

SERFF Tracking Number: RNIC-127966500 State: Arkansas
Filing Company: Reserve National Insurance Company State Tracking Number:
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: OP-1 Supplemental Outpatient Fixed Indemnity Policy
Project Name/Number: OP-1 Supplemental Outpatient Fixed Indemnity Policy/

Filing at a Glance

Company: Reserve National Insurance Company

Product Name: OP-1 Supplemental Outpatient Fixed Indemnity Policy SERFF Tr Num: RNIC-127966500 State: Arkansas

TOI: H21 Health - Other SERFF Status: Closed-Approved State Tr Num:
Sub-TOI: H21.000 Health - Other Co Tr Num: State Status: Approved-Closed
Filing Type: Form Reviewer(s): Donna Lambert

Disposition Date: 01/13/2012

Authors: Kyle Conrad, Brenda

Ingram, Mariana Garcia

Date Submitted: 01/09/2012

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date: 02/13/2012

State Filing Description:

General Information

Project Name: OP-1 Supplemental Outpatient Fixed Indemnity Policy

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: Resubmission

Individual Market Type: Individual

Filing Status Changed: 01/13/2012

State Status Changed: 01/13/2012

Created By: Brenda Ingram

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

January 9, 2012

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 09/21/2011

Domicile Status Comments:

Market Type: Individual

Previous Filing Number: RNIC-127627094

Overall Rate Impact:

Deemer Date:

Submitted By: Brenda Ingram

Ms. Donna Lambert

Life and Health Division

Arkansas Insurance Department

1200 West Third Street

Little Rock, AR 72201-1904

SERFF Tracking Number: RNIC-127966500 State: Arkansas
Filing Company: Reserve National Insurance Company State Tracking Number:
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: OP-1 Supplemental Outpatient Fixed Indemnity Policy
Project Name/Number: OP-1 Supplemental Outpatient Fixed Indemnity Policy/

RE: Resubmission of SERFF Tracking Number RNIC-127627094; State Tracking Number 49807
Reserve National Insurance Company - NAIC # 68462; FEIN# 73-0661453
Form OP-1 – Supplemental Outpatient Fixed Indemnity Policy
Form PEB-3 (1/11) – Existing Condition Benefit Endorsement
Form R-1 (1/11) – Elimination Rider
Form UAP-1 AR (10/11) – General A&H Application
Form OC OP-1 (Option 1) – Outline of Coverage
Form OC OP-1 (Option 2) – Outline of Coverage
Form RP-A&H – Notice to Applicant Regarding Replacement
Form HDI-Med. Notice – Important Notice to Persons on Medicare

Dear Ms. Lambert:

We are submitting the above-referenced forms, which we request you consider for approval. This filing was previously submitted, but the filing was “closed.” This filing is not subject to the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 or any of the regulations thereunder (collectively referred to as the “PPACA”).

We respond as follows to your objection letter dated 10/03/2011:

1. Form PEB-3 (1/11) was previously approved by your office on Serff tracking # RNIC-126983742 and Form R-1 (1/11) was previously approved by your office on Serff tracking # RNIC-126983742; State # 47727. Form RP-A&H was previously approved on 6/02/1999 and Form HDI-Med. Notice was previously approved on 5/08/2003 both of these form was pre-Serff.
2. We have included Form AR-INP (11/09) as a supporting document to reflect our compliance with Bulletin 15-2009.
3. In the policy, we have placed brackets around all variable text.
4. We have included an Explanation of Variable Text.
5. On page 4 of the application, in the section of text stating “IT IS AGREED...”, we have added language that the statements and answers “ARE STATEMENTS AND NOT WARRENTIES.

Form OP-1 provides the following fixed indemnity benefits as described in the policy: Outpatient X-Rays and Lab Tests Indemnity Benefit, Outpatient Doctor Visits Indemnity Benefit, Emergency Room Indemnity Benefit, Ambulance Indemnity Benefit, Prescription Indemnity Benefit and Preventive Care Indemnity Benefits for Colonoscopy,

SERFF Tracking Number: RNIC-127966500 State: Arkansas
Filing Company: Reserve National Insurance Company State Tracking Number:
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: OP-1 Supplemental Outpatient Fixed Indemnity Policy
Project Name/Number: OP-1 Supplemental Outpatient Fixed Indemnity Policy/

Mammogram, Pap Smear, Diabetes Testing and Prostate Examination. There are two benefit options, each with different indemnity benefit amounts for the foregoing benefit provisions, as shown on the Policy's schedule page. The Policy we submitted contains schedule pages for each of the two options.

For the following reasons, Form OP-1 is "excepted benefits" coverage, as defined by applicable law, and therefore is not subject to the requirements of the PPACA: (a) the benefits are provided under a separate policy; (b) this is fixed indemnity coverage in that all benefits are a fixed dollar amount that is payable regardless of the amount of expenses incurred; (c) there is no coordination of benefits with the benefits, exclusions or any other provision of any other health insurance coverage; and (d) each benefit is payable with respect to an event [as stated in Form OP-1] without regard to whether benefits are provided with respect to the same event under any other health insurance coverage.

Form OP-1 will be available to individuals age 0 through 64, and also to individuals who are 65 or older.

The following forms to be used with Form OP-1 are also included with this filing:

1. Form PEB-3 (1/11) – Existing Condition Benefit Endorsement, which, in accordance with our underwriting guidelines, may be selected by an applicant for coverage of certain pre-existing conditions after a reduced waiting period of 12 months. This form was previously approved by your office.
2. Form R-1 (1/11) – Elimination Rider, which, in accordance with our underwriting guidelines, will be used to permanently eliminate coverage for certain pre-existing conditions. This form was previously approved by your office.
3. Form UAP-1 AR (10/11) – General A&H Application, which will be used as the application for Form OP-1. Form UAP-1 AR (10/11) will also be used as the application for other accident and health policies previously approved by your office. This application will not be used for Medicare supplement policies.
4. Form OC OP-1 (Option 1) – Outline of Coverage, which will be used in connection with each application for Form OP-1 when the applicant selects the "Option 1" level of indemnity benefits.
5. Form OC OP-1 (Option 2) – Outline of Coverage, which will be used in connection with each application for Form OP-1 when the applicant selects the "Option 2" level of indemnity benefits.
6. Form RP-A&H – Notice to Applicant Regarding Replacement, which will be used in replacement situations. This form was previously approved by your office.
7. Form HDI-Med. Notice – Important Notice to Persons on Medicare, which will be used for each applicant who is eligible for Medicare at the time of application. This form was previously approved by your office.

SERFF Tracking Number: RNIC-127966500 State: Arkansas
Filing Company: Reserve National Insurance Company State Tracking Number:
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: OP-1 Supplemental Outpatient Fixed Indemnity Policy
Project Name/Number: OP-1 Supplemental Outpatient Fixed Indemnity Policy/

We are also submitting the rates and a supporting actuarial memorandum related to this filing.

If this filing meets with your approval, please provide us with appropriate evidence thereof.

Thank you for your consideration in this matter. 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]

Filing Company Information

Reserve National Insurance Company
601 East Britton Road
Oklahoma City, OK 73114
(405) 848-7931 ext. 549[Phone]
CoCode: 68462
Group Code: 215
Group Name: Reserve National
FEIN Number: 73-0661453
State of Domicile: Oklahoma
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: \$200.00
Retaliatory? No
Fee Explanation: Policy & 3 Forms
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Reserve National Insurance Company	\$200.00	01/09/2012	55123738

SERFF Tracking Number: RNIC-127966500 State: Arkansas
 Filing Company: Reserve National Insurance Company State Tracking Number:
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: OP-1 Supplemental Outpatient Fixed Indemnity Policy
 Project Name/Number: OP-1 Supplemental Outpatient Fixed Indemnity Policy/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	01/13/2012	01/13/2012

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	Donna Lambert	01/13/2012	01/13/2012	Brenda Ingram	01/13/2012	01/13/2012
Pending Industry Response	Donna Lambert	01/12/2012	01/12/2012	Kyle Conrad	01/12/2012	01/12/2012

SERFF Tracking Number: *RNIC-127966500* *State:* *Arkansas*
Filing Company: *Reserve National Insurance Company* *State Tracking Number:*
Company Tracking Number:
TOI: *H21 Health - Other* *Sub-TOI:* *H21.000 Health - Other*
Product Name: *OP-1 Supplemental Outpatient Fixed Indemnity Policy*
Project Name/Number: *OP-1 Supplemental Outpatient Fixed Indemnity Policy/*

Disposition

Disposition Date: 01/13/2012

Implementation Date: 02/13/2012

Status: Approved

HHS Status: HHS Approved

State Review: Not Reviewed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: RNIC-127966500 State: Arkansas

Filing Company: Reserve National Insurance Company State Tracking Number:

Company Tracking Number:

TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other

Product Name: OP-1 Supplemental Outpatient Fixed Indemnity Policy

Project Name/Number: OP-1 Supplemental Outpatient Fixed Indemnity Policy/

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved	Yes
Supporting Document	Form PEB-3 (1/11)	Approved	Yes
Supporting Document	Form R-1 (1/11)	Approved	Yes
Supporting Document	Form RP-A&H	Approved	Yes
Supporting Document	Form HDI-Med. Notice	Approved	Yes
Supporting Document	AR-INP (11/09)	Approved	Yes
Supporting Document	Explanation of Variable Text	Approved	Yes
Form (revised)	Supplemental Outpatient Fixed Indemnity Policy	Approved	Yes
Form	Supplemental Outpatient Fixed Indemnity Replaced Policy		Yes
Form	Supplemental Outpatient Fixed Indemnity Replaced Policy		Yes
Form	General A&H Application	Approved	Yes
Form	Outline of Coverage	Approved	Yes
Form	Outline of Coverage	Approved	Yes
Rate	Rates	Approved	Yes

SERFF Tracking Number: RNIC-127966500 State: Arkansas
Filing Company: Reserve National Insurance Company State Tracking Number:
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: OP-1 Supplemental Outpatient Fixed Indemnity Policy
Project Name/Number: OP-1 Supplemental Outpatient Fixed Indemnity Policy/

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 01/13/2012
Submitted Date 01/13/2012
Respond By Date 02/13/2012

Dear Kyle Conrad,

Objection 1

- Supplemental Outpatient Fixed Indemnity Policy, OP-1 (Form)

Comment: On page 7, Time Limit on Certain Defenses, the second sentence still refers to 2 years. Please change this to 3 years.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

SERFF Tracking Number: RNIC-127966500 State: Arkansas
 Filing Company: Reserve National Insurance Company State Tracking Number:
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: OP-1 Supplemental Outpatient Fixed Indemnity Policy
 Project Name/Number: OP-1 Supplemental Outpatient Fixed Indemnity Policy/

Response Letter

Response Letter Status Submitted to State
 Response Letter Date 01/13/2012
 Submitted Date 01/13/2012

Dear Donna Lambert,

Comments:

Please see our response below.

Response 1

Comments: We have made the revision that you requested.

Related Objection 1

Applies To:

- Supplemental Outpatient Fixed Indemnity Policy, OP-1 (Form)

Comment:

On page 7, Time Limit on Certain Defenses, the second sentence still refers to 2 years. Please change this to 3 years.

