

SERFF Tracking Number: AMLC-126162719 State: Arkansas  
 Filing Company: Liberty National Life Insurance Company State Tracking Number: 42943  
 Company Tracking Number: LMMGAP  
 TOI: H15I Individual Health - Sub-TOI: H15I.001 Health - Hospital/Surgical/Medical  
 Hospital/Surgical/Medical Expense Expense  
 Product Name: Limited Benefit Hospital and Surgical Expense Policy  
 Project Name/Number: Limited Benefit Hospital and Surgical Expense Policy/LMMGAP

## Filing at a Glance

Company: Liberty National Life Insurance Company

Product Name: Limited Benefit Hospital and Surgical Expense Policy SERFF Tr Num: AMLC-126162719 State: ArkansasLH

TOI: H15I Individual Health - Hospital/Surgical/Medical Expense SERFF Status: Closed State Tr Num: 42943

Sub-TOI: H15I.001 Health - Hospital/Surgical/Medical Expense Co Tr Num: LMMGAP State Status: Approved-Closed

Filing Type: Form/Rate Co Status: Reviewer(s): Rosalind Minor  
 Author: Mary Johnson Disposition Date: 07/23/2009  
 Date Submitted: 07/17/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

## General Information

Project Name: Limited Benefit Hospital and Surgical Expense Policy

Project Number: LMMGAP

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 07/23/2009

Deemer Date:

Filing Description:

Attached for your review and approval is the captioned Limited Benefit Hospital and Surgical Expense Policy Form LMMGAP that will be offered as an individual plan as well as a family plan to persons age 0-63 who currently have a Primary Medical Policy. We will pay benefits at the rate of 100% of any deductible, coinsurance and copays for which you or a covered family member are obligated to pay under their Primary Medical Policy, not to exceed the Maximum

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 07/23/2009

Corresponding Filing Tracking Number:

SERFF Tracking Number: AMLC-126162719 State: Arkansas  
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Annual Benefit each calendar year for inpatient Hospital Stays covered under the Primary Medical Policy.

Optional Hospital Outpatient Rider R-LMMGAP-HO is also being filed for approval for use with this product and will pay benefits equal to 50% of any deductible, coinsurance, and copays for which an Insured is responsible under their Primary Medical Policy, up to the Maximum Annual Benefit each calendar year for Outpatient Hospital services covered under the Primary Medical Policy.

Application(s) and Optional Dependent Form(s) LMGAPB(03)/LMGAPB-ODF will be used with Policy form LMMGAP.

These forms have been completed in John Doe fashion. The forms do not contain any unusual or unorthodox provisions or wording.

The Outline of Coverage and Actuarial Memorandum and rates for these forms are also attached.

These forms are being submitted for use in our underage health portfolio and will not replace any previously approved forms. They will be marketed through licensed agents.

## Company and Contact

### Filing Contact Information

Mary Johnson, Compliance Analyst mjohnson@torchmarkcorp.com  
3700 S. Stonebridge Drive (214) 544-5335 [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  
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## Filing Fees



SERFF Tracking Number: AMLC-126162719 State: Arkansas  
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## Correspondence Summary

### Dispositions

| Status          | Created By     | Created On | Date Submitted |
|-----------------|----------------|------------|----------------|
| Approved-Closed | Rosalind Minor | 07/23/2009 | 07/23/2009     |

### 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 | Rosalind Minor | 07/22/2009 | 07/22/2009     | Mary Johnson     | 07/22/2009 | 07/22/2009     |

### Amendments

| Item  | Schedule | Created By   | Created On | Date Submitted |
|-------|----------|--------------|------------|----------------|
| Rider | Form     | Mary Johnson | 07/17/2009 | 07/17/2009     |



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| <b>Item Type</b>           | <b>Item Name</b>                                     | <b>Item Status</b> | <b>Public Access</b> |
|----------------------------|--|--------------------|----------------------|
| <b>Supporting Document</b> | Flesch Certification                                 | Approved-Closed    | Yes                  |
| <b>Supporting Document</b> | Application  | Approved-Closed    | Yes                  |
| <b>Supporting Document</b> | Health - Actuarial Justification                     | Approved-Closed    | No                   |
| <b>Supporting Document</b> | Outline of Coverage                                  | Approved-Closed    | Yes                  |
| <b>Form (revised)</b>      | Limited Benefit Hospital and Surgical Expense Policy | Approved-Closed    | Yes                  |
| <b>Form</b>                | Limited Benefit Hospital and Surgical Expense Policy | Replaced           | Yes                  |
| <b>Form</b>                | Outline of Coverage                                  | Approved-Closed    | Yes                  |
| <b>Form</b>                | Application  | Approved-Closed    | Yes                  |
| <b>Form</b>                | Application Other Dependents                         | Approved-Closed    | Yes                  |
| <b>Form (revised)</b>      | Rider  | Approved-Closed    | Yes                  |
| <b>Form</b>                | Rider  | Replaced           | Yes                  |
| <b>Rate</b>                | Rates  | Approved-Closed    | Yes                  |

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 07/22/2009  
Submitted Date 07/22/2009

Respond By Date

Dear Mary Johnson,

This will acknowledge receipt of the captioned filing.

Objection 1

- Limited Benefit Hospital and Surgical Expense Policy (Form)

Comment:

The language under "Refund of Unearned Premiums on Death" state that upon the death of a FAMILY MEMEBER INSURED under this policy. Our law, ACA 23-85-134, state that upon the death of an insured. Please change your language in the policy to reflect the language of the law.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 07/22/2009  
Submitted Date 07/22/2009

Dear Rosalind Minor,

### Comments:

Thank you for your current review process of the above noted filing submission

### Response 1

Comments: As instructed in accordance to AR regulation ACA 23-85-134, the Unearned Premium Provision has been adjusted according to the cited regulation.

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**Related Objection 1**

Applies To:

- Limited Benefit Hospital and Surgical Expense Policy (Form)

Comment:

The language under "Refund of Unearned Premiums on Death" state that upon the death of a FAMILY MEMEBER INSURED under this policy. Our law, ACA 23-85-134, state that upon the death of an insured. Please change your language in the policy to reflect the language of the law.

**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 |
|--|-------------|--------------|---------------------------------------|---------|----------------------|-------------------|-----------------|
| Limited Benefit Hospital and Surgical Expense Policy | LMMGAP      |              | Policy/Contract/Fraternal Certificate | Initial |                      | 51                | LMMGAP-AR.pdf   |
| <b>Previous Version</b>                              |             |              |                                       |         |                      |                   |                 |
| Limited Benefit Hospital and Surgical Expense Policy | LMMGAP      |              | Policy/Contract/Fraternal Certificate | Initial |                      | 51                | LMMGAP-AR.pdf   |

No Rate/Rule Schedule items changed.

Thank you

Sincerely,  
 Mary Johnson

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**Amendment Letter**

Amendment Date:  
 Submitted Date: 07/17/2009

**Comments:**  
 The form type for the rider had to be changed

**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     |
|-------------|--|-----------|---------|-------------------|-------------------|-----------------|-------------------|-----------------|
| R-LMMGAP-HO | Certificate Amendment, Insert Page, Endorsement or Rider | Rider     | Initial |                   |                   |                 | 58                | R-LMMGAP-HO.pdf |

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## Form Schedule

Lead Form Number: LMMGAP

| Review Status   | Form Number | Form Type  | Form Name  | Action  | Action Specific Data | Readability | Attachment      |
|-----------------|-------------|--|--|---------|----------------------|-------------|-----------------|
| Approved-Closed | LMMGAP      | Policy/Contract  | Limited Benefit Hospital and Surgical Expense Policy Certificate | Initial |                      | 51          | LMMGAP-AR.pdf   |
| Approved-Closed | DS-LMMGAP   | Outline of Coverage                                      | Outline of Coverage  | Initial |                      | 56          | DS-LMMGAP.pdf   |
| Approved-Closed | LMGAPB(03)  | Application/Enrollment Form                              | Application  | Initial |                      | 51          | LMGAPB(03).pdf  |
| Approved-Closed | LMGAPB-ODF  | Application/Enrollment Form                              | Application Other Dependents                                     | Initial |                      | 51          | LMGAPB-ODF.pdf  |
| Approved-Closed | R-LMMGAP-HO | Certificate Amendment, Insert Page, Endorsement or Rider | Rider  | Initial |                      | 58          | R-LMMGAP-HO.pdf |

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

**LIBERTY NATIONAL LIFE INSURANCE COMPANY  
P. O. BOX 8080, MCKINNEY, TEXAS 75070 (972) 529-5085  
A LEGAL RESERVE STOCK COMPANY \* ADMINISTRATIVE OFFICES: MCKINNEY, TEXAS**

**30 DAY RIGHT TO EXAMINE POLICY**

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

**RENEWAL AGREEMENT**

YOU can continue this policy in force for successive renewal terms of 1 month, 3 months, 6 months or 12 months by paying appropriate renewal premiums before the end of the grace period. The appropriate renewal premiums will be those under OUR applicable table of premium rates that is in effect on the respective due dates of the premiums. WE have the right to change the renewal premiums for this policy when WE change, and in accordance with, OUR table of premium rates applicable to all policies of this form and class. Class is based on benefit amount, persons covered under the policy, benefit structure of the PRIMARY MEDICAL POLICY, state of issue, age at issue, gender, underwriting group and geographic rating area. WE also have the right to change the renewal premiums for this policy when the benefit structure of YOUR PRIMARY MEDICAL POLICY changes, in accordance with the table of premium rates applicable to all policies of this form and class.

**BENEFIT SCHEDULE**

MAXIMUM ANNUAL BENEFIT.....\$ [2,000.00]

THE COMBINED TOTAL BENEFITS PER COVERED PERSON PAYABLE UNDER THIS POLICY INCLUDING THE ADDITIONAL BENEFIT RIDERS, IF ANY, SHALL NEVER EXCEED THE MAXIMUM ANNUAL BENEFIT PER CALENDAR YEAR.

**POLICY SCHEDULE**

| INSURED    | POLICY NUMBER | EFFECTIVE DATE | INITIAL TERM EXPIRES ON | INITIAL PREMIUM |
|------------|---------------|----------------|-------------------------|-----------------|
| [John Doe] | [12346789]    | [08-01-09]     | [09-01-09]              | [\$44.00]       |

**ADDITIONAL BENEFITS**

[HOSPITAL Outpatient]

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

## INSURING CLAUSE

The COMPANY insures YOU against specified losses incurred by a COVERED PERSON. Benefits payable under this policy, subject to all of its provisions, limitations and exclusions, will be paid to YOU or, at OUR option, to the HOSPITAL, PHYSICIAN, or person providing any care, treatment, service, or supply covered by this policy. OUR obligation to make payment under this policy during any calendar year shall not exceed the MAXIMUM ANNUAL BENEFIT disclosed in the Benefit Schedule. A benefit will only be due and payable when a COVERED PERSON is obligated to pay a deductible, coinsurance or copayment under any PRIMARY MEDICAL POLICY providing benefits to such COVERED PERSON that is incurred for any covered care, treatment, service, or supply, or combination thereof, provided to or for a COVERED PERSON while this policy is in force. A deductible, coinsurance or copayment is incurred on the date the care, treatment, service, or supply is provided.

## PRE-EXISTING CONDITION LIMITATION

This policy does not insure YOU against loss incurred by any COVERED PERSON during the twelve (12) months immediately after the Effective Date of this policy if that loss results from a PRE-EXISTING CONDITION. In addition, any PRE-EXISTING CONDITION listed on the application is not covered for the first twelve (12) months after the policy Effective Date.

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## DEFINITIONS

Where used in this policy:

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

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

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

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

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

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

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

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

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

**INTENSIVE CARE** means care which is provided within a separate area or unit of a HOSPITAL that has been set aside for care of the critically ill or injured. The area or unit must have special monitoring equipment for the use of PHYSICIANS,

nurses or other medical specialists assisting in these units. INTENSIVE CARE does not include: step down, isolation, telemetry, or post INTENSIVE CARE units of a HOSPITAL.

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

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

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

**MAXIMUM ANNUAL BENEFIT** means the maximum sum of money that is payable by US for each COVERED PERSON under the provisions of this policy, including any rider whenever made a part of this policy, for the care, treatment, services and supplies provided to or for the COVERED PERSON during a calendar year.

**MEDICAL FOOD** means a food that is:

1. Intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles; and
2. Formulated to be consumed or administered enterally under the direction of a PHYSICIAN.

**MEDICALLY NECESSARY** means:

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

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

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

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

**PHYSICIAN and DOCTOR** mean a person duly licensed in the United States and duly qualified to provide care, treatment, services, or supplies for the INJURY or SICKNESS that is the subject of YOUR claim, or for the additional conditions or disorder, or diagnostic services, which are specifically covered under PART 3 of this policy. PHYSICIAN or DOCTOR does not include YOU or any member of YOUR immediate family.

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

**PRIMARY MEDICAL POLICY** means a comprehensive or basic medical insurance providing coverage for care, treatment, services and supplies provided by a HOSPITAL or PHYSICIAN. If a COVERED PERSON is enrolled in Medicare, then Medicare is such COVERED PERSON'S PRIMARY MEDICAL POLICY.

**SICKNESS** means a medical condition, illness, disease or disorder requiring medical diagnosis, care, advice or treatments which first manifests itself after the Effective Date of the policy and while this policy is in force. A medical condition, illness, disease, or disorder is "manifested" when it is diagnosed by a PHYSICIAN, or whenever the COVERED PERSON begins experiencing any symptom or sign of the medical condition, illness, disease, or disorder.

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

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

## **PART 1**

### **HOSPITAL INPATIENT BENEFIT**

WE will pay a benefit at the rate of 100% of any deductible, coinsurance and copayments which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY for MEDICALLY NECESSARY care, treatment, services and supplies provided by a HOSPITAL or PHYSICIAN to or for YOU or a covered FAMILY MEMBER during a necessary INPATIENT HOSPITAL STAY. Any such INPATIENT HOSPITAL STAY must be covered under the PRIMARY MEDICAL POLICY and must be the result of an INJURY or SICKNESS.

**The total benefits payable under this PART 1 for all INPATIENT HOSPITAL STAYS of any one COVERED PERSON during any one calendar year shall not exceed the MAXIMUM ANNUAL BENEFIT stated in the Benefit Schedule less all benefits paid under PART 3 together with all benefits paid under any riders selected and made a part of this policy.**

When filing a claim YOUR Proof of Loss to US must include the Explanation of Benefits provided pursuant to the PRIMARY MEDICAL POLICY or other documentation showing dollar amounts that YOU or a covered FAMILY MEMBER are obligated to pay under the PRIMARY MEDICAL POLICY.

## **PART 2 REFUND OF PREMIUMS FOR LOSS OF LIFE FROM INJURY**

WE will refund to YOUR estate the premiums paid for YOUR individual coverage under this policy if YOU die due to an INJURY while YOUR coverage is in force or effect. WE will refund to YOU the premiums paid under this policy for the coverage of a covered FAMILY MEMBER if that member dies due to an INJURY while his or her coverage under this policy is in force or effect.

To be entitled to said refund of premium, the death must occur while this policy is in force and within 180 days of the INJURY causing death.

## **PART 3 OTHER BENEFITS**

On the condition that a benefit for the following care, treatment, services, and supplies is not elsewhere provided in this policy, including any rider whenever made a part of this policy, WE will pay a benefit for the following care, treatment, services, and supplies provided to or for a COVERED PERSON while this policy is in force according to the terms, dollar amounts and maximums set forth below in this PART 3 with respect to such covered care, treatment, services, and supplies. ALL BENEFITS PAYABLE UNDER THIS PART 3 SHALL BE SUBJECT TO ALL POLICY PROVISIONS, LIMITATIONS AND EXCLUSIONS, AND DOLLAR-LIMIT PROVISIONS OF THIS POLICY, EXCEPT AS OTHERWISE SPECIFICALLY PROVIDED IN THIS PART 3. A benefit payable under this PART 3 shall not duplicate any benefit or benefits payable under PART 1 of this policy or any benefit rider made a part of this policy.

**The total benefits payable under this PART 3 for all care, treatment, services, and supplies provided to any one COVERED PERSON during any one calendar year shall not exceed the MAXIMUM ANNUAL BENEFIT stated in the Benefit Schedule less all benefits paid under PART 1 together with all benefits paid under any riders selected and made a part of this policy.**

When filing a claim YOUR Proof of Loss to US must include the Explanation of Benefits provided pursuant to the PRIMARY MEDICAL POLICY or other documentation showing dollar amounts that YOU or a covered FAMILY MEMBER are obligated to pay under the PRIMARY MEDICAL POLICY.

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

As described in PART 4(3), this policy does not provide benefits for normal pregnancy. However, for an INPATIENT HOSPITAL STAY for which benefits are otherwise provided under this policy to a COVERED PERSON for a distinct complication of pregnancy, WE will pay a benefit for an INPATIENT HOSPITAL STAY and inpatient care for a minimum of forty-eight (48) hours of inpatient care following vaginal delivery and a minimum of ninety-six (96) hours of inpatient care following a cesarean section for a mother, her newly born child, or both, in a HOSPITAL or any other health care facility licensed to provide obstetrical care, when that INPATIENT HOSPITAL STAY is deemed MEDICALLY NECESSARY by the attending PHYSICIAN, who is a medical doctor. Such benefit will be paid at the rate of 100% of any deductible, coinsurance and copayments for which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY not to exceed the MAXIMUM ANNUAL BENEFIT.

