

SERFF Tracking Number: GRTT-126869462 State: Arkansas  
Filing Company: United National Life Insurance Company of America State Tracking Number: 47161  
Company Tracking Number: U1050-AR  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: U1050-AR  
Project Name/Number: Limited Benefit /U1050-AR

## Filing at a Glance

Company: United National Life Insurance Company of America

Product Name: U1050-AR

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: GRTT-126869462 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 47161

Co Tr Num: U1050-AR

Author: Gillian Liang

Date Submitted: 10/28/2010

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 11/01/2010

Disposition Status: Approved-  
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name: Limited Benefit

Project Number: U1050-AR

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 11/01/2010

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: 11/01/2010

Created By: Gillian Liang

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Gillian Liang

PPACA: Not PPACA-Related

Filing Description:

RE: United National Life Insurance Company of America

NAIC # 92703; FEIN 37-1095206

Individual Accident and Health Insurance

Limited Benefit Health Policy U1050-AR

Doctor's Office Visit Benefit Rider RU10DRV

Emergency Benefit Rider RU10ER

Outpatient Surgery Benefit Rider RU10OPS

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Skilled Nursing Facility Benefit Rider RU10SNF  
Dental and Vision Benefit Rider RU10DV  
Application UAPPH3-10-AR  
Outline of Coverage OCU1050  
Actuarial Memorandum and Annual Premium Rate Sheets

Enclosed for filing are the above captioned forms. They are new and will not replace any form currently on file with your Department. Enclosed are the applicable rates and supporting actuarial data.

The enclosed forms provide limited benefit health coverage. The base plan offers daily benefits for injury, sickness, along with doctor's office visit benefit. Applicants will also be offered the riders referenced above.

Application UAPPH3-10-AR will be used in the solicitation of this product, but we ask for its general approval, in the event it may be used for similar products approved in the future.

Also enclosed are the actuarial memorandum and rates for previously approved Lump Sum Cancer Rider RU07LS (Approved on 10/25/2007 under SERFF Filing No. GRTT-125292922) which will be offered with this policy.

Bracketed material represents variability. Variations will be used to reflect policyholder selection, elections of optional benefits and changes in coverage offerings. Text within brackets will either be in or out of the issued forms. Numerals in brackets will change to reflect plan design.

We use multiple computer systems to generate forms. Therefore, actual issued forms may have a different font style than the submitted forms. As a result, provisions may appear on different pages and lines may not match up exactly. The wording and its order, however, will remain identical. We do not anticipate refile for a font style variation.

If you have questions on any aspect of this filing, please contact me at 847-904-5410 or by email at [glian@gtlic.com](mailto:glian@gtlic.com).

As always, your time and consideration of this submission for approval is sincerely appreciated.

## Company and Contact

### Filing Contact Information

Gillian Liang, Senior Compliance Analyst [glian@gtlic.com](mailto:glian@gtlic.com)  
1275 Milwaukee Ave. 847-904-5410 [Phone]  
Glenview, IL 60025 847-699-0093 [FAX]

### Filing Company Information

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 Project Name/Number: Limited Benefit /U1050-AR  
 United National Life Insurance Company of America CoCode: 92703 State of Domicile: Illinois  
 1275 Milwaukee Ave. Group Code: 903 Company Type:  
 Glenview, IL 60025 Group Name: State ID Number:  
 (847) 803-5252 ext. [Phone] FEIN Number: 37-1095206  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$400.00  
 Retaliatory? No  
 Fee Explanation: Filing fee for Arkansas is \$50.00 per form. For 7 forms 50 x 7 = \$350.00  
 Rate filing is \$50.00. Total fee is \$400.00.  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United National Life Insurance Company of America	\$400.00	10/28/2010	41281861

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/01/2010	11/01/2010

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Rate	Limited Benefit Policy	Gillian Liang	10/29/2010	10/29/2010
Rate	Doctor's Office Visit Benefit Rider	Gillian Liang	10/29/2010	10/29/2010
Rate	Emergency Benefit Rider	Gillian Liang	10/29/2010	10/29/2010
Rate	Outpatient Surgery Benefit Rider	Gillian Liang	10/29/2010	10/29/2010
Rate	Skilled Nursing Facility Benefit Rider	Gillian Liang	10/29/2010	10/29/2010
Rate	Dental and Vision Benefit Rider	Gillian Liang	10/29/2010	10/29/2010
Rate	Lump Sum Cancer Rider	Gillian Liang	10/29/2010	10/29/2010
Supporting Document	Health - Actuarial Justification	Gillian Liang	10/29/2010	10/29/2010

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## Disposition

Disposition Date: 11/01/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document (revised)	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Health - Actuarial Justification	Replaced	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Limited Benefit Policy	Approved-Closed	Yes
Form	Doctor's Office Visit Benefit Rider	Approved-Closed	Yes
Form	Emergency Benefit Rider	Approved-Closed	Yes
Form	Outpatient Sugery Benefit Rider	Approved-Closed	Yes
Form	Skilled Nursing Facility Benefit Rider	Approved-Closed	Yes
Form	Dental and Vision Benefit Rider	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Rate (revised)	Limited Benefit Policy	Approved-Closed	Yes
Rate	Limited Benefit Policy	Replaced	Yes
Rate (revised)	Doctor's Office Visit Benefit Rider	Approved-Closed	Yes
Rate	Doctor's Office Visit Benefit Rider	Replaced	Yes
Rate (revised)	Emergency Benefit Rider	Approved-Closed	Yes
Rate	Emergency Benefit Rider	Replaced	Yes
Rate (revised)	Outpatient Surgery Benefit Rider	Approved-Closed	Yes
Rate	Outpatient Surgery Benefit Rider	Replaced	Yes
Rate (revised)	Skilled Nursing Facility Benefit Rider	Approved-Closed	Yes
Rate	Skilled Nursing Facility Benefit Rider	Replaced	Yes
Rate (revised)	Dental and Vision Benefit Rider	Approved-Closed	Yes
Rate	Dental and Vision Benefit Rider	Replaced	Yes
Rate (revised)	Lump Sum Cancer Rider	Approved-Closed	Yes
Rate	Lump Sum Cancer Rider	Replaced	Yes

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**Amendment Letter**

Submitted Date: 10/29/2010

**Comments:**

We have corrected the monthly modal factor from .084 to .09 on the actuarial memorandums and rate sheets. We have attached corrected actuarial memorandums in the supporting document tab and the corrected rate sheets in the rate schedule tab.

We apologize for the inconvenience caused.

**Changed Items:**

**Rate/Rule Schedule Item Changes:**

Document Name:	Affected Form Numbers: (Comma Separated list)	Rate Action:	Rate Action Information:	Attach Document:
Limited Benefit Policy	U1050-AR	New		Rates-U1050-50%.pdf
Rates-U1050-50%.pdf	Doctor's Office Visit Benefit Rider	RU10DRV	New	
Rates-R10DRV-50%.pdf	Rates-R10DRV-50%.pdf	Emergency Benefit Rider	RU10ER	New
	Rates-RU10ER-50%.pdf	Rates-RU10ER-50%.pdf	Outpatient Surgery Benefit Rider	RU10OPS
New		Rates-RU10OPS-50%.pdf		Skilled Nursing Facility Benefit Rider
RU10SNF	New		Rates-RU10SNF-50%.pdf	Rates-RU10SNF-50%.pdf
Dental and Vision Benefit Rider	RU10DV	New		Rates-RU10DV-50%.pdf
Rates-RU10DV-50%.pdf	Lump Sum Cancer Rider	RU07LS	New	
Rates-RU07LS-50%.pdf	Rates-RU07LS-50%.pdf			

**Supporting Document Schedule Item Changes:**

SERFF Tracking Number: GRTT-126869462 State: Arkansas  
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America  
Company Tracking Number: U1050-AR  
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**Satisfied -Name: Health - Actuarial Justification**

Comment: We have corrected the monthly modal factor from .084 to .09 on the actuarial memorandums and rate sheets. We have attached corrected actuarial memorandums in the supporting document tab and the corrected rate sheets in the rate schedule tab.

We apologize for the inconvenience caused.

ActMemo-U1050-50%.pdf  
ActMemo-RU10DRV-50%.pdf  
ActMemo-RU10ER-50%.pdf  
ActMemo-RU10OPS-50%.pdf  
ActMemo-RU10SNF-50%.pdf  
ActMemo-RU10DV-50%.pdf  
ActMemo-RU07LS-50%.pdf

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## Form Schedule

### Lead Form Number: U1050-AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/01/2010	U1050-AR	Policy/Cont	Limited Benefit Policy/ ractal/Fraternal Certificate	Initial		50.870	Policy U1050-AR.pdf
Approved-Closed 11/01/2010	RU10DRV	Policy/Cont	Doctor's Office Visit ractal/Fraternal Benefit Rider Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		57.420	RU10DRV - Dr. Visit Rider.pdf
Approved-Closed 11/01/2010	RU10ER	Policy/Cont	Emergency Benefit ractal/Fraternal Rider Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		60.160	RU10ER - Emergency Benefit Rider.pdf
Approved-Closed 11/01/2010	RU10OPS	Policy/Cont	Outpatient Sugery ractal/Fraternal Benefit Rider Certificate: Amendment, Insert Page, Endorsement	Initial		53.610	RU10OPS - Outpatient Surgery Benefit Rider.pdf

<i>SERFF Tracking Number:</i>	<i>GRTT-126869462</i>	<i>State:</i>	<i>Arkansas</i>	
<i>Filing Company:</i>	<i>United National Life Insurance Company of America</i>	<i>State Tracking Number:</i>	<i>47161</i>	
<i>Company Tracking Number:</i>	<i>U1050-AR</i>			
<i>TOI:</i>	<i>H21 Health - Other</i>	<i>Sub-TOI:</i>	<i>H21.000 Health - Other</i>	
<i>Product Name:</i>	<i>U1050-AR</i>			
<i>Project Name/Number:</i>	<i>Limited Benefit /U1050-AR</i>			
Approved- RU10SNF	Policy/Cont Skilled Nursing	Initial	61.390	RU10SNF -
Closed	ract/Fratern Facility Benefit Rider			SNF Rider.pdf
11/01/2010	al			
	Certificate:			
	Amendmen			
	t, Insert			
	Page,			
	Endorseme			
	nt or Rider			
Approved- RU10DV	Policy/Cont Dental and Vision	Initial	50.620	RU10DV -
Closed	ract/Fratern Benefit Rider			Dental &
11/01/2010	al			Vision
	Certificate:			Rider.pdf
	Amendmen			
	t, Insert			
	Page,			
	Endorseme			
	nt or Rider			
Approved- UAPPH3-	Application/ Application	Initial	59.030	UAPPH3-10-
Closed 10-AR	Enrollment			AR.pdf
11/01/2010	Form			

**UNITED NATIONAL LIFE  
INSURANCE COMPANY  
OF AMERICA  
A Stock Company**

P.O. Box 1154  
Glenview, IL 60025-1154  
(847) 803-5252

**LIMITED BENEFIT  
POLICY**

Providing Limited Hospital  
Confinement Indemnity  
Benefits

**IMPORTANT NOTICE**

Please read the copy of the application attached to this policy. Carefully check the application and write to Us at the address shown above within 10 days if any information shown on it is not correct and complete. This policy was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

**WE PROMISE** to insure You for the benefits described in this Policy. These benefits are payable for hospital confinement and other specified benefits. Benefits are subject to the Policy definitions, provisions, limitations and exclusions.