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
Supplemental Outpatient Fixed Indemnity Policy	OP-1		Policy/Contract/Fraternal Certificate	Initial		86.255	OP-1_POLICY_ARKANSAS.pdf
Previous Version							
Supplemental Outpatient Fixed Indemnity Policy	OP-1		Policy/Contract/Fraternal Certificate	Initial		86.255	OP-1_POLICY_ARKANSAS

SERFF Tracking Number: RNIC-127966500 State: Arkansas
Filing Company: Reserve National Insurance Company State Tracking Number:
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: OP-1 Supplemental Outpatient Fixed Indemnity Policy
Project Name/Number: OP-1 Supplemental Outpatient Fixed Indemnity Policy/

Supplemental	OP-1	Policy/Contract/Fraternal Initial	86.255	AS.pdf
Outpatient Fixed		Certificate		OP-
Indemnity Policy				1_POLICY
				_ARKANS
				AS.pdf

No Rate/Rule Schedule items changed.

Thank you for your consideration. We hope this now meets with your approval.

Brenda Ingram
Compliance Assistant

Sincerely,
Brenda Ingram, Kyle Conrad, Mariana Garcia

SERFF Tracking Number: RNIC-127966500 State: Arkansas
Filing Company: Reserve National Insurance Company State Tracking Number:
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: OP-1 Supplemental Outpatient Fixed Indemnity Policy
Project Name/Number: OP-1 Supplemental Outpatient Fixed Indemnity Policy/

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 01/12/2012
Submitted Date 01/12/2012
Respond By Date 02/13/2012

Dear Kyle Conrad,

Thank you for your resubmission and responses to the objections in the first filing. Please make the following revisions so I can approve this submission.

Objection 1

- Supplemental Outpatient Fixed Indemnity Policy, OP-1 (Form)

Comment: 1. Please add a provision to comply with RR 18 Sec. 8 A(2).

2. Revise the statement on the cover page to more closely resemble that required by RR 18 Sec. 8 A(6).

3. The Time Limit on Certain Defenses is 3 years, not 2. 23-85-107. Please revise the provision.

4. The Proof of Loss and Time of Payment of Claims provisions both contain references to "periodic payments." Please delete these references as this policy only provides indemnity benefits.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

SERFF Tracking Number: RNIC-127966500 State: Arkansas
Filing Company: Reserve National Insurance Company State Tracking Number:
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: OP-1 Supplemental Outpatient Fixed Indemnity Policy
Project Name/Number: OP-1 Supplemental Outpatient Fixed Indemnity Policy/

Response Letter

Response Letter Status Submitted to State
Response Letter Date 01/12/2012
Submitted Date 01/12/2012

Dear Donna Lambert,

Comments:

Please see our responses below.

Response 1

Comments: 1. On page 9 of the policy, we have added a paragraph 10 to reflect RR 18 Sec. 8 A(2).

2. On page 1 of the policy, at the bottom of the page, we have revised the statement to resemble that under RR 18 Sec. 8 A(6).

3. On page 7 of the policy, we have revised the Time Limit on Certain Defenses provision to reflect a 3-year period.

4. On page 8 of the policy, we have revised the Proof of Loss and Time of Payment of Claims provisions by deleting the references to "periodic payments."

Related Objection 1

Applies To:

- Supplemental Outpatient Fixed Indemnity Policy, OP-1 (Form)

Comment:

1. Please add a provision to comply with RR 18 Sec. 8 A(2).

2. Revise the statement on the cover page to more closely resemble that required by RR 18 Sec. 8 A(6).

3. The Time Limit on Certain Defenses is 3 years, not 2. 23-85-107. Please revise the provision.

4. The Proof of Loss and Time of Payment of Claims provisions both contain references to "periodic payments." Please delete these references as this policy only provides indemnity benefits.

Changed Items:

No Supporting Documents changed.

SERFF Tracking Number: RNIC-127966500 State: Arkansas
 Filing Company: Reserve National Insurance Company State Tracking Number:
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: OP-1 Supplemental Outpatient Fixed Indemnity Policy
 Project Name/Number: OP-1 Supplemental Outpatient Fixed Indemnity Policy/

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Supplemental Outpatient Fixed Indemnity Policy	OP-1		Policy/Contract/Fraternal Certificate	Initial		86.255	OP-1_POLICY_ARKANSAS.pdf
Previous Version							
Supplemental Outpatient Fixed Indemnity Policy	OP-1		Policy/Contract/Fraternal Certificate	Initial		86.255	OP-1_POLICY_ARKANSAS.pdf

No Rate/Rule Schedule items changed.

We trust you will now approve this filing.

Thank you for your consideration.

Kyle Conrad
 Sr. Vice President and Associate Corp. Counsel
 Reserve National Insurance Company

Sincerely,
 Brenda Ingram, Kyle Conrad, Mariana Garcia

SERFF Tracking Number: RNIC-127966500 State: Arkansas
 Filing Company: Reserve National Insurance Company State Tracking Number:
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: OP-1 Supplemental Outpatient Fixed Indemnity Policy
 Project Name/Number: OP-1 Supplemental Outpatient Fixed Indemnity Policy/

Form Schedule

Lead Form Number: OP-1

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 01/13/2012	OP-1	Policy/Cont ract/Fratern al	Supplemental Outpatient Fixed Indemnity Policy Certificate	Initial		86.255	OP-1_POLICY_A RKANSAS.pdf
Approved 01/13/2012	UAP-1 AR (10/11)	Application/ Enrollment Form	General A&H Application	Revised	Replaced Form #: UAP-1 AR (1/11) Previous Filing #: 47727		UAP-1 AR 10.11.pdf
Approved 01/13/2012	OC OP-1 (Option 1)	Outline of Coverage	Outline of Coverage	Initial			OC OP-1 (Option 1).pdf
Approved 01/13/2012	OC OP-1 (Option 2)	Outline of Coverage	Outline of Coverage	Initial			OC OP-1 (Option 2).pdf

**THIS IS NOT A MEDICARE SUPPLEMENT POLICY.
THIS POLICY PAYS FIXED INDEMNITY BENEFIT AMOUNTS FOR COVERED
OUTPATIENT TREATMENT, WITH LIMITS ON THE AMOUNTS PAYABLE FOR
EACH COVERED TREATMENT AND IN EACH POLICY YEAR. IT IS RENEWABLE
AS PROVIDED IN THE RENEWAL SAFEGUARD PROVISION. PREMIUMS ARE
BASED ON EACH COVERED PERSON'S ATTAINED AGE. WE HAVE THE RIGHT
TO INCREASE PREMIUMS ON A CLASS BASIS BY STATE.**



601 East Britton Road ▪ Oklahoma City, OK 73114

When we use "we," "us," or "our" we mean Reserve National Insurance Company. When we use "you" or "your" we mean a Covered Person as defined in this Policy and as named on the Insured Schedule.

Reserve National Insurance Company agrees to indemnify the Covered Person(s) as hereinafter provided, subject, however, to all the provisions, conditions, exclusions, limits of liability and other terms in this Policy.

SUPPLEMENTAL OUTPATIENT FIXED INDEMNITY POLICY INSURING AGREEMENT

In consideration of the payment of the premium in advance and in reliance upon the statements in your application, a copy of which is attached and which forms a part of this Policy, we hereby indemnify the person(s) named on the Insured Schedule, commencing at 12:01 A.M., Standard Time, at the place where you reside, on the Effective Date shown on the Insured Schedule. The initial premium is for the policy term shown on the Insured Schedule. The renewal premium for later policy terms is due on the first day of the next policy term. The coverage provided by this Policy will cease if the renewal premium in effect is not paid when due or within the grace period. Each policy term will begin and end at 12:01 A.M., Standard Time, at the place where the Insured resides.

RENEWABILITY

Subject to the Termination provision, coverage under this Policy is renewable as provided in the **Renewal Safeguard** provision. Premiums are subject to change as provided in the Premium Payments provision.

IMPORTANT NOTICE

Please read the copy of the application attached to this Policy. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to the Company at 601 East Britton Road, Oklahoma City, Oklahoma 73114-7710, within 10 days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. The application is part of this Policy, which was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

NOTICE OF 10 DAY RIGHT TO EXAMINE POLICY

You are granted a period of 10 days from the date of delivery of this Policy to examine it. If you are not satisfied for any reason, this Policy may be returned within said 10 days to the Company at its Home Office or to the writing agent. Then the Company shall refund the premium paid, this Policy shall be void from its beginning, and you and Reserve National shall be in the same position as if it had never been issued.

**THIS IS A LIMITED POLICY.
THIS IS AN OUTPATIENT-ONLY POLICY
AND IT DOES NOT PAY BENEFITS FOR SURGERY OR HOSPITALIZATION.**

Read this Policy carefully with the Outline of Coverage.

TABLE OF CONTENTS

Benefits	Pages 4 & 5
Continuation of Coverage Upon Divorce	Page 6
Coverage for Spouse and Dependent Children.....	Page 7
Definitions.....	Page 3
Exclusions	Page 6
Important Notice.....	Page 1
Insured Schedule	Page 2
Insuring Agreement	Page 1
Limitation	Page 6
Notice of 10 Day Right to Examine Policy	Page 1
Policy Provisions	Page 9
Pre-Existing Conditions Limitation	Page 6
Premium Payments	Page 6
Renewability	Page 1
Renewal Safeguard	Page 7
Termination	Page 6
Uniform Provisions	Pages 7 & 8

INSURED SCHEDULE

		<u>Renewal Premium:</u>	Direct Bill	Bank Draft
Policy Number	[00-00-000000]	Monthly	N/A	[\$00.00]
Effective Date	[Feb. 1, 2011]	Quarterly	[\$00.00]	[\$00.00]
Initial Term Expires	[Feb. 1, 2011]	Semi Annual	[\$00.00]	N/A
Initial Premium	[\$00.00]	Annual	[\$00.00]	N/A
Insured	[JOHN DOE]	Agent	[RESERVE NATIONAL AGENT]	

Dependents

Spouse **[JANE DOE]**

- [DEPENDENT 1]**
- [DEPENDENT 2]**
- [DEPENDENT 3]**
- [DEPENDENT 4]**
- [DEPENDENT 5]**

Indemnity Benefits and Limitations for Each Covered Person in Each Policy Year
Benefits or Visits not used in one Policy Year are not carried forward to any future Policy Year.