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

Where coverage is provided to or for a COVERED PERSON under a PRIMARY MEDICAL POLICY for Breast Reconstructive Surgery and Prosthetic Device, WE will pay a benefit at the rate of 100% of any deductible, coinsurance and copayments for which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY for prosthetic devices, breast reconstructive surgery, or both, for a COVERED PERSON incident to a MASTECTOMY covered under this policy, including:

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

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

Where the PRIMARY MEDICAL POLICY does not provide any coverage for treatment and services for Breast Reconstructive Surgery and Prosthetic Device, WE will pay a sum equal to 20% of the incurred expenses not to exceed a maximum benefit of \$500 for all such treatment and services for Breast Reconstructive Surgery and Prosthetic Device provided to or for any one COVERED PERSON during any one calendar year.

### **3. CHILD PREVENTIVE HEALTH CARE SERVICES BENEFIT**

Where coverage is provided to or for a COVERED PERSON under a PRIMARY MEDICAL POLICY for Child Preventive Health Care Services, WE will pay a benefit at the rate of 100% of any deductible, coinsurance and copayments for which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY for expenses incurred by YOU or a covered FAMILY MEMBER for PERIODIC PREVENTIVE CARE VISITS related to CHILD PREVENTIVE HEALTH CARE SERVICES for a COVERED PERSON when that COVERED PERSON attains the following ages: birth, two weeks, two months, four months, six months, nine months, twelve months, fifteen months, eighteen months, two years, three years, four years, five years, six years, eight years, ten years, twelve years, fourteen years, sixteen years and eighteen years. CHILD PREVENTIVE HEALTH CARE SERVICES shall be limited to services provided by or under the supervision of a single PHYSICIAN or other primary health care provider who is a licensed medical doctor or doctor of osteopathy during the course of one visit.

Where the PRIMARY MEDICAL POLICY does not provide any coverage for treatment and services for Child Preventive Health Care Services, WE will pay a sum equal to 80% of the incurred expenses not to exceed a maximum benefit of \$250 for all such treatment and services for Child Preventive Health Care Services provided to or for any one COVERED PERSON during any one calendar year.

This benefit will be subject to copayment, coinsurance, deductible, or dollar limit provisions.

### **4. DIABETES BENEFIT**

Where coverage is provided to or for a COVERED PERSON under a PRIMARY MEDICAL POLICY for Diabetes, WE will pay a benefit at the rate of 100% of any deductible, coinsurance and copayments for which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY for expenses incurred by a COVERED PERSON for medically appropriate and necessary equipment, supplies, diabetes outpatient self-management training and educational services, or any combination thereof, used in the management and treatment of diabetes for persons with gestational, type I or type II diabetes, if the COVERED PERSON'S treating PHYSICIAN or a PHYSICIAN who specializes in the treatment of diabetes certifies that such services are necessary.

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

Where the PRIMARY MEDICAL POLICY does not provide any coverage for treatment and services for Diabetes, WE will pay a sum equal to 20% of the incurred expenses not to exceed a maximum benefit of \$1,500 for all such treatment and services for Diabetes provided to or for any one COVERED PERSON during any one calendar year.

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

Where coverage is provided to or for a COVERED PERSON under a PRIMARY MEDICAL POLICY for Anesthesia and Hospitalization for Dental Procedures, WE will pay a benefit at the rate of 100% of any deductible, coinsurance and copayments for which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY for general anesthesia, HOSPITAL charges, or both for dental care charges incurred in a HOSPITAL or AMBULATORY SURGICAL CENTER when the procedure is performed by (i) a fully accredited specialist in pediatric dentistry or other dentist fully accredited in a recognized dental specialty for which HOSPITAL or AMBULATORY SURGICAL CENTER privileges are granted; (ii) a dentist who is certified by virtue of completion of an accredited program of postgraduate training to be granted HOSPITAL or AMBULATORY SURGICAL CENTER privileges; or (iii) a dentist who has not yet satisfied certification requirements but has been granted HOSPITAL or AMBULATORY SURGICAL CENTER privileges; and when the COVERED PERSON receiving such treatment:

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

Where the PRIMARY MEDICAL POLICY does not provide any coverage for treatment and services for Anesthesia and Hospitalization for Dental Procedures, WE will pay a sum equal to 20% of the incurred expenses not to exceed a maximum benefit of \$100 for all such treatment and services for Anesthesia and Hospitalization for Dental Procedures provided to or for any one COVERED PERSON during any one calendar year.

This benefit does not cover routine dental care, including the diagnosis or treatment of disease or other dental conditions and procedures not specifically covered under this subpart of PART 3.

#### **6. SPEECH AND HEARING DISORDERS BENEFIT**

Where coverage is provided to or for a COVERED PERSON under a PRIMARY MEDICAL POLICY for Speech and Hearing Disorders, WE will pay a benefit at the rate of 100% of any deductible, coinsurance and copayments for which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY for the expenses incurred for MEDICALLY NECESSARY care and treatment of loss or impairment of speech or hearing, or both if treated by a speech pathologist, audiologist or speech language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association or both, and which fall within the scope of their license or certification. This benefit does not cover hearing aids, instruments or devices.

Where the PRIMARY MEDICAL POLICY does not provide any coverage for treatment and services for Speech and Hearing Disorders, WE will pay a sum equal to 20% of the incurred expenses not to exceed a maximum benefit of \$1,000 for all such treatment and services for Speech and Hearing Disorders provided to or for any one COVERED PERSON during any one calendar year.

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

Where coverage is provided to or for a COVERED PERSON under a PRIMARY MEDICAL POLICY for Medical Foods and Low Protein Modified Food Products, WE will pay a benefit at the rate of 100% of any deductible, coinsurance and copayments for which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY for the expense incurred for MEDICAL FOODS, LOW PROTEIN MODIFIED FOOD PRODUCTS, amino acid modified preparations and any other special dietary products and formulas for the treatment of INHERITED METABOLIC DISEASES if the MEDICAL FOODS or LOW PROTEIN MODIFIED FOOD PRODUCTS, amino acid modified preparations and other special dietary products and formulas are prescribed as MEDICALLY NECESSARY for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias and disorders of amino acid metabolism, and administered under the direction of a PHYSICIAN.

Where the PRIMARY MEDICAL POLICY does not provide any coverage for treatment and services for Medical Foods and Low Protein Modified Food Products, WE will pay a sum equal to 20% of the incurred expenses not to exceed a maximum benefit of \$2,400 for all such treatment and services for Medical Foods and Low Protein Modified Food Products provided to or for any one COVERED PERSON during any one calendar year.

#### **8. COLORECTAL CANCER SCREENING BENEFIT**

Where coverage is provided to or for a COVERED PERSON under a PRIMARY MEDICAL POLICY for Colorectal Cancer Screening, WE will pay a benefit at the rate of 100% of any deductible, coinsurance and copayments for which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY for the expense incurred for colorectal cancer examinations and laboratory tests for a COVERED PERSON who is 50 years of age or older, at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005, or experiencing the symptoms of colorectal cancer as determined by a PHYSICIAN licensed under the Arkansas Medical Practices Act, §17-95-201 et seq., §17-95-301 et seq., and §17-95-401 et seq., including bleeding from the rectum or blood in the stool, or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool that lasts more than five (5) days. The colorectal screening shall involve an examination of the entire colon, and WE will provide a benefit for colorectal cancer screening for any one of the following options:

- 1) An annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;
- 2) A double-contrast barium enema every five (5) years; or
- 3) A colonoscopy every ten (10) years, and follow-ups based on the following schedule:
  - i. If the initial colonoscopy is normal, a follow-up is covered once every ten (10) years;
  - ii. For individuals with one (1) or more neoplastic polyps, adenomatous polyps, and the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps was performed, a follow-up will be covered after three (3) years;
  - iii. If single tubular adenoma of less than one centimeter (1 cm) is found, a follow-up will be covered after five (5) years; and

- iv. For patients with large sessile adenomas greater than three centimeters (3 cm), a follow-up will be covered after six (6) months, or continuously until complete polyp removal is verified by colonoscopy.
- 4) Any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health determined in consultation with appropriate health care organizations.

Where the PRIMARY MEDICAL POLICY does not provide any coverage for treatment and services for Colorectal Cancer Screening, WE will pay a sum equal to 20% of the incurred expenses not to exceed a maximum benefit of \$1,000 for all such treatment and services for Colorectal Cancer Screening provided to or for any one COVERED PERSON during any one calendar year.

#### **9. MENTAL ILLNESS BENEFIT**

Where coverage is provided to or for a COVERED PERSON under a PRIMARY MEDICAL POLICY for Mental Illness, WE will pay a benefit at the rate of 100% of any deductible, coinsurance and copayments for which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY for expenses incurred for a COVERED PERSON for the treatment of MENTAL ILLNESS on an inpatient or outpatient basis. Benefits will be provided to the same extent as any other physical illness covered under this policy.

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

Where coverage is provided to or for a COVERED PERSON under a PRIMARY MEDICAL POLICY for Temporomandibular Joint Disorder and Craniomandibular Jaw Disorder, WE will pay a benefit at the rate of 100% of any deductible, coinsurance and copayments for which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY for the treatment and care provided to or for a COVERED PERSON for the diagnostic procedure and surgical treatment of temporomandibular and craniomandibular disorder if, under accepted medical standards, such diagnostic procedure or surgery is MEDICALLY NECESSARY to treat conditions caused by a congenital or developmental deformity, disease, disorder, or INJURY. A temporomandibular and craniomandibular disorder shall be considered to be a SICKNESS under this policy, and benefits will be paid under PART 1 as applicable. However, this policy does not include coverage for orthodontic appliances and treatment, crowns, bridges and dentures unless the disorder is trauma related.]

### **PART 4**

### **LIMITATIONS AND EXCLUSIONS**

WE will not pay benefits under this policy for:

1. Services not covered under the PRIMARY MEDICAL POLICY; or
2. Expenses in excess of benefit limits or maximums in the PRIMARY MEDICAL POLICY; or
3. Normal pregnancy (including childbirth, false labor, occasional spotting, PHYSICIAN-prescribed rest, morning SICKNESS, hyper emesis gravidarum, preeclampsia and similar conditions associated with a difficult pregnancy which do not constitute a distinct complication of pregnancy) or voluntary termination of pregnancy; or
4. Usual and customary routine nursery care, or well-baby care or immunizations; or any other usual and customary routine care and treatment following full term or premature birth, not incident and necessary to the treatment of INJURY or SICKNESS; or
5. Convalescent, skilled nursing, educational care or for nervous or mental disorders, unless covered by YOUR PRIMARY MEDICAL POLICY; or
6. Dental treatment, hearing aids or eye refractive exams, refractive surgery or refractive treatment; or
7. Any INPATIENT HOSPITAL STAY or other service for which YOU or a FAMILY MEMBER do not incur a charge; or
8. Any loss paid by any Workmen's Compensation or Employers' Liability Law; or
9. Any INPATIENT HOSPITAL STAY or other service that is not MEDICALLY NECESSARY, or is cosmetic in nature; or
10. Any expense incurred in excess of the usual, customary and regular charges for any service or materials in the geographic area where furnished; or
11. Charges incurred for professional radiological, pathological or EKG interpretations, unless covered by YOUR PRIMARY MEDICAL POLICY; or
12. Rehabilitative care services received at a facility not meeting the definition of a HOSPITAL, unless covered by YOUR PRIMARY MEDICAL POLICY; or
13. Treatment or services incurred outside of the U.S. boundaries; or
14. Infertility or sterilization treatment procedures, unless covered by YOUR PRIMARY MEDICAL POLICY.

### **POLICY PROVISIONS**

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

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

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

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

In the event of YOUR death or other termination of YOUR coverage, the following shall successively become the INSURED: (1) YOUR spouse (if YOUR spouse is a FAMILY MEMBER); or (2) YOUR eldest remaining FAMILY MEMBER.

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

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

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

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

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

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

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

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

**GRACE PERIOD:** This policy 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.

**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. When filing a claim, it is necessary to submit the Explanation of Benefits provided by YOUR PRIMARY MEDICAL POLICY, or other documentation showing amounts for which YOU are responsible for under the PRIMARY MEDICAL POLICY.

An Explanation of Benefits from YOUR PRIMARY MEDICAL POLICY or other documentation of deductible, coinsurance or copayments is necessary to determine benefits under this policy.

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

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

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

**PAYMENT OF CLAIMS:** Benefits will be paid, after WE receive a claim form and proper written Proof Of Loss satisfactory to US, to YOU unless YOU assign them to the DOCTOR or HOSPITAL. Any benefit unpaid at death will be paid to YOUR named beneficiary or, at OUR option, to YOUR estate. If benefits are payable to YOUR estate, WE can pay benefits up to \$3,000 to someone related to YOU by blood or marriage whom WE consider to be entitled to the benefits. WE will be discharged to the extent of any such payment made in good faith.

**PHYSICAL EXAMINATIONS:** WE, at OUR expense, have the right to have YOU or a FAMILY MEMBER examined as often as reasonably necessary while a claim is pending.

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

**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.

**REFUND OF UNEARNED PREMIUMS ON DEATH:** Upon the death of the INSURED under this policy, WE will refund any premiums paid on behalf of the insured to his or her estate, for any period beyond the ending of the policy month the death occurred, within 30 days after WE receive proof of death.

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



Secretary



President

**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  
3700 S Stonebridge Drive  
McKinney, Texas 75070  
Telephone: (972) 529-5085

Arkansas Insurance Department  
Consumer Services Division  
1200 West 3<sup>rd</sup> Street  
Little Rock, Arkansas 72201-1904  
Telephone: (501)371-2600

Agent's Name: \_\_\_\_\_ Agent's Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_

**LIBERTY NATIONAL LIFE INSURANCE COMPANY  
P. O. BOX 8080, MCKINNEY, TEXAS 75070 (972) 529-5085  
A LEGAL RESERVE STOCK COMPANY \* ADMINISTRATIVE OFFICES: MCKINNEY, TEXAS**

**OUTLINE OF COVERAGE - POLICY FORM LMMGAP**

Retain This Form For Your Records.

**LIMITED BENEFIT HOSPITAL AND SURGICAL EXPENSE POLICY  
For Persons Who Currently Have a Primary Medical Policy**

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

**Limited Benefit Hospital and Surgical Expense Policy Form LMMGAP** – This policy is designed to provide persons age 0-63 who currently have a Primary Medical Policy (a comprehensive or basic medical insurance providing coverage for care, treatment, services and supplies provided by a Hospital or Physician) with additional coverage for certain hospital and surgical expenses incurred as a result of a covered Injury or Sickness. Coverage is provided for certain deductibles, coinsurance and copayments for which You or a covered Family Member are obligated to pay under a Primary Medical Policy, subject to any limitations and exclusions set forth in the policy for which You are applying. Coverage is not provided for unlimited hospital or medical surgical expenses. **While this Outline of Coverage includes choices associated with the Maximum Annual Benefit and optional riders. Your policy Benefit Schedule will reflect Your chosen Maximum Annual Benefit amount and optional riders, as applied for and issued.**

**BENEFITS** - Eligible deductibles, coinsurance and copayments which You or a covered family member are obligated to pay under a Primary Medical Policy. Benefits listed below are subject to the Maximum Annual Benefit amount shown in Your policy Benefit Schedule.

**MAXIMUM ANNUAL BENEFIT** [\$2,000, \$2,500, \$3,000, \$4,000, \$5,000, \$6000, \$7000, \$7,500 or \$10,000]

The combined total benefits per covered person payable under this policy including the additional benefit riders, if any, shall never exceed the maximum annual benefit shown in Your policy benefit schedule per calendar year.

- 1. Hospital Inpatient Benefit** - Benefits are payable at the rate of **100%** of any deductible, coinsurance and copayments which You or a covered Family Member are obligated to pay under a Primary Medical Policy for Medically Necessary care, treatment, services and supplies provided by a Hospital or Physician to or for You or a covered Family Member during a necessary Inpatient Hospital Stay. Any such Inpatient Hospital Stay must be covered under the Primary Medical Policy and must be the result of an Injury or Sickness.
- 2. Refund of Premiums for Loss of Life from Accidental Injury** - We will refund the premiums paid for Your individual coverage under this policy if You die due to an Injury while Your coverage is in force or effect. We will refund to You the premiums paid under this policy for the coverage of a covered Family Member if that member dies due to an Injury while their coverage is in force or effect. Death must occur within 180 days of the Injury.
- 3. YOUR POLICY MAY CONTAIN OTHER BENEFITS MANDATED BY YOUR STATE. REFER TO PART 3 OF YOUR POLICY.**

## **HOSPITAL OUTPATIENT RIDER (Form R-LMMGAP-HO) OPTIONAL - Available for Additional Premium**

YOUR POLICY DOES NOT PROVIDE BENEFITS FOR OUTPATIENT SERVICES UNLESS YOU SELECTED THE OPTIONAL RIDER ON THE APPLICATION AND THE RIDER IS ISSUED. The rider expands the types of care, treatment, services and supplies for which a benefit may be payable. The rider does not increase the maximum annual benefit stated in the policy or certificate schedule.

