

SERFF Tracking Number: RNIC-126442339 State: Arkansas
Filing Company: Reserve National Insurance Company State Tracking Number: 44486
Company Tracking Number:
TOI: H15I Individual Health - Sub-TOI: H15I.001 Health - Hospital/Surgical/Medical
Hospital/Surgical/Medical Expense Expense
Product Name: Form PR-PS-AR - Amendment
Project Name/Number: Form PR-PS-AR - Amendment/

Filing at a Glance

Company: Reserve National Insurance Company

Product Name: Form PR-PS-AR - Amendment SERFF Tr Num: RNIC-126442339 State: Arkansas
TOI: H15I Individual Health - SERFF Status: Closed-Approved- State Tr Num: 44486
Hospital/Surgical/Medical Expense Closed
Sub-TOI: H15I.001 Health - Co Tr Num: State Status: Approved-Closed
Hospital/Surgical/Medical Expense
Filing Type: Form Reviewer(s): Rosalind Minor
Disposition Date: 01/06/2010
Authors: Kyle Conrad, Brenda Ingram
Date Submitted: 01/06/2010 Disposition Status: Approved-Closed
Implementation Date: Implementation Date:

Implementation Date Requested: On Approval
State Filing Description:

General Information

Project Name: Form PR-PS-AR - Amendment
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 01/06/2010

Deemer Date:
Submitted By: Brenda Ingram
Filing Description:
January 6, 2010

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 01/06/2010
Created By: Brenda Ingram
Corresponding Filing Tracking Number:

Ms. Rosalind D. Minor
Certified Rate and Form Analyst
Life and Health Division
Arkansas Insurance Department

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Product Name: Form PR-PS-AR - Amendment
Project Name/Number: Form PR-PS-AR - Amendment/
1200 West Third Street
Little Rock, AR 72201-1904

Re: Reserve National Insurance Company – NAIC #68462; FEIN# 73-0661453
Form PR-PS-AR – Amendment
Form OC PS-1 AR (1/10) – Outline of Coverage

Dear Ms. Minor:

We are submitting the above-referenced forms for your review and approval. This is a new filing not previously submitted.

Form PR-PS-AR is an amendment to our previously-approved Individual Hospital, Medical and Surgical Expense Policy Form PS-1, and is intended to reflect our compliance with ACA Sections 23-79-1302 and 23-79-1303, concerning coverage of prostate examinations, as added by 2009 House Bill 1031. Form PS-1 already has a prostate examination benefit, and Form PR-PS-AR merely amends the policy to comply with the new law. Form PR-PS-AR will not affect rates at this time. Form OC PS-1 AR (1/10) is a revised outline of coverage for Form PS-1, and reflects Amendment Form PR-PS-AR.

If this filing is acceptable, please furnish us with evidence of approval or filing by your office.

Thank you for your consideration. If there are any questions, you may contact me by telephone at (800) 874-1431, by fax at (405) 840-3426 or by e-mail at kconrad@unitrin.com.

Sincerely,

Kyle D. Conrad
Senior Vice President
and Associate Corporate Counsel

Company and Contact

Filing Contact Information

Kyle Conrad, Vice President & Associate Corporate Counsel
6100 N. W. Grand Blvd
Oklahoma City, OK 73118
kconrad@unitrin.com
800-874-1431 [Phone] 549 [Ext]

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Filing Company Information

Reserve National Insurance Company	CoCode: 68462	State of Domicile: Oklahoma
6100 N.W. Grand Boulevard	Group Code: 215	Company Type: Life and Health
Oklahoma City, OK 73118	Group Name: Reserve National	State ID Number:
(405) 848-7931 ext. 549[Phone]	FEIN Number: 73-0661453	

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: 2 forms
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Reserve National Insurance Company	\$50.00	01/06/2010	33288193

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/06/2010	01/06/2010

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Disposition

Disposition Date: 01/06/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 01/06/2010	Form PR-PS-AR	Policy/Cont ract/Fraternal	Amendment	Initial		57.859	AR PR-PS-AR.pdf
Approved-Closed 01/06/2010	OC PS-1 AR (1/10)	Outline of Coverage	Outline of Coverage	Revised	Replaced Form #: OC PS-1 AR (1/09) Previous Filing #:		OC PS-1 AR 1 10.pdf