Outpatient X-Rays and Lab Tests Indemnity Benefit:

- X-Ray Indemnity Benefit\$75.00
- CT Scan/MRI Indemnity Benefit\$750.00
- Lab Test Indemnity Benefit\$50.00
- Maximum Aggregate Outpatient X-Rays and Lab Tests Indemnity Benefit..\$2,000.00 Per Policy Year

Outpatient Doctor Visits Indemnity Benefit..... \$50.00 Per Visit

- This benefit is limited to 1 Visit Per Day and 4 Visits Per Policy Year

Emergency Room Indemnity Benefit.....\$500.00 Per Policy Year

- This benefit is limited to 1 Visit Per Policy Year

Ambulance Indemnity Benefit:

- Air Ambulance Indemnity Benefit\$1,500.00 Per Trip
 *This benefit is limited to 2 Air Ambulance Trips Per Policy Year
- Ground Ambulance Indemnity Benefit\$500.00 Per Trip
 *This benefit is limited to 4 Ground Ambulance Trips Per Policy Year

Prescription Indemnity Benefit:

- Benefit Per Prescription\$25.00
- Maximum Aggregate Prescription Drug Indemnity Benefit \$500.00 Per Policy Year

Preventive Care Indemnity Benefits (see the Policy for specific age and frequency limitations):

- Colonoscopy Indemnity Benefit\$500.00
- Mammogram Indemnity Benefit\$125.00
- Pap Smear Indemnity Benefit \$100.00
- Diabetes Testing Indemnity Benefit\$50.00
- Prostate Examination Indemnity Benefit\$75.00

- Continued on reverse side -

--HOME OFFICE--
 RESERVE NATIONAL INSURANCE COMPANY * 601 EAST BRITTON ROAD * OKLAHOMA CITY, OKLAHOMA 73114

INSURED SCHEDULE

		<u>Renewal Premium:</u>	Direct Bill	Bank Draft
Policy Number	[00-00-000000]	Monthly	N/A	[\$00.00]
Effective Date	[Feb. 1, 2012]	Quarterly	[\$00.00]	[\$00.00]
Initial Term Expires	[Feb. 1, 2012]	Semi Annual	[\$00.00]	N/A
Initial Premium	[\$00.00]	Annual	[\$00.00]	N/A
Insured	[JOHN DOE]	Agent	[RESERVE NATIONAL AGENT]	

Dependents

Spouse **[JANE DOE]**

- [DEPENDENT 1]**
- [DEPENDENT 2]**
- [DEPENDENT 3]**
- [DEPENDENT 4]**
- [DEPENDENT 5]**

Indemnity Benefits and Limitations for Each Covered Person in Each Policy Year
Benefits or Visits not used in one Policy Year are not carried forward to any future Policy Year.

Outpatient X-Rays and Lab Tests Indemnity Benefit:

- X-Ray Indemnity Benefit\$50.00
- CT Scan/MRI Indemnity Benefit\$500.00
- Lab Test Indemnity Benefit\$25.00
- Maximum Aggregate Outpatient X-Rays and Lab Tests Indemnity Benefit..\$1,000.00 Per Policy Year

Outpatient Doctor Visits Indemnity Benefit..... \$25.00 Per Visit

- This benefit is limited to 1 Visit Per Day and 4 Visits Per Policy Year

Emergency Room Indemnity Benefit.....\$300.00 Per Policy Year

- This benefit is limited to 1 Visit Per Policy Year

Ambulance Indemnity Benefit:

- Air Ambulance Indemnity Benefit\$1,500.00 Per Trip
 *This benefit is limited to 2 Air Ambulance Trips Per Policy Year
- Ground Ambulance Indemnity Benefit\$250.00 Per Trip
 *This benefit is limited to 4 Ground Ambulance Trips Per Policy Year

Prescription Indemnity Benefit:

- Benefit Per Prescription\$10.00
- Maximum Aggregate Prescription Drug Indemnity Benefit \$250.00 Per Policy Year

Preventive Care Indemnity Benefits (see the Policy for specific age and frequency limitations):

- Colonoscopy Indemnity Benefit\$500.00
- Mammogram Indemnity Benefit\$125.00
- Pap Smear Indemnity Benefit \$100.00
- Diabetes Testing Indemnity Benefit\$50.00
- Prostate Examination Indemnity Benefit\$75.00

- Continued on reverse side -

--HOME OFFICE--

RESERVE NATIONAL INSURANCE COMPANY * 601 EAST BRITTON ROAD * OKLAHOMA CITY, OKLAHOMA 73114

Endorsements and Eliminations

- [PEB-3 (1/11)] [Applicable to JOHN DOE only, no benefits shall be paid prior to the expiration of 12 months from Feb. 1, 2012, as a result of:
Diabetes, including any complications thereof.]
- [R-1 (1/11)] [Applicable to JANE DOE only, effective Feb. 1, 2012, benefits excluded for:
Pneumonia and/or any disease of the respiratory tract, including any complications thereof.]

DEFINITIONS

The following terms in this Policy are defined as follows:

COVERED PERSON: "Covered Person" means only (a) the Insured, (b) the Insured's spouse and (c) all of the Insured's dependent children, including adopted children; provided such insured, spouse and dependent children are listed by name on the Insured Schedule and the applicable premium is paid. Upon the insured's death, his/her surviving spouse shall become the Insured if such spouse is a Covered Person at the time of the Insured's death.

HOSPITAL: "Hospital" means only a legally constituted institution which operates pursuant to law and is primarily engaged in providing or operating (either on its premises or in facilities available to the hospital on a prearranged contractual basis) facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, for which a charge is made, including facilities for diagnosis and surgery under the supervision of a staff of one or more licensed physicians and which provides 24-hour nursing service by or under the supervision of registered nurses on duty. "Hospital" does not mean convalescent, nursing, rest, or extended care facilities, or facilities operated exclusively for treatment of the aged, or drug or alcohol abuse, whether such facilities are operated as a separate institution or as a section of an institution operated as a Hospital.

INJURY: "Injury" means a Covered Person's accidental bodily injury resulting directly and independently of all other causes from an accident which occurs while a Covered Person whose injury is the basis of a claim is covered under this Policy.

LOSS: "Loss" means the event of a Covered Person's receipt of covered treatment, services or supplies for which a fixed indemnity benefit is payable under this Policy. As used in this Policy, "Loss" does not relate to any economic loss suffered by a Covered Person.

OUTPATIENT: "Outpatient" means covered treatment of a Covered Person's Injury or Sickness performed on an outpatient basis by or under the supervision of a Physician in the Physician's office, a clinic, an independent laboratory or X-ray facility, an outpatient department of a Hospital or a Hospital emergency room.

PHYSICIAN: "Physician" means any legally qualified individual (other than you, your spouse, your or your spouse's parent, grandparent, child, grandchild or sibling, or the spouse of any such individual, or anyone living at your residence) who is duly licensed and practicing the healing arts within the scope of his/her authority and license.

POLICY YEAR: "Policy Year" means each successive 12-month period extending from the Effective Date of this Policy, so that each successive 12-month period constitutes a single Policy Year.

PRE-EXISTING CONDITION: "Pre-Existing Condition" means a condition that has been diagnosed, or has manifested itself to you within the five-year period immediately preceding the Effective Date of this 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 this Policy.

SICKNESS: "Sickness" means a Covered Person's sickness or disease that manifests itself after this Policy's Effective Date and while a Covered Person whose sickness is the basis of a claim is covered under this Policy.

BENEFITS

OUTPATIENT X-RAYS AND LAB TESTS INDEMNITY BENEFIT

If a Covered Person, while this Policy is in force, undergoes an Outpatient X-Ray, MRI, CT Scan or a laboratory test performed or directed by or under the supervision of a Physician as the result of an Injury or Sickness, we will pay indemnity benefits as follows:

- (a) For each such X-Ray, we will pay the X-Ray Indemnity Benefit in the amount shown on the Insured Schedule.
- (b) For each such MRI or CT Scan, we will pay the MRI/CT Scan Indemnity Benefit in the amount shown on the Insured Schedule.
- (c) For each such laboratory we will pay the Lab Test Indemnity Benefit in the amount shown on the Insured Schedule.
- (d) The maximum benefit we will pay for all X-Rays, MRIs, CT Scans and laboratory tests in a Policy Year is limited to the Maximum Aggregate Outpatient X-Rays and Lab Tests Indemnity Benefit shown on the Insured Schedule.

OUTPATIENT DOCTOR VISITS INDEMNITY BENEFIT

If a Covered Person, while this Policy is in force, receives personal treatment by a Physician in the Physician's office or a clinic, as the result of an Injury or Sickness or for a routine examination, we will pay the Outpatient Doctor Visits Indemnity Benefit in the amount shown on the Insured Schedule. This benefit is limited to one visit per day, and not to exceed four visits in a Policy Year.

EMERGENCY ROOM INDEMNITY BENEFIT

If a Covered Person, while this Policy is in force, receives personal treatment by a Physician in a Hospital emergency room as the result of an Injury or Sickness, we will pay the Emergency Room Indemnity Benefit in the amount shown on the Insured Schedule. This benefit is limited to one visit in a Policy Year.

AMBULANCE INDEMNITY BENEFIT

If a Covered Person, while this Policy is in force, is transported to or from a Hospital as a result of an Injury or Sickness, we will pay the applicable indemnity benefit as follows:

- (a) **Air Ambulance:** For air transportation by a licensed ambulance service, we will pay the Air Ambulance Indemnity Benefit in the amount shown on the Insured Schedule, limited to two air ambulance trips in a Policy Year.
- (b) **Ground Ambulance:** For ground transportation by a licensed ambulance service, we will pay the Ground Ambulance Indemnity Benefit in the amount shown on the Insured Schedule, limited to four ground ambulance trips in a Policy Year.

This benefit will not be payable for any ambulance trip that is taken for the purpose of convenience.

PRESCRIPTION INDEMNITY BENEFIT

If a Covered Person, while this Policy is in force, purchases a Prescription Drug as the result of an Injury or Sickness, we will pay the Benefit Per Prescription in the amount shown on the Insured Schedule for each such Prescription Drug. The maximum benefit we will pay for all Prescription Drugs in a Policy Year is limited to the Maximum Aggregate Prescription Drug Indemnity Benefit shown on the Insured Schedule. For purposes of this benefit, "Prescription Drug" means a drug or medication which: (a) requires a prescription written by a Physician and (b) is dispensed by a licensed pharmacist.

BENEFITS (Continued)

PREVENTIVE CARE INDEMNITY BENEFITS

If a Covered Person, who meets the requirements specified below, while this Policy is in force, undergoes one or more of the following types of preventive care performed or directed by or under the supervision of a Physician, we will pay indemnity benefits as follows:

(a) **Colonoscopy Indemnity Benefit:** For a colonoscopy for a Covered Person who is age 50 or older, to screen for the presence of colon cancer, we will pay the Colonoscopy Indemnity Benefit in the amount shown on the Insured Schedule, limited to one screening colonoscopy every five Policy Years.

(b) **Mammogram Indemnity Benefit:** For a mammogram for a female Covered Person, we will pay the Mammogram Indemnity Benefit in the amount shown on the Insured Schedule, limited to:

(i) One baseline mammogram examination for each female Covered Person who is at least 35, but less than 40 years of age;

(ii) One mammogram examination every two Policy Years for each female Covered Person who is at least 40, but less than 50 years of age; and

(iii) One mammogram examination every Policy Year for each female Covered Person who is 50 years of age or older.

(c) **Pap Smear Indemnity Benefit:** For a Pap Smear for a female Covered Person, we will pay the Pap Smear Indemnity Benefit in the amount shown on the Insured Schedule, limited to one Pap Smear in a Policy Year. For purposes of this benefit, "Pap Smear" means an examination of the tissues of the cervix of the uterus for the purpose of detecting cancer when performed upon the recommendation of a Physician.