**Hospital Outpatient Benefit (OPTIONAL)** – Benefits are payable at the rate of 50% of any deductible, coinsurance and copayments which You or a covered Family Member are obligated to pay under a Primary Medical Policy for Medically Necessary Outpatient Hospital Services provided to or for You or a covered Family Member. Any such Outpatient Hospital Services must be covered under the Primary Medical Policy and must be the result of an Injury or Sickness.

**Outpatient Hospital Services** means care, treatment, services and supplies provided by a Physician or facility for:

1. outpatient surgery in a Hospital or free-standing outpatient surgery center;
2. outpatient diagnostic testing in a Hospital or free-standing imaging facility or free-standing laboratory;
3. treatment in a Hospital emergency room; and
4. other outpatient treatment in a Hospital.

Outpatient Hospital Services shall not include care, treatment, services and supplies provided in a Doctor's office.

### **LIMITATIONS AND EXCLUSIONS**

We will not pay benefits under this policy for:

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

### **RENEWAL AGREEMENT**

You can continue this policy in force for successive renewal terms of 1 month, 3 months, 6 months or 12 months by paying appropriate renewal premiums before the end of the grace period. The appropriate renewal premiums will be those under Our applicable table of premium rates that is in effect on the respective due dates of the premiums. We have the right to change the renewal premiums for this policy when We change, and in accordance with, Our table of premium rates applicable to all policies of this form and class. Class is based on benefit amount, persons covered under the policy, benefit structure of the Primary Medical Policy, state of issue, age at issue, gender, underwriting group and geographic rating area.

We also have the right to change the renewal premiums for this policy when the benefit structure of Your Primary Medical Policy changes, in accordance with the table of premium rates applicable to all policies of this form and class.

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

**PREMIUM**

Your premium for the policy is monthly \$\_\_\_\_\_, quarterly \$ \_\_\_\_\_, semi-annually \$\_\_\_\_\_, or annually \$\_\_\_\_\_.

You pay a one time policy fee of \$\_\_\_\_\_.

Requested Effective Date (mm-dd-yyyy)

-  - 20

Payment Mode  Monthly  Semi-Annual  
 Quarterly  Annual

Payment Type  Bank Draft  Direct

Draft Day (01 to 28 only)

**BASE PLAN**

**Foundation Signature Series™**

- Proposed Insured  Child 1  Child 5  
 Spouse  Child 2  Child 6  
 Child 3  Child 7  
 Child 4  Child 8

**Maximum Annual Benefit**

- \$10,000  \$4,000  
 \$7,500  \$3,000  
 \$7,000  \$2,500  
 \$6,000  \$2,000  
 \$5,000

Premium

\$ ,    .

Additional Premium Included

**OPTIONAL RIDER**

**Hospital Outpatient Benefit \***

- Proposed Insured  Child 1  Child 5  
 Spouse  Child 2  Child 6  
 Child 3  Child 7  
 Child 4  Child 8

Premium

\$ ,    .

\* This rider does not increase the Maximum Annual Benefit.

**OPTIONAL LIFE INSURANCE**

**Life**

Proposed Insured

- 10 Yr. Term (18-63)  
 Whole Life (18-63)

Life Face Amount

\$ ,

Premium

\$ ,    .

Spouse

- 10 Yr. Term (18-63)  
 Whole Life (18-63)

\$ ,

\$ ,    .

**Child Term Rider**

- \$10,000  
 \$ 5,000

Total Premium \$ ,    .

Total Collected with Application \$ ,    .



**A LEGAL RESERVE STOCK COMPANY**

**IF THE ANSWER TO QUESTION 1 IS "YES" THEN CONTINUE. IF THE ANSWER IS "NO" THE PROPOSED INSURED IS NOT ELIGIBLE FOR COVERAGE.**

INSURED YES/NO SPOUSE YES/NO CHILD 1 YES/NO CHILD 2 YES/NO CHILD 3 YES/NO

1. Does the Proposed Insured or a Family Member have a Major Medical Policy or other comprehensive health coverage in force (or pending application)? Please list company, policy number and effective date (if available).  YES  NO
  2. During the past 90 days, except for minor illness of one (1) week or pregnancy, has any illness, injury or health related problem prevented the Proposed Insured or any Family Member from working full time at his/her regular occupation or performing the normal activities of a person of the same age?  YES  NO
  3. Has the Proposed Insured or any Family Member **EVER** been treated for, 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?  YES  NO
  4. Has the Proposed Insured or any Family Member **EVER** had:
    - a. a disease or disorder of the heart or circulatory system including heart attack or stroke; high blood pressure?  YES  NO
    - b. a disease or disorder of the eye, ear, nose, throat, lung, breast or reproductive organs?  YES  NO
    - c. a disease or disorder of the rectum, kidney, prostate, stomach, intestine, gall bladder, urinary bladder, liver, connective tissue, lupus, collagen disease, pancreas, pituitary or adrenal gland?  YES  NO
    - d. a disease or disorder of the brain (including retardation, dementia or Alzheimer's), mental or nervous system (including seizures or convulsions), back or spine, paralysis or arthritis?  YES  NO
    - e. cancer, tumor, diabetes, blood disorders including anemia or spleen disorder?  YES  NO
    - f. had his/her driver's license suspended or revoked because of a moving violation or been arrested for driving under the influence of alcohol or drugs?  YES  NO
    - g. received treatment for alcohol abuse or been advised by a physician to reduce alcohol consumption?  YES  NO
    - h. used or received treatment or consultation for heroin, cocaine or other similar agent or narcotic drug?  YES  NO
  5. During the past five (5) years, has the Proposed Insured or any Family Member:
    - a. Had any medical or surgical advice, treatment or operations or been advised to have medical or diagnostic test(s), procedure(s), or surgery that has not yet been performed, or is awaiting medical test results?  YES  NO
    - b. Been confined in a hospital?  YES  NO
  6. During the past two (2) years, has the Proposed Insured or any Family Member:
    - a. Had a cesarean section, miscarriage or serious complications of a previous pregnancy?  YES  NO
    - b. Been hospitalized 3 or more times?  YES  NO
    - c. Received any disability benefits?  YES  NO
  7. Does the Proposed Insured or any Family Member participate in any hazardous sports or avocations?  YES  NO  
No benefits will be provided for loss due to such participation.
  8. Does the Proposed Insured or any Family Member have any existing (or pending application for) health insurance?  YES  NO  
If "YES", list coverage type \_\_\_\_\_
  9. Does the Proposed Insured or any Family Member intend to replace or change any existing health insurance? If "YES" a replacement notice must be completed and signed.  YES  NO
  10. Have you received an outline of coverage?  YES  NO
- If Optional Life coverage is chosen, please answer the following questions.**
11. Has the Proposed Insured or Spouse used tobacco in any form within the past 12 months?  YES  NO
  12. Does the Proposed Insured or Spouse have any existing life insurance policies or annuity contract?  YES  NO
  13. Will the life insurance being applied for replace or change any existing life insurance or annuity contracts? If "YES" a replacement notice must be completed and signed.  YES  NO

SPLACEMENT



A LEGAL RESERVE STOCK COMPANY

If any Proposed Insured or any Family Member answered "Yes" to any of questions 2 - 7, provide details below for each "Yes" answer.

\* In column below list "I" for Insured, "S" for Spouse, "C1" for Child 1, "C2" for Child 2 and "C3" for Child 3.

| * | Dates | Illness/Injury | Operation? | Name/Address/Telephone of Doctors & Hospitals | Complete Recovery? |
|---|-------|----------------|------------|---|--------------------|
|   |       |                |            |   |                    |
|   |       |                |            |   |                    |
|   |       |                |            |   |                    |

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

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

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits application for insurance or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

**To the best of your knowledge as soliciting agent, is the insurance applied for intended to replace any existing life, annuity or health insurance policies or contracts?**  
 Yes  No

If "YES" a replacement notice must be completed and signed.

Date Application Signed (mm-dd-yyyy)  -  -   
 State

**Agent's Signature**  
 Last Name  Agent No.

**Proposed Insured**  
 Signed

Print First 5 Letters of Agent's Last Name  
 LMGAPB(03) SEND POLICY TO:  Agent  Insured

**Applicant (If other than the Proposed Insured)**  
 (The Policy will be sent to Insured unless otherwise instructed.)

**"Automatic" Payment Plan / Bank Draft**

Initials of Primary Insured



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

**Proposed Insured**

SS #    -   -

First Name                      M.I.

Last Name

**Child 4**

First Name                      M.I.   Male  Female Height (ft. in.)

Last Name                      Weight (lbs.)

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

I, the agent, have personally seen this person.  Yes  No

**Child 5**

First Name                      M.I.   Male  Female Height (ft. in.)

Last Name                      Weight (lbs.)

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

I, the agent, have personally seen this person.  Yes  No

**Child 6**

First Name                      M.I.   Male  Female Height (ft. in.)

Last Name                      Weight (lbs.)

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

I, the agent, have personally seen this person.  Yes  No

**Child 7**

First Name                      M.I.   Male  Female Height (ft. in.)

Last Name                      Weight (lbs.)

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

I, the agent, have personally seen this person.  Yes  No

**Child 8**

First Name                      M.I.   Male  Female Height (ft. in.)

Last Name                      Weight (lbs.)

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

I, the agent, have personally seen this person.  Yes  No

SAMPLE

Initials of Primary Insured

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

**IF THE ANSWER TO QUESTION 1 IS "YES" THEN CONTINUE. IF THE ANSWER IS "NO" THE PROPOSED INSURED IS NOT ELIGIBLE FOR COVERAGE.**

|  | CHILD 4<br>YES/NO                           | CHILD 5<br>YES/NO                           | CHILD 6<br>YES/NO                           | CHILD 7<br>YES/NO                           | CHILD 8<br>YES/NO                           |
|--|---|---|---|---|---|
| 1. Does the Proposed Insured or a Family Member have a Major Medical Policy or other comprehensive health coverage in force (or pending application)? Please list company, policy number and effective date (if available).  | <input type="radio"/> <input type="radio"/> |
| 2. During the past 90 days, except for minor illness of one (1) week or pregnancy, has any illness, injury or health related problem prevented the Proposed Insured or a Family Member from working full time at his/her regular occupation or performing the normal activities of a person of the same age? | <input type="radio"/> <input type="radio"/> |
| 3. Has the Proposed Insured or any Family Member <b>EVER</b> been treated for, 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"/> |
| 4. Has the Proposed Insured or any Family Member <b>EVER</b> had:  |   |   |   |   |   |
| a. a disease or disorder of the heart or circulatory system including heart attack or stroke; high blood pressure?   | <input type="radio"/> <input type="radio"/> |
| b. a disease or disorder of the eye, ear, nose, throat, lung, breast or reproductive organs?   | <input type="radio"/> <input type="radio"/> |
| c. a disease or disorder of the rectum, kidney, prostate, stomach, intestine, gall bladder, urinary bladder, liver, connective tissue, lupus, collagen disease, pancreas, pituitary or adrenal gland?  | <input type="radio"/> <input type="radio"/> |
| d. a disease or disorder of the brain (including retardation, dementia or Alzheimer's), mental or nervous system (including seizures or convulsions), back or spine, paralysis or arthritis?   | <input type="radio"/> <input type="radio"/> |
| e. cancer, tumor, diabetes, blood disorders including anemia or spleen disorder?   | <input type="radio"/> <input type="radio"/> |
| f. had his/her driver's license suspended or revoked because of a moving violation or been arrested for driving under the influence of alcohol or drugs?   | <input type="radio"/> <input type="radio"/> |
| g. received treatment for alcohol abuse or been advised by a physician to reduce alcohol consumption?  | <input type="radio"/> <input type="radio"/> |
| h. used or received treatment or consultation for heroin, cocaine or other similar agent or narcotic drug?   | <input type="radio"/> <input type="radio"/> |
| 5. During the past five (5) years, has the Proposed Insured or any Family Member had:  |   |   |   |   |   |
| a. Had any medical or surgical advice, treatment or operations or been advised to have medical or diagnostic test(s), procedure(s) or surgery that has not yet been performed, or is awaiting medical test results?  | <input type="radio"/> <input type="radio"/> |
| b. Been confined in a hospital?  | <input type="radio"/> <input type="radio"/> |
| 6. During the past two (2) years, has the Proposed Insured or any Family Member:   |   |   |   |   |   |
| a. Had a cesarean section, miscarriage or serious complications of a previous pregnancy?   | <input type="radio"/> <input type="radio"/> |
| b. Been hospitalized 3 or more times?  | <input type="radio"/> <input type="radio"/> |
| c. Received any disability benefits  | <input type="radio"/> <input type="radio"/> |
| 7. Does the Proposed Insured participate in any hazardous sports or avocations? No benefits will be provided for loss due to such participation.   | <input type="radio"/> <input type="radio"/> |
| 8. Does the Proposed Insured or any Family Member have any existing (or pending application for) health insurance? If "YES", List coverage type _____  | <input type="radio"/> <input type="radio"/> |
| 9. Does the Proposed Insured or any Family Member intend to replace any existing health insurance? If "YES" a replacement notice must be completed and signed.   | <input type="radio"/> <input type="radio"/> |

**If any Proposed Insured or Family Member answered "Yes" to any of questions 2 - 7, provide details below for each "Yes" answer.**

\* In column below list "C4" for Child 4, "C5" for Child 5, "C6" for Child 6, "C7" for Child 7 and "C8" for Child 8.

| * | Dates | Illness/Injury | Operation? | Name/Address/Telephone of Doctors & Hospitals | Complete Recovery? |
|---|-------|----------------|------------|---|--------------------|
|   |       |                |            |   |                    |
|   |       |                |            |   |                    |
|   |       |                |            |   |                    |



# LIBERTY NATIONAL LIFE INSURANCE COMPANY

A LEGAL RESERVE STOCK COMPANY \* ADMINISTRATIVE OFFICES: MCKINNEY, TEXAS

## HOSPITAL OUTPATIENT RIDER TO POLICY OR CERTIFICATE # \_\_\_\_\_

THIS RIDER EXPANDS THE TYPES OF CARE, TREATMENT, SERVICES AND SUPPLIES FOR WHICH A BENEFIT MAY BE PAYABLE. THIS RIDER DOES NOT INCREASE THE MAXIMUM ANNUAL BENEFIT STATED IN THE POLCY OR CERTIFICATE SCHEDULE. This rider amends and is made a part of the policy or certificate referenced in the Rider Schedule. It is subject to all provisions, conditions, limitations and exclusions of the policy or certificate which are not in direct conflict with those of this rider.

### 30-DAY RIGHT TO EXAMINE RIDER

If this rider is issued subsequent to the Effective Date of the policy or certificate described in the Rider Schedule, and if YOU are not satisfied with this rider for any reason, YOU may return it to OUR Administrative Office or to the agent within 30 days after YOU receive it. Any premium YOU paid for this rider will be refunded to YOU. In the event YOU return this rider to US, this rider will be void from its inception and it will be as if no rider ever existed between YOU and US.

**IMPORTANT NOTICE:** IF YOU COMPLETED A NEW APPLICATION TO OBTAIN THIS RIDER, A COPY IS ATTACHED TO THIS RIDER. PLEASE READ THIS APPLICATION CAREFULLY AND WRITE TO US AT THE ADDRESS SHOWN ABOVE WITHIN 10 DAYS IF ANY ANSWER OR INFORMATION SHOWN ON IT IS NOT CORRECT AND COMPLETE OR IF ANY PAST MEDICAL HISTORY HAS BEEN OMITTED FROM THE APPLICATION. THIS APPLICATION IS A PART OF THE RIDER AND THE RIDER WAS ISSUED ON THE BASIS THAT ALL INFORMATION AND ANSWERS TO ALL QUESTIONS SHOWN ON THE APPLICATION ARE CORRECT AND COMPLETE.

**Time Limit on Certain Defenses:** After 2 years from the Effective Date of this rider, only fraudulent misstatements in the application upon which this rider was issued may be used to void this rider or deny any claim for loss incurred after the 2-year period.

### INSURING CLAUSE

WE will pay YOU the benefit stated in this rider (Hospital Outpatient Benefit), subject to all the provisions, conditions, limitations and exclusions of the rider and policy or certificate referenced in the Rider Schedule, when WE receive timely written proof of loss satisfactory to US of losses or expenses incurred by a COVERED PERSON while the policy or certificate referenced in the Rider Schedule and this rider are in force with respect to that Covered Person.

### RIDER SCHEDULE

| COVERED PERSON | [POLICY] NUMBER | EFFECTIVE DATE | BENEFIT PERCENTAGE |
|----------------|-----------------|----------------|--------------------|
| [John Doe]     | [12345678]      | [08/01/2009]   | [50]%              |

Rider Premium: \$ \_\_\_\_\_ for every \_\_\_\_\_ months  
(included in the Policy Schedule or Certificate Schedule of the policy or certificate referenced above if no amount is shown here)

## ADDITIONAL DEFINITION

**OUTPATIENT HOSPITAL SERVICES** means care, treatment, services and supplies provided by a PHYSICIAN or facility for:

1. outpatient surgery in a HOSPITAL or free-standing outpatient surgery center;
2. outpatient diagnostic testing in a HOSPITAL or free-standing imaging facility or free-standing laboratory;
3. treatment in a HOSPITAL emergency room; and
4. other outpatient treatment in a HOSPITAL.

OUTPATIENT HOSPITAL SERVICES shall not include care, treatment, services and supplies provided in a DOCTOR'S office.