RESERVE NATIONAL INSURANCE COMPANY
OF OKLAHOMA CITY, OKLAHOMA

AMENDMENT

The Policy to which this Amendment is attached is hereby amended by deleting in its entirety the section entitled "Prostate Examinations" in the Benefits for Preventive Care provision on page 9 and replacing it with the following:

Prostate Examinations: If a male Covered Person, who is age 40 or older, while this Policy is in force, incurs expense for a Prostate Examination, we will pay the Benefit Percentage of the Expense Incurred, but not to exceed the Maximum Prostate Examination Benefit amount shown on the Insured Schedule. This benefit is limited to one Prostate Examination per Policy Year, or more frequent Prostate Examinations if recommended by a Physician or other qualified medical professional. For purposes of this benefit, "Prostate Examination" means the following procedures that are performed by a Physician or other qualified medical professional for the early detection of prostate cancer: (a) a digital rectal examination; (b) a prostate specific antigen (PSA) test; and (c) such other procedures recommended for the early detection of prostate cancer in accordance with guidelines established by the National Comprehensive Cancer Network, which guidelines may be revised from time to time. This benefit is not subject to the Policy's Deductible provision.

All the provisions, conditions, limitations and exclusions of the Policy to which this Amendment is attached which are not modified hereby and which are not in conflict herewith shall remain unchanged.

IN WITNESS WHEREOF, RESERVE NATIONAL INSURANCE COMPANY has caused this Amendment to be executed by its President and attested by its Secretary.


Secretary


President

There Are Limitations On the Amount of Benefits Payable For Each Covered Expense.



**Outline of Coverage for Scheduled Benefit
Hospital, Medical and Surgical Expense Policy Form PS-1**

Read Your Policy Carefully. This Outline of Coverage provides a very brief description of the important features of Scheduled Benefit Hospital, Medical and Surgical Expense Policy Form PS-1. This is not the insurance contract and only the actual provisions in the Policy will control. The Policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. **It is therefore important that you Read Your Policy Carefully!**

Scheduled Benefit Hospital, Medical and Surgical Expense Policy Form PS-1 is designed to help cover hospital, medical and surgical expenses that you incur as a result of a covered injury or sickness. Coverage is provided for the benefits outlined in paragraph II, subject to the limitations, exclusions, deductible and benefit percentage requirements outlined in paragraphs II, III and IV.

For covered treatment of each injury or sickness: A covered person must first satisfy the Deductible [see paragraph I (A) below] once in his/her lifetime for each injury or sickness while the Policy is in force before any benefits (except the Benefits for Preventive Care) are payable for such condition. Then, benefits payable are 80% of the expense incurred, but the amounts payable are limited to the maximum benefit amounts shown below [see paragraphs I (B) through (K) below].

I. Acknowledgment of Maximum Benefit Amounts

(A) Select Your Deductible Which Applies to Expenses Incurred for Each Injury or Sickness:

Deductible Selected \$ _____ ←

(B) Maximum Daily Hospital Room and Board Benefit:

80% of the Expense Incurred, up to \$ _____ ←

(C) Maximum Miscellaneous Hospital Inpatient Benefit:

80% of the Expense Incurred, up to \$ _____ ←

(D) Maximum Inpatient Diagnostic Radiology Benefit:

80% of the Expense Incurred, up to \$1,500 ←

(E) Maximum Inpatient Pathology Benefit:

80% of the Expense Incurred, up to \$1,000 ←

(F) Maximum Surgeon's Benefit:

80% of the Expense Incurred, up to Amounts Scheduled in the Policy for Each Operation ←

(G) Maximum Anesthesia Benefit:

80% of the Expense Incurred, up to 25% of the Applicable Surgical Benefit ←

(H) Maximum Mammogram Benefit*:

80% of the Expense Incurred, up to \$125 ←

(I) Maximum Pap Smear Benefit*:

80% of the Expense Incurred, up to \$100 ←

(J) Maximum Prostate Exam Benefit*:

80% of the Expense Incurred, up to \$75 ←

(K) Maximum Doctor Visit Benefit*:

After a \$20 co-pay, 80% of the Expense Incurred, up to \$65 per visit, up to 2 visits per policy year ←

Applicant's Signature for
Acknowledgement of Benefits

*The Benefits for Preventive Care are not subject to the Deductible.