(d) **Diabetes Testing Indemnity Benefit:** For a blood test for diabetes, we will pay the Diabetes Testing Indemnity Benefit in the amount shown on the Insured Schedule, limited to one blood test for diabetes in a Policy Year.

(e) **Prostate Examination Indemnity Benefit:** For a Prostate Examination for a male Covered Person who is age 50 or older, we will pay the Prostate Examination Indemnity Benefit in the amount shown on the Insured Schedule, limited to one Prostate Examination in a Policy Year. For purposes of this benefit, "Prostate Examination" means a digital rectal examination and prostate specific antigen (PSA) test for the purpose of detecting prostate cancer when performed upon the recommendation of a Physician.

LIMITATION

This Policy does not pay any benefit for any diagnosis or treatment of a Covered Person he/she is confined as an inpatient of a Hospital.

EXCLUSIONS

This Policy does not cover any Loss 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 this 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; (d) intoxication, alcoholism or alcohol related illnesses; (e) mental illness, nervous or emotional disorders; (f) 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; (g) 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 an insured 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; (h) pregnancy or conditions due to pregnancy, **except** that complications of pregnancy shall be covered as any other Sickness; (i) childbirth; (j) participation in a felony or attempted felony, riot or insurrection; (k) rest cures, custodial care and routine physical examinations, except as specifically provided herein; (l) surgical sterilization; (m) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet; (n) eye glasses, hearing aids and examination for the prescription or fitting thereof.

PRE-EXISTING CONDITIONS LIMITATION

Pre-Existing Conditions are not covered under this Policy until this Policy has been in force for a period of two years; provided, however, that no benefits whatsoever will be payable for Loss from any condition, either pre-existing or otherwise, which is completely excluded from coverage under this Policy by name or specific description on the date of the Loss.

PREMIUM PAYMENTS

(a) All premiums are payable in advance to the Company at its Home Office. The payment of any premium shall not maintain the insurance under any Policy in force beyond the day immediately preceding the due date of the next premium except as provided in the Grace Period provision.

(b) Premiums are subject to change. Premiums for this Policy are based on the attained age of each Covered Person, and 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, the Insured's state of residence and/or ZIP code. Any change will apply to future premiums for all policies with the same form number issued by us to individuals in the Insured's state of residence. We will give the Insured 31 days written notice before any premium change. No change in premium will be effective before the first policy anniversary.

TERMINATION

Subject to the Grace Period provision, coverage will immediately terminate at 12:01 A.M., Standard Time, at the place where the Insured resides, on the due date of any premium which is not paid.

CONTINUATION OF COVERAGE UPON DIVORCE

If a Covered Person ceases to be covered under this Policy by reason of divorce, such Covered Person may continue his/her coverage under a separate policy identical to this Policy, subject to the following: (a) such Covered Person must give written notice to the Company within 30 days of such divorce of his/her desire to continue coverage; (b) the continuation policy will be issued without evidence of insurability; (c) the premium for the continuation policy will be no more than the premium that would be charged such Covered Person had the divorce not occurred; and (d) any waiting periods will be considered satisfied under the continuation policy to the extent satisfied under the Policy.

COVERAGE FOR SPOUSE AND DEPENDENT CHILDREN

Coverage will be provided for the Insured's spouse and/or dependent children (including adopted children) who are listed by name on the Insured Schedule; provided the applicable premium is paid. If the Insured's spouse and/or dependent children are not covered by this Policy such individual(s) may be added after the Effective Date by submitting a written application and paying the correct premium for his/her coverage. We must approve the application for his/her coverage to be effective.

A newborn child of the Insured is automatically covered for 90 days from the moment of birth. We must receive notice of birth and payment of the applicable premium within 90 days after the child's date of birth or before the next premium due date, whichever is later, in order to have the newborn's coverage continue beyond such 90-day period.

A newborn child adopted by the Insured is automatically covered for 60 days from the moment of birth if the petition for adoption is filed within 60 days after the child's date of birth. We must receive written notice of birth and payment of the applicable premium within 60 days after the child's date of birth in order to have the newborn adopted child's coverage continue beyond such 60-day period.

A child adopted by the Insured more than 60 days after the date of birth is automatically covered for 60 days from the date the petition for adoption is filed. We must receive written notice of the filing of the petition for adoption and payment of the applicable premium within 60 days after the date of placement in order to have the adopted child's coverage continue beyond such 60-day period.

For purposes of this provision, an adopted child includes a minor child under the charge, care and control of the insured, and for whom the Insured has filed a petition to adopt. The coverage of an adopted child will terminate upon the dismissal or denial of the petition for adoption.

RENEWAL SAFEGUARD

This Policy is renewable as follows:

- (a) The Company may not decline to renew this Policy except for one or both of the following reasons:
 - (1) Renewal premiums are declined on all policies bearing the same form number as this Policy issued to persons in the same state in which the Insured resides; or
 - (2) Failure to correctly report matters inquired of in the application for this Policy.
- (b) While this Policy is in effect, the Company shall not have the right to place any restrictive amendment hereon with respect to any coverage in effect hereunder. **There shall be no change in rate classification on account of any physical impairment of a Covered Person or on account of any claims under this Policy.**
- (c) The Company's right to refuse renewal, which is expressly reserved as set forth in (a) above, may be exercised by giving written notice, at least thirty (30) days prior to the expiration of the term for which premium has been paid, to the Insured by either delivery or by mailing to his last address as shown by the records of the Company when, not less than thirty (30) days thereafter, such refusal of renewal shall be effective.

UNIFORM PROVISIONS

1. ENTIRE CONTRACT; CHANGES: This Policy with any endorsements or attachments, is the entire contract of insurance. Only one of our executive officers can approve a change. Such approval must be endorsed on or attached to this Policy. It may not be changed in any way by any agent.

2. TIME LIMIT ON CERTAIN DEFENSES: (a) After three years from the Effective Date of this Policy, no misstatement of a Covered Person, except a fraudulent misstatement made in the application, shall be used to void this Policy. After three years from the Effective Date of the coverage with respect to any claim which is made, no misstatement of any Covered Person eligible for coverage under this Policy, except a fraudulent misstatement contained in a written instrument signed by a Covered Person, shall be used to deny a claim for Loss commencing after expiration of such three years. (b) No claim for Loss that starts after three years from the Effective Date of coverage will be reduced or denied because a Sickness or condition had existed before the Effective Date of coverage. This does not include diseases or physical conditions excluded specifically by name or description on an elimination endorsement or in the Exclusions provision.

UNIFORM PROVISIONS (Continued)

3. GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium falling due after the first premium. During the grace period, the Policy shall continue in force.

4. REINSTATEMENT: This Policy shall lapse if you do not pay the premium before the end of the grace period. If we or any agent authorized by us to accept premium later accepts premium and does not require an application for reinstatement, such acceptance shall reinstate this Policy. If we or such agent require an application for reinstatement and issue a conditional receipt for the premium tendered, this Policy shall be reinstated upon our approval of such application. If we do not approve it, this Policy shall be reinstated on the 45th day after such conditional receipt, unless we give you prior written notice of disapproval. The reinstated Policy shall cover only an Injury caused by an accident occurring after the date of reinstatement or a Sickness beginning more than 10 days from such date. In all other respects you and the Company shall have the same rights under this Policy as were in effect before it lapsed, unless special conditions are added in connection with the reinstatement. Premium accepted in connection with this provision shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement.

5. NOTICE OF CLAIM: You must give us written notice of claim. It must be given within 20 days after a covered Loss occurs or starts, or as soon as you reasonably can. You may give the notice or you may have someone do it for you. Such notice should give your name and Policy number. Notice should be mailed to us at our home office at 601 East Britton Road, Oklahoma City, Oklahoma 73114-7710, or to any authorized agent.

6. CLAIM FORMS: When we receive your notice, we will give or provide you forms for filing proof of Loss. If we do not give or provide them within 15 days, you can meet the proof of Loss requirement by giving us a written statement of what happened. This statement should include the type and extent of your Loss. We must receive this statement within the time given for filing proof of Loss.

7. PROOF OF LOSS: Written proof of Loss must be given within 90 days after such Loss. If it was not reasonably possible to give written proof in the time required, we shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity, the proof required must be given no later than one year from the time specified.

8. TIME OF PAYMENT OF CLAIMS: We will pay benefits immediately upon receipt of due written proof of Loss for benefits provided under this Policy. Any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of due written proof.

9. PAYMENT OF CLAIM: (a) Subject to the Direct Payment of Medical Services provision, benefits will be paid to you. Loss-of-life benefits, if any, are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to your estate. Any other benefits unpaid at death may be paid, at our option, either to your beneficiary or estate. (b) If benefits are payable to your estate or a beneficiary who cannot execute a valid release, we can pay benefits up to \$1,000 to someone related to you or your 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.

10. PHYSICAL EXAMINATION: We, at our expense, may have you examined when and as often as we may reasonably require while a claim is pending.

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

12. CHANGE OF BENEFICIARY: Unless you make an irrevocable designation of beneficiary, only you shall have the right to change the beneficiary. Consent of the beneficiary shall not be required to make any change in this Policy. Also, no such consent shall be required for surrender or assignment of this Policy.

13. CANCELLATION: This Policy may not be cancelled by the Company, nor by you, during a period for which premium has been paid and officially accepted by the Company. The Company may not decline to renew this Policy, except as provided in the Termination provision or the Renewal Safeguard provision.

POLICY PROVISIONS

- 1. MISSTATEMENT OF AGE:** If the age of a Covered Person has been misstated, all benefits payable to that person shall be in the amount the premiums paid would have purchased at the correct age.
- 2. UNPAID PREMIUM:** Any due and unpaid premium for this Policy may be deducted from its benefits then payable.
- 3. ILLEGAL OCCUPATION:** We shall not be liable for any Loss to which a contributing cause was your commission or attempt to commit a felony. We shall not be liable for any Loss to which a contributing cause was your participation in an illegal occupation or illegal activity.
- 4. INTOXICANTS AND NARCOTICS:** We shall not be liable for any Loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic, unless administered on the advice of a physician.
- 5. CONFORMITY WITH STATE STATUTES:** The provisions of this Policy must conform with the laws of the state in which you reside on the date of issue. If any do not, they are hereby amended to conform.
- 6. DIRECT PAYMENT OF MEDICAL SERVICES:** Subject to any written direction of the Insured, the indemnities provided hereunder on account of medical services will be paid directly to the Insured.
- 7. ALTERNATIVE DISPUTE RESOLUTION:** (a) If a dispute arises between a Covered Person and the Company concerning the payment or non-payment of benefits under this Policy, either party may request that the dispute be referred to mediation. Such a request must be submitted to the other party in writing and must include a description of the issue(s) in dispute. The parties will then contact the American Arbitration Association, which will appoint a mediator who is experienced in resolving health insurance disputes. (b) If the decision of the mediator is in favor of the Covered Person, the Company will accept the decision and pay the cost of the mediator and any experts he/she consults with. (c) If the decision of the mediator is in favor of the Company, the Company will pay the cost of the mediator and any experts he/she consults with. (d) This provision will not affect any right of a Covered Person under the Legal Actions provision of this Policy or applicable law.
- 8. INDEPENDENT, NONCOORDINATED FIXED DOLLAR BENEFITS PAYABLE REGARDLESS OF EXPENSES INCURRED:** Each benefit under this Policy is a fixed dollar amount that is payable regardless of the amount of expenses incurred. Each benefit under this Policy is independent of and is not coordinated with the benefits, exclusions or any other provision of any other health insurance coverage or health plan. Each benefit under this Policy is payable with respect to an event without regard to whether benefits are provided with respect to the same event under any other health insurance coverage or health plan. Benefits payable under this Policy will not be reduced on account of any other health insurance coverage or health plan.
- 9. REFUND OF UNEARNED PREMIUM UPON DEATH OF COVERED PERSON:** In the event of a Covered Person's death, any benefits payable to his/her estate shall include any premium paid for any period beyond the date of such Covered Person's death. Said unearned premium shall be paid in a lump sum within 30 days following our receipt of due written proof of death.
- 10. RIDERS OR ENDORSEMENTS:** Except for riders or endorsements which effectuate a request made in writing by you or exercises a specifically reserved right under this Policy, all riders or endorsements added to this Policy after the date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage shall require signed acceptance by you. After the date of Policy issue, any rider or endorsement which increases benefits or coverage with a corresponding increase in premium during the Policy term must be agreed to in writing signed by you, except if the increased benefits or coverage is required by law.