**EFFECTIVE DATE.** This Policy begins at 12:01 a.m. standard time at Your residence on the Effective Date shown in the Policy Schedule.

**GUARANTEED RENEW-ABLE FOR LIFE.** You may keep this Policy in force during Your entire lifetime by paying the renewal premium at the intervals available to You at time of renewal. You must pay it by its due date or during the 31 days that follow. We cannot cancel or refuse to renew this Policy or place any restrictions on it if You pay Your premiums on time.

**PREMIUMS SUBJECT TO CHANGE.** We may change Your premiums by giving You at least 31 days prior written notice. We can only change the premium if We change it for all policies like Yours in Your state on a class basis.

If You have any problems, complaints or questions concerning this Policy, please write Us at the above address or call us at 800 207-8050. If We are unable to satisfy You, You may write the Arkansas Consumer Services Division, Department of Insurance, 1200 W. Third Street, Little Rock, AR 72201-1904 or call 800 282-9124.

**YOUR RIGHT TO EXAMINE THIS POLICY FOR 10 DAYS.** It is important to Us that You are satisfied with this Policy. If You are not satisfied with this Policy, You may return it to Us within 10 days of its receipt. Upon return We will void the Policy as of the Effective Date and You will receive a full refund of any premium You have paid.

**READ YOUR POLICY CAREFULLY.** This Policy is a legal contract between You and Us.

Signed for United National Life Insurance Company of America at Glenview, Illinois, on the Effective Date.



Secretary



President

**THIS IS A LIMITED POLICY – PLEASE READ IT CAREFULLY**

**THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review “The Guide to Health Insurance for People with Medicare” available from the company.”**

## INDEX

	<b>Page</b>
Renewal Provision.....	1
Right To Examine Policy.....	1
Policy Schedule.....	3
Consideration.....	4
Definitions.....	4, 5
Pre-Existing Condition Limitations .....	5
Benefits .....	6
Exclusions.....	6
General Provisions .....	7, 8
Premium and Reinstatement .....	6, 7
Claim Provisions .....	7

**UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA**  
P.O. BOX 1154, Glenview, Illinois 60025

**POLICY SCHEDULE**

POLICY NUMBER: UNL 123567  
EFFECTIVE DATE: OCTOBER 1, 2010  
NAME OF INSURED JOHN DOE AGE 55

ONE TIME APPLICATION FEE: \$

	BENEFIT AMOUNT	PREMIUM
HOSPITAL CONFINEMENT INDEMNITY BENEFIT AMOUNT	[\$100 - \$500 PER DAY]	[XXX.XX]
MAXIMUM BENEFIT PERIOD: [10, 20 DAYS] LIFETIME MAXIMUM: 365 DAYS		
DOCTOR'S OFFICE VISIT BENEFIT AMOUNT	\$30 PER VISIT	
DOCTOR'S OFFICE VISIT CALENDAR YEAR MAXIMUM: 20 VISITS		
DOCTOR'S OFFICE VISIT BENEFIT RIDER AMOUNT	[\$10, \$20, \$30 PER VISIT]	[XXX.XX]
EMERGENCY BENEFIT RIDER		[XXX.XX]
EMERGENCY ROOM BENEFIT AMOUNT	\$200 PER VISIT	
EMERGENCY ROOM CALENDAR YEAR MAXIMUM: 2 VISITS		
AMBULANCE SERVICE BENEFIT AMOUNT	\$200 PER TRIP	
AMBULANCE SERVICE CALENDAR YEAR MAXIMUM: 2 TRIPS		
OUTPATIENT SURGERY BENEFIT RIDER AMOUNT	[\$500, \$1000, \$1500]	[XXX.XX]
LIMITED TO ONE PER CALENDAR YEAR		
SKILLED NURSING FACILITY BENEFIT RIDER AMOUNT	[\$75, \$150 PER DAY]	[XXX.XX]
ELIMINATION PERIOD: 20 DAYS PER ONE PERIOD OF CONFINEMENT		
SKILLED NURSING MAXIMUM BENEFIT PERIOD: 80 DAYS		
SKILLED NURSING FACILITY LIFETIME MAXIMUM: 300 DAYS		
DENTAL AND VISION BENEFIT RIDER		[XXX.XX]
DEDUCTIBLE AMOUNT: \$100.00		
MAXIMUM AMOUNT:	1 <sup>ST</sup> CALENDAR YEAR:	80% UP TO \$250
	2 <sup>ND</sup> CALENDAR YEAR AND THEREAFTER:	80% UP TO \$750
		TOTAL PREMIUM [XXX.XX]

## CONSIDERATION

We have issued this Policy in consideration of the application and payment of the First Premium. The application and Policy Schedule are made a part of this Policy.

## POLICY DEFINITIONS

**Calendar Year:** Means the period beginning on the Effective Date and ending December 31st of that year. Thereafter it is the period from January 1st to December 31st of each following year.

**Doctor Office Visit Calendar Year Maximum:** Means the maximum number of visits We will pay for Doctor's Office Visit in a Calendar Year under the Policy and the optional Doctor's Office Visit Benefit rider, if applicable. The Doctor's Office Visit Calendar Year Maximum is shown in the Policy Schedule.

**Experimental/Investigational:** A drug, device or medical care or treatment will be considered experimental/ investigational if:

- The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished;
- The informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
- The drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal or state law requires such review and approval;
- Reliable evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- Reliable evidence shows that the prevailing opinion among experts regarding the drug, device or medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment.

**Doctor:** Means any licensed practitioner of the healing arts operating within the scope of his or her license in treating an Injury or Sickness. It does not include You, a Family Member, dentist, optometrist or ophthalmologist.

**Family Member:** A person who is related to You in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild). A Family Member includes an individual who normally lives in Your household.

**Hospital:** Means a place which meets the requirements shown below:

1. is legally operated to provide medical care and treatment of sick or injured persons;
2. is primarily engaged in providing medical, diagnostic and surgical facilities (either on its premises or in facilities available to the hospital on a formal pre-arranged basis);
3. has continuous 24 hour nursing services by, or under the supervision of, registered graduate professional nurses (R.N.); and
4. has a staff of one or more doctors available at all times.

Hospital also means a place which may not meet the above requirements, but is accredited as a hospital by the Joint Commission, American Osteopathic Association or the Commission on the Accreditation of Rehabilitation Facilities.

Hospital does not include a place, special ward, floor, or other accommodation used for:

1. a convalescent, skilled nursing, or rest home, or a home for the aged;
2. a place mainly providing custodial, educational, or rehabilitory care; or
3. a facility mainly used for treating drug addiction or alcoholism.

## Definitions (continued)

**Hospital Confinement/Confined:** Means medical care or treatment received while in a general hospital as a resident bed patient for which a charge for room and board was made.

**Injury:** Means bodily injury caused by an accident. The accident must occur while this Policy is in force. Any loss due to injury must begin while this Policy is in force.

**Lifetime Maximum:** Means the maximum days We will pay for Hospital Confinement as shown in the Policy Schedule.

**Maximum Benefit Period:** The number of days of hospitalization We will pay during any One Period of Confinement. The Maximum Benefit Period is shown in the Policy Schedule.

**Medically Necessary:** Means a service, supply, or hospital confinement that:

1. is prescribed by a doctor;
2. is required for the treatment or management of a medical symptom or condition;
3. is the most efficient and economical service which can safely be provided; and
4. is commonly accepted as proper for the treatment or management of a condition by an established United States medical society.

The term "Medically Necessary" does not include services which are Experimental or Investigative in nature, or which are provided mainly as a convenience.

The fact that a Doctor may prescribe, order, recommend or approve a service, supply or a confinement does not, of itself, make it Medically Necessary or a covered loss under this Policy even though it is not specifically listed as an exclusion.

**Mental or Nervous Disorder:** Means neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional diseases or disorders of any kind. It does not include Alzheimer's disease or any similar mental disorder which is organic in origin.

**One Period of Confinement:** For the purposes of determining a Maximum Benefit Period, One Period of Confinement begins when You become Hospital Confined. One Period of Confinement ends when there has been no additional Hospital Confinement for 60 consecutive days. If You have selected the optional Skilled Nursing Facility Benefit Rider, One Period of Confinement ends when there has been no additional Hospital Confinement or confinement to a Skilled Nursing Facility for 60 consecutive days. Subject to the Policy's Lifetime Maximum and Skilled Nursing Facility Lifetime Maximum if such rider has been selected and provided this Policy and any Skilled Nursing Facility Benefit Rider are in force, a new Maximum Benefit Period and a new Skilled Nursing Maximum Benefit Period will apply.

**Sickness:** Means illness or disease which manifests itself while this Policy is in force. Any loss due to sickness must begin while this Policy is in force. Complications of pregnancy will be considered a sickness.

**"You", "Your", and "Yours":** Refer to the Insured named in the Policy Schedule.

**"We", "Our", and "Us":** Means UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA.

**Week** means a period of 7 days beginning and ending on the following Saturday.

## PRE-EXISTING CONDITION LIMITATION

**PRE-EXISTING CONDITION:** A pre-existing condition is a condition for which: (a) medical advice or treatment was recommended by, or received from a Doctor, within the 6 month period before the Effective Date of Your coverage under the Policy or the Effective Date of Your coverage under any optional riders attached to the Policy; or (b) symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 6 month period before the Effective Date of Your coverage under the Policy or the Effective Date under any optional riders attached to the Policy.

