAL PROVISION**

You can renew and continue this policy in force during Your lifetime, for successive renewal terms 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 such 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 year of issue, area of the state in which You resided at issue, and underwriting group at issue for policyholders of this form in Your state.

The benefits provided by this policy which are designed to cover cost sharing amounts under Medicare will change automatically to coincide with any applicable changes in the deductible and/or Coinsurance amounts which You are required to pay under Medicare. The renewal premiums for this policy may change on the renewal date following the effective date of any such applicable change. Any such premium change will be based on the actuarial computations which We then use to determine the renewal premium.

---

**POLICY SCHEDULE**

---

<b>INSURED</b>	<b>POLICY NUMBER</b>	<b>EFFECTIVE DATE</b>	<b>INITIAL TERM EXPIRES ON</b>	<b>INITIAL PREMIUM</b>
[John Doe]	[0000000]	[01-01-09]	[01-01-10]	[\$0]

Your premiums may be increased due to unanticipated increasing health care costs for all policies in Your class.

If this policy is a replacement of an existing policy the “PRE-EXISTING CONDITIONS LIMITATIONS PROVISION” does not apply.

---

## TABLE OF CONTENTS

	Page
30 Day Right to Examine Policy .....	1
Guaranteed Renewal Provision.....	1
Pre-Existing Conditions Limitations Provision.....	2
Insuring Clause.....	2
Extended Benefit Provision .....	2
Definitions .....	2
Benefits For Hospital Stays - Medicare Part A.....	4
Medicare Blood Deductible Benefit .....	4
Benefits for Medical Expense - Medicare Part B.....	4
Limitations and Exclusions .....	4
Policy Provisions .....	4
Policy Provisions - Claims .....	6

---

### PRE-EXISTING CONDITIONS LIMITATIONS PROVISION

Loss due to a Pre-Existing Condition is not covered unless the loss is incurred more than 60 days after the policy effective date.

If You have a Pre-Existing Condition and qualify for open enrollment and have had a continuous period of creditable coverage for at least 6 months, We cannot exclude coverage based on the Pre-Existing Condition. If the period of creditable coverage is less than 6 months, We will give credit for the amount of time of creditable coverage You have had towards fulfilling the Pre-Existing Condition exclusion period.

If You are an Eligible Person who applied to enroll under this Medicare supplement policy not later than 63 days after the date of the termination or disenrollment, and who submitted evidence of the date of termination or disenrollment with the application, the Pre-Existing Conditions Limitations Provision will not apply.

### THE INSURING CLAUSE

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

### EXTENDED BENEFIT PROVISION

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

### DEFINITIONS

Where used in this policy:

**BENEFIT PERIOD** means the unit of time used in the Medicare program to measure use of services and availability of services under Medicare Part A hospital insurance.

**CALENDAR YEAR** means the period beginning on each January 1 and ending on the following December 31.

**COINSURANCE AMOUNTS** means the portion of Medicare approved expense You are obligated to pay but not including the Medicare Part A inpatient hospital deductible or Part B Calendar Year deductible.

**CONTINUOUS PERIOD OF CREDITABLE COVERAGE** means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

**CREDITABLE COVERAGE** means coverage of an individual provided by any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;
5. Chapter 55 of Title 10 United States Code (CHAMPUS);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);
9. A public health plan as defined in federal regulation; and
10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

**ELIGIBLE PERSON** means a person who submits evidence of the date of termination, disenrollment, or Medicare Part D enrollment as applies under the following plans: (1) Employee Welfare Benefit Plan; (2) Medicare Advantage plan; (3) Medicare Select Plan, Medicare Risk or Cost Plan, or Medicare HMO plan; or (4) Medicare supplement policy.

**HOSPITAL** means a lawfully operated hospital which has been accredited by the Joint Commission on Accreditation of Hospitals.

**HOSPITAL STAY** means one day or more of confinement within a hospital, as a resident patient under the care of a Physician, due to 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.

**MEDICARE** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

**MEDICARE ADVANTAGE PLAN** means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; (2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and (3) Medicare Advantage private fee-for-service plans.

**MEDICARE ELIGIBLE EXPENSES** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

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

**PRE-EXISTING CONDITION** means an Injury sustained or Sickness first manifesting itself prior to the policy effective date for which medical advice or treatment was recommended or given by a Physician within 6 months prior to the policy effective date.

**SICKNESS** means illness or disease of an insured person which first manifests itself after the effective date of insurance and while this policy is in force.

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

**YOU, YOUR, YOURS and INSURED** mean the person whose name is shown in the Policy Schedule.

## **BASIC CORE BENEFITS**

### **PART 1 BENEFITS FOR HOSPITAL STAYS - MEDICARE PART A**

We will pay the following benefits when You have a Hospital Stay for which benefits are paid by Medicare Part A:

- 1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
- 2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime reserve day used; and
- 3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

### **PART 2 MEDICARE BLOOD DEDUCTIBLE BENEFIT**

We will pay the expense You incur for coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations), unless replaced in accordance with Federal regulations.

### **PART 3 BENEFITS FOR MEDICAL EXPENSE - MEDICARE PART B**

If You incur a medical expense that is eligible under Medicare Part B, We will pay the following benefit for the Medicare approved charge:

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

Under this PART 3 of this policy, We will not pay benefits for (a) the Medicare Part B blood deductible for which benefits are paid under PART 2 of this policy, or (b) any portion of the Medicare Part B Calendar Year deductible.

### **PART 4 LIMITATIONS AND EXCLUSIONS**

We will not pay benefits under this policy for:

- 1) Any expense which You are not legally obligated to pay; or
- 2) Any services that are not medically necessary as determined by Medicare or are not furnished at the direction of and under the supervision of a Physician; or
- 3) Any portion of any expense for which payment is made by Medicare; or
- 4) Custodial or intermediate level care, or rest cures; or
- 5) Any type of expense not eligible for coverage under Medicare.

## **POLICY PROVISIONS**

**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 on 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.

Upon Your death, We will refund any premiums paid in Your behalf, for any period beyond the ending of the policy month the death occurred, within 30 days after We receive proof of death.

If death is due to Injury and this policy provides for the refund of premiums for death due to Injury, only one benefit will be paid, the largest.

**ENTIRE CONTRACT; CHANGES:** This policy, with the application and attached papers, is the entire contract between You and Us. No change in this policy will 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 60 days from the effective date will be reduced or denied because a Sickness or physical condition had existed before the effective date of this policy.

**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 (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.

**SUSPENSION OF COVERAGE WHILE ENTITLED TO MEDICAID:** By written notice to Us, You may request that benefits and premiums for You under this policy be suspended for the period in which You have been determined to be entitled to Medicaid. Written notice must be received by Us within 90 days after the date You become entitled to Medicaid. After We have received such notice, We will return to You any portion of premiums paid for the period of suspension less any claims paid. The suspension period shall not exceed 24 months.