IN WITNESS WHEREOF, Reserve National Insurance Company has caused this Policy to be issued as of the effective date, and to be executed by its President and Secretary at its Home Office at 601 East Britton Road, in the City of Oklahoma City, Oklahoma.


Secretary


President

RESERVE NATIONAL INSURANCE COMPANY
OKLAHOMA CITY, OKLAHOMA

EXISTING CONDITION BENEFIT ENDORSEMENT

Reserve National Insurance Company, in consideration of the payment of the additional premium which has been included in the premium shown in the schedule of the Policy to which this Endorsement is attached, agrees to provide, subject to the hereafter described waiting period, the benefits set forth in the Policy for the following conditions which have manifested themselves to the Covered Person prior to the Effective Date hereof: [February 1, 2012]

Name of Covered Person: [JOHN DOE]

Condition(s): [Diabetes, including any complications thereof.]

WAITING PERIOD: No benefit shall be paid prior to the expiration of 12 months from the Effective Date of this Endorsement as a result of the above-listed condition(s).

All the provisions, conditions and limitations of the Policy to which this Endorsement is attached which are not modified hereby and which are not in conflict herewith shall be applicable to this Endorsement.

IN WITNESS WHEREOF, RESERVE NATIONAL INSURANCE COMPANY has caused this Endorsement to be executed by its President to be effective on the date listed above.


Secretary


President

RESERVE NATIONAL INSURANCE COMPANY
OKLAHOMA CITY, OKLAHOMA

Policy No. [00-00-000000]

Effective Date Endor. [February 1, 2012]

ELIMINATION RIDER

This Policy is attached to and made a part of the above numbered Policy and shall be effective as shown above.

With respect to **[JANE DOE]** named as a Covered
Person hereunder, this Policy is hereby amended to exclude benefits for:

[Pneumonia and/or any disease of the respiratory tract,
including any complications thereof.]

IN WITNESS WHEREOF, **RESERVE NATIONAL INSURANCE CO.** has issued this Policy.


Secretary


President

**ENDORSEMENT(S), IF ANY, AND PHOTOCOPY OF THE APPLICATION
ATTACHED HERETO CONSTITUTE PART OF THE CONTRACT**

THIS SPACE INTENTIONALLY LEFT BLANK



601 East Britton Road ▪ Oklahoma City, OK 73114

SUPPLEMENTAL OUTPATIENT FIXED INDEMNITY POLICY

**This Policy provides fixed indemnity benefit amounts
for covered outpatient treatment
of a Covered Person's Injury or Sickness.**

Read it carefully with the outline of coverage.

AGENT CODE _____
MGR CODE _____

POLICY NUMBER(S): _____

EFFECTIVE DATE
Month _____ Day _____ Year _____

1. Full Name of Each Applicant

1	2	3	4	First	Middle Initial	Last	Social Security No.	Relation To Proposed Insured	BIRTH DATE			Age	Ht.	Wt.	Sex	
									Mo.	Day	Yr.					
1																
2																
3																
4																

Specified Disease Policy SD-1
 Scheduled Benefit Hospital, Medical, Surgical Expense Policy PS-1

Deductible \$	Daily Room Max. \$	Hospital Misc. Max. \$	Surgery Sch.*
Basic			
App't#	Mthly. Rt.	List Endorsements & Rates	PEB Table
1			
2			
3			
4			
*See the Policy for details.			Total _____

Fixed Indemnity Policy ACS-1 Surgery Schedule* _____
Qualifying Period Before Daily Hospital Indemnity Payable: _____ Days
Daily Hospital Indemnity Amount First 5 Days _____

Scheduled Benefit Accident-Only Policy SA-1
Deductible \$ _____ Daily Room Max. \$ _____

Basic	List Endorsements & Rates	PEB	Total Monthly
App't#	Mthly. Rt.	Table	Premium
1			
2			
3			
4			
*See the Policy for details.			Total _____

Accident Policy
 AP-79 AP-02-79
 AP-91 AP-91-70

App't #	Total Monthly Prem.
1	_____
2	_____
3	_____
4	_____
Total	_____

Dental/Vision Expense Policy
Pol. Yr. Ded. \$ _____
Pol. Yr. Max. \$ _____

App't #	Total Monthly Prem.
1	_____
2	_____
3	_____
4	_____
Total	_____

First Diagnosis Heart Attack / First Major Heart Surgery Indemnity Policy HRT-98
First Diagnosis Heart Attack Benefit (after 30 days) \$ _____
First Major Heart Surgery Benefit (after 30 days) \$ _____

App't #	Total Monthly Prem.	PEB Table
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____
Total	_____	_____

Supplemental Outpatient Policy
 OS-99 OP-2000 Deductible \$ _____
 OP-1 Option 1 _____ Option 2 _____

Basic	List Endorsements & Rates	PEB	Total Monthly
App't#	Mthly. Rt.	Table	Premium
1			
2			
3			
4			
Total			_____

Fixed Indemnity Policy SIP-1* Surgery Schedule** _____
 Hospital Indemnity Policy HDI **See the Policy for details.
Daily Indemnity Amount First 10 Days _____ Next 21 Days _____

Basic	List Endorsements & Rates	PEB	Total Monthly
App't#	Mthly. Rt.	Table	Premium
1			
2			
3			
4			
*Elimination Period Before Daily Indemnity is Payable: _____ Days			Total _____

Home Health Care Indemnity Policy HHC-95

Basic	List Endorsements & Rates	Total Monthly
App't#	Mthly. Rt.	Premium
1		
2		
3		
4		
Total		_____

Cancer Policy
 CFO-95-First Occurrence Cancer Benefit After 180 Days \$ _____
 CC-74 CC-91
App't # | Total Monthly Prem.

1	_____
2	_____
3	_____
4	_____
Total	_____

Cancer Policy ICD-2000
Daily Benefit: First 300 Days _____
Next 200 Days _____

App't #	Total Monthly Prem.
1	_____
2	_____
3	_____
4	_____
Total	_____

Critical Illness and Accidental Death Indemnity Policy CRI
Benefit for 1st Diagnosis Covered Critical Illness (after 180 days)/Accidental Death \$ _____

App't #	Total Monthly Prem.	PEB Table
1	_____	_____
Total		_____

Note: One applicant per policy for CRI.

2. Residence of Proposed Insured _____
Street No. / Rural Route and/or Box Number City State Zip Code

2.(a) Mailing Address of Proposed Insured, if different from above _____

3. Residence Telephone No. area code (_____) No: _____ Business or alternate area code (_____) No: _____

3.(a) E-mail address _____ 3.(b) Name, Address and Telephone No. of payor, if different from above _____

3.(c) Each Applicant's State of Birth _____

4.(a) Proposed Insured's Occupation(s) (state duties) _____ (b) Spouse's Occupation(s) (state duties) _____

5. Full Name of Beneficiary(ies) and Relationship _____

Without a Beneficiary Designation, benefits that are not assigned shall be paid to the Proposed Insured first named above if living, otherwise to the deceased's estate.

6. If submitted for purposes other than a new insurance application, please indicate: Policy Change Conversion Reinstatement:
Policy(ies) Number(s) _____ What benefit(s) are being requested? _____

7. Does any applicant have any Medicare supplement, hospital, medical or surgical insurance in force at the time of this application?
 Yes No If yes, which applicant(s) and details? _____

8. Does any applicant intend the replacement or change of any of his/her existing insurance policy(ies) in connection with this application for insurance? Yes No If yes, which applicant(s), company and amount? _____
(Complete replacement of insurance form.)

9. Has any applicant used any form of tobacco within the past year? Yes No Within the past 3 years? Yes No
If either are yes, which applicant(s)? _____

10. Does any applicant participate or contemplate participating in any type of aviation, other than as a passenger on a regularly scheduled airline? Yes No If yes, which applicant(s) and details? _____

11. In the last 5 years has any applicant participated in or does any applicant contemplate participating in any motorized vehicle racing, scuba or skin diving, sky diving, hang gliding, mountain climbing, rodeos, cliff diving, ballooning, parasailing and/or any professional or semi-professional athletics? Yes No Which applicant(s) and details? _____

12. Has any applicant been convicted of a felony or had his or her drivers license suspended or revoked? Yes No Which applicant(s) and details? _____

13. In the last 5 years, has any applicant had life, disability or health insurance declined, rated, modified, cancelled or not renewed?
 Yes No If yes, which applicant(s) and details? _____

14. Has any applicant ever requested or received a pension, benefits or payment because of an injury, sickness or disability?
 Yes No If yes, which applicant(s) and details? _____

15. Has any applicant applied for or is any applicant currently receiving Social Security disability benefits? Yes No If yes, which applicant(s) and details? _____

16. Does any applicant use a catheter, oxygen, respirator, dialysis machine, walker, wheelchair or similar medical equipment or appliance? Yes No If yes, which applicant(s) and details? _____

17. Is any applicant using any medication or drugs? Yes No If yes, which applicant(s) and name of medication? _____

18. Does any applicant currently have a dental crown or bridge, or wear dentures? Yes No If yes, which applicant(s) _____

19. Has any applicant been advised to have any dental work which has not been completed? Yes No If yes, which applicant(s) and details? _____

20. Does any applicant currently wear eyeglasses or contact lenses? Yes No If yes, which applicant(s) and details? _____

HAVE YOU, OR ANY APPLICANT, EVER HAD OR BEEN TOLD THAT YOU HAD, OR BEEN TREATED BY A PHYSICIAN OR OTHER PRACTITIONER FOR ANY OF THE FOLLOWING? (If "YES" circle the condition(s).)

