

SERFF Tracking Number: AMLC-126500747 State: Arkansas
Filing Company: Liberty National Life Insurance Company State Tracking Number: 44853
Company Tracking Number: MEDICARE SUPPLEMNT POLICY FORM LMSN10
TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.011 Plan N 2010
Standard Plans 2010
Product Name: Medicare Supplement Policy Form LMSN10
Project Name/Number: Medicare Supplement Policy Form LMSN10/Medicare Supplement Policy Form LMSN10

Filing at a Glance

Company: Liberty National Life Insurance Company

Product Name: Medicare Supplement Policy Form LMSN10 SERFF Tr Num: AMLC-126500747 State: Arkansas

TOI: MS08I Individual Medicare Supplement - Standard Plans 2010 SERFF Status: Closed-Approved- Closed State Tr Num: 44853

Sub-TOI: MS08I.011 Plan N 2010 Co Tr Num: MEDICARE SUPPLEMNT POLICY FORM LMSN10 State Status: Approved-Closed

Filing Type: Form/Rate

Author: Phylis Ballard

Date Submitted: 02/15/2010

Reviewer(s): Stephanie Fowler

Disposition Date: 04/13/2010

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date: 06/01/2010

State Filing Description:

General Information

Project Name: Medicare Supplement Policy Form LMSN10

Project Number: Medicare Supplement Policy Form LMSN10

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Filed in Nebraska, our state of domicile.

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 04/13/2010

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 04/13/2010

Deemer Date:

Submitted By: Phylis Ballard

Created By: Phylis Ballard

Corresponding Filing Tracking Number:

Medicare Supplement Policy Form LMSN10

Filing Description:

NAIC #290-65331

RE: Medicare Supplement Policy Form LMSN10

Outline of Coverage Form DS-LMS2010(02)

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Actuarial Memorandum and Rates

Enclosed for your review and approval are copies of the subject Medicare Supplement Policy and related forms.

These forms have been revised to comply with the requirements set forth by the MMA regarding Medicare Supplement insurance effective June 1, 2010.

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

Company and Contact

Filing Contact Information

Phylis Ballard, Compliance Analyst pballard@torchmarkcorp.com
 3700 S. Stonebridge Drive 972-569-3748 [Phone]
 McKinney, TX 75070 972-569-3728 [FAX]

Filing Company Information

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: 1 forms \$50 and 1 rate \$50 = \$100
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Liberty National Life Insurance Company	\$100.00	02/15/2010	34186649

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	04/13/2010	04/13/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Stephanie Fowler	04/12/2010	04/12/2010	Phylis Ballard	04/12/2010	04/12/2010
Pending Industry Response	Stephanie Fowler	03/17/2010	03/17/2010	Phylis Ballard	03/22/2010	03/22/2010

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Disposition

Disposition Date: 04/13/2010

Implementation Date: 06/01/2010

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	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	Yes
Supporting Document	Outline of Coverage	Approved	Yes
Form (revised)	Medicare Supplement Policy	Approved	Yes
Form	Medicare Supplement Policy	Disapproved	Yes
Rate (revised)	LMSN10	Approved	Yes
Rate	LMSN10	Disapproved	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 04/12/2010
Submitted Date 04/12/2010
Respond By Date 05/12/2010

Dear Phylis Ballard,

This will acknowledge receipt of the captioned filing.

Objection 1

- LMSN10, [LMSN10] (Rate)

Comment: Please submit the rates for Arkansas.

Please feel free to contact me if you have questions.

Sincerely,

Stephanie Fowler

Response Letter

Response Letter Status Submitted to State
Response Letter Date 04/12/2010
Submitted Date 04/12/2010

Dear Stephanie Fowler,

Comments:

This is in response to your request. I'm sorry I uploaded the incorrect rates.

Response 1

Comments: Attached are Arkansas rates for plan N.

Related Objection 1

Applies To:

- LMSN10, [LMSN10] (Rate)

Comment:

Please submit the rates for Arkansas.

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Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

Rate/Rule Schedule Item Changes

Document Name:	Affected Form Numbers:	Rate Action:	Rate Action Information:	Attach Document:
LMSN10	LMSN10	New	Previous State Filing Number	0
Previous Version				
LMSN10	LMSN10	New	Previous State Filing Number	0

Please let me know if you have any questions. Again I apologize for this inconvenience that I might have caused.

Sincerely,
 Phylis Ballard

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 03/17/2010
Submitted Date 03/17/2010
Respond By Date 04/19/2010

Dear Phylis Ballard,

This will acknowledge receipt of the captioned filing.

Objection 1

- Medicare Supplement Policy, LMSN10 (Form)

Comment: Page one, third and fourth paragraphs - Premiums can only be increased on the policy's anniversary date, these paragraphs make it sound like the premiums can be raised at any time. Also, AR Code Ann. 23-79-109(a)(4) states, "all Medicare supplement rates shall be based on a composite age basis only, and shall not be based on any age banding or other groupings." Please revise these paragraphs to comply.

Please feel free to contact me if you have questions.

Sincerely,

Stephanie Fowler

Response Letter

Response Letter Status Submitted to State
Response Letter Date 03/22/2010
Submitted Date 03/22/2010

Dear Stephanie Fowler,

Comments:

This is in response to your objection.

Response 1

Comments: Revised LMSN10 is attached.