A pre-existing condition is not covered unless the loss begins more than 6 months after the Effective Date of Your coverage under the Policy or the Effective Date of Your coverage under any optional riders attached to the Policy.

## BENEFIT PROVISIONS

We will pay benefits, as shown below, for Hospital Confinement, and visits to the Doctor's office which are Medically Necessary and due to Injury or Sickness.

The benefits, as shown below, are subject to the benefit amounts shown in the Policy Schedule, the definitions, limitations, exclusions, and other provisions of the Policy.

### A - Hospital Confinement Indemnity Benefit

We will pay the Hospital Confinement Indemnity Benefit Amount for each day You are confined in a Hospital when such confinement is Medically Necessary because of an Injury or Sickness. Benefits are not payable beyond the Maximum Benefit Period for any One Period of Hospital Confinement. The Hospital Confinement Indemnity Benefit Amount and Maximum Benefit Period are shown in the Policy Schedule.

We will not pay more than the Lifetime Maximum as shown in the Policy Schedule for Hospital Confinement.

Any one continuous period of hospitalization which begins while this Policy is in force won't be affected by the Policy ending.

### B - Doctor's Office Visit Benefit

We will pay the Doctor's Office Visit Benefit Amount as shown in the Policy Schedule, when You receive the medical services of a Doctor, limited to one visit to the Doctor's office per Week.

This benefit is limited to the Doctor's Office Visit Calendar Year Maximum, as shown in the Policy Schedule.

## EXCLUSIONS

This Policy does not cover loss:

1. For treatment, services or supplies which:
  - Are not Medically Necessary;
  - Are not prescribed by a Doctor as necessary to treat an Sickness or Injury;
  - Are determined to be Experimental/Investigational in nature by Us;
  - Are received without charge or legal obligation to pay;
  - Would not routinely be paid in the absence of insurance;
  - Are received from any Family Member.
2. For expenses incurred as a result of loss, or for treatment of an Injury or Sickness, due to war, or any action of war, declared or undeclared; service in the armed forces of any country.
3. For treatment of intentionally self-inflicted injuries or attempted suicide while sane or insane.
4. For treatment of an Injury or Sickness for which You are entitled to benefits under any Workers' Compensation or Occupational Disease Law (self-employed are covered for occupational Injury).
5. For treatment in a hospital operated by the federal government unless You, by law, must pay.
6. For normal pregnancy and childbirth if conception was before the effective date. Complications of pregnancy are covered as a Sickness.
7. For Mental or Nervous Disorders.
8. For treatment of an Injury that results from the commission of, or attempt to commit a felony, or from being engaged in an illegal activity.
9. For cosmetic surgery. However "cosmetic surgery" does not include reconstructive surgery which is incidental because of previous surgery due to trauma, infection, or other disease of the involved part.
10. For treatment of substance abuse, including alcoholism, drug addiction, narcotics, or hallucinogens.
11. For confinement or treatment received outside the United States or its possessions, unless loss is incurred while on a trip of not more than 60 days' duration.

## PREMIUM AND REINSTATEMENT

**Payment of Premium.** The first premium on Your Policy is payable on the Effective Date. After that, premiums are payable in the amount and mode shown on the Policy Schedule. Payments may be made at Our Home Office in Glenview, IL

If We accept a premium, this Policy will continue in force until the end of the term for which that premium was due.

The amount of the first premium is shown in the Policy Schedule and is based on Your initial mode of payment. The amount of each premium after the first is based on Your then current mode of payment and the premium then being charged for policies of this form number and premium classification issued in the same state.

**Grace Period.** This Policy has a grace period of 31 days for paying a premium. During the grace period, this Policy will stay in force. If a premium is not paid during the grace period, this Policy will terminate as of the due date of the premium.

**Reinstatement.** If a premium is not paid before the grace period ends, this Policy will lapse. Later acceptance of a premium by Us without asking for an application for reinstatement will reinstate this Policy as of 12:01 (Standard Time) on the day after the date We receive the premium.

If You are asked for an application, a conditional receipt for the premium will be given to You. If the application is approved, this Policy will be reinstated as of 12:01 (Standard Time) on the day after the date the reinstatement application is approved. Lacking such approval, this Policy will be reinstated on the 45<sup>th</sup> day after the date of the receipt unless We write You of Our disapproval before that date.

If reinstated, this Policy will only cover loss sustained after the date of reinstatement. In all other ways, Your rights and Ours will remain the same subject to any provision of the reinstatement. Premium will be applied as of the date of reinstatement.

**Refund of Premium:** We will refund that part of any premium paid beyond the end of the month in which Your death occurred. Payment will be made within 30 days after Our receipt of proof of Your death.

### CLAIM PROVISIONS

**Notice of Claim.** Written notice of claim must be sent to Us at Our Home Office or to an authorized agent, within 30 days after the start of a loss. Such notice must include Your name and Policy number. If notice cannot be given within that time, You must send the notice as soon as reasonably possible.

**Claim Forms.** We will send You claim forms when We receive written notice of loss. If forms are not received within 15 days after written notice of loss is sent, then proof of loss will be met by giving Us a written statement of the nature and extent of Your loss. You must send such proof within the time limit stated in the Proof of Loss provision of this Policy.

**Proof of Loss.** Written Proof of Loss must be given to Us within 90 days of such loss. If it was not reasonably possible to give Us 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. Unless You are legally unable to act, proof must be sent no later than 1 year after the time specified.

**Payment of Claims.** When We receive written proof of loss covered by this Policy, We will pay any benefits due to You or else to Your beneficiary.

If benefits are payable to Your estate or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay up to \$1,000 to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by Us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

**Time Payment of Claims.** Benefits will be paid as soon as We receive proper Proof of Loss unless this Policy provides for periodic payment. When this Policy provides for periodic payment, the benefits will accrue and will be paid monthly subject to proper proof of loss.

**Physical Examination and Autopsy.** We, at Our own expense, have the right to have a Doctor of Our choice examine You as often as reasonably necessary while a claim is pending. We may also have an autopsy made unless prohibited by law.

**Assignment.** No assignment of this Policy or its benefits, by You or Your legal representative, will affect Us unless it is in writing and sent to Us at Our Home Office. We are not responsible for the validity of the assignment. Any payment We make in good faith will end Our liability to the extent of the payment.

**Legal Action.** No legal action may be brought to recover on this Policy until 60 days after written proof of loss has been given as required. No such action may be brought after 3 years from the time written proof of loss was required to be given.

### GENERAL PROVISIONS

**Entire Contract; Changes.** This Policy with the application and attached papers is the entire contract between You and Us. No change in this Policy will be effective until approved by one of Our officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

**Term.** The first term begins at 12:01 a.m. (Standard Time) on the Effective Date shown on the Policy Schedule, but insurance will not be effective before the time the application is signed by the applicant and the first premium is paid. The first term ends at 12:00 midnight (Standard Time) on the First Renewal Date. Each renewal term begins at 12:01 a.m. (Standard Time) on the day after the date to which premium is paid. Renewal dates are determined by Your mode of payment. Your initial mode of payment is shown in the Policy Schedule

**Misstatement of Age.** If Your age has been misstated, the benefits will be those the premium paid would have purchased at the correct age. If the correct age is such that We would not have insured the person under this Policy, or such that the coverage would have terminated, We will refund all premiums paid for the period not covered, and We will not pay any claims incurred during that period.

**Conformity with State Statutes.** Any provision of this Policy, which, on the Effective Date, is in conflict with the laws of the State in which You reside, is amended to conform to the minimum requirements of those laws.

**Time Limit on Certain Defenses.** After 2 years from the Effective Date, no misstatements, except fraudulent misstatements, made by You in the application for such coverage shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of such 2 year period.

No claim for loss incurred commencing after 6 months from the Effective Date shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Effective Date of coverage.

**UNITED NATIONAL LIFE  
INSURANCE COMPANY  
OF AMERICA  
A Stock Company  
P.O. Box 1154  
Glenview, IL 60025-1154  
(847) 803-5252**

**LIMITED BENEFIT  
POLICY**  
Providing Limited Hospital  
Confinement Indemnity  
Benefits

**UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA**  
P. O. Box 1154, Glenview, Illinois, 60025-1154

**DOCTOR'S OFFICE VISIT BENEFIT RIDER**

**EFFECTIVE DATE:** \_\_\_\_\_

In consideration of the application and payment of the required Premium, this Rider is made a part of the Policy to which it is attached. This Rider takes effect on the Effective Date shown above. If no date is shown above, it begins on the Policy's Effective Date.

**YOUR THIRTY (30) DAY RIGHT TO RETURN THIS RIDER**

If You are not satisfied with this Rider, You may return it to Us within thirty (30) days of its receipt. You may return it to Us by mail or to the agent who sold it. We'll then refund all premiums paid for this Rider and it will be void.

**DOCTOR OFFICE VISIT BENEFIT**

We will pay the Doctor's Office Visit Benefit Amount, as shown in the Policy Schedule when You receive the medical services of a Doctor. This benefit is limited to one visit to the Doctor's office per Week. This benefit will be payable in addition to any Doctor's Office Visit Benefit payable under the Policy, if applicable.

This benefit is limited to the Doctor's Office Visit Calendar Year Maximum, as shown in the Policy Schedule.

**RENEWAL CONDITIONS**

This Rider is renewed when the Policy to which it is attached is renewed.

**TERMINATION**

This Rider will terminate on the earliest of:

1. The date the Policy to which this Rider is attached is terminated;
2. The date You ask Us, in writing, to cancel this Rider; or
3. The date the Policy lapses for non-payment of premium.

**PREMIUM**

This Rider requires the payment of premium in addition to the premium due for the Policy. The premium for this Benefit Rider is shown in the Policy Schedule.

We can change the premium for this Rider if We change it for all Riders like Yours in Your state on a class basis. We'll provide You with written notice of any change in the premium in the time required by Your state.

**CONDITIONS**

This Rider is subject to all terms, definitions, provisions, limitations, and exclusions of the Policy except where specifically changed by this Rider.

Signed for United National Life Insurance Company of America at Glenview, Illinois, by



Secretary



President

**UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA**  
P. O. Box 1154, Glenview, Illinois, 60025-1154

**EMERGENCY BENEFIT RIDER**

**EFFECTIVE DATE:** \_\_\_\_\_

In consideration of the application and payment of the required Premium, this Rider is made a part of the Policy to which it is attached. This Rider takes effect on the Effective Date shown above. If no date is shown above, it begins on the Policy's Effective Date.