21. Disorder of eyes, ears, nose, throat or glands?.... Yes No

22. Dizzy or fainting spells, seizures or convulsions or recurrent headache?..... Yes No

23. Paralysis, transient ischemic attack, stroke, cerebrovascular disease or insufficiency or hemorrhage, or any residuals thereof?.. Yes No

24. Mental, nervous, psychiatric disorder? Yes No

25. Senility disorder, Alzheimer's disease, organic brain syndrome or disorder, cerebral palsy, muscular dystrophy, multiple sclerosis, Lou Gehrig's disease, neurologic or muscular wasting disease?..... Yes No

26. Persistent shortness of breath, cough, blood spitting, bronchitis, asthma, allergies, emphysema, tuberculosis, pneumonia or other

lung or respiratory disorder(s)?..... Yes No
27. Chest pain, discomfort or tightness, any heartbeat abnormality, abnormal EKG, rheumatic fever, heart murmur, heart attack or other disorder of the heart?..... Yes No
28. Hypertension, high blood pressure, high cholesterol, carotid artery disease, coronary artery disorder, blood clot(s) or any other disorder of blood vessels?..... Yes No
29. Has any applicant been advised by a physician or other practitioner to have any form of heart surgery, coronary artery surgery, arteriogram, angioplasty or pacemaker?..... Yes No
30. Jaundice, intestinal bleeding, ulcer, hernia, colitis, diverticulitis, recurrent indigestion, esophageal reflux, or other disorder of the stomach, intestines, liver, hepatitis type B or C, gall bladder, pancreas or hemorrhoids?..... Yes No
31. Sugar or blood in urine, end stage renal failure, stone or other disorder of kidney, bladder, prostate or reproductive organs?..... Yes No
32. Diabetes or high blood sugar?..... Yes No
 If yes, which applicant(s) and age of onset? _____

33. Thyroid or other endocrine disorders?..... Yes No
34. Neuritis, sciatica, rheumatism, arthritis, gout, osteoporosis, or disorder of the muscles, ligaments, bones or joints, spine, back or disk disorder?..... Yes No
35. Deformity, lameness, amputation or disabling injury?..... Yes No
36. Disorder of the skin?..... Yes No
37. Disorder of the lymph glands, unexplained fevers, cyst, tumor, cancer (including leukemia, Hodgkin's disease or lymphoma) or malignant neoplasm?..... Yes No
38. Anemia, polycythemia vera, thrombocytopenia or other disorder of the blood?..... Yes No
39. Have you or any applicant ever been diagnosed as having or been treated for AIDS, ARC (AIDS Related Complex), HIV or other immune deficiency disorder or test results indicating exposure to

the AIDS virus?..... Yes No
40. Any sexually transmitted disease including syphilis, gonorrhea herpes, chlamydia or condyloma acuminata (anal or genital warts)?..... Yes No
41. Has any applicant sought or received advice or treatment for use of alcohol or drugs?..... Yes No
42. Has any female ever had any disorder or complications of menstruation, pregnancy, childbirth, the female organs or breasts?..... Yes No
43. Is any applicant now pregnant?..... Yes No
44. Is any male applicant an expectant parent or in the process of adopting?..... Yes No
45. Other than above, in the last 5 years, has any applicant been examined, advised or treated by any physician or practitioner?..... Yes No
46. In the last 5 years, has any applicant been a patient in a hospital, clinic, psychiatric clinic or other medical facility?..... Yes No
47. Has any applicant ever had an EKG, X-ray, CT scan, MRI or other test (other than for AIDS or HIV)?..... Yes No
48. Has any applicant lost or gained weight in the past 12 months?..... Yes No
 If yes, state amount and cause of loss or gain and indicate which applicant(s)_____

49. Has any applicant been advised not to donate or been refused to donate blood?..... Yes No
 If yes, which applicant(s) and explain why and by whom below.
50. Has any applicant ever had or been advised by a physician or other practitioner to have any type of organ transplant? Yes No
51. Other than above, in the last 5 years, has any applicant had any mental or physical disorder, checkup, consultation, illness, injury, surgery, been a patient in a hospital, clinic, sanatorium or other similar facility or been advised to have any hospitalization, surgery, biopsy, testing or treatment which was not completed, or had any departures from good health not mentioned above? Yes No
 If yes, give full details in Question #52 below.

52. EXPLAIN YES ANSWERS TO QUESTIONS 21-51. (Attach additional page(s) if needed.)

Applicant No.	Disease or Ailment	Treatment Received	Dates Treated For	Present Status of Ailment	Full Name and Address of Attending Physician

Personal Physician _____ Medical Designation _____ Phone Number (____) _____
 Address _____ City _____ State _____ Zip Code _____

(Continue explanations at top of next page if necessary)

UAP-1 AR (10/11)

To enroll in the E-Z Way pre-authorized payment plan for renewal premiums, check the monthly or quarterly payment box, sign and date the authorization, and return with a voided personal check. Not available for initial premium.

Through the E-Z Way plan, your bank will pay your future **renewal** premiums from your checking account. The E-Z Way plan will eliminate the necessity of writing a check.

To take advantage of this convenient plan, simply complete the right-side portion of this form. On your next billing date, the premium will be paid by your bank. The payment will be reflected in your bank statement.

**THE E-Z WAY PLAN AUTHORIZATION
TO RESERVE NATIONAL INSURANCE COMPANY**

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks or credits on my account by and payable to Reserve National Insurance Company, Oklahoma City, Oklahoma, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or credit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or credit. I further agree that if any such check or credit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

MONTHLY PAYMENT or **QUARTERLY PAYMENT**

_____ X _____
 Date Your signature EXACTLY as it appears on Bank Records



FOR HOME OFFICE USE

IT IS AGREED THAT ALL STATEMENTS AND ANSWERS CONTAINED IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE AS WRITTEN AND ARE CORRECTLY RECORDED, ARE STATEMENTS AND NOT WARRANTIES, AND THAT: 1. This application and any supplements thereto shall form the basis for and be a part of any insurance issued, and that all statements and answers in this application and any supplements are complete and true to the best of applicant's knowledge and belief. 2. The insurance applied for in this application shall not be considered in force until issued by the Company and the first premium paid. The Company shall have 60 days from the date signed in which to consider and act upon this application which the parties agree is a reasonable time. If within such period insurance has not been received by the applicant, or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company and the Company will return any premium tendered herewith. In connection with an application for insurance currently made to Reserve National Insurance Company, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy related service organization, or other medical or medically related facility, insurance company or MIB, Inc. ("MIB"), that has any health or medical records or knowledge concerning me or any of the members of my family named in said application, to disclose to the Company or its reinsurers any such information upon presentation of this authorization or reproduction thereof.

I understand that (a) an investigative consumer report may be obtained as to my insurability, including, if applicable, information as to character, general reputation, personal characteristics and mode of living; (b) this information will be obtained through personal interviews with my friends, neighbors and associates; and (c) additional information as to the nature and scope of any investigation requested will be furnished to me upon my written request made within a reasonable time after this application is completed. This authorization shall remain valid for a period of 24 months from the date hereof. I understand that I may revoke this authorization at any time by mailing written notice thereof to the Company at 601 East Britton Road, Oklahoma City, OK 73114.

I have paid to Reserve National Insurance Company the sum of \$ _____ which is a Monthly Quarterly Semi-Annual Annual premium, and I hold a receipt for that amount made up without alteration bearing the same date as this application.

If accepted by the Company the applicant requests coverage to be effective: A. Date of application, applicable only on quarterly or longer modes. B. Date of issue C. Other _____

SEND POLICY TO APPLICANT OR AGENT TO DELIVER.

I acknowledge receipt of an outline of coverage for which this application is made..... Yes No

I am 65 years old or older, or eligible for Medicare, and acknowledge receipt of a "Guide to Health Insurance for People with Medicare."..... Yes No

NOTICE: The proposed insured certifies that no person to be covered under the policy applied for is covered by Medicaid or any other Title XIX program. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SPECIAL NOTICE: I UNDERSTAND THAT THE RESERVE NATIONAL INSURANCE COMPANY POLICY I HAVE APPLIED FOR IS NOT DESIGNED TO COVER ALL MEDICAL EXPENSES. IT CONTAINS LIMITS ON THE AMOUNT OF BENEFITS PAYABLE. IT IS NOT CONSIDERED MAJOR MEDICAL COVERAGE BECAUSE OF THESE LIMITS.

Town and State where signed _____ this _____ day of _____, _____.

Signature of Owner (if other than Proposed Insured)

Signature of Proposed Insured/Applicant

The undersigned agent (a) represents Reserve National Insurance Company in connection with the insurance applied for; (b) will receive compensation from the Company if coverage is issued; and (c) may provide services to policyholders on behalf of the Company, subject to the Company's approval. The agent does not have authority to bind the Company.

I certify that I asked each question of the applicant personally and the answers have been accurately recorded hereon. _____

UAP-1 AR (10/11)

Signature of Agent



Another easy way to pay your premium is with your VISA, Mastercard or DISCOVER card.

Please charge to my:



ACCOUNT# AS SHOWN ON CARD

____-____-____-____

EXPIRATION DATE _____

PLEASE SELECT

Please charge my credit card for the initial premium.

Please charge my credit card for all future renewal premiums. I understand this authorization will remain in effect until revoked by me or until my credit card expires: Monthly Payment Quarterly Payment

Amount authorized \$ _____

AUTHORIZED SIGNATURE _____ (PLEASE SIGN HERE)

NAME OF CARDHOLDER _____ (PLEASE PRINT NAME AS SHOWN ON CARD)

DATE AUTHORIZED _____



THIS IS A SUPPLEMENTAL OUTPATIENT FIXED INDEMNITY POLICY. IT PROVIDES STATED BENEFIT AMOUNTS IN EACH POLICY YEAR WITHOUT REGARD TO THE AMOUNT OF EXPENSES INCURRED.

OUTLINE OF COVERAGE FOR SUPPLEMENTAL FIXED INDEMNITY POLICY FORM OP-1

Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of Supplemental Outpatient Fixed Indemnity Policy Form OP-1. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and Reserve National Insurance Company. It is therefore important that you **Read Your Policy Carefully!**

Supplemental Outpatient Fixed Indemnity Coverage is designed to provide coverage in the form of a stated indemnity benefit for covered outpatient treatment of a covered Injury or Sickness, subject to all the Policy's conditions, limitations and exclusions. Coverage is not provided for any benefits other than the fixed indemnity benefits described below. **THIS IS A LIMITED POLICY. THIS IS NOT MAJOR MEDICAL COVERAGE.**

Benefits, days or visits not used in one Policy Year are not carried forward to any future Policy Year.

I. BENEFITS

(1) Outpatient X-Rays and Lab Tests Indemnity Benefit: If a Covered Person undergoes an Outpatient X-Ray, MRI, CT Scan or a lab test performed or directed by or under the supervision of a Physician as the result of an Injury or Sickness, we will pay indemnity benefits as follows, **limited to the Maximum Aggregate Outpatient X-Rays, and Lab Test Indemnity Benefit of \$2,000.00 for all Outpatient X-Rays, MRIs, CT Scans and lab tests in a Policy Year:**

- (a) X-Rays:** We will pay **\$75.00** for each X-Ray.
- (b) MRIs and CT Scans:** We will pay **\$750.00** for each MRI or CT Scan.
- (c) Lab Tests:** We will pay **\$50.00** for each lab test.