Related Objection 1

Applies To:

- Medicare Supplement Policy, LMSN10 (Form)

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Comment:

Page one, third and fourth paragraphs - Premiums can only be increased on the policy's anniversary date, these paragraphs make it sound like the premiums can be raised at any time. Also, AR Code Ann. 23-79-109(a)(4) states, "all Medicare supplement rates shall be based on a composite age basis only, and shall not be based on any age banding or other groupings." Please revise these paragraphs to comply.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Medicare Supplement Policy	LMSN10		Policy/Contract/Fraternal Certificate	Initial		63.990	LMSN10ar.pdf
Previous Version							
Medicare Supplement Policy	LMSN10		Policy/Contract/Fraternal Certificate	Initial		63.990	LMSN10az.pdf

No Rate/Rule Schedule items changed.

If you have any questions, please let me know.

Sincerely,
 Phylis Ballard

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Form Schedule

Lead Form Number: Medicare Supplement Policy Form LMSN10

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 04/13/2010	LMSN10	Policy/Cont ract/Fratern al Certificate	Medicare Supplement Policy	Initial		63.990	LMSN10ar.pdf

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

MEDICARE SUPPLEMENT POLICY

BENEFIT PLAN N

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

LIBERTY NATIONAL LIFE INSURANCE COMPANY

P.O. BOX 8080 * MCKINNEY, TEXAS 75070 (972) 529-5085

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

30 DAY RIGHT TO EXAMINE POLICY

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

GUARANTEED RENEWAL PROVISION

You can renew and continue this policy in force during Your lifetime, for successive renewal terms by paying appropriate renewal premiums before the end of the grace period. The appropriate renewal premiums will be those under Our applicable table of premium rates that is in effect on the respective due dates of such premiums.

We have the right to change the renewal premiums for this policy when We change, and in accordance with, Our table of premium rates applicable to all policies of this form and class. Class is based on year of issue and underwriting group at issue for policyholders of this form in Your state. Your premiums may also be increased due to increasing health care costs for all policies in Your class.

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

POLICY SCHEDULE

INSURED	POLICY NUMBER	EFFECTIVE DATE	INITIAL TERM EXPIRES ON	INITIAL PREMIUM
[John Doe]	[0000000]	[06-01-10]	[06-01-11]	[\$0]

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

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PRE-EXISTING CONDITIONS LIMITATIONS PROVISION

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

If You have a Pre-Existing Condition and qualify for open enrollment or have had a continuous period of creditable coverage for at least 60 days, We cannot exclude coverage based on the Pre-Existing Condition. If the period of creditable coverage is less than 60 days, We will give credit for the amount of time of creditable coverage You have had towards fulfilling the Pre-Existing Condition exclusion period.

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

THE INSURING CLAUSE

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

EXTENDED BENEFIT PROVISION

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

DEFINITIONS

Where used in this policy:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

BASIC CORE BENEFITS

PART 1 BENEFITS FOR HOSPITAL STAYS - MEDICARE PART A

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

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

PART 2 MEDICARE BLOOD DEDUCTIBLE BENEFIT

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

PART 3 BENEFITS FOR MEDICAL EXPENSE - MEDICARE PART B

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

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

Under this PART 3 of this policy, Your copayment will be:

- (a) the lesser of twenty dollars (\$20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and
- (b) the lesser of fifty dollars (\$50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if You are admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

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

PART 4 HOSPICE CARE BENEFIT

We will pay the expense You incur for cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

ADDITIONAL BENEFITS

PART 5 MEDICARE PART A DEDUCTIBLE BENEFIT

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

PART 6 BENEFITS FOR SKILLED NURSING FACILITY STAYS - MEDICARE PART A

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

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

PART 7 MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY

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

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

PART 8 LIMITATIONS AND EXCLUSIONS

We will not pay benefits under this policy for:

- 1) Any expense which You are not legally obligated to pay; or
- 2) Any services that are not medically necessary as determined by Medicare or are not furnished at the direction of and under the supervision of a Physician; or
- 3) Any portion of any expense for which payment is made by Medicare; or
- 4) Custodial or intermediate level care, or rest cures; or
- 5) Any type of expense not eligible for coverage under Medicare, except as provided under PART 7.

POLICY PROVISIONS

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

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

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

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

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

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

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

No claim for loss incurred after 60 days from the effective date will be reduced or denied because a Sickness or physical condition had existed before the effective date of this policy.

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

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

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

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

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

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

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

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

Reinstitution of these coverages: (1) Shall not provide for any waiting period with respect to treatment of Pre-Existing Conditions; (2) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and (3) Shall provide for classification of premiums on terms at least as favorable to the policyholder as the premium classification terms that would have applied to the policyholder had the coverage not been suspended.

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

Notice should include Your name and Your Policy Number.

CLAIM FORMS: When We receive the notice of claim, We will send You any required forms for filing proof of loss, if applicable. If these forms are not given to You within 15 days, You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of Your loss.

PROOF OF LOSS: You must give written proof of loss to Us within 6 months after the date of such loss. If it was not reasonably possible to give written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than 1 year from the time specified unless You were legally incapacitated.

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

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

If benefits are payable to Your estate or a beneficiary who cannot execute a valid release, We can pay benefits up to \$1,000.00 to someone related to You or the beneficiary by blood or marriage whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

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

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

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

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

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



Secretary



President

Countersigned:

Licensed Resident Agent where required by law.