## HOSPITAL OUTPATIENT BENEFIT

WE will pay a benefit at the rate of [50]% of any deductible, coinsurance and copayments which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY for MEDICALLY NECESSARY OUTPATIENT HOSPITAL SERVICES provided to or for YOU or a covered FAMILY MEMBER. Any such OUTPATIENT HOSPITAL SERVICES must be covered under the PRIMARY MEDICAL POLICY and must be the result of an INJURY or SICKNESS.

The total benefits payable under this rider for all OUTPATIENT HOSPITAL SERVICES provided to any one COVERED PERSON during any one calendar year shall not exceed the MAXIMUM ANNUAL BENEFIT stated in the Benefit Schedule of the policy or certificate less all benefits paid under PART 1 of the policy or certificate together with all benefits paid under PART 3 of the policy or certificate.

When filing a claim YOUR Proof of Loss to US must include the Explanation of Benefits provided pursuant to the PRIMARY MEDICAL POLICY or other documentation showing dollar amounts that YOU or a covered FAMILY MEMBER are obligated to pay under the PRIMARY MEDICAL POLICY.

## RIDER PROVISIONS

**TERMINATION OF RIDER:** This rider will terminate without prior notice to you when the first of these occurs:

1. The policy or certificate referenced in the Rider Schedule lapses or expires, is canceled or otherwise terminated.
2. YOU do not pay the premium for the policy or certificate referenced in the Rider Schedule, or for this rider, by the end of the Grace Period.
3. YOU convert the policy or certificate referenced in the Rider Schedule.
4. The policy or certificate referenced in the Rider Schedule is rescinded by US.

**PAYMENT OF PREMIUM:** The premium amount for this rider is included in the Policy Schedule or Certificate Schedule of the policy or certificate referenced in the Rider Schedule. However, if this rider is issued subsequent to the Effective Date of the policy or certificate identified in the Rider Schedule, and unless the policy or certificate, including this rider, is reissued, the premium amount for this rider will be set forth in the Rider Schedule.

This rider is signed for US by OUR President and Secretary.



Secretary



President



SERFF Tracking Number: AMLC-126162719 State: Arkansas  
 Filing Company: Liberty National Life Insurance Company State Tracking Number: 42943  
 Company Tracking Number: LMMGAP  
 TOI: H151 Individual Health - Hospital/Surgical/Medical Expense Sub-TOI: H151.001 Health - Hospital/Surgical/Medical Expense  
 Product Name: Limited Benefit Hospital and Surgical Expense Policy  
 Project Name/Number: Limited Benefit Hospital and Surgical Expense Policy/LMMGAP

## Rate/Rule Schedule

| Review Status:      | Document Name: | Affected Form Numbers:<br>(Separated with commas) | Rate Action: | Rate Action Information: | Attachments                               |
|---------------------|----------------|---|--------------|--------------------------|---|
| Approved-<br>Closed | Rates          | LMMGAP, R-<br>LMMGAP-HO                           | New          |                          | LNL MMGAP<br>Rate Page - AR<br>090504.pdf |

**LIBERTY NATIONAL INSURANCE COMPANY**

McKinney, Texas

Policy Form LMMGAP

Hospital and Surgical Expense Policy

**NEW PRODUCT FILING**

**ARKANSAS**

**Proposed Annual Premium Rates**

**For Supplementing Policies With Only One Annual Deductible Per Person**

| Hospital Inpatient 100% (Excluding Mandated Benefits) |         |                                   |          |          |          |          |          |          |          |          |          |          |          |          |          |            |            |            |            |            |
|---|---------|-----------------------------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|------------|------------|------------|------------|------------|
| Sex   | Age     | Maximum Annual Benefit per Person |          |          |          |          |          |          |          |          |          |          |          |          |          |            |            |            |            |            |
|   |         | \$1,000                           | \$1,500  | \$2,000  | \$2,500  | \$3,000  | \$3,500  | \$4,000  | \$4,500  | \$5,000  | \$5,500  | \$6,000  | \$6,500  | \$7,000  | \$7,500  | \$8,000    | \$8,500    | \$9,000    | \$9,500    | \$10,000   |
| Male - Issue Age                                      | 18-25   | \$34.43                           | \$65.67  | \$70.51  | \$88.99  | \$102.08 | \$115.06 | \$137.72 | \$156.42 | \$178.20 | \$205.59 | \$221.98 | \$237.82 | \$245.19 | \$261.36 | \$281.93   | \$292.49   | \$297.99   | \$310.64   | \$322.74   |
|   | 26-30   | \$35.86                           | \$66.55  | \$86.35  | \$90.31  | \$114.95 | \$120.45 | \$139.70 | \$158.73 | \$191.62 | \$217.69 | \$235.84 | \$264.22 | \$270.49 | \$286.88 | \$303.05   | \$329.45   | \$344.19   | \$358.60   | \$349.14   |
|   | 31-35   | \$42.90                           | \$66.55  | \$87.45  | \$108.57 | \$128.04 | \$145.53 | \$169.18 | \$192.61 | \$215.82 | \$238.59 | \$260.92 | \$282.70 | \$303.93 | \$324.83 | \$345.29   | \$364.87   | \$384.12   | \$403.04   | \$421.41   |
|   | 36-40   | \$49.06                           | \$75.68  | \$102.30 | \$127.93 | \$151.80 | \$173.25 | \$202.18 | \$231.00 | \$259.93 | \$288.31 | \$316.47 | \$343.97 | \$371.14 | \$397.76 | \$423.83   | \$449.46   | \$474.54   | \$499.40   | \$524.04   |
|   | 41-45   | \$56.87                           | \$88.77  | \$120.67 | \$151.69 | \$180.73 | \$207.24 | \$242.55 | \$277.97 | \$313.72 | \$349.14 | \$384.56 | \$419.10 | \$453.64 | \$487.63 | \$521.29   | \$554.18   | \$586.85   | \$619.19   | \$650.65   |
|   | 46-50   | \$65.45                           | \$102.96 | \$140.91 | \$177.98 | \$213.07 | \$245.30 | \$288.64 | \$332.31 | \$376.42 | \$420.64 | \$464.97 | \$508.64 | \$551.98 | \$595.21 | \$638.00   | \$680.02   | \$721.71   | \$763.51   | \$804.21   |
|   | 51-55   | \$75.24                           | \$119.02 | \$163.90 | \$208.12 | \$250.47 | \$289.63 | \$342.43 | \$396.00 | \$450.34 | \$504.90 | \$559.46 | \$613.91 | \$667.81 | \$721.93 | \$775.28   | \$828.08   | \$880.44   | \$933.02   | \$984.61   |
|   | 56-60   | \$86.46                           | \$137.83 | \$190.30 | \$242.11 | \$291.72 | \$337.81 | \$399.96 | \$463.10 | \$527.45 | \$591.58 | \$656.48 | \$721.05 | \$785.40 | \$849.75 | \$913.55   | \$976.80   | \$1,039.50 | \$1,102.20 | \$1,164.46 |
| 61-63   | \$93.50 | \$149.38                          | \$206.47 | \$262.68 | \$316.36 | \$366.41 | \$433.62 | \$501.82 | \$571.45 | \$640.42 | \$710.49 | \$780.67 | \$850.63 | \$920.04 | \$989.67 | \$1,057.65 | \$1,125.52 | \$1,193.50 | \$1,261.15 |            |

| Hospital Inpatient 100% (Excluding Mandated Benefits) |         |                                   |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |            |            |          |
|---|---------|-----------------------------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|------------|------------|----------|
| Sex   | Age     | Maximum Annual Benefit per Person |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |            |            |          |
|   |         | \$1,000                           | \$1,500  | \$2,000  | \$2,500  | \$3,000  | \$3,500  | \$4,000  | \$4,500  | \$5,000  | \$5,500  | \$6,000  | \$6,500  | \$7,000  | \$7,500  | \$8,000  | \$8,500  | \$9,000    | \$9,500    | \$10,000 |
| Female - Issue Age                                    | 18-25   | \$50.38                           | \$77.44  | \$104.17 | \$129.80 | \$153.67 | \$175.45 | \$204.93 | \$234.74 | \$264.44 | \$293.92 | \$322.63 | \$351.23 | \$378.84 | \$406.01 | \$432.08 | \$457.49 | \$481.69   | \$505.45   | \$528.22 |
|   | 26-30   | \$60.83                           | \$92.95  | \$124.08 | \$153.67 | \$181.39 | \$206.25 | \$240.13 | \$274.34 | \$308.66 | \$342.87 | \$376.53 | \$409.75 | \$442.31 | \$474.43 | \$505.34 | \$535.59 | \$564.63   | \$592.90   | \$620.18 |
|   | 31-35   | \$67.10                           | \$103.40 | \$139.15 | \$173.25 | \$204.93 | \$233.75 | \$272.91 | \$312.40 | \$352.00 | \$391.71 | \$430.76 | \$469.70 | \$507.65 | \$545.27 | \$581.57 | \$617.54 | \$651.97   | \$685.96   | \$718.52 |
|   | 36-40   | \$67.21                           | \$103.73 | \$141.35 | \$177.87 | \$212.30 | \$243.76 | \$286.00 | \$328.68 | \$371.47 | \$414.37 | \$457.16 | \$499.29 | \$541.20 | \$582.45 | \$623.15 | \$662.97 | \$701.91   | \$740.08   | \$777.04 |
|   | 41-45   | \$67.21                           | \$103.73 | \$141.35 | \$177.87 | \$214.28 | \$248.05 | \$293.15 | \$338.69 | \$384.56 | \$430.87 | \$476.96 | \$522.50 | \$568.04 | \$612.81 | \$657.14 | \$700.48 | \$743.05   | \$784.85   | \$825.44 |
|   | 46-50   | \$67.21                           | \$103.73 | \$141.35 | \$177.87 | \$214.28 | \$248.05 | \$293.15 | \$338.69 | \$384.56 | \$430.87 | \$476.96 | \$522.61 | \$568.92 | \$615.01 | \$660.22 | \$705.32 | \$749.54   | \$792.99   | \$835.78 |
|   | 51-55   | \$67.21                           | \$103.73 | \$141.35 | \$177.87 | \$214.28 | \$248.05 | \$293.15 | \$340.56 | \$388.85 | \$438.02 | \$487.19 | \$536.47 | \$585.20 | \$634.26 | \$682.33 | \$730.62 | \$778.25   | \$825.22   | \$871.97 |
|   | 56-60   | \$67.21                           | \$105.71 | \$147.62 | \$189.42 | \$230.01 | \$268.07 | \$318.89 | \$371.14 | \$424.38 | \$478.06 | \$532.29 | \$586.19 | \$639.98 | \$693.99 | \$747.23 | \$800.58 | \$853.49   | \$905.85   | \$957.88 |
| 61-63   | \$73.59 | \$118.80                          | \$165.99 | \$212.74 | \$257.95 | \$300.19 | \$356.84 | \$414.70 | \$473.66 | \$533.17 | \$593.56 | \$653.40 | \$713.13 | \$773.30 | \$831.49 | \$890.23 | \$948.75 | \$1,006.06 | \$1,063.70 |          |

| Hospital Inpatient 100% (Excluding Mandated Benefits) |     |                                   |         |         |         |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
|---|-----|-----------------------------------|---------|---------|---------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
| Sex   | Age | Maximum Annual Benefit per Person |         |         |         |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
|   |     | \$1,000                           | \$1,500 | \$2,000 | \$2,500 | \$3,000  | \$3,500  | \$4,000  | \$4,500  | \$5,000  | \$5,500  | \$6,000  | \$6,500  | \$7,000  | \$7,500  | \$8,000  | \$8,500  | \$9,000  | \$9,500  | \$10,000 |
| Dep Child*  |     | \$36.08                           | \$68.75 | \$73.81 | \$93.17 | \$106.81 | \$120.56 | \$144.21 | \$163.79 | \$186.56 | \$215.27 | \$232.43 | \$248.93 | \$256.74 | \$273.68 | \$295.13 | \$306.24 | \$311.96 | \$325.16 | \$337.92 |

\*Dependent child rate is per child for up to 3 children. There is no premium charged for the 4th and later child on the same policy.

These rates will be discounted 10% when husband and wife are covered under the same policy.

Modal Factors: Semiannual = Annual x 0.520; Quarterly = Annual x 0.265; Monthly = Annual /11

**LIBERTY NATIONAL INSURANCE COMPANY**

McKinney, Texas

Policy Form LMMGAP

Hospital and Surgical Expense Policy

**NEW PRODUCT FILING**

**ARKANSAS**

Proposed Annual Premium Rates

For Supplementing Policies With Only One Annual Deductible Per Person

| Optional Hospital Outpatient at 50% |          |                                   |          |          |          |          |          |          |          |          |          |          |            |            |            |            |            |            |            |            |
|-------------------------------------|----------|-----------------------------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|------------|------------|------------|------------|------------|------------|------------|------------|
| Sex                                 | Age      | Maximum Annual Benefit per Person |          |          |          |          |          |          |          |          |          |          |            |            |            |            |            |            |            |            |
|                                     |          | \$1,000                           | \$1,500  | \$2,000  | \$2,500  | \$3,000  | \$3,500  | \$4,000  | \$4,500  | \$5,000  | \$5,500  | \$6,000  | \$6,500    | \$7,000    | \$7,500    | \$8,000    | \$8,500    | \$9,000    | \$9,500    | \$10,000   |
| Male - Issue Age                    | 18-25    | \$124.41                          | \$170.17 | \$208.78 | \$241.89 | \$271.26 | \$297.44 | \$320.98 | \$341.88 | \$360.58 | \$377.74 | \$393.25 | \$407.33   | \$419.87   | \$431.42   | \$441.87   | \$451.33   | \$460.46   | \$468.49   | \$476.19   |
|                                     | 26-30    | \$125.18                          | \$175.23 | \$218.46 | \$256.08 | \$289.52 | \$319.33 | \$346.28 | \$370.15 | \$391.71 | \$411.51 | \$429.44 | \$445.83   | \$461.01   | \$474.65   | \$487.52   | \$499.18   | \$510.07   | \$520.19   | \$529.76   |
|                                     | 31-35    | \$129.14                          | \$184.58 | \$233.64 | \$276.87 | \$315.59 | \$350.02 | \$381.48 | \$409.42 | \$435.05 | \$458.70 | \$480.04 | \$499.62   | \$517.88   | \$534.93   | \$550.55   | \$564.85   | \$578.27   | \$590.92   | \$602.47   |
|                                     | 36-40    | \$138.16                          | \$201.08 | \$257.73 | \$308.44 | \$353.98 | \$394.79 | \$432.30 | \$465.96 | \$496.54 | \$524.59 | \$550.33 | \$573.87   | \$595.87   | \$616.44   | \$635.36   | \$652.96   | \$669.35   | \$684.97   | \$699.16   |
|                                     | 41-45    | \$149.38                          | \$221.76 | \$287.87 | \$347.49 | \$401.50 | \$449.90 | \$494.12 | \$534.05 | \$570.68 | \$604.34 | \$635.36 | \$664.07   | \$690.69   | \$715.44   | \$738.43   | \$759.66   | \$779.57   | \$798.49   | \$815.76   |
|                                     | 46-50    | \$163.79                          | \$247.50 | \$323.95 | \$393.58 | \$456.72 | \$513.81 | \$565.73 | \$612.81 | \$656.26 | \$696.19 | \$732.82 | \$766.70   | \$798.05   | \$827.42   | \$854.92   | \$880.11   | \$903.87   | \$926.86   | \$947.87   |
|                                     | 51-55    | \$180.07                          | \$274.23 | \$361.68 | \$441.43 | \$513.81 | \$579.81 | \$640.31 | \$695.09 | \$745.91 | \$793.32 | \$836.22 | \$876.26   | \$913.11   | \$948.09   | \$980.54   | \$1,010.35 | \$1,038.62 | \$1,065.79 | \$1,090.87 |
|                                     | 56-60    | \$185.24                          | \$284.24 | \$376.97 | \$462.66 | \$540.87 | \$612.70 | \$678.81 | \$739.09 | \$794.97 | \$845.79 | \$893.42 | \$937.53   | \$978.45   | \$1,017.28 | \$1,053.14 | \$1,086.58 | \$1,118.04 | \$1,148.07 | \$1,176.45 |
| 61-63                               | \$195.69 | \$294.36                          | \$386.76 | \$483.12 | \$561.11 | \$632.83 | \$698.72 | \$769.78 | \$825.44 | \$876.04 | \$923.56 | \$967.56 | \$1,019.37 | \$1,046.98 | \$1,093.84 | \$1,127.17 | \$1,158.52 | \$1,188.33 | \$1,216.71 |            |