(2) Outpatient Doctor Visits Indemnity Benefit: If a Covered Person receives personal treatment by a Physician in the Physician's office or a clinic, as the result of an Injury or Sickness or for a routine examination, we will pay the Outpatient Doctor Visits Indemnity Benefit of **\$50.00** per visit, **limited to 1 visit per day and 4 visits in a Policy Year.**

(3) Emergency Room Indemnity Benefit: If a Covered Person receives personal treatment by a Physician in a Hospital emergency room as the result of an Injury or Sickness, we will pay the Emergency Room Indemnity Benefit of **\$500.00, limited to 1 visit in a Policy Year.**

(4) Ambulance Indemnity Benefit: If a Covered Person is transported to or from a Hospital as a result of an Injury or Sickness, we will pay the applicable benefit as follows:

- (a) Air Ambulance:** We will pay **\$1,500.00** for air transportation by a licensed ambulance service, **limited to 2 air ambulance trips per Policy Year.**
- (b) Ground Ambulance:** We will pay **\$500.00** for ground transportation by a licensed ambulance service, **limited to 4 ground ambulance trips per Policy Year.**

(5) Prescription Indemnity Benefit: If a Covered Person purchases a Prescription Drug as the result of an Injury or Sickness, we will pay **\$25.00** for each Prescription Drug, **limited to the Maximum Aggregate Prescription Drug Indemnity Benefit of \$500.00 for all Prescription Drugs in a Policy Year.**

(6) Preventive Care Indemnity Benefits: If a Covered Person, who meets the **requirements specified in the Policy**, undergoes one or more of the following types of preventive care performed or directed by or under the supervision of a Physician, we will pay indemnity benefits as follows:

(a) Colonoscopy Indemnity Benefit: For a colonoscopy for a Covered Person who is age 50 or older, to screen for the presence of colon cancer, we will pay the Colonoscopy Indemnity Benefit of **\$500.00, limited to 1 screening colonoscopy every 5 Policy Years.**

(b) Mammogram Indemnity Benefit: For a mammogram for a female Covered Person age 35 or older, and at age intervals specified in the Policy, we will pay the Mammogram Indemnity Benefit of **\$125.00.** See the Policy for details.

(c) Pap Smear Indemnity Benefit: For a Pap Smear for a female Covered Person, we will pay the Pap Smear Indemnity Benefit of **\$100.00, limited to 1 Pap Smear in a Policy Year.**

(d) Diabetes Testing Indemnity Benefit: For a blood test for diabetes, we will pay the Diabetes Testing Indemnity Benefit of **\$50.00, limited to 1 such blood test for diabetes in a Policy Year.**

(e) Prostate Examination Indemnity Benefit: For a Prostate Examination for a male Covered Person who is age 50 or older, we will pay the Prostate Cancer Examination Indemnity Benefit of **\$75.00, limited to 1 Prostate Examination in a Policy Year.**

II. EXCLUSIONS: The Policy does not pay benefits for any Loss 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; (d) intoxication, alcoholism or alcohol related illnesses; (e) mental illness, nervous or emotional disorders; (f) 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; (g) 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 an insured 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; (h) pregnancy or conditions due to pregnancy, **except** that complications of pregnancy shall be covered as any other Sickness; (i) childbirth; (j) participation in a felony or attempted felony, riot or insurrection; (k) rest cures, custodial care, and routine physical examinations, except as specifically provided; (l) surgical sterilization; (m) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet; (n) eye glasses, hearing aids and examination for the prescription or fitting thereof.

III. PRE-EXISTING CONDITIONS LIMITATION: Pre-Existing Conditions are not covered under the Policy until the Policy has been in force for a period of two years; provided, however, that no benefits whatsoever will be payable for Loss from any condition, either pre-existing or otherwise, which is completely excluded from coverage under the Policy by name or specific description on the date of Loss. "Pre-Existing Condition" means a condition that has been diagnosed, or has manifested itself to you within the five-year period immediately preceding the Effective Date of the 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 the Policy.

Coverage for some pre-existing conditions may be included after 12 months for an additional premium payable during the lifetime of your Policy by attachment of the PEB-3 (1/11) endorsement.

IV. _____ (applicant's initials to select) EXISTING CONDITION BENEFIT ENDORSEMENT PEB-3 (1/11): Pre-Existing Conditions disclosed on the application and listed on endorsement Form PEB-3 (1/11) will be covered after 12 months.

V. TERMINATION: Subject to the Policy's Grace Period provision, coverage will immediately terminate at 12:01 A.M., Standard Time, at the place where the Insured resides, on the due date of any premium which is not paid.

VI. RENEWAL SAFEGUARD: The Policy is renewable as follows:

(a) Subject to the Termination provisions of the Policy, we may not decline to renew the Policy except for one or both of the following reasons:

- (1) Renewal premiums are declined on all policies bearing the same form number as the Policy issued to persons in the state where you reside; or
- (2) Failure to correctly report matters inquired of in the application for the Policy.

(b) While the Policy is in effect, we shall not have the right to add any restrictive amendment. There shall be no change in rate classification on account of any physical impairment or on account of any claims incurred.

VII. PREMIUM PAYMENTS/PREMIUMS SUBJECT TO CHANGE:

(a) You have a grace period of 31 days for the payment of each premium which becomes due after the first premium. During this grace period the Policy will continue in force.

(b) Premiums are subject to change. Premiums are based on the attained age of each Covered Person, and 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, the insured's state of residence and/or ZIP code. We will give you 31 days written notice before any such premium change.

THIS IS A LIMITED POLICY.
IT PROVIDES ONLY THE FIXED INDEMNITY BENEFITS DESCRIBED ABOVE.

READ THE POLICY CAREFULLY WITH THIS OUTLINE OF COVERAGE.

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:

- **Form OP-1 provides limited benefits; it is not a major medical policy and is not designed to cover all medical expenses.**
- **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

This Outline of Coverage is to be delivered to the applicant at the time the application for insurance is completed. Supplemental Outpatient Fixed Indemnity Policy Form OP-1 is individually underwritten by Reserve National Insurance Company.



THIS IS A SUPPLEMENTAL OUTPATIENT FIXED INDEMNITY POLICY. IT PROVIDES STATED BENEFIT AMOUNTS IN EACH POLICY YEAR WITHOUT REGARD TO THE AMOUNT OF EXPENSES INCURRED.

OUTLINE OF COVERAGE FOR SUPPLEMENTAL FIXED INDEMNITY POLICY FORM OP-1

Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of Supplemental Outpatient Fixed Indemnity Policy Form OP-1. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and Reserve National Insurance Company. It is therefore important that you **Read Your Policy Carefully!**

Supplemental Outpatient Fixed Indemnity Coverage is designed to provide coverage in the form of a stated indemnity benefit for covered outpatient treatment of a covered Injury or Sickness, subject to all the Policy's conditions, limitations and exclusions. Coverage is not provided for any benefits other than the fixed indemnity benefits described below. **THIS IS A LIMITED POLICY. THIS IS NOT MAJOR MEDICAL COVERAGE.**

Benefits, days or visits not used in one Policy Year are not carried forward to any future Policy Year.

I. BENEFITS

(1) Outpatient X-Rays and Lab Tests Indemnity Benefit: If a Covered Person undergoes an Outpatient X-Ray, MRI, CT Scan or a lab test performed or directed by or under the supervision of a Physician as the result of an Injury or Sickness, we will pay indemnity benefits as follows, **limited to the Maximum Aggregate Outpatient X-Rays, and Lab Test Indemnity Benefit of \$1,000.00 for all Outpatient X-Rays, MRIs, CT Scans and lab tests in a Policy Year:**

- (a) X-Rays:** We will pay **\$50.00** for each X-Ray.
- (b) MRIs and CT Scans:** We will pay **\$500.00** for each MRI or CT Scan.
- (c) Lab Tests:** We will pay **\$25.00** for each lab test.

(2) Outpatient Doctor Visits Indemnity Benefit: If a Covered Person receives personal treatment by a Physician in the Physician's office or a clinic, as the result of an Injury or Sickness or for a routine examination, we will pay the Outpatient Doctor Visits Indemnity Benefit of **\$25.00** per visit, **limited to 1 visit per day and 4 visits in a Policy Year.**

(3) Emergency Room Indemnity Benefit: If a Covered Person receives personal treatment by a Physician in a Hospital emergency room as the result of an Injury or Sickness, we will pay the Emergency Room Indemnity Benefit of **\$300.00, limited to 1 visit in a Policy Year.**

(4) Ambulance Indemnity Benefit: If a Covered Person is transported to or from a Hospital as a result of an Injury or Sickness, we will pay the applicable benefit as follows:

- (a) Air Ambulance:** We will pay **\$1,500.00** for air transportation by a licensed ambulance service, **limited to 2 air ambulance trips per Policy Year.**
- (b) Ground Ambulance:** We will pay **\$250.00** for ground transportation by a licensed ambulance service, **limited to 4 ground ambulance trips per Policy Year.**

(5) Prescription Indemnity Benefit: If a Covered Person purchases a Prescription Drug as the result of an Injury or Sickness, we will pay **\$10.00** for each Prescription Drug, **limited to the Maximum Aggregate Prescription Drug Indemnity Benefit of \$250.00 for all Prescription Drugs in a Policy Year.**

(6) Preventive Care Indemnity Benefits: If a Covered Person, who meets the **requirements specified in the Policy**, undergoes one or more of the following types of preventive care performed or directed by or under the supervision of a Physician, we will pay indemnity benefits as follows:

(a) Colonoscopy Indemnity Benefit: For a colonoscopy for a Covered Person who is age 50 or older, to screen for the presence of colon cancer, we will pay the Colonoscopy Indemnity Benefit of **\$500.00, limited to 1 screening colonoscopy every 5 Policy Years.**

(b) Mammogram Indemnity Benefit: For a mammogram for a female Covered Person age 35 or older, and at age intervals specified in the Policy, we will pay the Mammogram Indemnity Benefit of **\$125.00.** See the Policy for details.

(c) Pap Smear Indemnity Benefit: For a Pap Smear for a female Covered Person, we will pay the Pap Smear Indemnity Benefit of **\$100.00, limited to 1 Pap Smear in a Policy Year.**

(d) Diabetes Testing Indemnity Benefit: For a blood test for diabetes, we will pay the Diabetes Testing Indemnity Benefit of **\$50.00, limited to 1 such blood test for diabetes in a Policy Year.**

(e) Prostate Examination Indemnity Benefit: For a Prostate Examination for a male Covered Person who is age 50 or older, we will pay the Prostate Cancer Examination Indemnity Benefit of **\$75.00, limited to 1 Prostate Examination in a Policy Year.**

II. EXCLUSIONS: The Policy does not pay benefits for any Loss 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; (d) intoxication, alcoholism or alcohol related illnesses; (e) mental illness, nervous or emotional disorders; (f) 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; (g) 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 an insured 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; (h) pregnancy or conditions due to pregnancy, **except** that complications of pregnancy shall be covered as any other Sickness; (i) childbirth; (j) participation in a felony or attempted felony, riot or insurrection; (k) rest cures, custodial care, and routine physical examinations, except as specifically provided; (l) surgical sterilization; (m) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet; (n) eye glasses, hearing aids and examination for the prescription or fitting thereof.