IMPORTANT NOTICE

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

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

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

Agent's Name: _____

Agent's Address: _____

Telephone: _____

SERFF Tracking Number: AMLC-126500747 State: Arkansas
 Filing Company: Liberty National Life Insurance Company State Tracking Number: 44853
 Company Tracking Number: MEDICARE SUPPLEMNT POLICY FORM LMSN10
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.011 Plan N 2010
 Standard Plans 2010
 Product Name: Medicare Supplement Policy Form LMSN10
 Project Name/Number: Medicare Supplement Policy Form LMSN10/Medicare Supplement Policy Form LMSN10

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved 04/13/2010	LMSN10	LMSN10	New		AR LMSN10 Rates.pdf

LIBERTY NATIONAL LIFE INSURANCE COMPANY
McKinney, Texas

Policy Form LMSN10

2010 New Product Filing

ARKANSAS

Proposed Annual Premium Rates
For Policies Issued with Issue Age Rates

Issue Age	Proposed Annual Rate
65 and Over	\$2,310

Modal Premium Formulas:

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

Quarterly = Annual / 4 (rounded to near dollar)

Monthly = Annual / 12 (rounded to near dollar)

For Company Use: Plan Code YK8

SERFF Tracking Number: AMLC-126500747 State: Arkansas
 Filing Company: Liberty National Life Insurance Company State Tracking Number: 44853
 Company Tracking Number: MEDICARE SUPPLEMNT POLICY FORM LMSN10
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.011 Plan N 2010
 Standard Plans 2010
 Product Name: Medicare Supplement Policy Form LMSN10
 Project Name/Number: Medicare Supplement Policy Form LMSN10/Medicare Supplement Policy Form LMSN10

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Accepted for Informational Purposes	04/13/2010

Comments:

Attachment:

AR Cert.pdf

	Item Status:	Status Date:
Satisfied - Item: Application	Approved	04/13/2010

Comments:

Filed and approved June 23, 2009.

Attachment:

LMA14(03).pdf

	Item Status:	Status Date:
Satisfied - Item: Outline of Coverage	Approved	04/13/2010

Comments:

Attachment:

DS-LMS2010(02).pdf

ARKANSAS

CERTIFICATION

This is to certify that the attached Policy Form LMSN10 has achieved a Flesch Reading Ease Score of 63.99 and complies with the requirements of Arkansas Stat. Ann. SS66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.



Michael J. Gaisbauer, Vice President

SUPPLEMENTAL FORMS

SCORE

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

PART I: APPLICANT INFORMATION

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

Applicant's First Name

Last Name

M.I.

Applicant's Mailing Address:

Street or Route

City State

Zip Code County

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

Street or Route

City State

Zip Code County

Social Security Number - -

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

Height (ft. in.)

Weight (lbs.)

Age Last Birthday

Sex Male Female

E-mail Address of Proposed Insured

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

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

TO THE BEST OF YOUR KNOWLEDGE:

Yes No

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

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

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

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

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

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

If you answered "YES":

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Yes No

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



PART II: ELIGIBILITY QUESTIONS (continued)

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

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

PART III

I. INVOLUNTARY TERMINATION OF COVERAGE:

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

What type of coverage was terminated? _____

Date of termination? - - Reason for termination? _____

II. VOLUNTARY TERMINATION OF COVERAGE:

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

What type of coverage was terminated? _____

Date of termination? - - Reason for termination? _____

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

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

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

PART V: AGENT CERTIFICATION

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

AGENT COMPLETES (Attach separate sheet, if necessary.)

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

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

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

Last Name

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

Agent No.

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

Agent's Signature

LMA14(03)

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

SPECIMEN

Initials of Proposed Insured

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

Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010

Benefit Plans A, B, F, HDF, N

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in Arizona.

[Plans E, H, I, and J are no longer available for sale.]

BASIC BENEFITS:

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

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of the Part B coinsurance or copayments.

Blood: First three pints of blood each year.

Hospice: Part A coinsurance.

A*	B*	C	D	F*	F**	G	K	L	M	N*
Basic, including 100% Part B coinsurance		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER				
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit \$[4620]; paid at 100% after limit reached	Out-of-pocket limit \$[2310]; paid at 100% after limit reached		

* Denotes plans available by Liberty National Life Insurance Company.

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

PREMIUM INFORMATION

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

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

[This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.]

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

This policy may not fully cover all your medical cost.

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

Liberty National Life Insurance Company Medicare Supplement Rates for Plan A

MALE

FEMALE

PREFERRED

ISSUE AGE	Effective Date: [01-01-10]		Plan Code: [YA4]	
	Annual	Semi Annual	Quarterly	Monthly
65	[1000]	[520]	[265]	[83]
66	[1100]	[572]	[292]	[92]
67	[1100]	[572]	[292]	[92]
68	[1100]	[572]	[292]	[92]
69	[1100]	[572]	[292]	[92]
70	[1200]	[624]	[318]	[100]
71	[1200]	[624]	[318]	[100]
72	[1200]	[624]	[318]	[100]
73	[1200]	[624]	[318]	[100]
74	[1200]	[624]	[318]	[100]
75	[1300]	[676]	[345]	[108]
76	[1300]	[676]	[345]	[108]
77	[1300]	[676]	[345]	[108]
78	[1300]	[676]	[345]	[108]
79	[1300]	[676]	[345]	[108]
80+	[1400]	[728]	[371]	[117]