II. Description of Benefits

(A) Benefits Payable While In The Hospital

- (1) **Hospital Expense Benefits:** For hospital expenses incurred while you are confined in a hospital, subject to the **Deductible**, we will pay **80%** of the expense incurred, **but not to exceed the amounts stated for any one injury or sickness:**

• Daily hospital room and board expenses incurred, **but not to exceed the Maximum Daily Hospital Room and Board Benefit shown on page 1, for up to 365 days for an adult and 60 days for a child under age 18, for any one injury or sickness.**

• Miscellaneous hospital inpatient expenses incurred, **but not to exceed the Maximum Miscellaneous Hospital Inpatient Benefit shown on page 1. The Maximum Miscellaneous Hospital Inpatient Benefit payable for any one injury or sickness is limited to the amount shown on page 1.**

Outpatient Radiation Therapy/Chemotherapy: Benefits relating to expenses incurred for outpatient radiation therapy or chemotherapy administered by or under the supervision of a physician for the treatment of **cancer** following a covered hospital confinement or surgical procedure for which Miscellaneous Hospital Inpatient Benefits were payable for the treatment of such cancer, will be payable as if incurred on an inpatient basis for such **cancer**, **but not to exceed in the aggregate a maximum benefit of \$1,000 per day for such outpatient radiation therapy or chemotherapy.**

- (2) **Benefit For Inpatient Diagnostic Radiology:** For interpretation of X-rays, CT Scans or MRIs by a radiologist, while you are confined in a hospital, subject to the **Deductible**, we will pay **80%** of the expense incurred, **but not to exceed a maximum benefit of \$1,500 for any one injury or sickness.**
- (3) **Benefit For Inpatient Pathology:** For services of a pathologist, while you are confined in a hospital, subject to the **Deductible**, we will pay **80%** of the expense incurred, **but not to exceed a maximum benefit of \$1,000 for any one injury or sickness.**

(B) Benefits Payable While In Or Out Of The Hospital

- (1) **Benefit For Surgeon:** For surgery performed by a physician, subject to the **Deductible**, we will pay **80%** of the expense incurred for the primary surgeon, **but not to exceed the applicable amount listed for each operation in the Schedule of Surgical Operations in the Policy.** The maximum aggregate benefit for all operations for any one injury or sickness is limited to \$_____. This benefit is not payable for expense incurred for a physician who assists the primary surgeon with a surgical operation.
- (2) **Benefit For Anesthesia:** For services of an anesthesiologist for a covered surgical procedure, subject to the **Deductible**, we will pay **80%** of the expense incurred, **but not to exceed a maximum benefit of 25% of the benefit provided for the surgical operation for any one injury or sickness.**

(C) Benefits Payable Out Of The Hospital – Benefits for Preventive Care

These benefits are not subject to the Deductible.

- (1) **Mammograms:** For a female covered person age 35 and over, we will pay **80%** of the expense incurred for mammograms performed at age intervals specified in the Policy, **but not to exceed a maximum benefit of \$125 for each mammogram.** This benefit is also payable if a covered person, her mother or her sister has had a history of breast cancer. See the Policy for details.
- (2) **Pap Smears:** For a female covered person, we will pay **80%** of the expense incurred for a Pap smear, **but not to exceed a maximum benefit of \$100 for each Pap smear**, limited to one Pap smear per policy year or more frequently if recommended by a physician.
- (3) **Prostate Exams:** For a male covered person age 40 and over, we will pay **80%** of the expense incurred for a prostate exam, **but not to exceed a maximum benefit of \$75 for each prostate exam**, limited to one prostate exam per policy year or more frequently if recommended by a physician or other qualified medical professional.
- (4) **Doctor Visits:** For personal treatment by a physician in his/her office, we will pay **80%** of the expense incurred in excess of a **\$20 co-pay per visit, but not to exceed a maximum benefit of \$65 for each visit**, limited to 1 visit per day with a maximum of 2 visits per policy year.

(D) Optional Benefits

The following items are optional benefits that may be available in your state. Your application reflects you have applied

for the additional benefits if indicated below:

- (1) _____ (applicant's initials to select) **Premium Rate Guarantee Rider:** We guarantee that the premium rate for each covered person will not increase prior to the expiration of **2 years or 3 years (as you select)** following the effective date of this rider. After the expiration of such period, each covered person's premium rate will be subject to increases under the Policy's provisions.
- **Select:** 2-Year Premium Rate Guarantee 3-Year Premium Rate Guarantee
- (2) _____ (applicant's initials to select) **Ambulance Benefit Rider:** For transportation to or from a Hospital by a licensed ambulance service, we will pay **80%** of the expense incurred, **but not to exceed the following maximum benefits:**
- (a) **Air Ambulance:** For air transportation by a licensed ambulance service, **the maximum benefit is \$5,000 for any one injury or sickness.**
- (b) **Ground Ambulance:** For ground transportation by a licensed ambulance service, **the maximum benefit is \$1,500 for any one injury or sickness.**
- (3) _____ (applicant's initials to select) **Prosthesis and Physical Therapy Benefit Rider:** For a prosthesis and physical therapy, subject to the Policy's **Deductible**, we will pay **80%** of the expense incurred, **but not to exceed the following maximum benefits:**
- (a) **Prosthesis** (a replacement part or device, whether organic or inorganic, implanted in the body to perform or augment a bodily function, such as a pacemaker, defibrillator, artificial limbs, joints or eyes, casts, splints, trusses or braces): For a prosthesis, **the maximum benefit is \$10,000 for any one injury or sickness.**
- (b) **Physical Therapy:** For physical therapy, **the maximum benefit is \$2,500 for any one injury or sickness, limited to \$50 per day.**
- (4) _____ (applicant's initials to select) **Outpatient Benefit Rider:** For the covered outpatient services listed below, we will pay benefits as follows, **subject to the Outpatient Deductible** you select, which **must be satisfied by each covered person in each policy year:**
- (a) **Outpatient Physician Visits:** For outpatient physician visits, we will pay **80%** of the expense incurred, **limited to 1 visit per day, and not to exceed 10 visits in each policy year with a maximum benefit of \$50 per visit.**
- (b) **Emergency Room:** For the use of a hospital emergency room, we will pay **80%** of the expense incurred, **limited to a maximum benefit of \$500 in each policy year.**
- (c) **Outpatient Diagnostic Lab Tests and X-Rays:** For outpatient diagnostic lab tests and X-rays (including CT scans and MRIs) we will pay **80%** of the expense incurred, **limited in the aggregate in each policy year to a maximum benefit of \$ _____.**

The Outpatient Deductible is separate from and in addition to the Deductible under the Policy.

• **Select:** Outpatient Deductible \$ _____.

- (5) _____ (applicant's initials to select) **Existing Condition Benefit Endorsement PEB-3 (7/89):** Pre-existing conditions disclosed on the application and listed on the Endorsement Form PEB-3 (7/89) will be covered after 12 months.

III. Exclusions

We will not pay if loss is caused or contributed to by: (a) injury or sickness sustained while serving in the armed forces of any country or international authority at war, whether war is declared or not (we will return the pro-rata premium for any period not covered by the Policy while you are in such service); (b) suicide or attempted suicide, while sane or insane, or any intentionally self-inflicted injury; (c) drug abuse, drug overdose or drug addiction, except as may be provided by endorsement; (d) intoxication, alcoholism or alcohol related illnesses, except as may be provided by endorsement; (e) mental illness, nervous or emotional disorders, except as may be provided by endorsement; (f) injury or sickness covered by any worker's compensation act, occupational diseases law or any motor vehicle no-fault law; (g) dental care or treatment, except that excluded dental care or treatment shall not include (1) reconstructive surgery when such service is incidental to trauma or (2) treatment of accidental injury to whole, natural teeth received within six months following an accident; (h) cosmetic or elective surgery (including surgery to correct myopia, hyperopia, presbyopia or astigmatism and surgery for weight loss or modification), except that excluded cosmetic surgery shall not include (1) reconstructive surgery when service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part, (2) reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect or (3) breast reconstruction in connection with mastectomy, including reconstructive surgery on a nondiseased breast to establish symmetry with a diseased breast on which reconstructive surgery has been performed; (i) pregnancy or conditions due to pregnancy, except complications of pregnancy shall be covered as a sickness; (j) childbirth, except as may be provided by endorsement; (k) participation in

a felony, riot or insurrection; (l) rest cures, custodial care, and routine physical examinations; (m) expenses incurred to the extent benefits are actually paid by Medicare; (n) charges that a covered person is not legally required to pay or that would not have been made if no insurance coverage had existed; (o) treatment received in a United States Government or Veterans hospital for which a covered person is not required to pay; (p) eye glasses, hearing aids and examination for the prescription or fitting thereof; (q) surgical sterilization; (r) any expense incurred in connection with the acquisition, purchase or transportation of human or animal organs used in transplant procedures.