If Your entitlement to Medicaid ends, You must send Us written notice of the loss of such entitlement within 90 days and pay the premium attributable to the period, effective as of the date of termination of entitlement. We will reinstate Your benefits and premiums under this policy as of the date Your entitlement ended. The reinstated coverage shall be the same as if no suspension has occurred.

**SUSPENSION OF COVERAGE WHILE ENTITLED TO BENEFITS UNDER A GROUP HEALTH PLAN:** By written notice to Us, You may request that benefits and premiums for You under this policy be suspended (for any period that may be provided by federal regulation) if You are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). Written notice must be received by Us within 90 days after the date You become entitled to coverage under the group health plan. After We have received such notice, We will return to You any portion of premiums paid for the period of suspension less any claims paid.

If Your entitlement to coverage under the group health plan ends, You must send Us written notice of the loss of such entitlement within 90 days and pay the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan. We will reinstitute Your benefits and premiums under this policy as of the date Your entitlement ended. The reinstated coverage shall be the same as if no suspension had occurred.

**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 any required forms for filing proof of loss, if applicable. 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 Your loss.

**PROOF OF LOSS:** You must give written proof of loss to Us within 6 months 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 will pay all benefits then due for such loss.

**PAYMENT OF CLAIMS:** Any benefits unpaid at Your death may be paid, at Our option, either to Your beneficiary or Your estate. All other benefits will be paid to You.

If benefits are payable to Your estate or a beneficiary who cannot execute a valid release, We can pay benefits up to \$1,000.00 to someone related to You or the beneficiary 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 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.

**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.



Secretary



President

Countersigned:

Licensed Resident Agent where required by law.

**IMPORTANT NOTICE**

This notice is to advise You that, should any problems arise concerning this insurance, You may contact the following:

**Consumer Service Department  
Liberty National Life Insurance Company  
P. O. Box 8080  
McKinney, Texas 75070  
Telephone: (972) 529-5085**

**Arkansas Insurance Department  
Consumer Services Division  
1200 West 3<sup>rd</sup> Street  
Little Rock, Arkansas 72201  
Telephone: (800) 852-5494 or  
(501) 371-2640**

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

**Agent's Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

\_\_\_\_\_

**NOTICE TO BUYER: This policy may not cover all of Your medical expenses.**

**MEDICARE SUPPLEMENT POLICY**

**BENEFIT PLAN B**

**GUARANTEED RENEWABLE FOR LIFE. COMPANY CANNOT CANCEL POLICY. COMPANY MAY CHANGE PREMIUM RATES BY CLASS AND AS MEDICARE BENEFITS CHANGE AS PROVIDED IN THE GUARANTEED RENEWAL PROVISION.**

**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.**

**GUARANTEED RENEWAL PROVISION**

**You can renew and continue this policy in force during Your lifetime, for successive renewal terms 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 such 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 year of issue, area of the state in which You resided at issue, and underwriting group at issue for policyholders of this form in Your state.**

**The benefits provided by this policy which are designed to cover cost sharing amounts under Medicare will change automatically to coincide with any applicable changes in the deductible and/or Coinsurance amounts which You are required to pay under Medicare. The renewal premiums for this policy may change on the renewal date following the effective date of any such applicable change. Any such premium change will be based on the actuarial computations which We then use to determine the renewal premium.**

---

**POLICY SCHEDULE**

---

<b>INSURED</b>	<b>POLICY NUMBER</b>	<b>EFFECTIVE DATE</b>	<b>INITIAL TERM EXPIRES ON</b>	<b>INITIAL PREMIUM</b>
[John Doe]	[0000000]	[01-01-09]	[01-01-10]	[\$0]

**Your premiums may be increased due to unanticipated increasing health care costs for all policies in Your class.**

**If this policy is a replacement of an existing policy the "PRE-EXISTING CONDITIONS LIMITATIONS PROVISION" does not apply.**

---

**TABLE OF CONTENTS**

	<b>Page</b>
<b>30 Day Right to Examine Policy .....</b>	<b>1</b>
<b>Guaranteed Renewal Provision.....</b>	<b>1</b>
<b>Pre-Existing Conditions Limitations Provision.....</b>	<b>2</b>
<b>Insuring Clause.....</b>	<b>2</b>
<b>Extended Benefit Provision .....</b>	<b>2</b>
<b>Definitions.....</b>	<b>2</b>
<b>Benefits For Hospital Stays - Medicare Part A.....</b>	<b>4</b>
<b>Medicare Blood Deductible Benefit .....</b>	<b>4</b>
<b>Benefits for Medical Expense - Medicare Part B.....</b>	<b>4</b>
<b>Medicare Part A Deductible Benefit .....</b>	<b>4</b>
<b>Limitations and Exclusions .....</b>	<b>4</b>
<b>Policy Provisions .....</b>	<b>4</b>
<b>Policy Provisions - Claims .....</b>	<b>6</b>

---

**PRE-EXISTING CONDITIONS LIMITATIONS PROVISION**

Loss due to a Pre-Existing Condition is not covered unless the loss is incurred more than 60 days after the policy effective date.

If You have a Pre-Existing Condition and qualify for open enrollment and have had a continuous period of creditable coverage for at least 6 months, We cannot exclude coverage based on the Pre-Existing Condition. If the period of creditable coverage is less than 6 months, We will give credit for the amount of time of creditable coverage You have had towards fulfilling the Pre-Existing Condition exclusion period.

If You are an Eligible Person who applied to enroll under this Medicare supplement policy not later than 63 days after the date of the termination or disenrollment, and who submitted evidence of the date of termination or disenrollment with the application, the Pre-Existing Conditions Limitations Provision will not apply.

**THE INSURING CLAUSE**

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

**EXTENDED BENEFIT PROVISION**

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

**DEFINITIONS**

Where used in this policy:

**BENEFIT PERIOD** means the unit of time used in the Medicare program to measure use of services and availability of services under Medicare Part A hospital insurance.

**CALENDAR YEAR** means the period beginning on each January 1 and ending on the following December 31.

**COINSURANCE AMOUNTS** means the portion of Medicare approved expense You are obligated to pay but not including the Medicare Part A inpatient hospital deductible or Part B Calendar Year deductible.