ISSUE AGE	Effective Date: [01-01-10]		Plan Code: [YA5]	
	Annual	Semi Annual	Quarterly	Monthly
65	[1000]	[520]	[265]	[83]
66	[1100]	[572]	[292]	[92]
67	[1100]	[572]	[292]	[92]
68	[1100]	[572]	[292]	[92]
69	[1100]	[572]	[292]	[92]
70	[1200]	[624]	[318]	[100]
71	[1200]	[624]	[318]	[100]
72	[1200]	[624]	[318]	[100]
73	[1200]	[624]	[318]	[100]
74	[1200]	[624]	[318]	[100]
75	[1300]	[676]	[345]	[108]
76	[1300]	[676]	[345]	[108]
77	[1300]	[676]	[345]	[108]
78	[1300]	[676]	[345]	[108]
79	[1300]	[676]	[345]	[108]
80+	[1400]	[728]	[371]	[117]

STANDARD

ISSUE AGE	Effective Date: [01-01-10]		Plan Code: [YA6]	
	Annual	Semi Annual	Quarterly	Monthly
65	[1000]	[520]	[265]	[83]
66	[1100]	[572]	[292]	[92]
67	[1100]	[572]	[292]	[92]
68	[1100]	[572]	[292]	[92]
69	[1100]	[572]	[292]	[92]
70	[1200]	[624]	[318]	[100]
71	[1200]	[624]	[318]	[100]
72	[1200]	[624]	[318]	[100]
73	[1200]	[624]	[318]	[100]
74	[1200]	[624]	[318]	[100]
75	[1300]	[676]	[345]	[108]
76	[1300]	[676]	[345]	[108]
77	[1300]	[676]	[345]	[108]
78	[1300]	[676]	[345]	[108]
79	[1300]	[676]	[345]	[108]
80+	[1400]	[728]	[371]	[117]

ISSUE AGE	Effective Date: [01-01-10]		Plan Code: [YA7]	
	Annual	Semi Annual	Quarterly	Monthly
65	[1000]	[520]	[265]	[83]
66	[1100]	[572]	[292]	[92]
67	[1100]	[572]	[292]	[92]
68	[1100]	[572]	[292]	[92]
69	[1100]	[572]	[292]	[92]
70	[1200]	[624]	[318]	[100]
71	[1200]	[624]	[318]	[100]
72	[1200]	[624]	[318]	[100]
73	[1200]	[624]	[318]	[100]
74	[1200]	[624]	[318]	[100]
75	[1300]	[676]	[345]	[108]
76	[1300]	[676]	[345]	[108]
77	[1300]	[676]	[345]	[108]
78	[1300]	[676]	[345]	[108]
79	[1300]	[676]	[345]	[108]
80+	[1400]	[728]	[371]	[117]

Liberty National Life Insurance Company Medicare Supplement Rates for Plan B

MALE				
ISSUE AGE	Effective Date: [01-01-10]		Plan Code: [YA4]	
	Annual	Semi Annual	Quarterly	Monthly
65	[1000]	[520]	[265]	[83]
66	[1100]	[572]	[292]	[92]
67	[1100]	[572]	[292]	[92]
68	[1100]	[572]	[292]	[92]
69	[1100]	[572]	[292]	[92]
70	[1200]	[624]	[318]	[100]
71	[1200]	[624]	[318]	[100]
72	[1200]	[624]	[318]	[100]
73	[1200]	[624]	[318]	[100]
74	[1200]	[624]	[318]	[100]
75	[1300]	[676]	[345]	[108]
76	[1300]	[676]	[345]	[108]
77	[1300]	[676]	[345]	[108]
78	[1300]	[676]	[345]	[108]
79	[1300]	[676]	[345]	[108]
80+	[1400]	[728]	[371]	[117]

PREFERRED

FEMALE				
ISSUE AGE	Effective Date: [01-01-10]		Plan Code: [YA5]	
	Annual	Semi Annual	Quarterly	Monthly
65	[1000]	[520]	[265]	[83]
66	[1100]	[572]	[292]	[92]
67	[1100]	[572]	[292]	[92]
68	[1100]	[572]	[292]	[92]
69	[1100]	[572]	[292]	[92]
70	[1200]	[624]	[318]	[100]
71	[1200]	[624]	[318]	[100]
72	[1200]	[624]	[318]	[100]
73	[1200]	[624]	[318]	[100]
74	[1200]	[624]	[318]	[100]
75	[1300]	[676]	[345]	[108]
76	[1300]	[676]	[345]	[108]
77	[1300]	[676]	[345]	[108]
78	[1300]	[676]	[345]	[108]
79	[1300]	[676]	[345]	[108]
80+	[1400]	[728]	[371]	[117]

STANDARD

ISSUE AGE	Effective Date: [01-01-10]		Plan Code: [YA6]	
	Annual	Semi Annual	Quarterly	Monthly
65	[1000]	[520]	[265]	[83]
66	[1100]	[572]	[292]	[92]
67	[1100]	[572]	[292]	[92]
68	[1100]	[572]	[292]	[92]
69	[1100]	[572]	[292]	[92]
70	[1200]	[624]	[318]	[100]
71	[1200]	[624]	[318]	[100]
72	[1200]	[624]	[318]	[100]
73	[1200]	[624]	[318]	[100]
74	[1200]	[624]	[318]	[100]
75	[1300]	[676]	[345]	[108]
76	[1300]	[676]	[345]	[108]
77	[1300]	[676]	[345]	[108]
78	[1300]	[676]	[345]	[108]
79	[1300]	[676]	[345]	[108]
80+	[1400]	[728]	[371]	[117]