IV. Pre-Existing Conditions

Pre-existing conditions are not covered under your Policy until your Policy has been in force for a period of two years; however, no benefits whatsoever will be payable for loss from any condition, either pre-existing or otherwise, which is completely excluded from coverage under your Policy by name or specific description on the date of the loss. "Pre-existing condition" means a condition which has been diagnosed, or has manifested itself to you within the five-year period immediately preceding the Effective Date of your Policy by a symptom or symptoms, whether the specific condition has been medically diagnosed or not, and causes loss within the two-year period following the Effective Date of your Policy.

Coverage for some pre-existing conditions may be included after 12 months for an additional premium payable during the life of your Policy by attachment of the PEB-3 (7/89) Endorsement.

V. Termination

A covered person's coverage will immediately terminate at 12:01 a.m., Standard Time, at the place where the insured resides, at the end of the 31-day grace period following the due date of any premium for that covered person which is not paid.

VI. Renewability

Subject to the limitations stated in the Termination provision, the Policy is guaranteed renewable at your option. We reserve the right to change the premiums for the Policy in accordance with the Premium Payments provision.

VII. Premium Payments

- (a) You have a grace period of 31 days for the payment of each premium which becomes due after the first premium.
- (b) Premiums may be changed. Premiums are based on the attained age of each covered person and the time the Policy is in force. Each covered person's premium may increase following his/her birthday. Premiums may also increase at any time due to the Company changing its table of rates applicable on a class basis in your state. Classes may be determined according to sex, attained age, smoking status and state of residence. We will give you 31 days notice before any such premium change.

PLEASE READ BEFORE SIGNING

THE SOLICITING AGENT SIGNING BELOW DOES NOT HAVE THE AUTHORITY TO BIND THE COMPANY OR TO WAIVE, CHANGE OR AMEND ANY TERM OR CONDITION OF A POLICY WHICH MAY BE ISSUED BY THE COMPANY.

I understand and acknowledge that:

• The benefits of Form PS-1 are limited as outlined herein.

- This is not major medical coverage.

• I have received a copy of this outline of coverage, which I have reviewed.

Dated this _____ day of _____, 20_____.

Signed at _____, State of _____.

Applicant's Signature

Agent's Signature

Date

<i>SERFF Tracking Number:</i>	<i>RNIC-126442339</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Reserve National Insurance Company</i>	<i>State Tracking Number:</i>	<i>44486</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H151 Individual Health - Hospital/Surgical/Medical Expense</i>	<i>Sub-TOI:</i>	<i>H151.001 Health - Hospital/Surgical/Medical Expense</i>
<i>Product Name:</i>	<i>Form PR-PS-AR - Amendment</i>		
<i>Project Name/Number:</i>	<i>Form PR-PS-AR - Amendment/</i>		

Supporting Document Schedules

		Item Status:	Status
Satisfied - Item:	Flesch Certification	Approved-Closed	Date: 01/06/2010
Comments:			
Attachment:			
	Form PR-PS-AR Readability Certificate.pdf		

		Item Status:	Status
Bypassed - Item:	Application	Approved-Closed	Date: 01/06/2010
Bypass Reason:	Not Applicable.		
Comments:			

		Item Status:	Status
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	Date: 01/06/2010
Bypass Reason:	Not Applicable.		
Comments:			

		Item Status:	Status
Satisfied - Item:	Outline of Coverage	Approved-Closed	Date: 01/06/2010
Comments:			
Attachment:			
	OC PS-1 AR 1 10.pdf		



READABILITY CERTIFICATION

FORM NUMBER: Form PR-PS-AR – Amendment

The words, sentences, and syllables of **Form PR-PS-AR** were counted to be used in the Flesch Readability Formula in order to determine the readability score of the form. Formal names, medical terms and words defined (implicitly or explicitly) in the policy/rider/endorsement were not counted.

WORDS:	166
SENTENCES:	8
SYLLABLES:	251

This resulted in a Flesch Readability score of **57.859**.

KYLE D. CONRAD
Senior Vice President
and Associate Corporate Counsel

There Are Limitations On the Amount of Benefits Payable For Each Covered Expense.



Outline of Coverage for Scheduled Benefit Hospital, Medical and Surgical Expense Policy Form PS-1

Read Your Policy Carefully. This Outline of Coverage provides a very brief description of the important features of Scheduled Benefit Hospital, Medical and Surgical Expense Policy Form PS-1. This is not the insurance contract and only the actual provisions in the Policy will control. The Policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. It is therefore important that you Read Your Policy Carefully!