**CONTINUOUS PERIOD OF CREDITABLE COVERAGE** means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

**CREDITABLE COVERAGE** means coverage of an individual provided by any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;
5. Chapter 55 of Title 10 United States Code (CHAMPUS);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);
9. A public health plan as defined in federal regulation; and
10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

**ELIGIBLE PERSON** means a person who submits evidence of the date of termination, disenrollment, or Medicare Part D enrollment as applies under the following plans: (1) Employee Welfare Benefit Plan; (2) Medicare Advantage plan; (3) Medicare Select Plan, Medicare Risk or Cost Plan, or Medicare HMO plan; or (4) Medicare supplement policy.

**HOSPITAL** means a lawfully operated hospital which has been accredited by the Joint Commission on Accreditation of Hospitals.

**HOSPITAL STAY** means one day or more of confinement within a hospital, as a resident patient under the care of a Physician, due to 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.

**MEDICARE** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

**MEDICARE ADVANTAGE PLAN** means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; (2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and (3) Medicare Advantage private fee-for-service plans.

**MEDICARE ELIGIBLE EXPENSES** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

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

**PRE-EXISTING CONDITION** means an Injury sustained or Sickness first manifesting itself prior to the policy effective date for which medical advice or treatment was recommended or given by a Physician within 6 months prior to the policy effective date.

**SICKNESS** means illness or disease of an insured person which first manifests itself after the effective date of insurance and while this policy is in force.

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

**YOU, YOUR, YOURS and INSURED** mean the person whose name is shown in the Policy Schedule.

## **BASIC CORE BENEFITS**

### **PART 1                    BENEFITS FOR HOSPITAL STAYS - MEDICARE PART A**

We will pay the following benefits when You have a Hospital Stay for which benefits are paid by Medicare Part A:

- 1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
- 2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime reserve day used; and
- 3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

### **PART 2                    MEDICARE BLOOD DEDUCTIBLE BENEFIT**

We will pay the expense You incur for coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations), unless replaced in accordance with Federal regulations.

### **PART 3                    BENEFITS FOR MEDICAL EXPENSE - MEDICARE PART B**

If You incur a medical expense that is eligible under Medicare Part B, We will pay the following benefit for the Medicare approved charge:

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

Under this PART 3 of this policy, We will not pay benefits for (a) the Medicare Part B blood deductible for which benefits are paid under PART 2 of this policy, or (b) any portion of the Medicare Part B Calendar Year deductible.

## **ADDITIONAL BENEFITS**

### **PART 4                    MEDICARE PART A DEDUCTIBLE BENEFIT**

We will pay the expense You incur for all of the Medicare Part A Inpatient hospital deductible amount per Benefit Period.

### **PART 5                    LIMITATIONS AND EXCLUSIONS**

We will not pay benefits under this policy for:

- 1) Any expense which You are not legally obligated to pay; or
- 2) Any services that are not medically necessary as determined by Medicare or are not furnished at the direction of and under the supervision of a Physician; or
- 3) Any portion of any expense for which payment is made by Medicare; or
- 4) Custodial or intermediate level care, or rest cures; or
- 5) Any type of expense not eligible for coverage under Medicare.

## **POLICY PROVISIONS**

**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 on 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.

Upon Your death, We will refund any premiums paid in Your behalf, for any period beyond the ending of the policy month the death occurred, within 30 days after We receive proof of death.

If death is due to Injury and this policy provides for the refund of premiums for death due to Injury, only one benefit will be paid, the largest.

**ENTIRE CONTRACT; CHANGES:** This policy, with the application and attached papers, is the entire contract between You and Us. No change in this policy will 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 60 days from the effective date will be reduced or denied because a Sickness or physical condition had existed before the effective date of this policy.

**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 (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.

**SUSPENSION OF COVERAGE WHILE ENTITLED TO MEDICAID:** By written notice to Us, You may request that benefits and premiums for You under this policy be suspended for the period in which You have been determined to be entitled to Medicaid. Written notice must be received by Us within 90 days after the date You become entitled to Medicaid. After We have received such notice, We will return to You any portion of premiums paid for the period of suspension less any claims paid. The suspension period shall not exceed 24 months.

If Your entitlement to Medicaid ends, You must send Us written notice of the loss of such entitlement within 90 days and pay the premium attributable to the period, effective as of the date of termination of entitlement. We will reinstate Your benefits and premiums under this policy as of the date Your entitlement ended. The reinstated coverage shall be the same as if no suspension has occurred.

**SUSPENSION OF COVERAGE WHILE ENTITLED TO BENEFITS UNDER A GROUP HEALTH PLAN:** By written notice to Us, You may request that benefits and premiums for You under this policy be suspended (for any period that may be provided by federal regulation) if You are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). Written notice must be received by Us within 90 days after the date You become entitled to coverage under the group health plan. After We have received such notice, We will return to You any portion of premiums paid for the period of suspension less any claims paid.

If Your entitlement to coverage under the group health plan ends, You must send Us written notice of the loss of such entitlement within 90 days and pay the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan. We will reinstitute Your benefits and premiums under this policy as of the date Your entitlement ended. The reinstated coverage shall be the same as if no suspension had occurred.

**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 any required forms for filing proof of loss, if applicable. 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 Your loss.

**PROOF OF LOSS:** You must give written proof of loss to Us within 6 months 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 will pay all benefits then due for such loss.

**PAYMENT OF CLAIMS:** Any benefits unpaid at Your death may be paid, at Our option, either to Your beneficiary or Your estate. All other benefits will be paid to You.

If benefits are payable to Your estate or a beneficiary who cannot execute a valid release, We can pay benefits up to \$1,000.00 to someone related to You or the beneficiary 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 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.

**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.



Secretary



President

Countersigned:

Licensed Resident Agent where required by law.

**IMPORTANT NOTICE**

This notice is to advise You that, should any problems arise concerning this insurance, You may contact the following:

**Consumer Service Department  
Liberty National Life Insurance Company  
P. O. Box 8080  
McKinney, Texas 75070  
Telephone: (972) 529-5085**

**Arkansas Insurance Department  
Consumer Services Division  
1200 West 3<sup>rd</sup> Street  
Little Rock, Arkansas 72201  
Telephone: (800) 852-5494 or  
(501) 371-2640**

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

**Agent's Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

\_\_\_\_\_

**NOTICE TO BUYER: This policy may not cover all of Your medical expenses.**

**MEDICARE SUPPLEMENT POLICY**

**BENEFIT PLAN F**

**GUARANTEED RENEWABLE FOR LIFE. COMPANY CANNOT CANCEL POLICY. COMPANY MAY CHANGE PREMIUM RATES BY CLASS AND AS MEDICARE BENEFITS CHANGE AS PROVIDED IN THE GUARANTEED RENEWAL PROVISION.**

**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.

**GUARANTEED RENEWAL PROVISION**

You can renew and continue this policy in force during Your lifetime, for successive renewal terms 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 such 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 year of issue, area of the state in which You resided at issue, and underwriting group at issue for policyholders of this form in Your state.