| Optional Hospital Outpatient at 50% |          |                                   |          |          |          |          |          |          |          |          |          |          |            |            |            |            |            |            |            |            |
|-------------------------------------|----------|-----------------------------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|------------|------------|------------|------------|------------|------------|------------|------------|
| Sex                                 | Age      | Maximum Annual Benefit per Person |          |          |          |          |          |          |          |          |          |          |            |            |            |            |            |            |            |            |
|                                     |          | \$1,000                           | \$1,500  | \$2,000  | \$2,500  | \$3,000  | \$3,500  | \$4,000  | \$4,500  | \$5,000  | \$5,500  | \$6,000  | \$6,500    | \$7,000    | \$7,500    | \$8,000    | \$8,500    | \$9,000    | \$9,500    | \$10,000   |
| Female - Issue Age                  | 18-25    | \$141.79                          | \$205.92 | \$263.56 | \$316.36 | \$364.87 | \$409.75 | \$451.22 | \$489.72 | \$525.69 | \$559.13 | \$589.16 | \$617.65   | \$643.06   | \$667.26   | \$688.82   | \$709.28   | \$727.54   | \$744.70   | \$760.10   |
|                                     | 26-30    | \$145.42                          | \$212.08 | \$272.58 | \$328.13 | \$379.17 | \$426.47 | \$470.14 | \$510.84 | \$548.68 | \$583.77 | \$615.89 | \$646.03   | \$673.53   | \$699.16   | \$722.48   | \$744.26   | \$764.06   | \$782.54   | \$799.37   |
|                                     | 31-35    | \$151.80                          | \$222.64 | \$286.88 | \$345.73 | \$399.74 | \$449.46 | \$495.00 | \$537.02 | \$575.85 | \$611.93 | \$644.82 | \$675.51   | \$703.45   | \$730.07   | \$754.05   | \$777.04   | \$797.72   | \$817.63   | \$835.45   |
|                                     | 36-40    | \$159.61                          | \$235.29 | \$303.60 | \$366.30 | \$423.39 | \$475.42 | \$522.39 | \$565.62 | \$605.33 | \$642.07 | \$675.95 | \$706.75   | \$735.57   | \$762.30   | \$787.27   | \$810.48   | \$832.15   | \$852.94   | \$871.97   |
|                                     | 41-45    | \$166.21                          | \$246.62 | \$319.77 | \$386.76 | \$448.14 | \$503.80 | \$554.29 | \$600.38 | \$642.51 | \$681.45 | \$717.09 | \$749.54   | \$779.68   | \$807.73   | \$834.02   | \$858.44   | \$881.54   | \$903.21   | \$923.45   |
|                                     | 46-50    | \$175.56                          | \$262.79 | \$342.54 | \$415.91 | \$482.68 | \$543.40 | \$599.39 | \$649.99 | \$695.97 | \$738.21 | \$777.04 | \$812.68   | \$845.79   | \$876.81   | \$905.08   | \$932.47   | \$957.66   | \$981.42   | \$1,003.97 |
|                                     | 51-55    | \$186.01                          | \$281.38 | \$369.38 | \$450.78 | \$525.47 | \$593.67 | \$656.04 | \$713.24 | \$765.60 | \$813.78 | \$858.44 | \$899.69   | \$937.75   | \$973.94   | \$1,006.83 | \$1,038.51 | \$1,067.88 | \$1,095.71 | \$1,121.89 |
|                                     | 56-60    | \$188.21                          | \$286.33 | \$378.18 | \$463.65 | \$542.85 | \$615.34 | \$682.11 | \$743.27 | \$799.59 | \$851.84 | \$900.46 | \$944.90   | \$986.48   | \$1,026.19 | \$1,062.05 | \$1,096.70 | \$1,129.04 | \$1,159.29 | \$1,188.22 |
| 61-63                               | \$196.35 | \$293.04                          | \$383.57 | \$467.83 | \$556.60 | \$628.10 | \$693.99 | \$754.27 | \$809.82 | \$861.30 | \$909.26 | \$963.82 | \$1,004.74 | \$1,043.90 | \$1,079.21 | \$1,113.42 | \$1,145.32 | \$1,175.13 | \$1,203.62 |            |

| Optional Hospital Outpatient at 50% |     |                                   |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
|-------------------------------------|-----|-----------------------------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
| Sex                                 | Age | Maximum Annual Benefit per Person |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
|                                     |     | \$1,000                           | \$1,500  | \$2,000  | \$2,500  | \$3,000  | \$3,500  | \$4,000  | \$4,500  | \$5,000  | \$5,500  | \$6,000  | \$6,500  | \$7,000  | \$7,500  | \$8,000  | \$8,500  | \$9,000  | \$9,500  | \$10,000 |
| Dep Child*                          |     | \$102.63                          | \$143.00 | \$177.10 | \$205.37 | \$229.35 | \$249.92 | \$267.52 | \$282.81 | \$296.45 | \$307.89 | \$318.34 | \$327.14 | \$335.17 | \$342.21 | \$348.81 | \$354.86 | \$360.69 | \$365.53 | \$370.37 |

\*Dependent child rate is per child for up to 3 children. There is no premium charged for the 4th and later child on the same policy. These rates will be discounted 10% when husband and wife are covered under the same policy.  
 Modal Factors: Semiannual = Annual x 0.520; Quarterly = Annual x 0.265; Monthly = Annual /11

**LIBERTY NATIONAL INSURANCE COMPANY**

McKinney, Texas

Policy Form LMMGAP

Hospital and Surgical Expense Policy

**NEW PRODUCT FILING**

**ARKANSAS**

Proposed Annual Premium Rates

For Supplementing Policies That Can Have Multiple Annual Deductibles Per Person

| Hospital Inpatient 100% (Excluding Mandated Benefits) |       |                                   |          |          |          |          |          |          |            |            |            |            |            |            |            |            |            |            |            |            |
|---|-------|-----------------------------------|----------|----------|----------|----------|----------|----------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|
| Sex   | Age   | Maximum Annual Benefit per Person |          |          |          |          |          |          |            |            |            |            |            |            |            |            |            |            |            |            |
|   |       | \$1,000                           | \$1,500  | \$2,000  | \$2,500  | \$3,000  | \$3,500  | \$4,000  | \$4,500    | \$5,000    | \$5,500    | \$6,000    | \$6,500    | \$7,000    | \$7,500    | \$8,000    | \$8,500    | \$9,000    | \$9,500    | \$10,000   |
| Male - Issue Age                                      | 18-25 | \$68.86                           | \$131.34 | \$141.02 | \$177.98 | \$204.16 | \$230.12 | \$275.44 | \$312.84   | \$356.40   | \$411.18   | \$443.96   | \$475.64   | \$490.38   | \$522.72   | \$563.86   | \$584.98   | \$595.98   | \$621.28   | \$645.48   |
|   | 26-30 | \$71.72                           | \$133.10 | \$172.70 | \$180.62 | \$229.90 | \$240.90 | \$279.40 | \$317.46   | \$383.24   | \$435.38   | \$471.68   | \$528.44   | \$540.98   | \$573.76   | \$606.10   | \$658.90   | \$688.38   | \$717.20   | \$698.28   |
|   | 31-35 | \$85.80                           | \$133.10 | \$174.90 | \$217.14 | \$256.08 | \$291.06 | \$338.36 | \$385.22   | \$431.64   | \$477.18   | \$521.84   | \$565.40   | \$607.86   | \$649.66   | \$690.58   | \$729.74   | \$768.24   | \$806.08   | \$842.82   |
|   | 36-40 | \$98.12                           | \$151.36 | \$204.60 | \$255.86 | \$303.60 | \$346.50 | \$404.36 | \$462.00   | \$519.86   | \$576.62   | \$632.94   | \$687.94   | \$742.28   | \$795.52   | \$847.66   | \$898.92   | \$949.08   | \$998.80   | \$1,048.08 |
|   | 41-45 | \$113.74                          | \$177.54 | \$241.34 | \$303.38 | \$361.46 | \$414.48 | \$485.10 | \$555.94   | \$627.44   | \$698.28   | \$769.12   | \$838.20   | \$907.28   | \$975.26   | \$1,042.58 | \$1,108.36 | \$1,173.70 | \$1,238.38 | \$1,301.30 |
|   | 46-50 | \$130.90                          | \$205.92 | \$281.82 | \$355.96 | \$426.14 | \$490.60 | \$577.28 | \$664.62   | \$752.84   | \$841.28   | \$929.94   | \$1,017.28 | \$1,103.96 | \$1,190.42 | \$1,276.00 | \$1,360.04 | \$1,443.42 | \$1,527.02 | \$1,608.42 |
|   | 51-55 | \$150.48                          | \$238.04 | \$327.80 | \$416.24 | \$500.94 | \$579.26 | \$684.86 | \$792.00   | \$900.68   | \$1,009.80 | \$1,118.92 | \$1,227.82 | \$1,335.62 | \$1,443.86 | \$1,550.56 | \$1,656.16 | \$1,760.88 | \$1,866.04 | \$1,969.22 |
|   | 56-60 | \$172.92                          | \$275.66 | \$380.60 | \$484.22 | \$583.44 | \$675.62 | \$799.92 | \$926.20   | \$1,054.90 | \$1,183.16 | \$1,312.96 | \$1,442.10 | \$1,570.80 | \$1,699.50 | \$1,827.10 | \$1,953.60 | \$2,079.00 | \$2,204.40 | \$2,328.92 |
|   | 61-63 | \$187.00                          | \$298.76 | \$412.94 | \$525.36 | \$632.72 | \$732.82 | \$867.24 | \$1,003.64 | \$1,142.90 | \$1,280.84 | \$1,420.98 | \$1,561.34 | \$1,701.26 | \$1,840.08 | \$1,979.34 | \$2,115.30 | \$2,251.04 | \$2,387.00 | \$2,522.30 |

| Hospital Inpatient 100% (Excluding Mandated Benefits) |       |                                   |          |          |          |          |          |          |          |          |            |            |            |            |            |            |            |            |            |            |
|---|-------|-----------------------------------|----------|----------|----------|----------|----------|----------|----------|----------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|
| Sex   | Age   | Maximum Annual Benefit per Person |          |          |          |          |          |          |          |          |            |            |            |            |            |            |            |            |            |            |
|   |       | \$1,000                           | \$1,500  | \$2,000  | \$2,500  | \$3,000  | \$3,500  | \$4,000  | \$4,500  | \$5,000  | \$5,500    | \$6,000    | \$6,500    | \$7,000    | \$7,500    | \$8,000    | \$8,500    | \$9,000    | \$9,500    | \$10,000   |
| Female - Issue Age                                    | 18-25 | \$100.76                          | \$154.88 | \$208.34 | \$259.60 | \$307.34 | \$350.90 | \$409.86 | \$469.48 | \$528.88 | \$587.84   | \$645.26   | \$702.46   | \$757.68   | \$812.02   | \$864.16   | \$914.98   | \$963.38   | \$1,010.90 | \$1,056.44 |
|   | 26-30 | \$121.66                          | \$185.90 | \$248.16 | \$307.34 | \$362.78 | \$412.50 | \$480.26 | \$548.68 | \$617.32 | \$685.74   | \$753.06   | \$819.50   | \$884.62   | \$948.86   | \$1,010.68 | \$1,071.18 | \$1,129.26 | \$1,185.80 | \$1,240.36 |
|   | 31-35 | \$134.20                          | \$206.80 | \$278.30 | \$346.50 | \$409.86 | \$467.50 | \$545.82 | \$624.80 | \$704.00 | \$783.42   | \$861.52   | \$939.40   | \$1,015.30 | \$1,090.54 | \$1,163.14 | \$1,235.08 | \$1,303.94 | \$1,371.92 | \$1,437.04 |
|   | 36-40 | \$134.42                          | \$207.46 | \$282.70 | \$355.74 | \$424.60 | \$487.52 | \$572.00 | \$657.36 | \$742.94 | \$828.74   | \$914.32   | \$998.58   | \$1,082.40 | \$1,164.90 | \$1,246.30 | \$1,325.94 | \$1,403.82 | \$1,480.16 | \$1,554.08 |
|   | 41-45 | \$134.42                          | \$207.46 | \$282.70 | \$355.74 | \$428.56 | \$496.10 | \$586.30 | \$677.38 | \$769.12 | \$861.74   | \$953.92   | \$1,045.00 | \$1,136.08 | \$1,225.62 | \$1,314.28 | \$1,400.96 | \$1,486.10 | \$1,569.70 | \$1,650.88 |
|   | 46-50 | \$134.42                          | \$207.46 | \$282.70 | \$355.74 | \$428.56 | \$496.10 | \$586.30 | \$677.38 | \$769.12 | \$861.74   | \$953.92   | \$1,045.22 | \$1,137.84 | \$1,230.02 | \$1,320.44 | \$1,410.64 | \$1,499.08 | \$1,585.98 | \$1,671.56 |
|   | 51-55 | \$134.42                          | \$207.46 | \$282.70 | \$355.74 | \$428.56 | \$496.10 | \$586.30 | \$681.12 | \$777.70 | \$876.04   | \$974.38   | \$1,072.94 | \$1,170.40 | \$1,268.52 | \$1,364.66 | \$1,461.24 | \$1,556.50 | \$1,650.44 | \$1,743.94 |
|   | 56-60 | \$134.42                          | \$211.42 | \$295.24 | \$378.84 | \$460.02 | \$536.14 | \$637.78 | \$742.28 | \$848.76 | \$956.12   | \$1,064.58 | \$1,172.38 | \$1,279.96 | \$1,387.98 | \$1,494.46 | \$1,601.16 | \$1,706.98 | \$1,811.70 | \$1,915.76 |
|   | 61-63 | \$147.18                          | \$237.60 | \$331.98 | \$425.48 | \$515.90 | \$600.38 | \$713.68 | \$829.40 | \$947.32 | \$1,066.34 | \$1,187.12 | \$1,306.80 | \$1,426.26 | \$1,546.60 | \$1,662.98 | \$1,780.46 | \$1,897.50 | \$2,012.12 | \$2,127.40 |

| Hospital Inpatient 100% (Excluding Mandated Benefits) |     |                                   |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
|---|-----|-----------------------------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
| Sex   | Age | Maximum Annual Benefit per Person |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
|   |     | \$1,000                           | \$1,500  | \$2,000  | \$2,500  | \$3,000  | \$3,500  | \$4,000  | \$4,500  | \$5,000  | \$5,500  | \$6,000  | \$6,500  | \$7,000  | \$7,500  | \$8,000  | \$8,500  | \$9,000  | \$9,500  | \$10,000 |
| Dep Child*  |     | \$72.16                           | \$137.50 | \$147.62 | \$186.34 | \$213.62 | \$241.12 | \$288.42 | \$327.58 | \$373.12 | \$430.54 | \$464.86 | \$497.86 | \$513.48 | \$547.36 | \$590.26 | \$612.48 | \$623.92 | \$650.32 | \$675.84 |

\*Dependent child rate is per child for up to 3 children. There is no premium charged for the 4th and later child on the same policy. These rates will be discounted 10% when husband and wife are covered under the same policy.  
 Modal Factors: Semiannual = Annual x 0.520; Quarterly = Annual x 0.265; Monthly = Annual /11

**LIBERTY NATIONAL INSURANCE COMPANY**

**McKinney, Texas**

**Policy Form LMMGAP**

**Hospital and Surgical Expense Policy**

**NEW PRODUCT FILING**

**ARKANSAS**

**Proposed Annual Premium Rates**

**For Supplementing Policies That Can Have Multiple Annual Deductibles Per Person**

|                  |       | Optional Hospital Outpatient at 50% |          |          |          |            |            |            |            |            |            |            |            |            |            |            |            |            |            |            |
|------------------|-------|-------------------------------------|----------|----------|----------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|
|                  |       | Maximum Annual Benefit per Person   |          |          |          |            |            |            |            |            |            |            |            |            |            |            |            |            |            |            |
| Sex              | Age   | \$1,000                             | \$1,500  | \$2,000  | \$2,500  | \$3,000    | \$3,500    | \$4,000    | \$4,500    | \$5,000    | \$5,500    | \$6,000    | \$6,500    | \$7,000    | \$7,500    | \$8,000    | \$8,500    | \$9,000    | \$9,500    | \$10,000   |
| Male - Issue Age | 18-25 | \$248.82                            | \$340.34 | \$417.56 | \$483.78 | \$542.52   | \$594.88   | \$641.96   | \$683.76   | \$721.16   | \$755.48   | \$786.50   | \$814.66   | \$839.74   | \$862.84   | \$883.74   | \$902.66   | \$920.92   | \$936.98   | \$952.38   |
|                  | 26-30 | \$250.36                            | \$350.46 | \$436.92 | \$512.16 | \$579.04   | \$638.66   | \$692.56   | \$740.30   | \$783.42   | \$823.02   | \$858.88   | \$891.66   | \$922.02   | \$949.30   | \$975.04   | \$998.36   | \$1,020.14 | \$1,040.38 | \$1,059.52 |
|                  | 31-35 | \$258.28                            | \$369.16 | \$467.28 | \$553.74 | \$631.18   | \$700.04   | \$762.96   | \$818.84   | \$870.10   | \$917.40   | \$960.08   | \$999.24   | \$1,035.76 | \$1,069.86 | \$1,101.10 | \$1,129.70 | \$1,156.54 | \$1,181.84 | \$1,204.94 |
|                  | 36-40 | \$276.32                            | \$402.16 | \$515.46 | \$616.88 | \$707.96   | \$789.58   | \$864.60   | \$931.92   | \$993.08   | \$1,049.18 | \$1,100.66 | \$1,147.74 | \$1,191.74 | \$1,232.88 | \$1,270.72 | \$1,305.92 | \$1,338.70 | \$1,369.94 | \$1,398.32 |
|                  | 41-45 | \$298.76                            | \$443.52 | \$575.74 | \$694.98 | \$803.00   | \$899.80   | \$988.24   | \$1,068.10 | \$1,141.36 | \$1,208.68 | \$1,270.72 | \$1,328.14 | \$1,381.38 | \$1,430.88 | \$1,476.86 | \$1,519.32 | \$1,559.14 | \$1,596.98 | \$1,631.52 |
|                  | 46-50 | \$327.58                            | \$495.00 | \$647.90 | \$787.16 | \$913.44   | \$1,027.62 | \$1,131.46 | \$1,225.62 | \$1,312.52 | \$1,392.38 | \$1,465.64 | \$1,533.40 | \$1,596.10 | \$1,654.84 | \$1,709.84 | \$1,760.22 | \$1,807.74 | \$1,853.72 | \$1,895.74 |
|                  | 51-55 | \$360.14                            | \$548.46 | \$723.36 | \$882.86 | \$1,027.62 | \$1,159.62 | \$1,280.62 | \$1,390.18 | \$1,491.82 | \$1,586.64 | \$1,672.44 | \$1,752.52 | \$1,826.22 | \$1,896.18 | \$1,961.08 | \$2,020.70 | \$2,077.24 | \$2,131.58 | \$2,181.74 |
|                  | 56-60 | \$370.48                            | \$568.48 | \$753.94 | \$925.32 | \$1,081.74 | \$1,225.40 | \$1,357.62 | \$1,478.18 | \$1,589.94 | \$1,691.58 | \$1,786.84 | \$1,875.06 | \$1,956.90 | \$2,034.56 | \$2,106.28 | \$2,173.16 | \$2,236.08 | \$2,296.14 | \$2,352.90 |
|                  | 61-63 | \$391.38                            | \$588.72 | \$773.52 | \$966.24 | \$1,122.22 | \$1,265.66 | \$1,397.44 | \$1,539.56 | \$1,650.88 | \$1,752.08 | \$1,847.12 | \$1,935.12 | \$2,038.74 | \$2,093.96 | \$2,187.68 | \$2,254.34 | \$2,317.04 | \$2,376.66 | \$2,433.42 |