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For covered treatment of each injury or sickness: A covered person must first satisfy the Deductible [see paragraph I (A) below] once in his/her lifetime for each injury or sickness while the Policy is in force before any benefits (except the Benefits for Preventive Care) are payable for such condition. Then, benefits payable are 80% of the expense incurred, but the amounts payable are limited to the maximum benefit amounts shown below [see paragraphs I (B) through (K) below].

I. Acknowledgment of Maximum Benefit Amounts

(A) Select Your Deductible Which Applies to Expenses Incurred for Each Injury or Sickness:

Deductible Selected \$ _____

(B) Maximum Daily Hospital Room and Board Benefit:

80% of the Expense Incurred, up to \$ _____

(C) Maximum Miscellaneous Hospital Inpatient Benefit:

80% of the Expense Incurred, up to \$ _____

(D) Maximum Inpatient Diagnostic Radiology Benefit:

80% of the Expense Incurred, up to \$1,500

(E) Maximum Inpatient Pathology Benefit:

80% of the Expense Incurred, up to \$1,000

(F) Maximum Surgeon's Benefit:

80% of the Expense Incurred, up to Amounts Scheduled in the Policy for Each Operation

(G) Maximum Anesthesia Benefit:

80% of the Expense Incurred, up to 25% of the Applicable Surgical Benefit

(H) Maximum Mammogram Benefit*:

80% of the Expense Incurred, up to \$125

(I) Maximum Pap Smear Benefit*:

80% of the Expense Incurred, up to \$100

(J) Maximum Prostate Exam Benefit*:

80% of the Expense Incurred, up to \$75

(K) Maximum Doctor Visit Benefit*:

After a \$20 co-pay, 80% of the Expense Incurred, up to \$65 per visit, up to 2 visits per policy year

Applicant's Signature for Acknowledgement of Benefits

*The Benefits for Preventive Care are not subject to the Deductible.

II. Description of Benefits

(A) Benefits Payable While In The Hospital

- (1) **Hospital Expense Benefits:** For hospital expenses incurred while you are confined in a hospital, subject to the **Deductible**, we will pay **80%** of the expense incurred, **but not to exceed the amounts stated for any one injury or sickness:**

• Daily hospital room and board expenses incurred, **but not to exceed the Maximum Daily Hospital Room and Board Benefit shown on page 1, for up to 365 days for an adult and 60 days for a child under age 18, for any one injury or sickness.**

• Miscellaneous hospital inpatient expenses incurred, **but not to exceed the Maximum Miscellaneous Hospital Inpatient Benefit shown on page 1. The Maximum Miscellaneous Hospital Inpatient Benefit payable for any one injury or sickness is limited to the amount shown on page 1.**

Outpatient Radiation Therapy/Chemotherapy: Benefits relating to expenses incurred for outpatient radiation therapy or chemotherapy administered by or under the supervision of a physician for the treatment of **cancer** following a covered hospital confinement or surgical procedure for which Miscellaneous Hospital Inpatient Benefits were payable for the treatment of such cancer, will be payable as if incurred on an inpatient basis for such **cancer**, **but not to exceed in the aggregate a maximum benefit of \$1,000 per day for such outpatient radiation therapy or chemotherapy.**

- (2) **Benefit For Inpatient Diagnostic Radiology:** For interpretation of X-rays, CT Scans or MRIs by a radiologist, while you are confined in a hospital, subject to the **Deductible**, we will pay **80%** of the expense incurred, **but not to exceed a maximum benefit of \$1,500 for any one injury or sickness.**
- (3) **Benefit For Inpatient Pathology:** For services of a pathologist, while you are confined in a hospital, subject to the **Deductible**, we will pay **80%** of the expense incurred, **but not to exceed a maximum benefit of \$1,000 for any one injury or sickness.**

(B) Benefits Payable While In Or Out Of The Hospital

- (1) **Benefit For Surgeon:** For surgery performed by a physician, subject to the **Deductible**, we will pay **80%** of the expense incurred for the primary surgeon, **but not to exceed the applicable amount listed for each operation in the Schedule of Surgical Operations in the Policy.** The maximum aggregate benefit for all operations for any one injury or sickness is limited to \$_____. This benefit is not payable for expense incurred for a physician who assists the primary surgeon with a surgical operation.
- (2) **Benefit For Anesthesia:** For services of an anesthesiologist for a covered surgical procedure, subject to the **Deductible**, we will pay **80%** of the expense incurred, **but not to exceed a maximum benefit of 25% of the benefit provided for the surgical operation for any one injury or sickness.**

(C) Benefits Payable Out Of The Hospital – Benefits for Preventive Care

These benefits are not subject to the Deductible.