The benefits provided by this policy which are designed to cover cost sharing amounts under Medicare will change automatically to coincide with any applicable changes in the deductible and/or Coinsurance amounts which You are required to pay under Medicare. The renewal premiums for this policy may change on the renewal date following the effective date of any such applicable change. Any such premium change will be based on the actuarial computations which We then use to determine the renewal premium.

---

**POLICY SCHEDULE**

---

<b>INSURED</b>	<b>POLICY NUMBER</b>	<b>EFFECTIVE DATE</b>	<b>INITIAL TERM EXPIRES ON</b>	<b>INITIAL PREMIUM</b>
[John Doe]	[0000000]	[01-01-09]	[01-01-10]	[\$0]

Your premiums may be increased due to unanticipated increasing health care costs for all policies in Your class.

If this policy is a replacement of an existing policy the "PRE-EXISTING CONDITIONS LIMITATIONS PROVISION" does not apply.

---

## TABLE OF CONTENTS

	Page
30 Day Right to Examine Policy .....	1
Guaranteed Renewal Provision.....	1
Pre-Existing Conditions Limitations Provision.....	2
Insuring Clause.....	2
Extended Benefit Provision .....	2
Definitions .....	2
Benefits For Hospital Stays - Medicare Part A.....	4
Medicare Blood Deductible Benefit .....	4
Benefits for Medical Expense - Medicare Part B .....	4
Medicare Part A Deductible Benefit .....	5
Benefits For Skilled Nursing Facility Stays - Medicare Part A.....	5
Medicare Part B Deductible Benefit .....	5
100% Excess Expense Benefit - Medicare Part B .....	5
Medically Necessary Emergency Care In A Foreign Country .....	5
Limitations and Exclusions .....	5
Policy Provisions .....	5
Policy Provisions - Claims .....	7

---

### PRE-EXISTING CONDITIONS LIMITATIONS PROVISION

Loss due to a Pre-Existing Condition is not covered unless the loss is incurred more than 60 days after the policy effective date.

If You have a Pre-Existing Condition and qualify for open enrollment and have had a continuous period of creditable coverage for at least 6 months, We cannot exclude coverage based on the Pre-Existing Condition. If the period of creditable coverage is less than 6 months, We will give credit for the amount of time of creditable coverage You have had towards fulfilling the Pre-Existing Condition exclusion period.

If You are an Eligible Person who applied to enroll under this Medicare supplement policy not later than 63 days after the date of the termination or disenrollment, and who submitted evidence of the date of termination or disenrollment with the application, the Pre-Existing Conditions Limitations Provision will not apply.

### THE INSURING CLAUSE

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

### EXTENDED BENEFIT PROVISION

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

### DEFINITIONS

Where used in this policy:

**BENEFIT PERIOD** means the unit of time used in the Medicare program to measure use of services and availability of services under Medicare Part A hospital insurance.

**CALENDAR YEAR** means the period beginning on each January 1 and ending on the following December 31.

**COINSURANCE AMOUNTS** means the portion of Medicare approved expense You are obligated to pay but not including the Medicare Part A inpatient hospital deductible or Part B Calendar Year deductible.

**CONTINUOUS PERIOD OF CREDITABLE COVERAGE** means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

**CREDITABLE COVERAGE** means coverage of an individual provided by any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;
5. Chapter 55 of Title 10 United States Code (CHAMPUS);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);
9. A public health plan as defined in federal regulation; and
10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

**ELIGIBLE PERSON** means a person who submits evidence of the date of termination, disenrollment, or Medicare Part D enrollment as applies under the following plans: (1) Employee Welfare Benefit Plan; (2) Medicare Advantage plan; (3) Medicare Select Plan, Medicare Risk or Cost Plan, or Medicare HMO plan; or (4) Medicare supplement policy.

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

**HOSPITAL** means a lawfully operated hospital which has been accredited by the Joint Commission on Accreditation of Hospitals.

**HOSPITAL STAY** means one day or more of confinement within a hospital, as a resident patient under the care of a Physician, due to 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.

**MEDICARE** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

**MEDICARE ADVANTAGE PLAN** means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; (2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and (3) Medicare Advantage private fee-for-service plans.

**MEDICARE ELIGIBLE EXPENSES** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

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

**PRE-EXISTING CONDITION** means an Injury sustained or Sickness first manifesting itself prior to the policy effective date for which medical advice or treatment was recommended or given by a Physician within 6 months prior to the policy effective date.

**SICKNESS** means illness or disease of an insured person which first manifests itself after the effective date of insurance and while this policy is in force.

**SKILLED NURSING FACILITY** means a facility certified by Medicare as a Skilled Nursing Facility.

**SKILLED NURSING FACILITY STAY** means one day or more of confinement within a Skilled Nursing Facility, as a resident patient under the care of a Physician, following a Hospital Stay of at least 3 days. The Skilled Nursing Facility Stay must be for further treatment of the Injury or Sickness requiring the Hospital Stay and begin within 30 days of hospital discharge.

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

**YOU, YOUR, YOURS** and **INSURED** mean the person whose name is shown in the Policy Schedule.

## **BASIC CORE BENEFITS**

### **PART 1 BENEFITS FOR HOSPITAL STAYS - MEDICARE PART A**

We will pay the following benefits when You have a Hospital Stay for which benefits are paid by Medicare Part A:

- 1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
- 2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime reserve day used; and
- 3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

### **PART 2 MEDICARE BLOOD DEDUCTIBLE BENEFIT**

We will pay the expense You incur for coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations), unless replaced in accordance with Federal regulations.

### **PART 3 BENEFITS FOR MEDICAL EXPENSE - MEDICARE PART B**

If You incur a medical expense that is eligible under Medicare Part B, We will pay the following benefit for the Medicare approved charge:

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

Under this PART 3 of this policy, We will not pay benefits for (a) the Medicare Part B blood deductible for which benefits are paid under PART 2 of this policy, or (b) any portion of the Medicare Part B Calendar Year deductible.

## **ADDITIONAL BENEFITS**

### **PART 4 MEDICARE PART A DEDUCTIBLE BENEFIT**

We will pay the expense You incur for all of the Medicare Part A Inpatient hospital deductible amount per Benefit Period.

### **PART 5 BENEFITS FOR SKILLED NURSING FACILITY STAYS - MEDICARE PART A**

When You have a posthospital Skilled Nursing Facility Stay which is eligible under Medicare Part A, We will pay the following benefit:

Coverage for the actual billed charges up to the Coinsurance Amount from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital Skilled Nursing Facility care eligible under Medicare Part A .