|                    |       | Optional Hospital Outpatient at 50% |          |          |          |            |            |            |            |            |            |            |            |            |            |            |            |            |            |            |
|--------------------|-------|-------------------------------------|----------|----------|----------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|
|                    |       | Maximum Annual Benefit per Person   |          |          |          |            |            |            |            |            |            |            |            |            |            |            |            |            |            |            |
| Sex                | Age   | \$1,000                             | \$1,500  | \$2,000  | \$2,500  | \$3,000    | \$3,500    | \$4,000    | \$4,500    | \$5,000    | \$5,500    | \$6,000    | \$6,500    | \$7,000    | \$7,500    | \$8,000    | \$8,500    | \$9,000    | \$9,500    | \$10,000   |
| Female - Issue Age | 18-25 | \$283.58                            | \$411.84 | \$527.12 | \$632.72 | \$729.74   | \$819.50   | \$902.44   | \$979.44   | \$1,051.38 | \$1,118.26 | \$1,178.32 | \$1,235.30 | \$1,286.12 | \$1,334.52 | \$1,377.64 | \$1,418.56 | \$1,455.08 | \$1,489.40 | \$1,520.20 |
|                    | 26-30 | \$290.84                            | \$424.16 | \$545.16 | \$656.26 | \$758.34   | \$852.94   | \$940.28   | \$1,021.68 | \$1,097.36 | \$1,167.54 | \$1,231.78 | \$1,292.06 | \$1,347.06 | \$1,398.32 | \$1,444.96 | \$1,488.52 | \$1,528.12 | \$1,565.08 | \$1,598.74 |
|                    | 31-35 | \$303.60                            | \$445.28 | \$573.76 | \$691.46 | \$799.48   | \$898.92   | \$990.00   | \$1,074.04 | \$1,151.70 | \$1,223.86 | \$1,289.64 | \$1,351.02 | \$1,406.90 | \$1,460.14 | \$1,508.10 | \$1,554.08 | \$1,595.44 | \$1,635.26 | \$1,670.90 |
|                    | 36-40 | \$319.22                            | \$470.58 | \$607.20 | \$732.60 | \$846.78   | \$950.84   | \$1,044.78 | \$1,131.24 | \$1,210.66 | \$1,284.14 | \$1,351.90 | \$1,413.50 | \$1,471.14 | \$1,524.60 | \$1,574.54 | \$1,620.96 | \$1,664.30 | \$1,705.88 | \$1,743.94 |
|                    | 41-45 | \$332.42                            | \$493.24 | \$639.54 | \$773.52 | \$896.28   | \$1,007.60 | \$1,108.58 | \$1,200.76 | \$1,285.02 | \$1,362.90 | \$1,434.18 | \$1,499.08 | \$1,559.36 | \$1,615.46 | \$1,668.04 | \$1,716.88 | \$1,763.08 | \$1,806.42 | \$1,846.90 |
|                    | 46-50 | \$351.12                            | \$525.58 | \$685.08 | \$831.82 | \$965.36   | \$1,086.80 | \$1,198.78 | \$1,299.98 | \$1,391.94 | \$1,476.42 | \$1,554.08 | \$1,625.36 | \$1,691.58 | \$1,753.62 | \$1,810.16 | \$1,864.94 | \$1,915.32 | \$1,962.84 | \$2,007.94 |
|                    | 51-55 | \$372.02                            | \$562.76 | \$738.76 | \$901.56 | \$1,050.94 | \$1,187.34 | \$1,312.08 | \$1,426.48 | \$1,531.20 | \$1,627.56 | \$1,716.88 | \$1,799.38 | \$1,875.50 | \$1,947.88 | \$2,013.66 | \$2,077.02 | \$2,135.76 | \$2,191.42 | \$2,243.78 |
|                    | 56-60 | \$376.42                            | \$572.66 | \$756.36 | \$927.30 | \$1,085.70 | \$1,230.68 | \$1,364.22 | \$1,486.54 | \$1,599.18 | \$1,703.68 | \$1,800.92 | \$1,889.80 | \$1,972.96 | \$2,052.38 | \$2,124.10 | \$2,193.40 | \$2,258.08 | \$2,318.58 | \$2,376.44 |
|                    | 61-63 | \$392.70                            | \$586.08 | \$767.14 | \$935.66 | \$1,113.20 | \$1,256.20 | \$1,387.98 | \$1,508.54 | \$1,619.64 | \$1,722.60 | \$1,818.52 | \$1,927.64 | \$2,009.48 | \$2,087.80 | \$2,158.42 | \$2,226.84 | \$2,290.64 | \$2,350.26 | \$2,407.24 |

|            |     | Optional Hospital Outpatient at 50% |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
|------------|-----|-------------------------------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
|            |     | Maximum Annual Benefit per Person   |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |          |
| Sex        | Age | \$1,000                             | \$1,500  | \$2,000  | \$2,500  | \$3,000  | \$3,500  | \$4,000  | \$4,500  | \$5,000  | \$5,500  | \$6,000  | \$6,500  | \$7,000  | \$7,500  | \$8,000  | \$8,500  | \$9,000  | \$9,500  | \$10,000 |
| Dep Child* |     | \$205.26                            | \$286.00 | \$354.20 | \$410.74 | \$458.70 | \$499.84 | \$535.04 | \$565.62 | \$592.90 | \$615.78 | \$636.68 | \$654.28 | \$670.34 | \$684.42 | \$697.62 | \$709.72 | \$721.38 | \$731.06 | \$740.74 |

\*Dependent child rate is per child for up to 3 children. There is no premium charged for the 4th and later child on the same policy. These rates will be discounted 10% when husband and wife are covered under the same policy.  
 Modal Factors: Semiannual = Annual x 0.520; Quarterly = Annual x 0.265; Monthly = Annual /11

**LIBERTY NATIONAL INSURANCE COMPANY**

**McKinney, Texas**

**Policy Form LMMGAP**

**Hospital and Surgical Expense Policy**

**NEW PRODUCT FILING**

**ARKANSAS**

**Proposed Annual Premium Rates**

**For All Policies**

| Mandated Benefits for ARKANSAS |       |        |
|--------------------------------|-------|--------|
| Sex                            | Age   |        |
| <b>Male - Issue Age</b>        | 18-25 | \$3.08 |
|                                | 26-30 | \$3.08 |
|                                | 31-35 | \$3.19 |
|                                | 36-40 | \$3.19 |
|                                | 41-45 | \$3.19 |
|                                | 46-50 | \$3.19 |
|                                | 51-55 | \$3.19 |
|                                | 56-60 | \$3.19 |
|                                | 61-63 | \$3.19 |

| Mandated Benefits for ARKANSAS |       |        |
|--------------------------------|-------|--------|
| Sex                            | Age   |        |
| <b>Female - Issue Age</b>      | 18-25 | \$2.09 |
|                                | 26-30 | \$2.09 |
|                                | 31-35 | \$2.09 |
|                                | 36-40 | \$2.09 |
|                                | 41-45 | \$4.18 |
|                                | 46-50 | \$4.18 |
|                                | 51-55 | \$4.18 |
|                                | 56-60 | \$4.18 |
|                                |       | 61-63  |

| Mandated Benefits for ARKANSAS |                   |                |
|--------------------------------|-------------------|----------------|
| Sex                            | Age               |                |
|                                | <b>Dep Child*</b> | <b>\$62.48</b> |

\*Dependent child rate is per child for up to 3 children. There is no premium charged for the 4th and later child on the same policy.

These rates will be discounted 10% when husband and wife are covered under the same policy.

Modal Factors: Semiannual = Annual x 0.520; Quarterly = Annual x 0.265; Monthly = Annual /11

SERFF Tracking Number: AMLC-126162719 State: Arkansas  
Filing Company: Liberty National Life Insurance Company State Tracking Number: 42943  
Company Tracking Number: LMMGAP  
TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical  
Hospital/Surgical/Medical Expense Expense  
Product Name: Limited Benefit Hospital and Surgical Expense Policy  
Project Name/Number: Limited Benefit Hospital and Surgical Expense Policy/LMMGAP

## Supporting Document Schedules

**Satisfied -Name:** Flesch Certification **Review Status:** Approved-Closed 07/23/2009  
**Comments:**  
**Attachment:**  
S1351LN Readability Certification 3.pdf

**Satisfied -Name:** Application **Review Status:** Approved-Closed 07/23/2009  
**Comments:**  
New filing submission, form is also attached to the forms tab.  
**Attachment:**  
LMGAPB(03).pdf

**Satisfied -Name:** Outline of Coverage **Review Status:** Approved-Closed 07/23/2009  
**Comments:**  
New filing submission, form also attached to forms tab.  
**Attachment:**  
DS-LMMGAP.pdf

**LIBERTY NATIONAL LIFE INSURANCE COMPANY**  
P. O. BOX 8080, MCKINNEY, TEXAS 75070 (972) 529-5085  
A LEGAL RESERVE STOCK COMPANY \* ADMINISTRATIVE OFFICES: MCKINNEY, TEXAS

**READABILITY CERTIFICATION**

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

| <b><u>FORM</u></b>                             | <b><u>SCORE</u></b> |
|--|---------------------|
| POLICY FORM LMMGAP                             | 51.48               |
| OPTIONAL OUTPATIENT RIDER FORM R-LMMGAP-HO(10) | 58.00               |
| APPLICATION FORM LMGAPB                        | 51.01               |
| OPTIONAL DEPENDENT FORM LMGAPB-ODF             | 51.01               |
| DS-LMMGAP(10) OUTLINE OF COVERAGE              | 56.00               |



\_\_\_\_\_  
Michael J. Gaisbauer, Vice President

July 17, 2009

Date

Requested Effective Date (mm-dd-yyyy)

-  - 20

Payment Mode  Monthly  Semi-Annual  
 Quarterly  Annual

Payment Type  Bank Draft  Direct

Draft Day (01 to 28 only)

**BASE PLAN**

**Foundation Signature Series™**

- Proposed Insured  Child 1  Child 5  
 Spouse  Child 2  Child 6  
 Child 3  Child 7  
 Child 4  Child 8

**Maximum Annual Benefit**

- \$10,000  \$4,000  
 \$7,500  \$3,000  
 \$7,000  \$2,500  
 \$6,000  \$2,000  
 \$5,000

Premium

\$ ,    .

Additional Premium Included

**OPTIONAL RIDER**

**Hospital Outpatient Benefit \***

- Proposed Insured  Child 1  Child 5  
 Spouse  Child 2  Child 6  
 Child 3  Child 7  
 Child 4  Child 8

Premium

\$ ,    .

\* This rider does not increase the Maximum Annual Benefit.

**OPTIONAL LIFE INSURANCE**

**Life**

Proposed Insured

- 10 Yr. Term (18-63)  
 Whole Life (18-63)

Life Face Amount

\$ ,

Premium

\$ ,    .

Spouse

- 10 Yr. Term (18-63)  
 Whole Life (18-63)

\$ ,

\$ ,    .

**Child Term Rider**

- \$10,000  
 \$ 5,000

Total Premium \$ ,    .

Total Collected with Application \$ ,    .



**A LEGAL RESERVE STOCK COMPANY**

**IF THE ANSWER TO QUESTION 1 IS "YES" THEN CONTINUE. IF THE ANSWER IS "NO" THE PROPOSED INSURED IS NOT ELIGIBLE FOR COVERAGE.**

| INSURED<br>YES/NO | SPOUSE<br>YES/NO | CHILD 1<br>YES/NO | CHILD 2<br>YES/NO | CHILD 3<br>YES/NO |
|-------------------|------------------|-------------------|-------------------|-------------------|
|-------------------|------------------|-------------------|-------------------|-------------------|

- |  |                       |                       |                       |                       |                       |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Does the Proposed Insured or a Family Member have a Major Medical Policy or other comprehensive health coverage in force (or pending application)? Please list company, policy number and effective date (if available).  | <input type="radio"/> |
| 2. During the past 90 days, except for minor illness of one (1) week or pregnancy, has any illness, injury or health related problem prevented the Proposed Insured or any Family Member from working full time at his/her regular occupation or performing the normal activities of a person of the same age? | <input type="radio"/> |
| 3. Has the Proposed Insured or any Family Member <b>EVER</b> been treated for, 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"/> |
| 4. Has the Proposed Insured or any Family Member <b>EVER</b> had:  |                       |                       |                       |                       |                       |
| a. a disease or disorder of the heart or circulatory system including heart attack or stroke; high blood pressure?   | <input type="radio"/> |
| b. a disease or disorder of the eye, ear, nose, throat, lung, breast or reproductive organs?   | <input type="radio"/> |
| c. a disease or disorder of the rectum, kidney, prostate, stomach, intestine, gall bladder, urinary bladder, liver, connective tissue, lupus, collagen disease, pancreas, pituitary or adrenal gland?  | <input type="radio"/> |
| d. a disease or disorder of the brain (including retardation, dementia or Alzheimer's), mental or nervous system (including seizures or convulsions), back or spine, paralysis or arthritis?   | <input type="radio"/> |
| e. cancer, tumor, diabetes, blood disorders including anemia or spleen disorder?   | <input type="radio"/> |
| f. had his/her driver's license suspended or revoked because of a moving violation or been arrested for driving under the influence of alcohol or drugs?   | <input type="radio"/> |
| g. received treatment for alcohol abuse or been advised by a physician to reduce alcohol consumption?  | <input type="radio"/> |
| h. used or received treatment or consultation for heroin, cocaine or other similar agent or narcotic drug?   | <input type="radio"/> |
| 5. During the past five (5) years, has the Proposed Insured or any Family Member:  |                       |                       |                       |                       |                       |
| a. Had any medical or surgical advice, treatment or operations or been advised to have medical or diagnostic test(s), procedure(s), or surgery that has not yet been performed, or is awaiting medical test results?   | <input type="radio"/> |
| b. Been confined in a hospital?  | <input type="radio"/> |
| 6. During the past two (2) years, has the Proposed Insured or any Family Member:   |                       |                       |                       |                       |                       |
| a. Had a cesarean section, miscarriage or serious complications of a previous pregnancy?   | <input type="radio"/> |
| b. Been hospitalized 3 or more times?  | <input type="radio"/> |
| c. Received any disability benefits?   | <input type="radio"/> |
| 7. Does the Proposed Insured or any Family Member participate in any hazardous sports or avocations?<br>No benefits will be provided for loss due to such participation.   | <input type="radio"/> |
| 8. Does the Proposed Insured or any Family Member have any existing (or pending application for) health insurance?<br>If "YES", list coverage type _____   | <input type="radio"/> |
| 9. Does the Proposed Insured or any Family Member intend to replace or change any existing health insurance? If "YES" a replacement notice must be completed and signed.   | <input type="radio"/> |
| 10. Have you received an outline of coverage?  | <input type="radio"/> | <input type="radio"/> |                       |                       |                       |
| <b>If Optional Life coverage is chosen, please answer the following questions.</b>   |                       |                       |                       |                       |                       |
| 11. Has the Proposed Insured or Spouse used tobacco in any form within the past 12 months?   | <input type="radio"/> | <input type="radio"/> |                       |                       |                       |
| 12. Does the Proposed Insured or Spouse have any existing life insurance policies or annuity contract?   | <input type="radio"/> | <input type="radio"/> |                       |                       |                       |
| 13. Will the life insurance being applied for replace or change any existing life insurance or annuity contracts? If "YES" a replacement notice must be completed and signed.  | <input type="radio"/> | <input type="radio"/> |                       |                       |                       |

**A LEGAL RESERVE STOCK COMPANY**

If any Proposed Insured or any Family Member answered "Yes" to any of questions 2 - 7, provide details below for each "Yes" answer.