- (1) **Mammograms:** For a female covered person age 35 and over, we will pay **80%** of the expense incurred for mammograms performed at age intervals specified in the Policy, **but not to exceed a maximum benefit of \$125 for each mammogram.** This benefit is also payable if a covered person, her mother or her sister has had a history of breast cancer. See the Policy for details.
- (2) **Pap Smears:** For a female covered person, we will pay **80%** of the expense incurred for a Pap smear, **but not to exceed a maximum benefit of \$100 for each Pap smear**, limited to one Pap smear per policy year or more frequently if recommended by a physician.
- (3) **Prostate Exams:** For a male covered person age 40 and over, we will pay **80%** of the expense incurred for a prostate exam, **but not to exceed a maximum benefit of \$75 for each prostate exam**, limited to one prostate exam per policy year or more frequently if recommended by a physician or other qualified medical professional.
- (4) **Doctor Visits:** For personal treatment by a physician in his/her office, we will pay **80%** of the expense incurred in excess of a **\$20 co-pay per visit, but not to exceed a maximum benefit of \$65 for each visit**, limited to 1 visit per day with a maximum of 2 visits per policy year.

(D) Optional Benefits

The following items are optional benefits that may be available in your state. Your application reflects you have applied

for the additional benefits if indicated below:

- (1) _____ (applicant's initials to select) **Premium Rate Guarantee Rider:** We guarantee that the premium rate for each covered person will not increase prior to the expiration of **2 years or 3 years (as you select)** following the effective date of this rider. After the expiration of such period, each covered person's premium rate will be subject to increases under the Policy's provisions.
- **Select:** 2-Year Premium Rate Guarantee 3-Year Premium Rate Guarantee
- (2) _____ (applicant's initials to select) **Ambulance Benefit Rider:** For transportation to or from a Hospital by a licensed ambulance service, we will pay **80%** of the expense incurred, **but not to exceed the following maximum benefits:**
- (a) **Air Ambulance:** For air transportation by a licensed ambulance service, **the maximum benefit is \$5,000 for any one injury or sickness.**
- (b) **Ground Ambulance:** For ground transportation by a licensed ambulance service, **the maximum benefit is \$1,500 for any one injury or sickness.**
- (3) _____ (applicant's initials to select) **Prosthesis and Physical Therapy Benefit Rider:** For a prosthesis and physical therapy, subject to the Policy's **Deductible**, we will pay **80%** of the expense incurred, **but not to exceed the following maximum benefits:**
- (a) **Prosthesis** (a replacement part or device, whether organic or inorganic, implanted in the body to perform or augment a bodily function, such as a pacemaker, defibrillator, artificial limbs, joints or eyes, casts, splints, trusses or braces): For a prosthesis, **the maximum benefit is \$10,000 for any one injury or sickness.**
- (b) **Physical Therapy:** For physical therapy, **the maximum benefit is \$2,500 for any one injury or sickness, limited to \$50 per day.**
- (4) _____ (applicant's initials to select) **Outpatient Benefit Rider:** For the covered outpatient services listed below, we will pay benefits as follows, **subject to the Outpatient Deductible** you select, which **must be satisfied by each covered person in each policy year:**
- (a) **Outpatient Physician Visits:** For outpatient physician visits, we will pay **80%** of the expense incurred, **limited to 1 visit per day, and not to exceed 10 visits in each policy year with a maximum benefit of \$50 per visit.**
- (b) **Emergency Room:** For the use of a hospital emergency room, we will pay **80%** of the expense incurred, **limited to a maximum benefit of \$500 in each policy year.**
- (c) **Outpatient Diagnostic Lab Tests and X-Rays:** For outpatient diagnostic lab tests and X-rays (including CT scans and MRIs) we will pay **80%** of the expense incurred, **limited in the aggregate in each policy year to a maximum benefit of \$ _____.**

The Outpatient Deductible is separate from and in addition to the Deductible under the Policy.

• **Select:** Outpatient Deductible \$ _____.