### **PART 6 MEDICARE PART B DEDUCTIBLE BENEFIT**

We will pay the expense You incur for all of the Medicare Part B deductible amount per Calendar Year regardless of Hospital confinement.

### **PART 7 100% EXCESS EXPENSE BENEFIT - MEDICARE PART B**

We will pay 100% of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

### **PART 8 MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY**

We will pay benefits for coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare Eligible Expenses for Medically Necessary Emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which began during the first 60 consecutive days of each trip outside of the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000.

For the purposes of this benefit, "Emergency Care" shall mean care needed immediately because of an Injury or an illness of sudden and unexpected onset.

### **PART 9 LIMITATIONS AND EXCLUSIONS**

We will not pay benefits under this policy for:

- 1) Any expense which You are not legally obligated to pay; or
- 2) Any services that are not medically necessary as determined by Medicare or are not furnished at the direction of and under the supervision of a Physician; or
- 3) Any portion of any expense for which payment is made by Medicare; or
- 4) Custodial or intermediate level care, or rest cures; or
- 5) Any type of expense not eligible for coverage under Medicare, except as provided under Part 8.

## **POLICY PROVISIONS**

**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 on 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.

**Upon Your death, We will refund any premiums paid in Your behalf, for any period beyond the ending of the policy month the death occurred, within 30 days after We receive proof of death.**

**If death is due to Injury and this policy provides for the refund of premiums for death due to Injury, only one benefit will be paid, the largest.**

**ENTIRE CONTRACT; CHANGES:** This policy, with the application and attached papers, is the entire contract between You and Us. No change in this policy will 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 60 days from the effective date will be reduced or denied because a Sickness or physical condition had existed before the effective date of this policy.**

**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 (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.**

**SUSPENSION OF COVERAGE WHILE ENTITLED TO MEDICAID:** By written notice to Us, You may request that benefits and premiums for You under this policy be suspended for the period in which You have been determined to be entitled to Medicaid. Written notice must be received by Us within 90 days after the date You become entitled to Medicaid. After We have received such notice, We will return to You any portion of premiums paid for the period of suspension less any claims paid. The suspension period shall not exceed 24 months.

**If Your entitlement to Medicaid ends, You must send Us written notice of the loss of such entitlement within 90 days and pay the premium attributable to the period, effective as of the date of termination of entitlement. We will reinstate Your benefits and premiums under this policy as of the date Your entitlement ended. The reinstated coverage shall be the same as if no suspension has occurred.**

**SUSPENSION OF COVERAGE WHILE ENTITLED TO BENEFITS UNDER A GROUP HEALTH PLAN:** By written notice to Us, You may request that benefits and premiums for You under this policy be suspended (for any period that may be provided by federal regulation) if You are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). Written notice must be received by Us within 90 days after the date You become entitled to coverage under the group health plan. After We have received such notice, We will return to You any portion of premiums paid for the period of suspension less any claims paid.

If Your entitlement to coverage under the group health plan ends, You must send Us written notice of the loss of such entitlement within 90 days and pay the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan. We will reinstitute Your benefits and premiums under this policy as of the date Your entitlement ended. The reinstated coverage shall be the same as if no suspension had occurred.

**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 any required forms for filing proof of loss, if applicable. 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 Your loss.

**PROOF OF LOSS:** You must give written proof of loss to Us within 6 months 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 will pay all benefits then due for such loss.

**PAYMENT OF CLAIMS:** Any benefits unpaid at Your death may be paid, at Our option, either to Your beneficiary or Your estate. All other benefits will be paid to You.

If benefits are payable to Your estate or a beneficiary who cannot execute a valid release, We can pay benefits up to \$1,000.00 to someone related to You or the beneficiary 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 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.

**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.



Secretary



President

Countersigned:

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

**IMPORTANT NOTICE**

This notice is to advise You that, should any problems arise concerning this insurance, You may contact the following:

**Consumer Service Department  
Liberty National Life Insurance Company  
P. O. Box 8080  
McKinney, Texas 75070  
Telephone: (972) 529-5085**

**Arkansas Insurance Department  
Consumer Services Division  
1200 West 3<sup>rd</sup> Street  
Little Rock, Arkansas 72201  
Telephone: (800) 852-5494 or  
(501) 371-2640**

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

**Agent's Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

\_\_\_\_\_

**NOTICE TO BUYER:** This policy may not cover all of Your medical expenses.

**MEDICARE SUPPLEMENT POLICY  
HIGH DEDUCTIBLE BENEFIT PLAN F**

**GUARANTEED RENEWABLE FOR LIFE. COMPANY CANNOT CANCEL POLICY.  
COMPANY MAY CHANGE PREMIUM RATES BY CLASS AND AS MEDICARE BENEFITS  
CHANGE AS PROVIDED IN THE GUARANTEED RENEWAL PROVISION.**

**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.

**GUARANTEED RENEWAL PROVISION**

You can renew and continue this policy in force during Your lifetime, for successive renewal terms 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 such 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 year of issue, area of the state in which You resided at issue, and underwriting group at issue for policyholders of this form in Your state.

The benefits provided by this policy which are designed to cover cost sharing amounts under Medicare will change automatically to coincide with any applicable changes in the deductible and/or Coinsurance amounts which You are required to pay under Medicare. The renewal premiums for this policy may change on the renewal date following the effective date of any such applicable change. Any such premium change will be based on the actuarial computations which We then use to determine the renewal premium.

---

**POLICY SCHEDULE**

---

<b>INSURED</b>	<b>POLICY NUMBER</b>	<b>EFFECTIVE DATE</b>	<b>INITIAL TERM EXPIRES ON</b>	<b>INITIAL PREMIUM</b>	<b>ANNUAL HIGH DEDUCTIBLE</b>
[John Doe]	[0000000]	[01-01-09]	[01-01-10]	[\$0]	[\$2,000]

This policy contains an annual high deductible as shown in the policy schedule above. This deductible will be adjusted for inflation each Calendar Year.

Your premiums may be increased due to unanticipated increasing health care costs for all policies in Your class.

If this policy is a replacement of an existing policy the "PRE-EXISTING CONDITIONS LIMITATIONS PROVISION" does not apply.

---

## TABLE OF CONTENTS

	Page
30 Day Right to Examine Policy .....	1
Guaranteed Renewal Provision.....	1
Pre-Existing Conditions Limitations Provision.....	2
Insuring Clause.....	2
Extended Benefit Provision .....	2
Definitions .....	2
Benefits For Hospital Stays - Medicare Part A.....	4
Medicare Blood Deductible Benefit .....	4
Benefits for Medical Expense - Medicare Part B .....	5
Medicare Part A Deductible Benefit .....	5
Benefits For Skilled Nursing Facility Stays - Medicare Part A.....	5
Medicare Part B Deductible Benefit .....	5
100% Excess Expense Benefit - Medicare Part B .....	5
Medically Necessary Emergency Care In A Foreign Country .....	5
Limitations and Exclusions .....	6
Policy Provisions .....	6
Policy Provisions - Claims .....	7

---

### PRE-EXISTING CONDITIONS LIMITATIONS PROVISION

Loss due to a Pre-Existing Condition is not covered unless the loss is incurred more than 60 days after the policy effective date.