**YOUR THIRTY (30) DAY RIGHT TO RETURN THIS RIDER**

If You are not satisfied with this Rider, You may return it to Us within thirty (30) days of its receipt. You may return it to Us by mail or to the agent who sold it. We'll then refund all premiums paid for this Rider and it will be void.

**RIDER DEFINITIONS**

**Ambulance:** A vehicle which is licensed solely as an ambulance by the local regulatory body to provide transportation to a Hospital or transportation from one Hospital to another for those individuals who are unable to travel to receive medical care by any other means or the Hospital cannot provide the needed care.

**Ambulance Service Benefit Amount:** The amount We will pay per Ambulance trip. The Ambulance Service Benefit Amount is shown on the Policy Schedule.

**Emergency Medical Condition:** The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of bodily organ or part, or would place the person's health in serious jeopardy.

**Emergency Services:** Covered health care services which are Medically Necessary to evaluate and treat an Emergency Medical Condition, provided in a hospital emergency department.

**BENEFIT**

We will pay benefits, as shown below, for Emergency Room and Ambulance Service.

**A - Emergency Room Benefit**

We will pay the Emergency Room Benefit Amount as shown in the Policy Schedule, when You visit the emergency room of a hospital for Emergency Services.

We will not pay more than the Emergency Room Calendar Year Maximum shown in the Policy Schedule.

**B – Ambulance Service Benefit**

We will pay the Ambulance Service Benefit Amount shown in the Policy Schedule, if a licensed surface ambulance service transports You to a Hospital for Emergency Services.

We will not pay more than the Ambulance Service Calendar Year Maximum shown in the Policy Schedule.

**RENEWAL CONDITIONS**

This Rider is renewed when the Policy to which it is attached is renewed.

## TERMINATION

This Rider will terminate on the earliest of:

1. The date the Policy to which this Rider is attached is terminated;
2. The date You ask Us, in writing, to cancel this Rider; or
3. The date the Policy lapses for non-payment of premium.

## PREMIUM

This Rider requires the payment of premium in addition to the premium due for the Policy. The premium for this Benefit Rider is shown in the Policy Schedule.

We can change the premium for this Rider if We change it for all Riders like Yours in Your state on a class basis. We'll provide You with written notice of any change in the premium in the time required by Your state.

## CONDITIONS

This Rider is subject to all terms, definitions, provisions, limitations, and exclusions of the Policy except where specifically changed by this Rider.

Signed for United National Life Insurance Company of America at Glenview, Illinois, by



Secretary



President

**UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA**

P. O. Box 1154, Glenview, Illinois 60025-1154

(847) 803-5252

**OUTPATIENT SURGERY BENEFIT RIDER**

**EFFECTIVE DATE:** \_\_\_\_\_

This Rider is part of the Policy to which it is attached. It is issued in consideration of the application and payment of the required premium. It takes effect on the Effective Date shown above at 12:01 a.m. Standard Time where You live. If no date is shown above, it begins on the Policy's Effective Date.

**YOUR THIRTY (30) DAY RIGHT TO RETURN THIS RIDER**

If You are not satisfied with this Rider, You may return it to Us within thirty (30) days of its receipt. You may return it to Us by mail or to the agent who sold it. We'll then refund all premiums paid for this Rider and it will be void.

**RIDER DEFINITIONS**

**Ambulatory Surgical Center:** A facility which is accredited by a national accrediting body or licensed by a state agency and which:

- Is equipped and operated to provide medical care and treatment by a Doctor;
- Does not provide services or accommodations for overnight stays;
- Has a full time medical staff that is under the supervision of a duly licensed Doctor;
- Has at least one licensed registered nurse (R.N.) on duty at all times when patients are in the facility;
- Has at least one operating room and one recovery room and is equipped to support any surgery performed;
- Has X-ray and laboratory diagnostic facilities;
- Maintains a medical record for each patient; and
- Has a written agreement with at least one Hospital for the immediate transfer of patients who develop complications or need confinement.

**Complication of Pregnancy:** means a condition of pregnancy that substantially increases the level of medical care and treatment required for the management of the pregnancy. "Complications of Pregnancy" shall include, but not be limited to, puerperal infection, eclampsia, emergency (non-elective) cesarean section delivery, ectopic pregnancy and toxemia.

**Outpatient Facility:** A facility which

- meets licensing and other legal requirements and is equipped to provide surgical services;
- is classified by the Hospital as an out-patient facility; and
- You are confined for less than 24 hours.

**Outpatient Surgery Benefit Amount:** The amount payable for a surgical procedure performed in an Ambulatory Surgical Center or Outpatient Facility of a Hospital. The Outpatient Surgery Benefit Amount is shown in the Policy Schedule.

**Sound Natural Teeth:** Natural teeth, the major portion of the individual tooth which is present, regardless of filings and caps; and is not carious, abscessed or defective.

**BENEFIT PROVISION**

We will pay benefits, as shown below, for surgery performed in an Ambulatory Surgical Center or Outpatient Facility of a Hospital that are Medically Necessary due to an Injury, Sickness.

**BENEFITS**

We will pay the Outpatient Surgery Benefit Amount for a surgical procedure performed by a Doctor when such procedure is performed in an Ambulatory Surgical Center or Outpatient Facility of a Hospital. Surgical procedures and the services and supplies related to the surgical procedures are limited to one occurrence per Calendar Year.

We won't pay for multiple surgical procedures when such procedures are performed through the same incision or in immediate succession.

### GENERAL EXCLUSIONS

The following General Exclusions are in addition to the exclusions contained in the Policy to which this Rider is attached. We won't pay benefits for:

1. Surgical procedures performed in a Doctor's office or when Hospital Confined;
2. Surgery for corns, calluses and bunions; deviated nasal septum, including submucous resection and/or other surgical corrections thereof unless due to injury occurring while coverage is in force;
3. Surgery for removal of breast implants. This exclusion shall not apply to the removal of breast implants for the Medically Necessary treatment of a covered Sickness or Injury, unless the implants were implanted solely for cosmetic purposes and not for surgery performed as reconstruction resulting from an Sickness or Injury;
4. Surgery for non-malignant warts, moles (boils) and lesions unless Medically Necessary;
5. Dental surgery except oral surgery for excision of tumors, growths and cysts of the jaw and mouth and surgery to Sound Natural Teeth made necessary by Injury;
6. Surgery for refractive anomalies;
7. Elective surgery not required to treat a Sickness or Injury;
8. Surgical procedure performed for cosmetic purposes only, unless such cosmetic surgery is to restore normal appearance following Sickness or Injury;
9. Surgical procedure associated with childbirth except when required due to Complications of Pregnancy.

### RENEWAL CONDITIONS

This Rider is renewed when the Policy to which it is attached is renewed.

### TERMINATION

This Rider will terminate on the earliest of:

1. The date the Policy to which this Rider is attached is terminated;
2. The date You ask Us, in writing, to cancel this Rider; or
3. The date the Policy lapses for non-payment of premium.

### PREMIUM

This Rider requires the payment of premium in addition to the premium due for the Policy. The premium for this Rider is shown on the Policy Schedule.

We can change the premium for this Rider if We change it for all riders like Yours in Your state on a class basis. Before any change in premium becomes effective, We'll provide You with advance written notice in the time required by Your state.

### CONDITIONS

This Rider is subject to all terms, definitions, provisions, limitations and exclusions of the Policy to which it is attached, except, where specifically changed by this Rider.

Signed at United National Life Insurance Company of America in Glenview, Illinois by



Secretary



President

**UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA**  
P. O. Box 1154, Glenview, Illinois, 60025-1154

**SKILLED NURSING FACILITY BENEFIT RIDER**

**EFFECTIVE DATE:** \_\_\_\_\_

In consideration of the application and payment of the required Premium, this Rider is made a part of the Policy to which it is attached. This Rider takes effect on the Effective Date shown above. If no date is shown above, it begins on the Policy's Effective Date.

**YOUR THIRTY (30) DAY RIGHT TO RETURN THIS RIDER**

If You are not satisfied with this Rider, You may return it to Us within thirty (30) days of its receipt. You may return it to Us by mail or to the agent who sold it. We'll then refund all premiums paid for this Rider and it will be void.

**RIDER DEFINITIONS**

**Elimination Period:** The number of days You must be confined in a Skilled Nursing Facility before any Skilled Nursing Facility Benefit is payable. There is only one Elimination Period per One Period of Confinement. The Elimination Period is shown in the Policy Schedule.

**Skilled Nursing Facility:** A place that:

- Is legally operated as a Skilled Nursing Facility;
- Primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Care under the supervision of a Doctor;
- Provides continuous 24-hour a day nursing service by or under the supervision of a registered professional nurse (RN); and
- Maintains a daily medical record on each patient.

Skilled Nursing Facility also means a place which may not meet the above rules, but is a nursing facility that is either approved for payment of Medicare benefits or could get such approval if so requested.

A Skilled Nursing Facility does not mean or include any home or facility, or part thereof, used primarily for:

- rest, residential, retirement, and custodial care; or
- hospice care. Hospice care means services which are designed to provide pain relief, symptom management and support services to dying persons and their families.

**Skilled Nursing Care:** Care that is certified as Medically Necessary by a Doctor and which requires the skills of professional personnel such as a registered or a licensed practical nurse and is provided either directly by or under the supervision of these personnel. It is not intermediate, domiciliary, custodial or retirement care.

**Skilled Nursing Facility Benefit Amount:** The amount We will pay for each day of confinement in a Skilled Nursing Facility following any applicable Elimination Period. The Skilled Nursing Facility Benefit Amount is shown in the Policy Schedule.

**Skilled Nursing Facility Lifetime Maximum:** Means the maximum days We will pay during your lifetime for Skilled Nursing Facility Confinement as shown in the Policy Schedule.

**Skilled Nursing Maximum Benefit Period:** The number of days of Skilled Nursing Care we will pay during any One Period of Confinement following any applicable Elimination Period. The Skilled Nursing Maximum Benefit Period is shown in the Policy Schedule.

## **SKILLED NURSING FACILITY BENEFIT**

Subject to the following conditions and satisfying the Elimination Period, we will pay the Skilled Nursing Facility Benefit Amount for each day You are confined to a Skilled Nursing Facility and receiving Skilled Nursing Care:

1. You have first been Hospital Confined for 3 or more consecutive days;
2. The Skilled Nursing Facility confinement begins within 30 days after such Hospital Confinement;
3. Your Doctor must certify the need for the Skilled Nursing Facility confinement; and
4. The Skilled Nursing Facility confinement is for the same Injury or Sickness as the Hospital Confinement for which We paid benefits.