ISSUE AGE	Effective Date: [01-01-10]		Plan Code: [YA7]	
	Annual	Semi Annual	Quarterly	Monthly
65	[1000]	[520]	[265]	[83]
66	[1100]	[572]	[292]	[92]
67	[1100]	[572]	[292]	[92]
68	[1100]	[572]	[292]	[92]
69	[1100]	[572]	[292]	[92]
70	[1200]	[624]	[318]	[100]
71	[1200]	[624]	[318]	[100]
72	[1200]	[624]	[318]	[100]
73	[1200]	[624]	[318]	[100]
74	[1200]	[624]	[318]	[100]
75	[1300]	[676]	[345]	[108]
76	[1300]	[676]	[345]	[108]
77	[1300]	[676]	[345]	[108]
78	[1300]	[676]	[345]	[108]
79	[1300]	[676]	[345]	[108]
80+	[1400]	[728]	[371]	[117]

Liberty National Life Insurance Company Medicare Supplement Rates for Plan F

MALE

ISSUE AGE	Effective Date: [01-01-10]		Plan Code: [YA4]	
	Annual	Semi Annual	Quarterly	Monthly
65	[1000]	[520]	[265]	[83]
66	[1100]	[572]	[292]	[92]
67	[1100]	[572]	[292]	[92]
68	[1100]	[572]	[292]	[92]
69	[1100]	[572]	[292]	[92]
70	[1200]	[624]	[318]	[100]
71	[1200]	[624]	[318]	[100]
72	[1200]	[624]	[318]	[100]
73	[1200]	[624]	[318]	[100]
74	[1200]	[624]	[318]	[100]
75	[1300]	[676]	[345]	[108]
76	[1300]	[676]	[345]	[108]
77	[1300]	[676]	[345]	[108]
78	[1300]	[676]	[345]	[108]
79	[1300]	[676]	[345]	[108]
80+	[1400]	[728]	[371]	[117]

PREFERRED

FEMALE

ISSUE AGE	Effective Date: [01-01-10]		Plan Code: [YA5]	
	Annual	Semi Annual	Quarterly	Monthly
65	[1000]	[520]	[265]	[83]
66	[1100]	[572]	[292]	[92]
67	[1100]	[572]	[292]	[92]
68	[1100]	[572]	[292]	[92]
69	[1100]	[572]	[292]	[92]
70	[1200]	[624]	[318]	[100]
71	[1200]	[624]	[318]	[100]
72	[1200]	[624]	[318]	[100]
73	[1200]	[624]	[318]	[100]
74	[1200]	[624]	[318]	[100]
75	[1300]	[676]	[345]	[108]
76	[1300]	[676]	[345]	[108]
77	[1300]	[676]	[345]	[108]
78	[1300]	[676]	[345]	[108]
79	[1300]	[676]	[345]	[108]
80+	[1400]	[728]	[371]	[117]

STANDARD

ISSUE AGE	Effective Date: [01-01-10]		Plan Code: [YA6]	
	Annual	Semi Annual	Quarterly	Monthly
65	[1000]	[520]	[265]	[83]
66	[1100]	[572]	[292]	[92]
67	[1100]	[572]	[292]	[92]
68	[1100]	[572]	[292]	[92]
69	[1100]	[572]	[292]	[92]
70	[1200]	[624]	[318]	[100]
71	[1200]	[624]	[318]	[100]
72	[1200]	[624]	[318]	[100]
73	[1200]	[624]	[318]	[100]
74	[1200]	[624]	[318]	[100]
75	[1300]	[676]	[345]	[108]
76	[1300]	[676]	[345]	[108]
77	[1300]	[676]	[345]	[108]
78	[1300]	[676]	[345]	[108]
79	[1300]	[676]	[345]	[108]
80+	[1400]	[728]	[371]	[117]

ISSUE AGE	Effective Date: [01-01-10]		Plan Code: [YA7]	
	Annual	Semi Annual	Quarterly	Monthly
65	[1000]	[520]	[265]	[83]
66	[1100]	[572]	[292]	[92]
67	[1100]	[572]	[292]	[92]
68	[1100]	[572]	[292]	[92]
69	[1100]	[572]	[292]	[92]
70	[1200]	[624]	[318]	[100]
71	[1200]	[624]	[318]	[100]
72	[1200]	[624]	[318]	[100]
73	[1200]	[624]	[318]	[100]
74	[1200]	[624]	[318]	[100]
75	[1300]	[676]	[345]	[108]
76	[1300]	[676]	[345]	[108]
77	[1300]	[676]	[345]	[108]
78	[1300]	[676]	[345]	[108]
79	[1300]	[676]	[345]	[108]
80+	[1400]	[728]	[371]	[117]

Liberty National Life Insurance Company Medicare Supplement Rates for Plan HDF

MALE

FEMALE

PREFERRED

ISSUE AGE	Effective Date: [01-01-10]		Plan Code: [YA4]	
	Annual	Semi Annual	Quarterly	Monthly
65	[1000]	[520]	[265]	[83]
66	[1100]	[572]	[292]	[92]
67	[1100]	[572]	[292]	[92]
68	[1100]	[572]	[292]	[92]
69	[1100]	[572]	[292]	[92]
70	[1200]	[624]	[318]	[100]
71	[1200]	[624]	[318]	[100]
72	[1200]	[624]	[318]	[100]
73	[1200]	[624]	[318]	[100]
74	[1200]	[624]	[318]	[100]
75	[1300]	[676]	[345]	[108]
76	[1300]	[676]	[345]	[108]
77	[1300]	[676]	[345]	[108]
78	[1300]	[676]	[345]	[108]
79	[1300]	[676]	[345]	[108]
80+	[1400]	[728]	[371]	[117]