If You have a Pre-Existing Condition and qualify for open enrollment and have had a continuous period of creditable coverage for at least 6 months, We cannot exclude coverage based on the Pre-Existing Condition. If the period of creditable coverage is less than 6 months, We will give credit for the amount of time of creditable coverage You have had towards fulfilling the Pre-Existing Condition exclusion period.

If You are an Eligible Person who applied to enroll under this Medicare supplement policy not later than 63 days after the date of the termination or disenrollment, and who submitted evidence of the date of termination or disenrollment with the application, the Pre-Existing Conditions Limitations Provision will not apply.

### THE INSURING CLAUSE

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

### EXTENDED BENEFIT PROVISION

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

### DEFINITIONS

Where used in this policy:

**BENEFIT PERIOD** means the unit of time used in the Medicare program to measure use of services and availability of services under Medicare Part A hospital insurance.

**CALENDAR YEAR** means the period beginning on each January 1 and ending on the following December 31.

**COINSURANCE AMOUNTS** means the portion of Medicare approved expense You are obligated to pay but not including the Medicare Part A inpatient hospital deductible or Part B Calendar Year deductible.

**CONTINUOUS PERIOD OF CREDITABLE COVERAGE** means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

**CREDITABLE COVERAGE** means coverage of an individual provided by any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;
5. Chapter 55 of Title 10 United States Code (CHAMPUS);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);
9. A public health plan as defined in federal regulation; and
10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

**ELIGIBLE PERSON** means a person who submits evidence of the date of termination, disenrollment, or Medicare Part D enrollment as applies under the following plans: (1) Employee Welfare Benefit Plan; (2) Medicare Advantage plan; (3) Medicare Select Plan, Medicare Risk or Cost Plan, or Medicare HMO plan; or (4) Medicare supplement policy.

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

**HOSPITAL** means a lawfully operated hospital which has been accredited by the Joint Commission on Accreditation of Hospitals.

**HOSPITAL STAY** means one day or more of confinement within a hospital, as a resident patient under the care of a Physician, due to 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.

**MEDICARE** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

**MEDICARE ADVANTAGE PLAN** means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; (2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and (3) Medicare Advantage private fee-for-service plans.

**MEDICARE ELIGIBLE EXPENSES** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

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

**PRE-EXISTING CONDITION** means an Injury sustained or Sickness first manifesting itself prior to the policy effective date for which medical advice or treatment was recommended or given by a Physician within 6 months prior to the policy effective date.

**SICKNESS** means illness or disease of an insured person which first manifests itself after the effective date of insurance and while this policy is in force.

**SKILLED NURSING FACILITY** means a facility certified by Medicare as a Skilled Nursing Facility.

**SKILLED NURSING FACILITY STAY** means one day or more of confinement within a Skilled Nursing Facility, as a resident patient under the care of a Physician, following a Hospital Stay of at least 3 days. The Skilled Nursing Facility Stay must be for further treatment of the Injury or Sickness requiring the Hospital Stay and begin within 30 days of hospital discharge.

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

**YOU, YOUR, YOURS and INSURED** mean the person whose name is shown in the Policy Schedule.

### **BASIC CORE BENEFITS**

**ANNUAL HIGH DEDUCTIBLE:** We will pay the following benefits after You pay the annual high deductible each Calendar Year. The annual high deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by this policy, and shall be in addition to any other specific benefit deductibles. Expenses incurred prior to the effective date of Your policy will not be applied to this deductible. The annual high deductible amount is shown in the policy schedule and shall be adjusted annually.

#### **PART 1 BENEFITS FOR HOSPITAL STAYS - MEDICARE PART A**

We will pay the following benefits when You have a Hospital Stay for which benefits are paid by Medicare Part A:

- 1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
- 2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime reserve day used; and
- 3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

#### **PART 2 MEDICARE BLOOD DEDUCTIBLE BENEFIT**

We will pay the expense You incur for coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations), unless replaced in accordance with Federal regulations.

**PART 3 BENEFITS FOR MEDICAL EXPENSE - MEDICARE PART B**

If You incur a medical expense that is eligible under Medicare Part B, We will pay the following benefit for the Medicare approved charge:

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

Under this PART 3 of this policy, We will not pay benefits for (a) the Medicare Part B blood deductible for which benefits are paid under PART 2 of this policy, or (b) any portion of the Medicare Part B Calendar Year deductible.

**ADDITIONAL BENEFITS**

**ANNUAL HIGH DEDUCTIBLE:** We will pay the following benefits after You pay the annual high deductible each Calendar Year. The annual high deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by this policy, and shall be in addition to any other specific benefit deductibles. Expenses incurred prior to the effective date of Your policy will not be applied to this deductible. The annual high deductible amount is shown in the policy schedule and shall be adjusted annually.

**PART 4 MEDICARE PART A DEDUCTIBLE BENEFIT**

We will pay the expense You incur for all of the Medicare Part A Inpatient hospital deductible amount per Benefit Period.

**PART 5 BENEFITS FOR SKILLED NURSING FACILITY STAYS - MEDICARE PART A**

When You have a posthospital Skilled Nursing Facility Stay which is eligible under Medicare Part A, We will pay the following benefit:

Coverage for the actual billed charges up to the Coinsurance Amount from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital Skilled Nursing Facility care eligible under Medicare Part A .

**PART 6 MEDICARE PART B DEDUCTIBLE BENEFIT**

We will pay the expense You incur for all of the Medicare Part B deductible amount per Calendar Year regardless of Hospital confinement.

**PART 7 100% EXCESS EXPENSE BENEFIT - MEDICARE PART B**

We will pay 100% of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

**PART 8 MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY**

We will pay benefits for coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare Eligible Expenses for Medically Necessary Emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which began during the first 60 consecutive days of each trip outside of the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000.

For the purposes of this benefit, "Emergency Care" shall mean care needed immediately because of an Injury or an illness of sudden and unexpected onset.