\* In column below list "I" for Insured, "S" for Spouse, "C1" for Child 1, "C2" for Child 2 and "C3" for Child 3.

| * | Dates | Illness/Injury | Operation? | Name/Address/Telephone of Doctors & Hospitals | Complete Recovery? |
|---|-------|----------------|------------|---|--------------------|
|   |       |                |            |   |                    |
|   |       |                |            |   |                    |
|   |       |                |            |   |                    |

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

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

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits application for insurance or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

**To the best of your knowledge as soliciting agent, is the insurance applied for intended to replace any existing life, annuity or health insurance policies or contracts?**  
 Yes  No

If "YES" a replacement notice must be completed and signed.

Date Application Signed (mm-dd-yyyy)  -  -   
 State

**Agent's Signature**  
 Last Name  Agent No.

**Proposed Insured**  
 Signed

Print First 5 Letters of Agent's Last Name  
 LMGAPB(03) SEND POLICY TO:  Agent  Insured

**Applicant (If other than the Proposed Insured)**  
 (The Policy will be sent to Insured unless otherwise instructed.)

**"Automatic" Payment Plan / Bank Draft**

Initials of Primary 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 COVERAGE - POLICY FORM LMMGAP**

Retain This Form For Your Records.

**LIMITED BENEFIT HOSPITAL AND SURGICAL EXPENSE POLICY  
For Persons Who Currently Have a Primary Medical Policy**

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

**Limited Benefit Hospital and Surgical Expense Policy Form LMMGAP** – This policy is designed to provide persons age 0-63 who currently have a Primary Medical Policy (a comprehensive or basic medical insurance providing coverage for care, treatment, services and supplies provided by a Hospital or Physician) with additional coverage for certain hospital and surgical expenses incurred as a result of a covered Injury or Sickness. Coverage is provided for certain deductibles, coinsurance and copayments for which You or a covered Family Member are obligated to pay under a Primary Medical Policy, subject to any limitations and exclusions set forth in the policy for which You are applying. Coverage is not provided for unlimited hospital or medical surgical expenses. **While this Outline of Coverage includes choices associated with the Maximum Annual Benefit and optional riders. Your policy Benefit Schedule will reflect Your chosen Maximum Annual Benefit amount and optional riders, as applied for and issued.**

**BENEFITS** - Eligible deductibles, coinsurance and copayments which You or a covered family member are obligated to pay under a Primary Medical Policy. Benefits listed below are subject to the Maximum Annual Benefit amount shown in Your policy Benefit Schedule.

**MAXIMUM ANNUAL BENEFIT** [\$2,000, \$2,500, \$3,000, \$4,000, \$5,000, \$6000, \$7000, \$7,500 or \$10,000]

The combined total benefits per covered person payable under this policy including the additional benefit riders, if any, shall never exceed the maximum annual benefit shown in Your policy benefit schedule per calendar year.

- 1. Hospital Inpatient Benefit** - Benefits are payable at the rate of **100%** of any deductible, coinsurance and copayments which You or a covered Family Member are obligated to pay under a Primary Medical Policy for Medically Necessary care, treatment, services and supplies provided by a Hospital or Physician to or for You or a covered Family Member during a necessary Inpatient Hospital Stay. Any such Inpatient Hospital Stay must be covered under the Primary Medical Policy and must be the result of an Injury or Sickness.
- 2. Refund of Premiums for Loss of Life from Accidental Injury** - We will refund the premiums paid for Your individual coverage under this policy if You die due to an Injury while Your coverage is in force or effect. We will refund to You the premiums paid under this policy for the coverage of a covered Family Member if that member dies due to an Injury while their coverage is in force or effect. Death must occur within 180 days of the Injury.
- 3. YOUR POLICY MAY CONTAIN OTHER BENEFITS MANDATED BY YOUR STATE. REFER TO PART 3 OF YOUR POLICY.**

## **HOSPITAL OUTPATIENT RIDER (Form R-LMMGAP-HO) OPTIONAL - Available for Additional Premium**

YOUR POLICY DOES NOT PROVIDE BENEFITS FOR OUTPATIENT SERVICES UNLESS YOU SELECTED THE OPTIONAL RIDER ON THE APPLICATION AND THE RIDER IS ISSUED. The rider expands the types of care, treatment, services and supplies for which a benefit may be payable. The rider does not increase the maximum annual benefit stated in the policy or certificate schedule.

**Hospital Outpatient Benefit (OPTIONAL)** – Benefits are payable at the rate of 50% of any deductible, coinsurance and copayments which You or a covered Family Member are obligated to pay under a Primary Medical Policy for Medically Necessary Outpatient Hospital Services provided to or for You or a covered Family Member. Any such Outpatient Hospital Services must be covered under the Primary Medical Policy and must be the result of an Injury or Sickness.

**Outpatient Hospital Services** means care, treatment, services and supplies provided by a Physician or facility for:

1. outpatient surgery in a Hospital or free-standing outpatient surgery center;
2. outpatient diagnostic testing in a Hospital or free-standing imaging facility or free-standing laboratory;
3. treatment in a Hospital emergency room; and
4. other outpatient treatment in a Hospital.

Outpatient Hospital Services shall not include care, treatment, services and supplies provided in a Doctor's office.

### **LIMITATIONS AND EXCLUSIONS**

We will not pay benefits under this policy for:

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

### **RENEWAL AGREEMENT**

You can continue this policy in force for successive renewal terms of 1 month, 3 months, 6 months or 12 months by paying appropriate renewal premiums before the end of the grace period. The appropriate renewal premiums will be those under Our applicable table of premium rates that is in effect on the respective due dates of the premiums. We have the right to change the renewal premiums for this policy when We change, and in accordance with, Our table of premium rates applicable to all policies of this form and class. Class is based on benefit amount, persons covered under the policy, benefit structure of the Primary Medical Policy, state of issue, age at issue, gender, underwriting group and geographic rating area.

We also have the right to change the renewal premiums for this policy when the benefit structure of Your Primary Medical Policy changes, in accordance with the table of premium rates applicable to all policies of this form and class.

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

**PREMIUM**

Your premium for the policy is monthly \$\_\_\_\_\_, quarterly \$ \_\_\_\_\_, semi-annually \$\_\_\_\_\_, or annually \$\_\_\_\_\_.

You pay a one time policy fee of \$\_\_\_\_\_.



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

**LIBERTY NATIONAL LIFE INSURANCE COMPANY  
P. O. BOX 8080, MCKINNEY, TEXAS 75070 (972) 529-5085  
A LEGAL RESERVE STOCK COMPANY \* ADMINISTRATIVE OFFICES: MCKINNEY, TEXAS**

**30 DAY RIGHT TO EXAMINE POLICY**

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

**RENEWAL AGREEMENT**

YOU can continue this policy in force for successive renewal terms of 1 month, 3 months, 6 months or 12 months by paying appropriate renewal premiums before the end of the grace period. The appropriate renewal premiums will be those under OUR applicable table of premium rates that is in effect on the respective due dates of the premiums. WE have the right to change the renewal premiums for this policy when WE change, and in accordance with, OUR table of premium rates applicable to all policies of this form and class. Class is based on benefit amount, persons covered under the policy, benefit structure of the PRIMARY MEDICAL POLICY, state of issue, age at issue, gender, underwriting group and geographic rating area. WE also have the right to change the renewal premiums for this policy when the benefit structure of YOUR PRIMARY MEDICAL POLICY changes, in accordance with the table of premium rates applicable to all policies of this form and class.

**BENEFIT SCHEDULE**

MAXIMUM ANNUAL BENEFIT.....\$ [2,000.00]

THE COMBINED TOTAL BENEFITS PER COVERED PERSON PAYABLE UNDER THIS POLICY INCLUDING THE ADDITIONAL BENEFIT RIDERS, IF ANY, SHALL NEVER EXCEED THE MAXIMUM ANNUAL BENEFIT PER CALENDAR YEAR.

**POLICY SCHEDULE**

| INSURED    | POLICY NUMBER | EFFECTIVE DATE | INITIAL TERM EXPIRES ON | INITIAL PREMIUM |
|------------|---------------|----------------|-------------------------|-----------------|
| [John Doe] | [12346789]    | [08-01-09]     | [09-01-09]              | [\$44.00]       |

**ADDITIONAL BENEFITS**

[HOSPITAL Outpatient]

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

## INSURING CLAUSE

The COMPANY insures YOU against specified losses incurred by a COVERED PERSON. Benefits payable under this policy, subject to all of its provisions, limitations and exclusions, will be paid to YOU or, at OUR option, to the HOSPITAL, PHYSICIAN, or person providing any care, treatment, service, or supply covered by this policy. OUR obligation to make payment under this policy during any calendar year shall not exceed the MAXIMUM ANNUAL BENEFIT disclosed in the Benefit Schedule. A benefit will only be due and payable when a COVERED PERSON is obligated to pay a deductible, coinsurance or copayment under any PRIMARY MEDICAL POLICY providing benefits to such COVERED PERSON that is incurred for any covered care, treatment, service, or supply, or combination thereof, provided to or for a COVERED PERSON while this policy is in force. A deductible, coinsurance or copayment is incurred on the date the care, treatment, service, or supply is provided.

## PRE-EXISTING CONDITION LIMITATION

This policy does not insure YOU against loss incurred by any COVERED PERSON during the twelve (12) months immediately after the Effective Date of this policy if that loss results from a PRE-EXISTING CONDITION. In addition, any PRE-EXISTING CONDITION listed on the application is not covered for the first twelve (12) months after the policy Effective Date.

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## DEFINITIONS

Where used in this policy:

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

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

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

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

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

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

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

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

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

**INTENSIVE CARE** means care which is provided within a separate area or unit of a HOSPITAL that has been set aside for care of the critically ill or injured. The area or unit must have special monitoring equipment for the use of PHYSICIANS,

nurses or other medical specialists assisting in these units. INTENSIVE CARE does not include: step down, isolation, telemetry, or post INTENSIVE CARE units of a HOSPITAL.

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

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

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

**MAXIMUM ANNUAL BENEFIT** means the maximum sum of money that is payable by US for each COVERED PERSON under the provisions of this policy, including any rider whenever made a part of this policy, for the care, treatment, services and supplies provided to or for the COVERED PERSON during a calendar year.

**MEDICAL FOOD** means a food that is:

1. Intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles; and
2. Formulated to be consumed or administered enterally under the direction of a PHYSICIAN.

**MEDICALLY NECESSARY** means:

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

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

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

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

**PHYSICIAN and DOCTOR** mean a person duly licensed in the United States and duly qualified to provide care, treatment, services, or supplies for the INJURY or SICKNESS that is the subject of YOUR claim, or for the additional conditions or disorder, or diagnostic services, which are specifically covered under PART 3 of this policy. PHYSICIAN or DOCTOR does not include YOU or any member of YOUR immediate family.

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

**PRIMARY MEDICAL POLICY** means a comprehensive or basic medical insurance providing coverage for care, treatment, services and supplies provided by a HOSPITAL or PHYSICIAN. If a COVERED PERSON is enrolled in Medicare, then Medicare is such COVERED PERSON'S PRIMARY MEDICAL POLICY.

**SICKNESS** means a medical condition, illness, disease or disorder requiring medical diagnosis, care, advice or treatments which first manifests itself after the Effective Date of the policy and while this policy is in force. A medical condition, illness, disease, or disorder is "manifested" when it is diagnosed by a PHYSICIAN, or whenever the COVERED PERSON begins experiencing any symptom or sign of the medical condition, illness, disease, or disorder.

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

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

## **PART 1**

### **HOSPITAL INPATIENT BENEFIT**

WE will pay a benefit at the rate of 100% of any deductible, coinsurance and copayments which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY for MEDICALLY NECESSARY care, treatment, services and supplies provided by a HOSPITAL or PHYSICIAN to or for YOU or a covered FAMILY MEMBER during a necessary INPATIENT HOSPITAL STAY. Any such INPATIENT HOSPITAL STAY must be covered under the PRIMARY MEDICAL POLICY and must be the result of an INJURY or SICKNESS.

**The total benefits payable under this PART 1 for all INPATIENT HOSPITAL STAYS of any one COVERED PERSON during any one calendar year shall not exceed the MAXIMUM ANNUAL BENEFIT stated in the Benefit Schedule less all benefits paid under PART 3 together with all benefits paid under any riders selected and made a part of this policy.**

When filing a claim YOUR Proof of Loss to US must include the Explanation of Benefits provided pursuant to the PRIMARY MEDICAL POLICY or other documentation showing dollar amounts that YOU or a covered FAMILY MEMBER are obligated to pay under the PRIMARY MEDICAL POLICY.

## **PART 2 REFUND OF PREMIUMS FOR LOSS OF LIFE FROM INJURY**

WE will refund to YOUR estate the premiums paid for YOUR individual coverage under this policy if YOU die due to an INJURY while YOUR coverage is in force or effect. WE will refund to YOU the premiums paid under this policy for the coverage of a covered FAMILY MEMBER if that member dies due to an INJURY while his or her coverage under this policy is in force or effect.

To be entitled to said refund of premium, the death must occur while this policy is in force and within 180 days of the INJURY causing death.

## **PART 3 OTHER BENEFITS**

On the condition that a benefit for the following care, treatment, services, and supplies is not elsewhere provided in this policy, including any rider whenever made a part of this policy, WE will pay a benefit for the following care, treatment, services, and supplies provided to or for a COVERED PERSON while this policy is in force according to the terms, dollar amounts and maximums set forth below in this PART 3 with respect to such covered care, treatment, services, and supplies. ALL BENEFITS PAYABLE UNDER THIS PART 3 SHALL BE SUBJECT TO ALL POLICY PROVISIONS, LIMITATIONS AND EXCLUSIONS, AND DOLLAR-LIMIT PROVISIONS OF THIS POLICY, EXCEPT AS OTHERWISE SPECIFICALLY PROVIDED IN THIS PART 3. A benefit payable under this PART 3 shall not duplicate any benefit or benefits payable under PART 1 of this policy or any benefit rider made a part of this policy.

**The total benefits payable under this PART 3 for all care, treatment, services, and supplies provided to any one COVERED PERSON during any one calendar year shall not exceed the MAXIMUM ANNUAL BENEFIT stated in the Benefit Schedule less all benefits paid under PART 1 together with all benefits paid under any riders selected and made a part of this policy.**

When filing a claim YOUR Proof of Loss to US must include the Explanation of Benefits provided pursuant to the PRIMARY MEDICAL POLICY or other documentation showing dollar amounts that YOU or a covered FAMILY MEMBER are obligated to pay under the PRIMARY MEDICAL POLICY.

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

As described in PART 4(3), this policy does not provide benefits for normal pregnancy. However, for an INPATIENT HOSPITAL STAY for which benefits are otherwise provided under this policy to a COVERED PERSON for a distinct complication of pregnancy, WE will pay a benefit for an INPATIENT HOSPITAL STAY and inpatient care for a minimum of forty-eight (48) hours of inpatient care following vaginal delivery and a minimum of ninety-six (96) hours of inpatient care following a cesarean section for a mother, her newly born child, or both, in a HOSPITAL or any other health care facility licensed to provide obstetrical care, when that INPATIENT HOSPITAL STAY is deemed MEDICALLY NECESSARY by the attending PHYSICIAN, who is a medical doctor. Such benefit will be paid at the rate of 100% of any deductible, coinsurance and copayments for which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY not to exceed the MAXIMUM ANNUAL BENEFIT.

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

Where coverage is provided to or for a COVERED PERSON under a PRIMARY MEDICAL POLICY for Breast Reconstructive Surgery and Prosthetic Device, WE will pay a benefit at the rate of 100% of any deductible, coinsurance and copayments for which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY for prosthetic devices, breast reconstructive surgery, or both, for a COVERED PERSON incident to a MASTECTOMY covered under this policy, including:

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

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

Where the PRIMARY MEDICAL POLICY does not provide any coverage for treatment and services for Breast Reconstructive Surgery and Prosthetic Device, WE will pay a sum equal to 20% of the incurred expenses not to exceed a maximum benefit of \$500 for all such treatment and services for Breast Reconstructive Surgery and Prosthetic Device provided to or for any one COVERED PERSON during any one calendar year.

### **3. CHILD PREVENTIVE HEALTH CARE SERVICES BENEFIT**

Where coverage is provided to or for a COVERED PERSON under a PRIMARY MEDICAL POLICY for Child Preventive Health Care Services, WE will pay a benefit at the rate of 100% of any deductible, coinsurance and copayments for which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY for expenses incurred by YOU or a covered FAMILY MEMBER for PERIODIC PREVENTIVE CARE VISITS related to CHILD PREVENTIVE HEALTH CARE SERVICES for a COVERED PERSON when that COVERED PERSON attains the following ages: birth, two weeks, two months, four months, six months, nine months, twelve months, fifteen months, eighteen months, two years, three years, four years, five years, six years, eight years, ten years, twelve years, fourteen years, sixteen years and eighteen years. CHILD PREVENTIVE HEALTH CARE SERVICES shall be limited to services provided by or under the supervision of a single PHYSICIAN or other primary health care provider who is a licensed medical doctor or doctor of osteopathy during the course of one visit.

Where the PRIMARY MEDICAL POLICY does not provide any coverage for treatment and services for Child Preventive Health Care Services, WE will pay a sum equal to 80% of the incurred expenses not to exceed a maximum benefit of \$250 for all such treatment and services for Child Preventive Health Care Services provided to or for any one COVERED PERSON during any one calendar year.