We will not pay for any other levels of care that do not meet the definition of Skilled Nursing Care.

We will not pay more than the number of days shown in the Skilled Nursing Maximum Benefit Period for any One Period of Confinement.

We will not pay more than the Skilled Nursing Facility Lifetime Maximum as shown in the Policy Schedule for Skilled Nursing Facility Confinement.

### **RENEWAL CONDITIONS**

This Rider is renewed when the Policy to which it is attached is renewed.

### **TERMINATION**

This Rider will terminate on the earliest of:

1. The date the Policy to which this Rider is attached is terminated;
2. The date You ask Us, in writing, to cancel this Rider; or
3. The date the Policy lapses for non-payment of premium.

### **PREMIUM**

This Rider requires the payment of premium in addition to the premium due for the Policy. The premium for this Benefit Rider is shown in the Policy Schedule.

We can change the premium for this Rider if We change it for all Riders like Yours in Your state on a class basis. We'll provide You with written notice of any change in the premium in the time required by Your state.

### **CONDITIONS**

This Rider is subject to all terms, provisions, limitations, and exclusions of the Policy except where specifically changed by this Rider.

Signed for United National Life Insurance Company of America at Glenview, Illinois, by



Secretary



President

**UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA**  
P. O. Box 1154, Glenview, Illinois, 60025-1154

**DENTAL AND VISION BENEFIT RIDER**

**EFFECTIVE DATE:** \_\_\_\_\_

In consideration of the application and payment of the required Premium, this Rider is made a part of the Policy to which it is attached. This Rider takes effect on the Effective Date shown above. If no date is shown above, it begins on the Policy's Effective Date.

**YOUR THIRTY (30) DAY RIGHT TO RETURN THIS RIDER**

If You are not satisfied with this Rider, You may return it to Us within thirty (30) days of its receipt. You may return it to Us by mail or to the agent who sold it. We'll then refund all premiums paid for this Rider and it will be void.

**RIDER DEFINITIONS**

**Rider Deductible:** Means a dollar amount of covered expenses You must pay each Calendar Year before We pay any benefits. The Deductible amount is shown in the Policy Schedule.

A new Deductible will apply each Calendar Year.

**Dentist:** Means a person who is licensed to practice dentistry in the state where services are rendered and is acting within the scope of that license. A Dentist shall also mean a licensed doctor performing dental services within the scope of that license. It does not include You, or a Family Member.

**Doctor:** Means any licensed Dentist, Ophthalmologist and Optometrist. It does not include You, or a Family Member.

**Insured Percent:** Means the percentage of covered expenses We pay for covered expenses during each Calendar Year after the Deductible is satisfied. The Insured Percent is shown in the Policy Schedule.

**Maximum Amount:** Means the maximum benefit amounts for services provided by a Dentist, Ophthalmologist, Optometrist or Doctor, which are payable during the first Calendar Year and thereafter as shown in the Policy Schedule.

**Necessary Dental Treatment:** Dental services or supplies which are consistent with currently accepted dental practice. Any operation, treatment, service or supply not a valid course of treatment recognized by the American Dental Association is not considered Necessary Dental Treatment.

**Ophthalmologist:** Means a physician who specializes in ophthalmology in the state where services are rendered and is acting within the scope of that license. It does not include You, or a Family Member.

**Optometrist:** Means a specialist licensed to practice optometrist in the state where services are rendered and is acting within the scope of that license. It does not include You, or a Family Member.

**Usual and Customary Expense:** Means the usual fee charged by your Doctor for a given service and which is within the range of fees charged by other doctors in the same area for similar services.

**DENTAL AND VISION PROVISION**

We will pay the Dental and Vision benefits subject to the:

1. Rider Deductible;
2. Insured Percent of covered expenses up to the maximum amount per Calendar Year;
3. Definitions, limitations and exclusions and other provisions of the Policy and this Rider.

## **DENTAL AND VISION BENEFIT**

We will pay the Usual and Customary Expenses You incur for necessary dental and vision treatment for the services and supplies shown below. After You satisfy the Rider Deductible, We will pay the Insured Percent of covered expenses up to the Maximum Amount per Calendar Year. The Deductible, Insured Percent and the Maximum Amounts are shown in the Policy Schedule.

### **1. Dental**

We will pay the Maximum Amount for services of a licensed Dentist including the cost of fillings, prophylaxis, bridges, and dentures, prescribed as necessary by a Dentist.

Any replacement or repair of existing bridges or dentures will not be covered until after this Rider has been in effect for 6 months unless needed as a result of Injury.

### **2. Vision**

We will pay the Maximum Amount for visits for the purpose of eye refractions to a licensed ophthalmologist or optometrist including the cost of eyeglasses or contact lenses prescribed by such doctor.

Standard frame, limited to one frame in any 24 consecutive months.

Contact lenses, limited to one pair in any 12 consecutive months. This benefit is in lieu of lenses and frame.

Any replacement or repair of existing eyeglasses or contact lenses will not be covered until after this Rider has been in force for 6 months unless needed as a result of Injury.

## **EXCLUSIONS**

Benefits will not be paid for dental expenses arising from or in connection with:

- A service not furnished by a Dentist, except:
  - That performed by a Dental Hygienist under the supervision of a Dentist; and
  - X-rays ordered by a Dentist.
- Treatment, services or supplies which:
  - Are not Necessary Dental Treatment, except as provided herein;
  - Are Experimental/Investigational in nature.
- Treatment by a Family Member.
- Services or supplies for which there would be no charge in the absence of insurance.
- A service furnished to You for:
  - Cosmetic purposes, unless needed as a result of Injury. Facing on crowns, on pontics, posterior to the second bicuspid shall always be considered cosmetic; or
  - Dental care of congenital or developmental malformation (unless benefits for orthodontic services are specifically provided in the Schedule).
- Implants; replacement of lost or stolen appliances, replacement of orthodontic retainers, athletic mouthguards, precision or semi-precision attachments; denture duplication; or sealants.
- Oral hygiene instructions; plague control; acid etch; or prescription for take-home fluoride.
- Overdentures and associated procedures.
- Services not completed by the end of the month in which insurance terminates.
- Any replacement or repair for existing bridges or dentures during the 6 month period starting on the date coverage becomes effective for You under this Rider, unless needed as a result of Injury.
- Orthodontic related expense, unless specifically provided.

Benefits will not be paid for vision expenses arising from or in connection with:

- Treatment, services or supplies which:
  - Are Experimental/Investigational in nature;
  - Are received without charge or legal obligation to pay; or
  - Treatment by any Family Member.
- Conditions covered by Worker's Compensation Services.
- Services and supplies in connection with special procedures such as: orthoptics or vision training and subnormal vision aids.
- Non-prescription (plano) eyewear.
- Medical or surgical treatments of the eyes, unless to correct refraction of the eyes.
- Eye examinations required by an employer as a condition of employment.

- Any replacement or repair for existing eyeglasses or contact lenses during the 6 month period starting on the date coverage becomes effective for You under this Rider, unless needed as a result of Injury.
- Any service or material provided by another vision plan.

**RENEWAL CONDITIONS**

This Rider is renewed when the Policy to which it is attached is renewed.

**TERMINATION**

This Rider will terminate on the earliest of:

1. The date the Policy to which this Rider is attached is terminated;
2. The date You ask Us, in writing, to cancel this Rider; or
3. The date the Policy lapses for non-payment of premium.

**PREMIUM**

This Rider requires the payment of premium in addition to the premium due for the Policy. The premium for this Benefit Rider is shown in the Policy Schedule.

We can change the premium for this Rider if We change it for all Riders like Yours in Your state on a class basis. We'll provide You with written notice of any change in the premium in the time required by Your state.

**CONDITIONS**

This Rider is subject to all terms, definitions, provisions, limitations, and exclusions of the Policy except where specifically changed by this Rider.

Signed for United National Life Insurance Company of America at Glenview, Illinois, by



Secretary



President

Section A: Applicant Information

Applying For: (please check one) [ ] New Coverage [ ] Reinstatement [ ] Increase in Benefits

Applicant

1. Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Social Sec # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

2. Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

3. Telephone (Day) \_\_\_\_\_ Applicant's E-mail Address \_\_\_\_\_

Section B: Coverage Selection and Premiums

Plan: Hospital Confinement with Doctor Office Visit Benefit

Choose Number of Hospital Days Payable Per Benefit Period

[ ] 10 Days [ ] 20 Days

Choose an amount from \$100 - \$500 per day

(in \$50 increments) \$ \_\_\_\_\_

Optional Riders:

- [ ] Additional Doctor's Office Benefit Rider [ ] \$10 [ ] \$20 [ ] \$30
[ ] Outpatient Surgery Benefit Rider [ ] \$500 [ ] \$1000 [ ] \$1500
[ ] Skilled Nursing Facility Benefit Rider [ ] \$75 [ ] \$150
[ ] Lump Sum Cancer Rider [ ] \$2500 [ ] \$5000
[ ] Emergency Benefit Rider
[ ] Dental and Vision Benefit Rider

Total Premium: \$ \_\_\_\_\_ [ ] Draft 1st Premium (Draft date for 1st premium must be same as Effective Date)

Draft Date (For other than drafting 1st premium) \_\_\_\_\_ Requested Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Premium Payment Mode: [ ] Monthly (.09) [ ] Quarterly (.265) [ ] Semi-Annual (.52) [ ] Annual

Premium Payment Method: [ ] Bank Draft [ ] Credit Card [ ] List Bill (must be 4 or more applicants)

Section C: Medical/Underwriting Questions

If answer to any part of question 1 to 7 is "Yes", the applicant is not eligible for the policy.