- (5) _____ (applicant's initials to select) **Existing Condition Benefit Endorsement PEB-3 (7/89):** Pre-existing conditions disclosed on the application and listed on the Endorsement Form PEB-3 (7/89) will be covered after 12 months.

III. Exclusions

We will not pay if loss is caused or contributed to by: (a) injury or sickness sustained while serving in the armed forces of any country or international authority at war, whether war is declared or not (we will return the pro-rata premium for any period not covered by the Policy while you are in such service); (b) suicide or attempted suicide, while sane or insane, or any intentionally self-inflicted injury; (c) drug abuse, drug overdose or drug addiction, except as may be provided by endorsement; (d) intoxication, alcoholism or alcohol related illnesses, except as may be provided by endorsement; (e) mental illness, nervous or emotional disorders, except as may be provided by endorsement; (f) injury or sickness covered by any worker's compensation act, occupational diseases law or any motor vehicle no-fault law; (g) dental care or treatment, except that excluded dental care or treatment shall not include (1) reconstructive surgery when such service is incidental to trauma or (2) treatment of accidental injury to whole, natural teeth received within six months following an accident; (h) cosmetic or elective surgery (including surgery to correct myopia, hyperopia, presbyopia or astigmatism and surgery for weight loss or modification), except that excluded cosmetic surgery shall not include (1) reconstructive surgery when service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part, (2) reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect or (3) breast reconstruction in connection with mastectomy, including reconstructive surgery on a nondiseased breast to establish symmetry with a diseased breast on which reconstructive surgery has been performed; (i) pregnancy or conditions due to pregnancy, except complications of pregnancy shall be covered as a sickness; (j) childbirth, except as may be provided by endorsement; (k) participation in

a felony, riot or insurrection; (l) rest cures, custodial care, and routine physical examinations; (m) expenses incurred to the extent benefits are actually paid by Medicare; (n) charges that a covered person is not legally required to pay or that would not have been made if no insurance coverage had existed; (o) treatment received in a United States Government or Veterans hospital for which a covered person is not required to pay; (p) eye glasses, hearing aids and examination for the prescription or fitting thereof; (q) surgical sterilization; (r) any expense incurred in connection with the acquisition, purchase or transportation of human or animal organs used in transplant procedures.

IV. Pre-Existing Conditions

Pre-existing conditions are not covered under your Policy until your Policy has been in force for a period of two years; however, no benefits whatsoever will be payable for loss from any condition, either pre-existing or otherwise, which is completely excluded from coverage under your Policy by name or specific description on the date of the loss. "Pre-existing condition" means a condition which has been diagnosed, or has manifested itself to you within the five-year period immediately preceding the Effective Date of your Policy by a symptom or symptoms, whether the specific condition has been medically diagnosed or not, and causes loss within the two-year period following the Effective Date of your Policy.

Coverage for some pre-existing conditions may be included after 12 months for an additional premium payable during the life of your Policy by attachment of the PEB-3 (7/89) Endorsement.

V. Termination

A covered person's coverage will immediately terminate at 12:01 a.m., Standard Time, at the place where the insured resides, at the end of the 31-day grace period following the due date of any premium for that covered person which is not paid.

VI. Renewability

Subject to the limitations stated in the Termination provision, the Policy is guaranteed renewable at your option. We reserve the right to change the premiums for the Policy in accordance with the Premium Payments provision.

VII. Premium Payments

- (a) You have a grace period of 31 days for the payment of each premium which becomes due after the first premium.
- (b) Premiums may be changed. Premiums are based on the attained age of each covered person and the time the Policy is in force. Each covered person's premium may increase following his/her birthday. Premiums may also increase at any time due to the Company changing its table of rates applicable on a class basis in your state. Classes may be determined according to sex, attained age, smoking status and state of residence. We will give you 31 days notice before any such premium change.

PLEASE READ BEFORE SIGNING

THE SOLICITING AGENT SIGNING BELOW DOES NOT HAVE THE AUTHORITY TO BIND THE COMPANY OR TO WAIVE, CHANGE OR AMEND ANY TERM OR CONDITION OF A POLICY WHICH MAY BE ISSUED BY THE COMPANY.

I understand and acknowledge that:

• The benefits of Form PS-1 are limited as outlined herein.

- This is not major medical coverage.

• I have received a copy of this outline of coverage, which I have reviewed.

Dated this _____ day of _____, 20_____.

Signed at _____, State of _____.

Applicant's Signature

Agent's Signature

Date