This benefit will be subject to copayment, coinsurance, deductible, or dollar limit provisions.

### **4. DIABETES BENEFIT**

Where coverage is provided to or for a COVERED PERSON under a PRIMARY MEDICAL POLICY for Diabetes, WE will pay a benefit at the rate of 100% of any deductible, coinsurance and copayments for which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY for expenses incurred by a COVERED PERSON for medically appropriate and necessary equipment, supplies, diabetes outpatient self-management training and educational services, or any combination thereof, used in the management and treatment of diabetes for persons with gestational, type I or type II diabetes, if the COVERED PERSON'S treating PHYSICIAN or a PHYSICIAN who specializes in the treatment of diabetes certifies that such services are necessary.

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

Where the PRIMARY MEDICAL POLICY does not provide any coverage for treatment and services for Diabetes, WE will pay a sum equal to 20% of the incurred expenses not to exceed a maximum benefit of \$1,500 for all such treatment and services for Diabetes provided to or for any one COVERED PERSON during any one calendar year.

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

Where coverage is provided to or for a COVERED PERSON under a PRIMARY MEDICAL POLICY for Anesthesia and Hospitalization for Dental Procedures, WE will pay a benefit at the rate of 100% of any deductible, coinsurance and copayments for which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY for general anesthesia, HOSPITAL charges, or both for dental care charges incurred in a HOSPITAL or AMBULATORY SURGICAL CENTER when the procedure is performed by (i) a fully accredited specialist in pediatric dentistry or other dentist fully accredited in a recognized dental specialty for which HOSPITAL or AMBULATORY SURGICAL CENTER privileges are granted; (ii) a dentist who is certified by virtue of completion of an accredited program of postgraduate training to be granted HOSPITAL or AMBULATORY SURGICAL CENTER privileges; or (iii) a dentist who has not yet satisfied certification requirements but has been granted HOSPITAL or AMBULATORY SURGICAL CENTER privileges; and when the COVERED PERSON receiving such treatment:

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

Where the PRIMARY MEDICAL POLICY does not provide any coverage for treatment and services for Anesthesia and Hospitalization for Dental Procedures, WE will pay a sum equal to 20% of the incurred expenses not to exceed a maximum benefit of \$100 for all such treatment and services for Anesthesia and Hospitalization for Dental Procedures provided to or for any one COVERED PERSON during any one calendar year.

This benefit does not cover routine dental care, including the diagnosis or treatment of disease or other dental conditions and procedures not specifically covered under this subpart of PART 3.

#### **6. SPEECH AND HEARING DISORDERS BENEFIT**

Where coverage is provided to or for a COVERED PERSON under a PRIMARY MEDICAL POLICY for Speech and Hearing Disorders, WE will pay a benefit at the rate of 100% of any deductible, coinsurance and copayments for which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY for the expenses incurred for MEDICALLY NECESSARY care and treatment of loss or impairment of speech or hearing, or both if treated by a speech pathologist, audiologist or speech language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association or both, and which fall within the scope of their license or certification. This benefit does not cover hearing aids, instruments or devices.

Where the PRIMARY MEDICAL POLICY does not provide any coverage for treatment and services for Speech and Hearing Disorders, WE will pay a sum equal to 20% of the incurred expenses not to exceed a maximum benefit of \$1,000 for all such treatment and services for Speech and Hearing Disorders provided to or for any one COVERED PERSON during any one calendar year.

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

Where coverage is provided to or for a COVERED PERSON under a PRIMARY MEDICAL POLICY for Medical Foods and Low Protein Modified Food Products, WE will pay a benefit at the rate of 100% of any deductible, coinsurance and copayments for which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY for the expense incurred for MEDICAL FOODS, LOW PROTEIN MODIFIED FOOD PRODUCTS, amino acid modified preparations and any other special dietary products and formulas for the treatment of INHERITED METABOLIC DISEASES if the MEDICAL FOODS or LOW PROTEIN MODIFIED FOOD PRODUCTS, amino acid modified preparations and other special dietary products and formulas are prescribed as MEDICALLY NECESSARY for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias and disorders of amino acid metabolism, and administered under the direction of a PHYSICIAN.

Where the PRIMARY MEDICAL POLICY does not provide any coverage for treatment and services for Medical Foods and Low Protein Modified Food Products, WE will pay a sum equal to 20% of the incurred expenses not to exceed a maximum benefit of \$2,400 for all such treatment and services for Medical Foods and Low Protein Modified Food Products provided to or for any one COVERED PERSON during any one calendar year.

#### **8. COLORECTAL CANCER SCREENING BENEFIT**

Where coverage is provided to or for a COVERED PERSON under a PRIMARY MEDICAL POLICY for Colorectal Cancer Screening, WE will pay a benefit at the rate of 100% of any deductible, coinsurance and copayments for which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY for the expense incurred for colorectal cancer examinations and laboratory tests for a COVERED PERSON who is 50 years of age or older, at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005, or experiencing the symptoms of colorectal cancer as determined by a PHYSICIAN licensed under the Arkansas Medical Practices Act, §17-95-201 et seq., §17-95-301 et seq., and §17-95-401 et seq., including bleeding from the rectum or blood in the stool, or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool that lasts more than five (5) days. The colorectal screening shall involve an examination of the entire colon, and WE will provide a benefit for colorectal cancer screening for any one of the following options:

- 1) An annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;
- 2) A double-contrast barium enema every five (5) years; or
- 3) A colonoscopy every ten (10) years, and follow-ups based on the following schedule:
  - i. If the initial colonoscopy is normal, a follow-up is covered once every ten (10) years;
  - ii. For individuals with one (1) or more neoplastic polyps, adenomatous polyps, and the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps was performed, a follow-up will be covered after three (3) years;
  - iii. If single tubular adenoma of less than one centimeter (1 cm) is found, a follow-up will be covered after five (5) years; and

- iv. For patients with large sessile adenomas greater than three centimeters (3 cm), a follow-up will be covered after six (6) months, or continuously until complete polyp removal is verified by colonoscopy.
- 4) Any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health determined in consultation with appropriate health care organizations.

Where the PRIMARY MEDICAL POLICY does not provide any coverage for treatment and services for Colorectal Cancer Screening, WE will pay a sum equal to 20% of the incurred expenses not to exceed a maximum benefit of \$1,000 for all such treatment and services for Colorectal Cancer Screening provided to or for any one COVERED PERSON during any one calendar year.

#### **9. MENTAL ILLNESS BENEFIT**

Where coverage is provided to or for a COVERED PERSON under a PRIMARY MEDICAL POLICY for Mental Illness, WE will pay a benefit at the rate of 100% of any deductible, coinsurance and copayments for which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY for expenses incurred for a COVERED PERSON for the treatment of MENTAL ILLNESS on an inpatient or outpatient basis. Benefits will be provided to the same extent as any other physical illness covered under this policy.

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

Where coverage is provided to or for a COVERED PERSON under a PRIMARY MEDICAL POLICY for Temporomandibular Joint Disorder and Craniomandibular Jaw Disorder, WE will pay a benefit at the rate of 100% of any deductible, coinsurance and copayments for which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY for the treatment and care provided to or for a COVERED PERSON for the diagnostic procedure and surgical treatment of temporomandibular and craniomandibular disorder if, under accepted medical standards, such diagnostic procedure or surgery is MEDICALLY NECESSARY to treat conditions caused by a congenital or developmental deformity, disease, disorder, or INJURY. A temporomandibular and craniomandibular disorder shall be considered to be a SICKNESS under this policy, and benefits will be paid under PART 1 as applicable. However, this policy does not include coverage for orthodontic appliances and treatment, crowns, bridges and dentures unless the disorder is trauma related.]

### **PART 4**

### **LIMITATIONS AND EXCLUSIONS**

WE will not pay benefits under this policy for:

1. Services not covered under the PRIMARY MEDICAL POLICY; or
2. Expenses in excess of benefit limits or maximums in the PRIMARY MEDICAL POLICY; or
3. Normal pregnancy (including childbirth, false labor, occasional spotting, PHYSICIAN-prescribed rest, morning SICKNESS, hyper emesis gravidarum, preeclampsia and similar conditions associated with a difficult pregnancy which do not constitute a distinct complication of pregnancy) or voluntary termination of pregnancy; or
4. Usual and customary routine nursery care, or well-baby care or immunizations; or any other usual and customary routine care and treatment following full term or premature birth, not incident and necessary to the treatment of INJURY or SICKNESS; or
5. Convalescent, skilled nursing, educational care or for nervous or mental disorders, unless covered by YOUR PRIMARY MEDICAL POLICY; or
6. Dental treatment, hearing aids or eye refractive exams, refractive surgery or refractive treatment; or
7. Any INPATIENT HOSPITAL STAY or other service for which YOU or a FAMILY MEMBER do not incur a charge; or
8. Any loss paid by any Workmen's Compensation or Employers' Liability Law; or
9. Any INPATIENT HOSPITAL STAY or other service that is not MEDICALLY NECESSARY, or is cosmetic in nature; or
10. Any expense incurred in excess of the usual, customary and regular charges for any service or materials in the geographic area where furnished; or
11. Charges incurred for professional radiological, pathological or EKG interpretations, unless covered by YOUR PRIMARY MEDICAL POLICY; or
12. Rehabilitative care services received at a facility not meeting the definition of a HOSPITAL, unless covered by YOUR PRIMARY MEDICAL POLICY; or
13. Treatment or services incurred outside of the U.S. boundaries; or
14. Infertility or sterilization treatment procedures, unless covered by YOUR PRIMARY MEDICAL POLICY.

### **POLICY PROVISIONS**

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

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

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

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

In the event of YOUR death or other termination of YOUR coverage, the following shall successively become the INSURED: (1) YOUR spouse (if YOUR spouse is a FAMILY MEMBER); or (2) YOUR eldest remaining FAMILY MEMBER.

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

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

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

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

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

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

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

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

**GRACE PERIOD:** This policy 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.

**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. When filing a claim, it is necessary to submit the Explanation of Benefits provided by YOUR PRIMARY MEDICAL POLICY, or other documentation showing amounts for which YOU are responsible for under the PRIMARY MEDICAL POLICY.

An Explanation of Benefits from YOUR PRIMARY MEDICAL POLICY or other documentation of deductible, coinsurance or copayments is necessary to determine benefits under this policy.

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

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

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

**PAYMENT OF CLAIMS:** Benefits will be paid, after WE receive a claim form and proper written Proof Of Loss satisfactory to US, to YOU unless YOU assign them to the DOCTOR or HOSPITAL. Any benefit unpaid at death will be paid to YOUR named beneficiary or, at OUR option, to YOUR estate. If benefits are payable to YOUR estate, WE can pay benefits up to \$3,000 to someone related to YOU by blood or marriage whom WE consider to be entitled to the benefits. WE will be discharged to the extent of any such payment made in good faith.

**PHYSICAL EXAMINATIONS:** WE, at OUR expense, have the right to have YOU or a FAMILY MEMBER examined as often as reasonably necessary while a claim is pending.

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

**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.

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

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



Secretary



President

**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  
3700 S Stonebridge Drive  
McKinney, Texas 75070  
Telephone: (972) 529-5085

Arkansas Insurance Department  
Consumer Services Division  
1200 West 3<sup>rd</sup> Street  
Little Rock, Arkansas 72201-1904  
Telephone: (501)371-2600

Agent's Name: \_\_\_\_\_ Agent's Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_

# LIBERTY NATIONAL LIFE INSURANCE COMPANY

A LEGAL RESERVE STOCK COMPANY \* ADMINISTRATIVE OFFICES: MCKINNEY, TEXAS

## HOSPITAL OUTPATIENT RIDER TO POLICY OR CERTIFICATE # \_\_\_\_\_

THIS RIDER EXPANDS THE TYPES OF CARE, TREATMENT, SERVICES AND SUPPLIES FOR WHICH A BENEFIT MAY BE PAYABLE. THIS RIDER DOES NOT INCREASE THE MAXIMUM ANNUAL BENEFIT STATED IN THE POLCY OR CERTIFICATE SCHEDULE. This rider amends and is made a part of the policy or certificate referenced in the Rider Schedule. It is subject to all provisions, conditions, limitations and exclusions of the policy or certificate which are not in direct conflict with those of this rider.

### 30-DAY RIGHT TO EXAMINE RIDER

If this rider is issued subsequent to the Effective Date of the policy or certificate described in the Rider Schedule, and if YOU are not satisfied with this rider for any reason, YOU may return it to OUR Administrative Office or to the agent within 30 days after YOU receive it. Any premium YOU paid for this rider will be refunded to YOU. In the event YOU return this rider to US, this rider will be void from its inception and it will be as if no rider ever existed between YOU and US.

**IMPORTANT NOTICE:** IF YOU COMPLETED A NEW APPLICATION TO OBTAIN THIS RIDER, A COPY IS ATTACHED TO THIS RIDER. PLEASE READ THIS APPLICATION CAREFULLY AND WRITE TO US AT THE ADDRESS SHOWN ABOVE WITHIN 10 DAYS IF ANY ANSWER OR INFORMATION SHOWN ON IT IS NOT CORRECT AND COMPLETE OR IF ANY PAST MEDICAL HISTORY HAS BEEN OMITTED FROM THE APPLICATION. THIS APPLICATION IS A PART OF THE RIDER AND THE RIDER WAS ISSUED ON THE BASIS THAT ALL INFORMATION AND ANSWERS TO ALL QUESTIONS SHOWN ON THE APPLICATION ARE CORRECT AND COMPLETE.

**Time Limit on Certain Defenses:** After 2 years from the Effective Date of this rider, only fraudulent misstatements in the application upon which this rider was issued may be used to void this rider or deny any claim for loss incurred after the 2-year period.

### INSURING CLAUSE

WE will pay YOU the benefit stated in this rider (Hospital Outpatient Benefit), subject to all the provisions, conditions, limitations and exclusions of the rider and policy or certificate referenced in the Rider Schedule, when WE receive timely written proof of loss satisfactory to US of losses or expenses incurred by a COVERED PERSON while the policy or certificate referenced in the Rider Schedule and this rider are in force with respect to that Covered Person.

### RIDER SCHEDULE

| COVERED PERSON | [POLICY] NUMBER | EFFECTIVE DATE | BENEFIT PERCENTAGE |
|----------------|-----------------|----------------|--------------------|
| [John Doe]     | [12345678]      | [08/01/2009]   | [50]%              |

Rider Premium: \$ \_\_\_\_\_ for every \_\_\_\_\_ months  
(included in the Policy Schedule or Certificate Schedule of the policy or certificate referenced above if no amount is shown here)

## ADDITIONAL DEFINITION

**OUTPATIENT HOSPITAL SERVICES** means care, treatment, services and supplies provided by a PHYSICIAN or facility for:

1. outpatient surgery in a HOSPITAL or free-standing outpatient surgery center;
2. outpatient diagnostic testing in a HOSPITAL or free-standing imaging facility or free-standing laboratory;
3. treatment in a HOSPITAL emergency room; and
4. other outpatient treatment in a HOSPITAL.

OUTPATIENT HOSPITAL SERVICES shall not include care, treatment, services and supplies provided in a DOCTOR'S office.

## HOSPITAL OUTPATIENT BENEFIT

WE will pay a benefit at the rate of [50]% of any deductible, coinsurance and copayments which YOU or a covered FAMILY MEMBER are obligated to pay under a PRIMARY MEDICAL POLICY for MEDICALLY NECESSARY OUTPATIENT HOSPITAL SERVICES provided to or for YOU or a covered FAMILY MEMBER. Any such OUTPATIENT HOSPITAL SERVICES must be covered under the PRIMARY MEDICAL POLICY and must be the result of an INJURY or SICKNESS.

The total benefits payable under this rider for all OUTPATIENT HOSPITAL SERVICES provided to any one COVERED PERSON during any one calendar year shall not exceed the MAXIMUM ANNUAL BENEFIT stated in the Benefit Schedule of the policy or certificate less all benefits paid under PART 1 of the policy or certificate together with all benefits paid under PART 3 of the policy or certificate.

When filing a claim YOUR Proof of Loss to US must include the Explanation of Benefits provided pursuant to the PRIMARY MEDICAL POLICY or other documentation showing dollar amounts that YOU or a covered FAMILY MEMBER are obligated to pay under the PRIMARY MEDICAL POLICY.

## RIDER PROVISIONS

**TERMINATION OF RIDER:** This rider will terminate without prior notice to you when the first of these occurs:

1. The policy or certificate referenced in the Rider Schedule lapses or expires, is canceled or otherwise terminated.
2. YOU do not pay the premium for the policy or certificate referenced in the Rider Schedule, or for this rider, by the end of the Grace Period.
3. YOU convert the policy or certificate referenced in the Rider Schedule.
4. The policy or certificate referenced in the Rider Schedule is rescinded by US.

**PAYMENT OF PREMIUM:** The premium amount for this rider is included in the Policy Schedule or Certificate Schedule of the policy or certificate referenced in the Rider Schedule. However, if this rider is issued subsequent to the Effective Date of the policy or certificate identified in the Rider Schedule, and unless the policy or certificate, including this rider, is reissued, the premium amount for this rider will be set forth in the Rider Schedule.

This rider is signed for US by OUR President and Secretary.



Secretary



President