## **PART 9**

## **LIMITATIONS AND EXCLUSIONS**

We will not pay benefits under this policy for:

- 1) Any expense which You are not legally obligated to pay; or
- 2) Any services that are not medically necessary as determined by Medicare or are not furnished at the direction of and under the supervision of a Physician; or
- 3) Any portion of any expense for which payment is made by Medicare; or
- 4) Custodial or intermediate level care, or rest cures; or
- 5) Any type of expense not eligible for coverage under Medicare, except as provided under Part 8.

## **POLICY PROVISIONS**

**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 on 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.

Upon Your death, We will refund any premiums paid in Your behalf, for any period beyond the ending of the policy month the death occurred, within 30 days after We receive proof of death.

If death is due to Injury and this policy provides for the refund of premiums for death due to Injury, only one benefit will be paid, the largest.

**ENTIRE CONTRACT; CHANGES:** This policy, with the application and attached papers, is the entire contract between You and Us. No change in this policy will 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 60 days from the effective date will be reduced or denied because a Sickness or physical condition had existed before the effective date of this policy.

**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 (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.

**SUSPENSION OF COVERAGE WHILE ENTITLED TO MEDICAID:** By written notice to Us, You may request that benefits and premiums for You under this policy be suspended for the period in which You have been determined to be entitled to Medicaid. Written notice must be received by Us within 90 days after the date You become entitled to Medicaid. After We have received such notice, We will return to You any portion of premiums paid for the period of suspension less any claims paid. The suspension period shall not exceed 24 months.

If Your entitlement to Medicaid ends, You must send Us written notice of the loss of such entitlement within 90 days and pay the premium attributable to the period, effective as of the date of termination of entitlement. We will reinstate Your benefits and premiums under this policy as of the date Your entitlement ended. The reinstated coverage shall be the same as if no suspension has occurred.

**SUSPENSION OF COVERAGE WHILE ENTITLED TO BENEFITS UNDER A GROUP HEALTH PLAN:** By written notice to Us, You may request that benefits and premiums for You under this policy be suspended (for any period that may be provided by federal regulation) if You are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). Written notice must be received by Us within 90 days after the date You become entitled to coverage under the group health plan. After We have received such notice, We will return to You any portion of premiums paid for the period of suspension less any claims paid.

If Your entitlement to coverage under the group health plan ends, You must send Us written notice of the loss of such entitlement within 90 days and pay the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan. We will reinstate Your benefits and premiums under this policy as of the date Your entitlement ended. The reinstated coverage shall be the same as if no suspension had occurred.

**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 any required forms for filing proof of loss, if applicable. 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 Your loss.

**PROOF OF LOSS:** You must give written proof of loss to Us within 6 months 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 will pay all benefits then due for such loss.

**PAYMENT OF CLAIMS:** Any benefits unpaid at Your death may be paid, at Our option, either to Your beneficiary or Your estate. All other benefits will be paid to You.

If benefits are payable to Your estate or a beneficiary who cannot execute a valid release, We can pay benefits up to \$1,000.00 to someone related to You or the beneficiary 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 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.

**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.



Secretary



President

Countersigned:

Licensed Resident Agent where required by law.

**IMPORTANT NOTICE**

This notice is to advise You that, should any problems arise concerning this insurance, You may contact the following:

Consumer Service Department  
Liberty National Life Insurance Company  
P. O. Box 8080  
McKinney, Texas 75070  
Telephone: (972) 529-5085

Arkansas Insurance Department  
Consumer Services Division  
1200 West 3<sup>rd</sup> Street  
Little Rock, Arkansas 72201  
Telephone: (800) 852-5494 or  
(501) 371-2640

Agent's Name: \_\_\_\_\_

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

Telephone: \_\_\_\_\_

\_\_\_\_\_

**NOTICE TO BUYER: This policy may not cover all of Your medical expenses.**

**MEDICARE SUPPLEMENT POLICY**

**BENEFIT PLAN B**

**GUARANTEED RENEWABLE FOR LIFE. COMPANY CANNOT CANCEL POLICY. COMPANY MAY CHANGE PREMIUM RATES BY CLASS AND AS MEDICARE BENEFITS CHANGE AS PROVIDED IN THE GUARANTEED RENEWAL PROVISION.**

**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.**

**GUARANTEED RENEWAL PROVISION**

**You can renew and continue this policy in force during Your lifetime, for successive renewal terms 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 such 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 year of issue, area of the state in which You resided at issue, and underwriting group at issue for policyholders of this form in Your state.**

**The benefits provided by this policy which are designed to cover cost sharing amounts under Medicare will change automatically to coincide with any applicable changes in the deductible and/or Coinsurance amounts which You are required to pay under Medicare. The renewal premiums for this policy may change on the renewal date following the effective date of any such applicable change. Any such premium change will be based on the actuarial computations which We then use to determine the renewal premium.**

---

**POLICY SCHEDULE**

---

<b>INSURED</b>	<b>POLICY NUMBER</b>	<b>EFFECTIVE DATE</b>	<b>INITIAL TERM EXPIRES ON</b>	<b>INITIAL PREMIUM</b>
[John Doe]	[0000000]	[01-01-09]	[01-01-10]	[\$0]

**Your premiums may be increased due to unanticipated increasing health care costs for all policies in Your class.**

**If this policy is a replacement of an existing policy the “PRE-EXISTING CONDITIONS LIMITATIONS PROVISION” does not apply.**

---

## TABLE OF CONTENTS

	Page
30 Day Right to Examine Policy .....	1
Guaranteed Renewal Provision.....	1
Pre-Existing Conditions Limitations Provision.....	2
Insuring Clause.....	2
Extended Benefit Provision .....	2
Definitions .....	2
Benefits For Hospital Stays - Medicare Part A.....	4
Medicare Blood Deductible Benefit .....	4
Benefits for Medical Expense - Medicare Part B .....	4
Medicare Part A Deductible Benefit .....	4
Limitations and Exclusions .....	4
Policy Provisions .....	4
Policy Provisions - Claims .....	6

---

### PRE-EXISTING CONDITIONS LIMITATIONS PROVISION

Loss due to a Pre-Existing Condition is not covered unless the loss is incurred more than 6 months after the policy effective date.

If You have a Pre-Existing Condition and qualify for open enrollment and have had a continuous period of creditable coverage for at least 6 months, We cannot exclude coverage based on the Pre-Existing Condition. If the period of creditable coverage is less than 6 months, We will give credit for the amount of time of creditable coverage You have had towards fulfilling the Pre-Existing Condition exclusion period.

If You are an Eligible Person who applied to enroll under this Medicare supplement policy not later than 63 days after the date of the termination or disenrollment, and who submitted evidence of the date of termination or disenrollment with the application, the Pre-Existing Conditions Limitations Provision will not apply.

### THE INSURING CLAUSE

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

### EXTENDED BENEFIT PROVISION

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

### DEFINITIONS

Where used in this policy:

**BENEFIT PERIOD** means the unit of time used in the Medicare program to measure use of services and availability of services under Medicare Part A hospital insurance.