- 1. In the past 2 years, have you had or received treatment or medical advice by a medical practitioner for the following conditions:
a. Internal cancer or melanoma or diabetes treated by insulin? [ ] Yes [ ] No
b. Disabling osteoporosis or disabling arthritis, kidney disease requiring dialysis or transplant, chronic lung disease requiring the use of oxygen, cirrhosis of the liver, or any disorder requiring transplant?.. [ ] Yes [ ] No
c. Alcohol or drug abuse, or any disorder of the central nervous system including but not limited to multiple sclerosis, muscular dystrophy, cerebral palsy, or Amyotrophic lateral sclerosis (ALS)?..... [ ] Yes [ ] No
d. Dementia, mental deterioration, or diminished mental capacity?..... [ ] Yes [ ] No
2. In the past 6 months have you had a heart attack, heart bypass, angioplasty, congestive heart failure, stroke, or TIA (Transient Ischemic Attack)?..... [ ] Yes [ ] No
3. Do you require assistance with two or more of the following activities: bathing, dressing, using the toilet, indoor or outdoor mobility or eating; do you use oxygen for medical condition, or are you suffering from paralysis or had any type of amputation due to a disease?..... [ ] Yes [ ] No
4. Have you ever been treated for or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for the presence of the Human Immunodeficiency Virus (HIV)?..... [ ] Yes [ ] No
5. In the past 12 months, have you been advised to seek treatment or medical advice from a medical practitioner or have you experienced any symptoms that would have caused a person to seek medical advice for any of the conditions listed in questions 1 through 4 but have not yet done so?..... [ ] Yes [ ] No
6. Are you now confined to a hospital or nursing home or receiving home health care or are you currently awaiting such confinement or assistance or have you been advised to have surgery that you have not yet had?..... [ ] Yes [ ] No
7. Are you covered under a state Medicaid program?..... [ ] Yes [ ] No

**To be completed if choosing the Lump Sum Cancer Rider and/or the Dental/Vision Rider.**

8. In the past 10 years have you had, been diagnosed as having, received medication for, or been treated by a medical practitioner for leukemia, Hodgkin's or Non-Hodgkin's disease, malignant melanoma, sarcoma, or any other internal cancer or had radiation or chemotherapy for any of these conditions? (If answer is "Yes", you are not eligible for Lump Sum Cancer rider.).....  Yes  No
9. Do you currently wear eye glasses or contacts?.....  Yes  No

**Section D: Replacement Question**

10. Will the coverage(s) being applied for replace any existing hospital, medical, major medical, or hospital confinement indemnity insurance in this or any other company? .....  Yes  No  
 If yes, Company \_\_\_\_\_ (submit appropriate replacement form – if needed in your state).

**Section E: Authorization / Agreement**

ALL STATEMENTS MADE IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE, TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT THE STATEMENTS FORM THE BASIS UPON WHICH INSURANCE WILL BE MADE EFFECTIVE. I UNDERSTAND THAT OMISSIONS, MISREPRESENTATIONS OR MISSTATEMENTS COULD RESULT IN DENIAL OF AN OTHERWISE VALID CLAIM AND/OR RESCISSION, VOIDING, OR REFORMATION OF INSURANCE.

I understand that insurance applied for will not become effective until: a) approved and issued by UNL; b) I have been furnished written notice of the effective date; and c) I have paid the premium in full. I understand that any changes in my health conditions, if applicable, from the date of this application until insurance becomes effective, may result in the declination of my coverage. No agent or other representative of UNL has required, permitted, or encouraged me to answer any question inaccurately or has waived any conditions of this application. I have received a copy of the Pre-Notice which describes how information is obtained and used by UNL. If this application is completed electronically, I understand the Pre-Notice will be delivered electronically or with the policy. If the application is completed over the phone the Pre-Notice will be delivered with the policy.

**AUTHORIZATION:** I authorize United National Life Insurance Company of America (herein referred to as the "Company"), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my physical condition, other coverage and any other information needed to underwrite my application for insurance such as criminal or motor vehicle records. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes), such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, insurance company or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any information provided to our health division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from the Medical Information Bureau. This Authorization includes all information about drugs, alcoholism, and mental illness. I understand and agree that the Company or its representatives may conduct a phone interview or face-to-face assessment as part of the underwriting process. I agree that this Authorization will be valid for 24 months from the date signed, and know that I or my authorized representative may have a photocopy of it.

I have received an Outline of Coverage. If this application is completed electronically, I understand the Outline of Coverage will be delivered electronically or with the policy. If the application is completed over the phone the Outline of Coverage will be delivered with the policy.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or, so long as UNL has a legal right to contest a claim under the coverage or the coverage itself. Revocation requests should be sent in writing to my agent or to the attention of the Underwriting Manager.

I understand once information is disclosed pursuant to this Authorization, such information will continue to be protected by UNL in accordance with federal or state law. I also understand that my application for insurance can be declined if I choose not to sign this Authorization.

Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_ Signed at City and State \_\_\_\_\_

**AGENT'S STATEMENT**

I am not aware of any additional information which may have a bearing on the insurability of anyone proposed for insurance on this application and any supplement to it. I have advised the applicant not to withhold any information relative to this application and its questions. I have advised the applicant to review the application for completeness and accuracy and that no coverage is in effect until the applicant is notified in writing by United National Life Insurance Company of America. I certify that I asked all the questions and truthfully and accurately recorded the answers contained herein (except if application is completed electronically or over the phone). **To the best of my knowledge and belief, the insurance applied for:  is or is likely or  is not or is not likely to replace or change any existing policy(ies) or contract(s).**

Agent's Name (Printed) \_\_\_\_\_ Agent's Signature \_\_\_\_\_ Agent Code \_\_\_\_\_ Agent's E-mail \_\_\_\_\_ Date \_\_\_\_\_

Mail policy to:  Agent  Policyholder

SERFF Tracking Number: GRTT-126869462 State: Arkansas  
 Filing Company: United National Life Insurance Company of America State Tracking Number: 47161  
 Company Tracking Number: U1050-AR  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: U1050-AR  
 Project Name/Number: Limited Benefit /U1050-AR

## Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 11/01/2010	Limited Benefit Policy	U1050-AR	New		Rates-U1050-50%.pdf
Approved-Closed 11/01/2010	Doctor's Office Visit Benefit Rider	RU10DRV	New		Rates-R10DRV-50%.pdf
Approved-Closed 11/01/2010	Emergency Benefit Rider	RU10ER	New		Rates-RU10ER-50%.pdf
Approved-Closed 11/01/2010	Outpatient Surgery Benefit Rider	RU10OPS	New		Rates-RU10OPS-50%.pdf
Approved-Closed 11/01/2010	Skilled Nursing Facility Benefit Rider	RU10SNF	New		Rates-RU10SNF-50%.pdf
Approved-Closed 11/01/2010	Dental and Vision Benefit Rider	RU10DV	New		Rates-RU10DV-50%.pdf
Approved-	Lump Sum Cancer	RU07LS	New		Rates-RU07LS-

SERFF Tracking Number: GRTT-126869462 State: Arkansas  
Filing Company: United National Life Insurance Company of State Tracking Number: 47161  
America  
Company Tracking Number: U1050-AR  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: U1050-AR  
Project Name/Number: Limited Benefit /U1050-AR

Closed Rider  
11/01/2010

50%.pdf

United National Life Insurance Company  
Annual Premium Rates  
Form U1050

<b>Annual Premium Rate per \$50 per Day Hospital Confinement</b>		
Issue Age	10 Days	20 Days
40-44	59	68
45-49	63	72
50-54	66	76
55-59	72	85
60-64	82	100
65-69	95	140
70-74	115	170
75-79	130	195
80-84	140	215
85+	155	240

<b>Annual Premium Rate \$30 per Visit Doctor Office Visit</b>		
Issue Age	10 Days	20 Days
40-44	195	195
45-49	225	225
50-54	255	255
55-59	285	285
60-64	360	360
65-69	390	390
70-74	450	450
75-79	540	540
80-84	540	540
85+	540	540

<b>Modal Factors</b>	
Mode	Factor
A	1.000
S	0.520
Q	0.265
M	0.090

The Basic Annual Premium is equal to the annual premium per \$50 times the number of 50 dollar increments chosen plus the annual premium for the \$30 Doctor Office Visit

United National Life Insurance Company  
Annual Premium Rates  
Doctor Office Visit  
Form RU10DRV

Annual Premium Rate per \$10 per Visit Doctor Office Visit	
Issue Ages	\$10
40-44	65
45-49	75
50-54	85
55-59	95
60-64	120
65-69	130
70-74	150
75-79	180
80-84	180
85+	180

Modal Factors	
Mode	Factor
A	1.000
S	0.520
Q	0.265
M	0.090

United National Life Insurance Company  
Annual Premium Rates  
Emergency Benefit Rider  
Form RU10ER

<b>Annual Premium Rate \$200 ER/AMB Skilled Nursing Rider</b>	
<b>Issue Ages</b>	<b>\$200</b>
40-44	90
45-49	90
50-54	90
55-59	90
60-64	100
65-69	110
70-74	125
75-79	140
80-84	155
85+	160

<b>Modal Factors</b>	
<b>Mode</b>	<b>Factor</b>
A	1.000
S	0.520
Q	0.265
M	0.090

United National Life Insurance Company  
Annual Premium Rates  
Outpatient Surgery Rider  
Form RU10OPS

Annual Premium Rate per \$500 Benefit Outpatient Surgery	
Issue Ages	\$500
40-44	113
45-49	143
50-54	175
55-59	213
60-64	245
65-69	275
70-74	290
75-79	290
80-84	290
85+	290

Modal Factors	
Mode	Factor
A	1.000
S	0.520
Q	0.265
M	0.090

United National Life Insurance Company  
 Annual Premium Rates  
 Skilled Nursing Rider  
 Form RU10SNF

<b>Annual Premium Rate per \$75 per day Skilled Nursing Rider</b>	
Issue Ages	\$75
40-44	11
45-49	14
50-54	18
55-59	25
60-64	46
65-69	72
70-74	129
75-79	220
80-84	370
85+	508

Modal Factors	
Mode	Factor
A	1.000
S	0.520
Q	0.265
M	0.090

United National Life Insurance Company  
Annual Premium Rates  
Dental/Vision Rider  
Form RU10DV

Annual Premium Rate	
Dental/Vision	
Issue Ages	80% up to Max
40-44	340
45-49	365
50-54	385
55-59	405
60-64	415
65-69	415
70-74	415
75-79	415
80-84	415
85+	415

Modal Factors	
Mode	Factor
A	1.000
S	0.520
Q	0.265
M	0.090

**United National Insurance Company**

**Lump Sum Cancer Rider**

**Individual Rates per \$2,500 Benefit**

Rider Form: RU07LS

Issue Age	Annual Rate
40-44	40
45-49	40
50-54	63
55-59	63
60-64	81
65-69	92
70-74	105
75-79	114
80-84	115
85+	119

Modal Factors	
Annual	1.000
Semi	0.520
Quarterly	0.265
Mo. PAC	0.090

SERFF Tracking Number: GRTT-126869462 State: Arkansas  
 Filing Company: United National Life Insurance Company of America State Tracking Number: 47161  
 Company Tracking Number: U1050-AR  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: U1050-AR  
 Project Name/Number: Limited Benefit /U1050-AR

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	11/01/2010
<b>Comments:</b>		
<b>Attachment:</b> AR Readability Certification U1050 et al.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved-Closed	11/01/2010
<b>Comments:</b> Filing new application - please see form schedule.		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Outline of Coverage	Approved-Closed	11/01/2010
<b>Comments:</b>		
<b>Attachment:</b> OCU1050 (bracketed).pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> PPACA Uniform Compliance Summary	Approved-Closed	11/01/2010
<b>Bypass Reason:</b> Not applicable.		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Statement of Variability	Approved-Closed	11/01/2010
<b>Comments:</b>		



## CERTIFICATE OF READABILITY

Form Number(s): U1050-AR, RU10DRV, RU10ER, RU10OPS, RU10SNF, RU10DV, UAPPH3-10-AR and OCU1050

Flesch Test Score(s): 50.87, 57.42, 60.16, 53.61, 61.39, 50.62, 59.03 and 51.56 respectively.