ISSUE AGE	Effective Date: [01-01-10]		Plan Code: [YA5]	
	Annual	Semi Annual	Quarterly	Monthly
65	[1000]	[520]	[265]	[83]
66	[1100]	[572]	[292]	[92]
67	[1100]	[572]	[292]	[92]
68	[1100]	[572]	[292]	[92]
69	[1100]	[572]	[292]	[92]
70	[1200]	[624]	[318]	[100]
71	[1200]	[624]	[318]	[100]
72	[1200]	[624]	[318]	[100]
73	[1200]	[624]	[318]	[100]
74	[1200]	[624]	[318]	[100]
75	[1300]	[676]	[345]	[108]
76	[1300]	[676]	[345]	[108]
77	[1300]	[676]	[345]	[108]
78	[1300]	[676]	[345]	[108]
79	[1300]	[676]	[345]	[108]
80+	[1400]	[728]	[371]	[117]

STANDARD

ISSUE AGE	Effective Date: [01-01-10]		Plan Code: [YA6]	
	Annual	Semi Annual	Quarterly	Monthly
65	[1000]	[520]	[265]	[83]
66	[1100]	[572]	[292]	[92]
67	[1100]	[572]	[292]	[92]
68	[1100]	[572]	[292]	[92]
69	[1100]	[572]	[292]	[92]
70	[1200]	[624]	[318]	[100]
71	[1200]	[624]	[318]	[100]
72	[1200]	[624]	[318]	[100]
73	[1200]	[624]	[318]	[100]
74	[1200]	[624]	[318]	[100]
75	[1300]	[676]	[345]	[108]
76	[1300]	[676]	[345]	[108]
77	[1300]	[676]	[345]	[108]
78	[1300]	[676]	[345]	[108]
79	[1300]	[676]	[345]	[108]
80+	[1400]	[728]	[371]	[117]

ISSUE AGE	Effective Date: [01-01-10]		Plan Code: [YA7]	
	Annual	Semi Annual	Quarterly	Monthly
65	[1000]	[520]	[265]	[83]
66	[1100]	[572]	[292]	[92]
67	[1100]	[572]	[292]	[92]
68	[1100]	[572]	[292]	[92]
69	[1100]	[572]	[292]	[92]
70	[1200]	[624]	[318]	[100]
71	[1200]	[624]	[318]	[100]
72	[1200]	[624]	[318]	[100]
73	[1200]	[624]	[318]	[100]
74	[1200]	[624]	[318]	[100]
75	[1300]	[676]	[345]	[108]
76	[1300]	[676]	[345]	[108]
77	[1300]	[676]	[345]	[108]
78	[1300]	[676]	[345]	[108]
79	[1300]	[676]	[345]	[108]
80+	[1400]	[728]	[371]	[117]

Liberty National Life Insurance Company Medicare Supplement Rates for Plan N

MALE

FEMALE

PREFERRED

ISSUE AGE	Effective Date: [01-01-10]		Plan Code: [YA4]	
	Annual	Semi Annual	Quarterly	Monthly
65	[1000]	[520]	[265]	[83]
66	[1100]	[572]	[292]	[92]
67	[1100]	[572]	[292]	[92]
68	[1100]	[572]	[292]	[92]
69	[1100]	[572]	[292]	[92]
70	[1200]	[624]	[318]	[100]
71	[1200]	[624]	[318]	[100]
72	[1200]	[624]	[318]	[100]
73	[1200]	[624]	[318]	[100]
74	[1200]	[624]	[318]	[100]
75	[1300]	[676]	[345]	[108]
76	[1300]	[676]	[345]	[108]
77	[1300]	[676]	[345]	[108]
78	[1300]	[676]	[345]	[108]
79	[1300]	[676]	[345]	[108]
80+	[1400]	[728]	[371]	[117]

ISSUE AGE	Effective Date: [01-01-10]		Plan Code: [YA5]	
	Annual	Semi Annual	Quarterly	Monthly
65	[1000]	[520]	[265]	[83]
66	[1100]	[572]	[292]	[92]
67	[1100]	[572]	[292]	[92]
68	[1100]	[572]	[292]	[92]
69	[1100]	[572]	[292]	[92]
70	[1200]	[624]	[318]	[100]
71	[1200]	[624]	[318]	[100]
72	[1200]	[624]	[318]	[100]
73	[1200]	[624]	[318]	[100]
74	[1200]	[624]	[318]	[100]
75	[1300]	[676]	[345]	[108]
76	[1300]	[676]	[345]	[108]
77	[1300]	[676]	[345]	[108]
78	[1300]	[676]	[345]	[108]
79	[1300]	[676]	[345]	[108]
80+	[1400]	[728]	[371]	[117]