**CALENDAR YEAR** means the period beginning on each January 1 and ending on the following December 31.

**COINSURANCE AMOUNTS** means the portion of Medicare approved expense You are obligated to pay but not including the Medicare Part A inpatient hospital deductible or Part B Calendar Year deductible.

**CONTINUOUS PERIOD OF CREDITABLE COVERAGE** means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

**CREDITABLE COVERAGE** means coverage of an individual provided by any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;
5. Chapter 55 of Title 10 United States Code (CHAMPUS);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);
9. A public health plan as defined in federal regulation; and
10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

**ELIGIBLE PERSON** means a person who submits evidence of the date of termination, disenrollment, or Medicare Part D enrollment as applies under the following plans: (1) Employee Welfare Benefit Plan; (2) Medicare Advantage plan; (3) Medicare Select Plan, Medicare Risk or Cost Plan, or Medicare HMO plan; or (4) Medicare supplement policy.

**HOSPITAL** means a lawfully operated hospital which has been accredited by the Joint Commission on Accreditation of Hospitals.

**HOSPITAL STAY** means one day or more of confinement within a hospital, as a resident patient under the care of a Physician, due to 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.

**MEDICARE** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

**MEDICARE ADVANTAGE PLAN** means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; (2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and (3) Medicare Advantage private fee-for-service plans.

**MEDICARE ELIGIBLE EXPENSES** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

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

**PRE-EXISTING CONDITION** means an Injury sustained or Sickness first manifesting itself prior to the policy effective date for which medical advice or treatment was recommended or given by a Physician within 6 months prior to the policy effective date.

**SICKNESS** means illness or disease of an insured person which first manifests itself after the effective date of insurance and while this policy is in force.

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

**YOU, YOUR, YOURS and INSURED** mean the person whose name is shown in the Policy Schedule.

## **BASIC CORE BENEFITS**

### **PART 1                    BENEFITS FOR HOSPITAL STAYS - MEDICARE PART A**

We will pay the following benefits when You have a Hospital Stay for which benefits are paid by Medicare Part A:

- 1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
- 2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime reserve day used; and
- 3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

### **PART 2                    MEDICARE BLOOD DEDUCTIBLE BENEFIT**

We will pay the expense You incur for coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations), unless replaced in accordance with Federal regulations.

### **PART 3                    BENEFITS FOR MEDICAL EXPENSE - MEDICARE PART B**

If You incur a medical expense that is eligible under Medicare Part B, We will pay the following benefit for the Medicare approved charge:

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

Under this PART 3 of this policy, We will not pay benefits for (a) the Medicare Part B blood deductible for which benefits are paid under PART 2 of this policy, or (b) any portion of the Medicare Part B Calendar Year deductible.

## **ADDITIONAL BENEFITS**

### **PART 4                    MEDICARE PART A DEDUCTIBLE BENEFIT**

We will pay the expense You incur for all of the Medicare Part A Inpatient hospital deductible amount per Benefit Period.

### **PART 5                    LIMITATIONS AND EXCLUSIONS**

We will not pay benefits under this policy for:

- 1) Any expense which You are not legally obligated to pay; or
- 2) Any services that are not medically necessary as determined by Medicare or are not furnished at the direction of and under the supervision of a Physician; or
- 3) Any portion of any expense for which payment is made by Medicare; or
- 4) Custodial or intermediate level care, or rest cures; or
- 5) Any type of expense not eligible for coverage under Medicare.

## **POLICY PROVISIONS**

**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 on 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.

Upon Your death, We will refund any premiums paid in Your behalf, for any period beyond the ending of the policy month the death occurred, within 30 days after We receive proof of death.

If death is due to Injury and this policy provides for the refund of premiums for death due to Injury, only one benefit will be paid, the largest.

**ENTIRE CONTRACT; CHANGES:** This policy, with the application and attached papers, is the entire contract between You and Us. No change in this policy will 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 6 months from the effective date will be reduced or denied because a Sickness or physical condition had existed before the effective date of this policy.

**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 (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.

**SUSPENSION OF COVERAGE WHILE ENTITLED TO MEDICAID:** By written notice to Us, You may request that benefits and premiums for You under this policy be suspended for the period in which You have been determined to be entitled to Medicaid. Written notice must be received by Us within 90 days after the date You become entitled to Medicaid. After We have received such notice, We will return to You any portion of premiums paid for the period of suspension less any claims paid. The suspension period shall not exceed 24 months.

If Your entitlement to Medicaid ends, You must send Us written notice of the loss of such entitlement within 90 days and pay the premium attributable to the period, effective as of the date of termination of entitlement. We will reinstate Your benefits and premiums under this policy as of the date Your entitlement ended. The reinstated coverage shall be the same as if no suspension has occurred.

**SUSPENSION OF COVERAGE WHILE ENTITLED TO BENEFITS UNDER A GROUP HEALTH PLAN:** By written notice to Us, You may request that benefits and premiums for You under this policy be suspended (for any period that may be provided by federal regulation) if You are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). Written notice must be received by Us within 90 days after the date You become entitled to coverage under the group health plan. After We have received such notice, We will return to You any portion of premiums paid for the period of suspension less any claims paid.

If Your entitlement to coverage under the group health plan ends, You must send Us written notice of the loss of such entitlement within 90 days and pay the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan. We will reinstitute Your benefits and premiums under this policy as of the date Your entitlement ended. The reinstated coverage shall be the same as if no suspension had occurred.

**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 any required forms for filing proof of loss, if applicable. 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 Your loss.

**PROOF OF LOSS:** You must give written proof of loss to Us within 6 months 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 will pay all benefits then due for such loss.

**PAYMENT OF CLAIMS:** Any benefits unpaid at Your death may be paid, at Our option, either to Your beneficiary or Your estate. All other benefits will be paid to You.

If benefits are payable to Your estate or a beneficiary who cannot execute a valid release, We can pay benefits up to \$1,000.00 to someone related to You or the beneficiary 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 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.

**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.



Secretary



President

Countersigned:

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

**IMPORTANT NOTICE**

This notice is to advise You that, should any problems arise concerning this insurance, You may contact the following:

**Consumer Service Department  
Liberty National Life Insurance Company  
P. O. Box 8080  
McKinney, Texas 75070  
Telephone: (972) 529-5085**

**Arkansas Insurance Department  
Consumer Services Division  
1200 West 3<sup>rd</sup> Street  
Little Rock, Arkansas 72201  
Telephone: (800) 852-5494 or  
(501) 371-2640**

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

**Agent's Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

\_\_\_\_\_