I hereby certify that to the best of my knowledge and belief, the above form(s) meet the minimum reading ease requirements of your Department. The Flesch Reading Ease Test score(s) are listed above.

UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA



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Allan J. Heindl, FLMI, HIA, AIRC  
Vice President – Product Approval & Compliance

Date: October 20, 2010

**UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA**

P. O. Box 1154, Glenview, Illinois 60025-1154  
(847) 803-5252

**LIMITED BENEFIT HEALTH COVERAGE**

Guaranteed Renewable for Life  
Premiums May Be Changed By Class

**OUTLINE OF COVERAGE**

For Policy Form U1050

[With Optional Rider Forms RU10DRV, RU10ER, RU10OPS, RU10SNF, RU10DV, and RU07LS]

**KEEP THIS OUTLINE FOR YOUR RECORDS**

**THIS IS NOT A MEDICARE SUPPLEMENT POLICY**

**THIS IS A LIMITED BENEFIT POLICY - READ YOUR POLICY CAREFULLY** – This Outline of Coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. Your policy sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

**LIMITED BENEFIT COVERAGE** – Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

**One Period of Confinement:** For the purposes of determining a Maximum Benefit Period, One Period of Confinement begins when you become Hospital Confined. One Period of Confinement ends when there has been no additional Hospital Confinement for 60 consecutive days. If you have selected the optional Skilled Nursing Facility Benefit Rider, One Period of Confinement ends when there has been no additional Hospital Confinement or confinement to a Skilled Nursing Facility for 60 consecutive days. Subject to the Policy’s Lifetime Maximum and Skilled Nursing Facility Lifetime Maximum if such rider has been selected and provided the policy and any Skilled Nursing Facility Benefit Rider are in force, a new Maximum Benefit Period and a new Skilled Nursing Maximum Benefit Period will apply.

**BENEFITS**

We will pay benefits, as shown below, for Hospital Confinement, and visits to the Doctor's office which are Medically Necessary and due to Injury or Sickness.

**A : HOSPITAL CONFINEMENT INDEMNITY BENEFIT**

We will pay the Hospital Confinement Indemnity Benefit Amount for each day you are confined in a Hospital when such confinement is Medically Necessary because of an Injury or Sickness. Benefits are not payable beyond the Maximum Benefit Period for any One Period of Hospital Confinement.

Hospital Confinement Indemnity Amount \$\_\_\_\_\_ per day

Maximum Benefit Period selected:  10 days  20 days

We will not pay more than the Lifetime Maximum of 365 days for Hospital Confinement.

**B - DOCTOR'S OFFICE VISIT BENEFIT**

We will pay the Doctor’s Office Visit Benefit Amount of \$30 per visit, when you receive the medical services of a Doctor, limited to one visit to the Doctor's office per week.

This benefit is limited to the Doctor’s Office Visit Calendar Year Maximum of 20 visits.

## **LIMITATIONS AND EXCLUSIONS:**

**PRE-EXISTING CONDITION:** A pre-existing condition is a condition for which: (a) medical advice or treatment was recommended by, or received from a doctor, within the 6 month period before the effective date of your coverage under the policy or the effective date of your coverage under any optional riders attached to the policy; or (b) symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 6 month period before the effective date of your coverage under the policy or the effective date under any optional riders attached to the policy.

A pre-existing condition is not covered unless the loss begins more than 6 months after the effective date of your coverage under the policy or the effective date of your coverage under any optional riders attached to the policy.

### **EXCLUSIONS:**

We won't pay benefits for:

1. For treatment, services or supplies which:
  - Are not Medically Necessary;
  - Are not prescribed by a doctor as necessary to treat an Sickness or Injury;
  - Are determined to be Experimental/Investigational in nature by us;
  - Are received without charge or legal obligation to pay;
  - Would not routinely be paid in the absence of insurance;
  - Are received from any Family Member.
2. For expenses incurred as a result of loss, or for treatment of an Injury or Sickness, due to war, or any action of war, declared or undeclared; service in the armed forces of any country.
3. For treatment of intentionally self-inflicted injuries or attempted suicide while sane or insane.
4. For treatment of an Injury or Sickness for which you are entitled to benefits under any Workers' Compensation or Occupational Disease Law (self-employed are covered for occupational Injury).
5. For treatment in a hospital operated by the federal government unless you, by law, must pay.
6. For normal pregnancy and childbirth if conception was before the effective date. Complications of pregnancy are covered as a Sickness.
7. For Mental or Nervous Disorders.
8. For treatment of an Injury that results from the commission of, or attempt to commit a felony, or from being engaged in an illegal activity.
9. For cosmetic surgery. However "cosmetic surgery" does not include reconstructive surgery which is incidental because of previous surgery due to trauma, infection, or other disease of the involved part.
10. For treatment of substance abuse, including alcoholism, drug addiction, narcotics, or hallucinogens.
11. For confinement or treatment received outside the United States or its possessions, unless loss is incurred while on a trip of not more than 60 days' duration.

### **[OPTIONAL COVERAGE(S):**

The following coverage(s) are only applicable if you choose to purchase them for an additional premium.]

### **[OPTIONAL DOCTOR'S OFFICE VISIT BENEFIT RIDER RU10DRV**

If this rider is purchased, we will pay the Doctor's Office Visit Benefit Amount, when you receive the medical services of a doctor. This benefit is limited to one visit to the doctor's office per week. This benefit will be payable in addition to any Doctor's Office Visit Benefit payable under the policy, if applicable.

This benefit is limited to the Doctor's Office Visit Calendar Year Maximum of 20 visits (Note: the calendar year maximum of 20 visits is applicable to the policy's Doctor's Office Visit Benefit and this optional rider combined).

Doctor's Office Visit Benefit Amount selected:     \$10     \$20     \$30]

**[OPTIONAL EMERGENCY BENEFIT RIDER RU10ER**

If this rider is purchased, we will pay benefits, as shown below, for Emergency Room and Ambulance Service.

**A - Emergency Room Benefit**

We will pay the Emergency Room Benefit Amount of \$200 per visit, when you visit the emergency room of a hospital for Emergency Services. We will not pay more than the Emergency Room Calendar Year Maximum of 2 visits.

**B – Ambulance Service Benefit**

We will pay the Ambulance Service Benefit Amount of \$200 per trip, if a licensed surface ambulance service transports you to a Hospital for Emergency Services. We will not pay more than the Ambulance Service Calendar Year Maximum of 2 trips.]

**[OPTIONAL OUTPATIENT SURGERY BENEFIT RIDER RU10OPS**

If this rider is purchased, we will pay the Outpatient Surgery Benefit Amount for a surgical procedure performed by a Doctor when such procedure is performed in an Ambulatory Surgical Center or Outpatient Facility of a Hospital. Surgical procedures and the services and supplies related to the surgical procedures are limited to one occurrence per calendar year.

**Outpatient Surgery Benefit Rider Exclusions**

The following rider exclusions are in addition to the exclusions contained in the policy to which this rider is attached. We won't pay benefits for:

1. Surgical procedures performed in a Doctor's office or when Hospital Confined;
2. Surgery for corns, calluses and bunions; deviated nasal septum, including submucous resection and/or other surgical corrections thereof unless due to injury occurring while coverage is in force;
3. Surgery for removal of breast implants. This exclusion shall not apply to the removal of breast implants for the Medically Necessary treatment of a covered Sickness or Injury, unless the implants were implanted solely for cosmetic purposes and not for surgery performed as reconstruction resulting from an Sickness or Injury;
4. Surgery for non-malignant warts, moles (boils) and lesions unless Medically Necessary;
5. Dental surgery except oral surgery for excision of tumors, growths and cysts of the jaw and mouth and surgery to Sound Natural Teeth made necessary by Injury;
6. Surgery for refractive anomalies;
7. Elective surgery not required to treat a Sickness or Injury;
8. Surgical procedure performed for cosmetic purposes only, unless such cosmetic surgery is to restore normal appearance following Sickness or Injury;
9. Surgical procedure associated with childbirth except when required due to Complications of Pregnancy.

Outpatient Surgery Benefit Amount selected:  \$500  \$1000  \$1500]

**[OPTIONAL SKILLED NURSING FACILITY BENEFIT RIDER RU10SNF**

**Elimination Period:** The number of days you must be confined in a Skilled Nursing Facility before any Skilled Nursing Facility Benefit is payable. There is only one Elimination Period per One Period of Confinement. The Elimination Period is 20 days per One Period of Confinement.

If this rider is purchased and subject to the following conditions and satisfying the Elimination Period, we will pay the Skilled Nursing Facility Benefit Amount for each day you are confined to a Skilled Nursing Facility and receiving Skilled Nursing Care:

1. You have first been Hospital Confined for 3 or more consecutive days;
2. The Skilled Nursing Facility confinement begins within 30 days after such Hospital Confinement;
3. Your Doctor must certify the need for the Skilled Nursing Facility confinement; and
4. The Skilled Nursing Facility confinement is for the same Injury or Sickness as the Hospital Confinement for which we paid benefits.

We will not pay more than the Skilled Nursing Maximum Benefit Period of 80 days for any One Period of Confinement.

We will not pay more than the Skilled Nursing Facility Lifetime Maximum of 300 days for Skilled Nursing Facility Confinement.]