STANDARD

ISSUE AGE	Effective Date: [01-01-10]		Plan Code: [YA6]	
	Annual	Semi Annual	Quarterly	Monthly
65	[1000]	[520]	[265]	[83]
66	[1100]	[572]	[292]	[92]
67	[1100]	[572]	[292]	[92]
68	[1100]	[572]	[292]	[92]
69	[1100]	[572]	[292]	[92]
70	[1200]	[624]	[318]	[100]
71	[1200]	[624]	[318]	[100]
72	[1200]	[624]	[318]	[100]
73	[1200]	[624]	[318]	[100]
74	[1200]	[624]	[318]	[100]
75	[1300]	[676]	[345]	[108]
76	[1300]	[676]	[345]	[108]
77	[1300]	[676]	[345]	[108]
78	[1300]	[676]	[345]	[108]
79	[1300]	[676]	[345]	[108]
80+	[1400]	[728]	[371]	[117]

ISSUE AGE	Effective Date: [01-01-10]		Plan Code: [YA7]	
	Annual	Semi Annual	Quarterly	Monthly
65	[1000]	[520]	[265]	[83]
66	[1100]	[572]	[292]	[92]
67	[1100]	[572]	[292]	[92]
68	[1100]	[572]	[292]	[92]
69	[1100]	[572]	[292]	[92]
70	[1200]	[624]	[318]	[100]
71	[1200]	[624]	[318]	[100]
72	[1200]	[624]	[318]	[100]
73	[1200]	[624]	[318]	[100]
74	[1200]	[624]	[318]	[100]
75	[1300]	[676]	[345]	[108]
76	[1300]	[676]	[345]	[108]
77	[1300]	[676]	[345]	[108]
78	[1300]	[676]	[345]	[108]
79	[1300]	[676]	[345]	[108]
80+	[1400]	[728]	[371]	[117]

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION * Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1100]	\$0	[\$1100] (Part A Deductible)
61st thru 90th day	All but [\$275] a day	[\$275] a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but [\$550] a day	[\$550] a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0 **
– Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but [\$137.50] a day	\$0	Up to [\$137.50] a day
101st day and after	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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

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

* Once you have been billed [\$155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First [\$155] of Medicare Approved Amounts*	\$0	\$0	[\$155] (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next [\$155] of Medicare Approved Amounts*	\$0	\$0	[\$155] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	\$0	\$0
– Durable medical equipment			
First [\$155] of Medicare Approved Amounts*	\$0	\$0	[\$155] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION *			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1100]	[\$1100] (Part A Deductible)	\$0
61st thru 90th day	All but [\$275] a day	[\$275] a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but [\$550] a day	[\$550] a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0 **
– Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but [\$137.50] a day	\$0	Up to [\$137.50] a day
101st day and after	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness			
	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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

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

* Once you have been billed [\$155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First [\$155] of Medicare Approved Amounts*	\$0	\$0	[\$155] (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next [\$155] of Medicare Approved Amounts*	\$0	\$0	[\$155] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	\$0	\$0
– Durable medical equipment			
First [\$155] of Medicare Approved Amounts*	\$0	\$0	[\$155] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

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

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$2000] DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO [\$2000] DEDUCTIBLE, ** YOU PAY
HOSPITALIZATION * Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1100]	[\$1100] (Part A Deductible)	\$0
61st thru 90th day	All but [\$275] a day	[\$275] a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but [\$550] a day	[\$550] a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0 ***
– Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE * You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but [\$137.50] a day	Up to [\$137.50] a day	\$0
101st day and after	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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

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

- * Once you have been billed [\$155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.
- ** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$2000] DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO [\$2000] DEDUCTIBLE, ** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	[\$155] (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next [\$155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs [\$155] (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First [\$155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 [\$155] (Part B Deductible) 20%	\$0 \$0 \$0
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OTHER BENEFITS – NOT COVERED BY MEDICARE

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

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION *			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1100]	[\$1100] (Part A Deductible)	\$0
61st thru 90th day	All but [\$275] a day	[\$275] a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but [\$550] a day	[\$550] a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0 **
– Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but [\$137.50] a day	Up to [\$68.75] a day	\$0
101st day and after	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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

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

* Once you have been billed [\$155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Balance, other than up to [\$20] per office visit and up to [\$50] per emergency room visit. The copayment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	[\$155] (Part B Deductible) Up to [\$20] per office visit and up to [\$50] per emergency room visit. The copayment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next [\$155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 [\$155] (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First [\$155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$155] (Part B Deductible) \$0
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OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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SERFF Tracking Number: AMLC-126500747 State: Arkansas
 Filing Company: Liberty National Life Insurance Company State Tracking Number: 44853
 Company Tracking Number: MEDICARE SUPPLEMNT POLICY FORM LMSN10
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.011 Plan N 2010
 Standard Plans 2010
 Product Name: Medicare Supplement Policy Form LMSN10
 Project Name/Number: Medicare Supplement Policy Form LMSN10/Medicare Supplement Policy Form LMSN10

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)
02/15/2010	Form	Medicare Supplement Policy	03/22/2010	LMSN10az.pdf (Superceded)
02/15/2010	Rate and Rule	LMSN10	04/12/2010	AZ LMSN10 Rates.pdf (Superceded)

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

MEDICARE SUPPLEMENT POLICY

BENEFIT PLAN N

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

LIBERTY NATIONAL LIFE INSURANCE COMPANY

P.O. BOX 8080 * MCKINNEY, TEXAS 75070 (972) 529-5085

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

30 DAY RIGHT TO EXAMINE POLICY

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

GUARANTEED RENEWAL PROVISION

You can renew and continue this policy in force during Your lifetime, for successive renewal terms by paying appropriate renewal premiums before the end of the grace period. The appropriate renewal premiums will be those under Our applicable table of premium rates that is in effect on the respective due dates of such premiums.