## **[OPTIONAL DENTAL AND VISION BENEFIT RIDER RU10DV**

If this rider is purchased, we will pay the Usual and Customary Expenses you incur for necessary dental and vision treatment for the services and supplies shown below. After you satisfy the Rider Deductible, we will pay the Insured Percent of covered expenses up to the Maximum Amount per Calendar Year. The Deductible amount is \$100 per calendar year. The Maximum Amount for the 1<sup>st</sup> Calendar year is 80% up to \$250 and the 2<sup>nd</sup> Calendar year is 80% up to \$750.

### **1. Dental**

We will pay the Maximum Amount for services of a licensed Dentist including the cost of fillings, prophylaxis, bridges, and dentures, prescribed as necessary by a Dentist.

Any replacement or repair of existing bridges or dentures will not be covered until after this Rider has been in effect for 6 months unless needed as a result of Injury.

### **2. Vision**

We will pay the Maximum Amount for visits for the purpose of eye refractions to a licensed ophthalmologist or optometrist including the cost of eyeglasses or contact lenses prescribed by such doctor.

Standard frame, limited to one frame in any 24 consecutive months.

Contact lenses, limited to one pair in any 12 consecutive months. This benefit is in lieu of lenses and frame.

Any replacement or repair of existing eyeglasses or contact lenses will not be covered until after this Rider has been in force for 6 months unless needed as a result of Injury.

### **Dental and Vision Benefit Rider Exclusions**

Benefits will not be paid for dental expenses arising from or in connection with:

- A service not furnished by a Dentist, except:
  - That performed by a Dental Hygienist under the supervision of a Dentist; and
  - X-rays ordered by a Dentist.
- Treatment, services or supplies which:
  - Are not Necessary Dental Treatment, except as provided herein;
  - Are Experimental/Investigational in nature.
- Treatment by a Family Member.
- Services or supplies for which there would be no charge in the absence of insurance.
- A service furnished to you for:
  - Cosmetic purposes, unless needed as a result of Injury. Facing on crowns, on pontics, posterior to the second bicuspid shall always be considered cosmetic; or
  - Dental care of congenital or developmental malformation (unless benefits for orthodontic services are specifically provided in the Schedule).
- Implants; replacement of lost or stolen appliances, replacement of orthodontic retainers, athletic mouthguards, precision or semi-precision attachments; denture duplication; or sealants.
- Oral hygiene instructions; plague control; acid etch; or prescription for take-home fluoride.
- Overdentures and associated procedures.
- Services not completed by the end of the month in which insurance terminates.
- Any replacement or repair for existing bridges or dentures during the 6 month period starting on the date coverage becomes effective for you under the Rider, unless needed as a result of Injury.
- Orthodontic related expense, unless specifically provided.

Benefits will not be paid for vision expenses arising from or in connection with:

- Treatment, services or supplies which:
  - Are Experimental/Investigational in nature;
  - Are received without charge or legal obligation to pay; or
  - Treatment by any Family Member.
- Conditions covered by Worker's Compensation Services.
- Services and supplies in connection with special procedures such as: orthoptics or vision training and subnormal vision aids.
- Non-prescription (plano) eyewear.
- Medical or surgical treatments of the eyes, unless to correct refraction of the eyes.
- Eye examinations required by an employer as a condition of employment.
- Any replacement or repair for existing eyeglasses or contact lenses during the 6 month period starting on the date coverage becomes effective for you under this Rider, unless needed as a result of Injury.
- Any service or material provided by another vision plan.]



**United National Life Insurance Company of America**

**Statement of Variability  
For U1050-AR (Policy Schedule)**

The bracketing of variable text in the Policy Schedule of policy form U1050 is limited to the following:

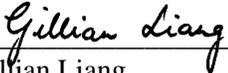
1. Policy Number: assigned at issue.
2. Effective Date: date policy becomes effective.
3. Name of Insured: applicants name.
4. Premium: varies in context of the method, mode, and benefits selected by the insured.\*
5. Hospital Confinement Indemnity Benefit Amount: depends on plan selected in Section B of application.\*
6. Maximum Benefit Period: selected in Section B of application.\*
7. Doctor's Office Visit Benefit Amount: included if plan selected in Section B of application.\*
8. Emergency Benefit Amount: included if selected in Section B of application.\*
9. Outpatient Surgery Benefit Amount: included if plan selected in Section B of application.\*
10. Skilled Nursing Facility Benefit Amount: included if plan selected in Section B of application.\*
11. Dental and Vision Benefit Amount: included if selected in Section B of application.\*

\* Variability is limited to changing these portions only in context that remains compliant with the state insurance regulatory requirements. Any new benefit amounts, benefit periods, or rates will be filed with the State Department of Insurance before use. The Company reserves the right to discontinue marketing benefit riders not mandated under state law.

**For UAPPH3-10-AR (Application)**

We are filing the following as variable:

1. The marketing name "Choice Plus" on the top left hand corner of the application.
  2. Section A – Applicant information, in the event we may later choose to add, remove, or replace those methods of contacting the applicant.
  3. Section B – Coverage Selection.
- Variability is limited to changing these portions only in context that remains compliant with the state insurance regulatory requirements. The Company reserves the right to discontinue marketing benefit riders not mandated under state law and remove them from the application without re-filing for approval. The Company also reserves the right to add benefit plans and benefit riders, subject to such additional plans and/or riders receiving prior approval in the state, and add them to the Plan and Optional riders sections without refiling this application for approval.

  
\_\_\_\_\_  
Gillian Liang  
Senior Compliance Analyst  
United National Life Insurance Company of America  
October 20, 2010

SERFF Tracking Number: GRIT-126869462 State: Arkansas  
 Filing Company: United National Life Insurance Company of America State Tracking Number: 47161  
 Company Tracking Number: U1050-AR  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: U1050-AR  
 Project Name/Number: Limited Benefit /U1050-AR

## Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
10/28/2010	Rate and Rule	Limited Benefit Policy	10/29/2010	Rates U1050 50%.pdf (Superseded)
10/28/2010	Rate and Rule	Doctor's Office Visit Benefit Rider	10/29/2010	Rates RU10DRV 50%.pdf (Superseded)
10/28/2010	Rate and Rule	Emergency Benefit Rider	10/29/2010	Rates RU10ER 50%.pdf (Superseded)
10/28/2010	Rate and Rule	Outpatient Surgery Benefit Rider	10/29/2010	Rates RU10OPS 50%.pdf (Superseded)
10/28/2010	Rate and Rule	Skilled Nursing Facility Benefit Rider	10/29/2010	Rates RU10SNF 50%.pdf (Superseded)
10/28/2010	Rate and Rule	Dental and Vision Benefit Rider	10/29/2010	Rates RU10DV 50%.pdf (Superseded)
10/28/2010	Rate and Rule	Lump Sum Cancer Rider	10/29/2010	Rates RU07LS 50%.pdf (Superseded)

United National Life Insurance Company  
Annual Premium Rates  
Form U1050

<b>Annual Premium Rate per \$50 per Day Hospital Confinement</b>		
Issue Age	10 Days	20 Days
40-44	59	68
45-49	63	72
50-54	66	76
55-59	72	85
60-64	82	100
65-69	95	140
70-74	115	170
75-79	130	195
80-84	140	215
85+	155	240

<b>Annual Premium Rate \$30 per Visit Doctor Office Visit</b>		
Issue Age	10 Days	20 Days
40-44	195	195
45-49	225	225
50-54	255	255
55-59	285	285
60-64	360	360
65-69	390	390
70-74	450	450
75-79	540	540
80-84	540	540
85+	540	540

<b>Modal Factors</b>	
Mode	Factor
A	1.000
S	0.520
Q	0.265
M	0.084

The Basic Annual Premium is equal to the annual premium per \$50 times the number of 50 dollar increments chosen plus the annual premium for the \$30 Doctor Office Visit

United National Life Insurance Company  
Annual Premium Rates  
Doctor Office Visit  
Form RU10DRV

Annual Premium Rate per \$10 per Visit Doctor Office Visit	
Issue Ages	\$10
40-44	65
45-49	75
50-54	85
55-59	95
60-64	120
65-69	130
70-74	150
75-79	180
80-84	180
85+	180

Modal Factors	
Mode	Factor
A	1.000
S	0.520
Q	0.265
M	0.084

United National Life Insurance Company  
Annual Premium Rates  
Emergency Benefit Rider  
Form RU10ER

<b>Annual Premium Rate \$200 ER/AMB Skilled Nursing Rider</b>	
<b>Issue Ages</b>	<b>\$200</b>
40-44	90
45-49	90
50-54	90
55-59	90
60-64	100
65-69	110
70-74	125
75-79	140
80-84	155
85+	160

<b>Modal Factors</b>	
<b>Mode</b>	<b>Factor</b>
A	1.000
S	0.520
Q	0.265
M	0.084

United National Life Insurance Company  
Annual Premium Rates  
Outpatient Surgery Rider  
Form RU10OPS

Annual Premium Rate per \$500 Benefit Outpatient Surgery	
Issue Ages	\$500
40-44	113
45-49	143
50-54	175
55-59	213
60-64	245
65-69	275
70-74	290
75-79	290
80-84	290
85+	290

Modal Factors	
Mode	Factor
A	1.000
S	0.520
Q	0.265
M	0.084

United National Life Insurance Company  
Annual Premium Rates  
Skilled Nursing Rider  
Form RU10SNF

<b>Annual Premium Rate per \$75 per day Skilled Nursing Rider</b>	
<b>Issue Ages</b>	<b>\$75</b>
40-44	11
45-49	14
50-54	18
55-59	25
60-64	46
65-69	72
70-74	129
75-79	220
80-84	370
85+	508

<b>Modal Factors</b>	
<b>Mode</b>	<b>Factor</b>
A	1.000
S	0.520
Q	0.265
M	0.084

United National Life Insurance Company  
Annual Premium Rates  
Dental/Vision Rider  
Form RU10DV

Annual Premium Rate	
Dental/Vision	
Issue Ages	80% up to Max
40-44	340
45-49	365
50-54	385
55-59	405
60-64	415
65-69	415
70-74	415
75-79	415
80-84	415
85+	415

Modal Factors	
Mode	Factor
A	1.000
S	0.520
Q	0.265
M	0.084

**United National Insurance Company**

**Lump Sum Cancer Rider**

**Individual Rates per \$2,500 Benefit**

Rider Form: RU07LS

Issue Age	Annual Rate
40-44	40
45-49	40
50-54	63
55-59	63
60-64	81
65-69	92
70-74	105
75-79	114
80-84	115
85+	119

Modal Factors	
Annual	1.000
Semi	0.509
Quarterly	0.259
Mo. PAC	0.089