We have the right to change the renewal premiums for this policy when We change, and in accordance with, Our table of premium rates applicable to all policies of this form and class. Class is based on gender, year of issue, age at issue, area of the state in which You resided at issue, and underwriting group at issue for policyholders of this form in Your state. Your premiums may be increased due to unanticipated increasing health care costs for all policies in Your class.

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

POLICY SCHEDULE

INSURED	POLICY NUMBER	EFFECTIVE DATE	INITIAL TERM EXPIRES ON	INITIAL PREMIUM
[John Doe]	[0000000]	[06-01-10]	[06-01-11]	[\$0]

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

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PRE-EXISTING CONDITIONS LIMITATIONS PROVISION

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

If You have a Pre-Existing Condition and qualify for open enrollment and have had a continuous period of creditable coverage for at least 60 days, We cannot exclude coverage based on the Pre-Existing Condition. If the period of creditable coverage is less than 60 days, We will give credit for the amount of time of creditable coverage You have had towards fulfilling the Pre-Existing Condition exclusion period.

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

THE INSURING CLAUSE

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

EXTENDED BENEFIT PROVISION

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

DEFINITIONS

Where used in this policy:

BENEFIT PERIOD means the period starting with the first day You enter the hospital and ends when You have been out of the hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row, including the day of discharge.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

BASIC CORE BENEFITS

PART 1 BENEFITS FOR HOSPITAL STAYS - MEDICARE PART A

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

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

PART 2 MEDICARE BLOOD DEDUCTIBLE BENEFIT

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

PART 3 BENEFITS FOR MEDICAL EXPENSE - MEDICARE PART B

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

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

Under this PART 3 of this policy, Your copayment will be:

- (a) the lesser of twenty dollars (\$20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and
- (b) the lesser of fifty dollars (\$50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if You are admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

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

PART 4

HOSPICE CARE BENEFIT

We will pay the expense You incur for cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

ADDITIONAL BENEFITS

PART 5

MEDICARE PART A DEDUCTIBLE BENEFIT

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

PART 6 BENEFITS FOR SKILLED NURSING FACILITY STAYS - MEDICARE PART A

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

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

PART 7 MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY

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

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

PART 8

LIMITATIONS AND EXCLUSIONS

We will not pay benefits under this policy for:

- 1) Any expense which You are not legally obligated to pay; or
- 2) Any services that are not medically necessary as determined by Medicare or are not furnished at the direction of and under the supervision of a Physician; or
- 3) Any portion of any expense for which payment is made by Medicare; or
- 4) Custodial or intermediate level care, or rest cures; or
- 5) Any type of expense not eligible for coverage under Medicare, except as provided under PART 7.

POLICY PROVISIONS

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

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

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

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

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

No claim for loss incurred after 60 days from the effective date will be reduced or denied because a Sickness or physical condition had existed before the effective date of this policy.

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

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

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

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

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

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

Reinstitution of these coverages: (1) Shall not provide for a waiting period with respect to treatment of Pre-Existing Conditions; (2) Shall provide for coverage that is substantially equivalent to coverage in effect before the date of suspension; and (3) Shall provide for classification of premiums on terms at least as favorable to the policyholder as the premium classification terms that would have applied to the policyholder had the coverage not been suspended.

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

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

Reinstitution of these coverages: (1) Shall not provide for any waiting period with respect to treatment of Pre-Existing Conditions; (2) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and (3) Shall provide for classification of premiums on terms at least as favorable to the policyholder as the premium classification terms that would have applied to the policyholder had the coverage not been suspended.

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

Notice should include Your name and Your Policy Number.

CLAIM FORMS: When We receive the notice of claim, We will send You any required forms for filing proof of loss, if applicable. If these forms are not given to You within 15 days, You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of Your loss.

PROOF OF LOSS: You must give written proof of loss to Us within 6 months after the date of such loss. If it was not reasonably possible to give written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than 1 year from the time specified unless You were legally incapacitated.

TIME OF PAYMENT OF CLAIMS: Indemnities will be paid immediately upon receipt of due written proof of loss. All accrued indemnities will be paid not less than monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

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

If benefits are payable to Your estate or a beneficiary who cannot execute a valid release, We can pay benefits up to \$1,000.00 to someone related to You or the beneficiary by blood or marriage whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

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

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

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

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

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



Secretary



President

Countersigned:

Licensed Resident Agent where required by law.

LIBERTY NATIONAL LIFE INSURANCE COMPANY

McKinney, Texas

Policy Form LMSN10

2010 New Product Filing

ARIZONA

Proposed Annual Premium Rates For Policies Issued with Issue Age Rates

Issue Age	Proposed Annual Base Rate
65	\$2,374
66 - 69	\$2,472
70 - 74	\$2,629
75 - 79	\$2,783
80 & Over	\$2,897

Rate Adjustment Factors:

Sex and Underwriting

Male Preferred	1.068
Female Preferred	0.929
Male Standard	1.229
Female Standard	1.068

Modal Premium Formulas:

Annual	= Annual Base Rate * Sex and Underwriting Factor (rounded to near dollar)
Semi-Annual	= Annual / 2 (rounded to near dollar)
Quarterly	= Annual / 4 (rounded to near dollar)
Monthly	= Annual / 12 (rounded to near dollar)

For Company Use: Plan Codes YK0 / YK1 / YK2 / YK3