III. PRE-EXISTING CONDITIONS LIMITATION: Pre-Existing Conditions are not covered under the Policy until the Policy has been in force for a period of two years; provided, however, that no benefits whatsoever will be payable for Loss from any condition, either pre-existing or otherwise, which is completely excluded from coverage under the Policy by name or specific description on the date of Loss. "Pre-Existing Condition" means a condition that has been diagnosed, or has manifested itself to you within the five-year period immediately preceding the Effective Date of the 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 the Policy.

Coverage for some pre-existing conditions may be included after 12 months for an additional premium payable during the lifetime of your Policy by attachment of the PEB-3 (1/11) endorsement.

IV. _____ (applicant's initials to select) EXISTING CONDITION BENEFIT ENDORSEMENT PEB-3 (1/11): Pre-Existing Conditions disclosed on the application and listed on endorsement Form PEB-3 (1/11) will be covered after 12 months.

V. TERMINATION: Subject to the Policy's Grace Period provision, coverage will immediately terminate at 12:01 A.M., Standard Time, at the place where the Insured resides, on the due date of any premium which is not paid.

VI. RENEWAL SAFEGUARD: The Policy is renewable as follows:

(a) Subject to the Termination provisions of the Policy, we may not decline to renew the Policy except for one or both of the following reasons:

- (1) Renewal premiums are declined on all policies bearing the same form number as the Policy issued to persons in the state where you reside; or
- (2) Failure to correctly report matters inquired of in the application for the Policy.

(b) While the Policy is in effect, we shall not have the right to add any restrictive amendment. There shall be no change in rate classification on account of any physical impairment or on account of any claims incurred.

VII. PREMIUM PAYMENTS/PREMIUMS SUBJECT TO CHANGE:

(a) You have a grace period of 31 days for the payment of each premium which becomes due after the first premium. During this grace period the Policy will continue in force.

(b) Premiums are subject to change. Premiums are based on the attained age of each Covered Person, and 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, the insured's state of residence and/or ZIP code. We will give you 31 days written notice before any such premium change.

THIS IS A LIMITED POLICY.
IT PROVIDES ONLY THE FIXED INDEMNITY BENEFITS DESCRIBED ABOVE.

READ THE POLICY CAREFULLY WITH THIS OUTLINE OF COVERAGE.

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:

- **Form OP-1 provides limited benefits; it is not a major medical policy and is not designed to cover all medical expenses.**
- **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

This Outline of Coverage is to be delivered to the applicant at the time the application for insurance is completed. Supplemental Outpatient Fixed Indemnity Policy Form OP-1 is individually underwritten by Reserve National Insurance Company.

SERFF Tracking Number: RNIC-127966500 State: Arkansas
 Filing Company: Reserve National Insurance Company State Tracking Number:
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: OP-1 Supplemental Outpatient Fixed Indemnity Policy
 Project Name/Number: OP-1 Supplemental Outpatient Fixed Indemnity Policy/

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved Rates 01/13/2012		OP-1	New		OP-1 rates AR.pdf

**Reserve National Insurance Company
Out-of-Hospital Indemnity Policy
Policy Form – OP-1**

Attained Age	OP-1 - High option - Non-Tobacco				
	Bank Draft Rate	Regular Monthly Rate	Quarterly Rate	Semi-Annual Rate	Annual Rate
0-17	\$60.10	\$65.30	\$192.00	\$380.05	\$720.90
18-25	\$66.10	\$71.85	\$211.25	\$418.15	\$793.20
26-28	\$72.75	\$79.05	\$232.40	\$460.05	\$872.70
29-31	\$76.05	\$82.65	\$243.00	\$481.00	\$912.45
32-34	\$79.50	\$86.40	\$254.00	\$502.85	\$953.85
35-37	\$83.10	\$90.35	\$265.65	\$525.85	\$997.45
38-40	\$86.95	\$94.50	\$277.85	\$550.00	\$1,043.30
41-43	\$90.90	\$98.80	\$290.45	\$575.00	\$1,090.75
44-46	\$95.05	\$103.30	\$303.70	\$601.20	\$1,140.45
47-49	\$99.35	\$108.00	\$317.50	\$628.55	\$1,192.30
50-52	\$108.55	\$118.00	\$346.90	\$686.75	\$1,302.70
53-55	\$118.65	\$128.95	\$379.10	\$750.50	\$1,423.60
56-58	\$129.65	\$140.90	\$414.25	\$820.05	\$1,555.55
59-61	\$141.65	\$153.95	\$452.60	\$896.00	\$1,699.60
62-64	\$154.80	\$168.25	\$494.65	\$979.20	\$1,857.50
65-67	\$169.15	\$183.85	\$540.50	\$1,070.00	\$2,029.70
68-70	\$184.85	\$200.90	\$590.65	\$1,169.25	\$2,217.95
71-75	\$202.00	\$219.55	\$645.50	\$1,277.80	\$2,423.85
>75 *	\$202.00	\$219.55	\$645.50	\$1,277.80	\$2,423.85

Attained Age	OP-1 - High option - Tobacco				
	Bank Draft Rate	Regular Monthly Rate	Quarterly Rate	Semi-Annual Rate	Annual Rate
0-17	\$60.10	\$65.30	\$192.00	\$380.05	\$720.90
18-25	\$76.05	\$82.65	\$243.00	\$481.00	\$912.45
26-28	\$83.65	\$90.90	\$267.25	\$529.05	\$1,003.55
29-31	\$87.45	\$95.05	\$279.45	\$553.20	\$1,049.35
32-34	\$91.40	\$99.35	\$292.10	\$578.20	\$1,096.80
35-37	\$95.60	\$103.90	\$305.45	\$604.70	\$1,147.05
38-40	\$100.00	\$108.70	\$319.60	\$632.65	\$1,200.05
41-43	\$104.50	\$113.60	\$334.00	\$661.15	\$1,254.15
44-46	\$109.30	\$118.80	\$349.25	\$691.40	\$1,311.55
47-49	\$114.25	\$124.20	\$365.15	\$722.85	\$1,371.15
50-52	\$124.85	\$135.70	\$398.95	\$789.75	\$1,498.15
53-55	\$136.45	\$148.30	\$436.00	\$863.10	\$1,637.25
56-58	\$149.10	\$162.05	\$476.45	\$943.15	\$1,789.05
59-61	\$162.90	\$177.05	\$520.55	\$1,030.45	\$1,954.65
62-64	\$178.00	\$193.50	\$568.90	\$1,126.15	\$2,136.25
65-67	\$194.55	\$211.45	\$621.65	\$1,230.65	\$2,334.40
68-70	\$212.55	\$231.05	\$679.30	\$1,344.70	\$2,550.80
71-75	\$232.30	\$252.50	\$742.35	\$1,469.55	\$2,787.60
>75 *	\$232.30	\$252.50	\$742.35	\$1,469.55	\$2,787.60

* Renewal only

Reserve National Insurance Company
Out-of-Hospital Indemnity Policy
Policy Form – OP-1

Attained Age	OP-1 - Low option - Non-Tobacco				
	Bank Draft Rate	Regular Monthly Rate	Quarterly Rate	Semi-Annual Rate	Annual Rate
0-17	\$36.05	\$39.20	\$115.20	\$228.05	\$432.55
18-25	\$39.65	\$43.10	\$126.75	\$250.90	\$475.90
26-28	\$43.65	\$47.45	\$139.45	\$276.05	\$523.60
29-31	\$45.65	\$49.60	\$145.80	\$288.60	\$547.45
32-34	\$47.70	\$51.85	\$152.40	\$301.70	\$572.30
35-37	\$49.85	\$54.20	\$159.40	\$315.50	\$598.45
38-40	\$52.15	\$56.70	\$166.70	\$330.00	\$626.00
41-43	\$54.55	\$59.30	\$174.25	\$345.00	\$654.45
44-46	\$57.05	\$62.00	\$182.20	\$360.70	\$684.25
47-49	\$59.60	\$64.80	\$190.50	\$377.15	\$715.40
50-52	\$65.15	\$70.80	\$208.15	\$412.05	\$781.60
53-55	\$71.20	\$77.35	\$227.45	\$450.30	\$854.15
56-58	\$77.80	\$84.55	\$248.55	\$492.05	\$933.35
59-61	\$85.00	\$92.35	\$271.55	\$537.60	\$1,019.75
62-64	\$92.90	\$100.95	\$296.80	\$587.50	\$1,114.50
65-67	\$101.50	\$110.30	\$324.30	\$642.00	\$1,217.80
68-70	\$110.90	\$120.55	\$354.40	\$701.55	\$1,330.75
71-75	\$121.20	\$131.75	\$387.30	\$766.70	\$1,454.30
>75 *	\$121.20	\$131.75	\$387.30	\$766.70	\$1,454.30

Attained Age	OP-1 - Low option - Tobacco				
	Bank Draft Rate	Regular Monthly Rate	Quarterly Rate	Semi-Annual Rate	Annual Rate
0-17	\$36.05	\$39.20	\$115.25	\$228.15	\$432.75
18-25	\$45.60	\$49.55	\$145.70	\$288.40	\$547.05
26-28	\$50.20	\$54.55	\$160.40	\$317.50	\$602.25
29-31	\$52.50	\$57.05	\$167.75	\$332.05	\$629.85
32-34	\$54.90	\$59.65	\$175.35	\$347.15	\$658.55
35-37	\$57.35	\$62.35	\$183.30	\$362.90	\$688.35
38-40	\$60.00	\$65.20	\$191.70	\$379.45	\$719.80
41-43	\$62.75	\$68.20	\$200.50	\$396.90	\$752.95
44-46	\$65.60	\$71.30	\$209.60	\$414.95	\$787.15
47-49	\$68.55	\$74.50	\$219.05	\$433.60	\$822.50
50-52	\$74.90	\$81.40	\$239.30	\$473.75	\$898.65
53-55	\$81.85	\$88.95	\$261.50	\$517.70	\$982.00
56-58	\$89.45	\$97.25	\$285.90	\$566.00	\$1,073.65
59-61	\$97.70	\$106.20	\$312.25	\$618.10	\$1,172.45
62-64	\$106.80	\$116.10	\$341.35	\$675.70	\$1,281.75
65-67	\$116.70	\$126.85	\$372.95	\$738.25	\$1,400.40
68-70	\$127.55	\$138.65	\$407.65	\$806.95	\$1,530.70
71-75	\$139.40	\$151.50	\$445.40	\$881.75	\$1,672.55
>75 *	\$139.40	\$151.50	\$445.40	\$881.75	\$1,672.55

* Renewal only

SERFF Tracking Number: RNIC-127966500 State: Arkansas
 Filing Company: Reserve National Insurance Company State Tracking Number:
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: OP-1 Supplemental Outpatient Fixed Indemnity Policy
 Project Name/Number: OP-1 Supplemental Outpatient Fixed Indemnity Policy/

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved	01/13/2012
Comments:		
Attachment: Readability Certification OP-1.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved	01/13/2012
Comments:		
Attachment: UAP-1 AR 10.11.pdf		

	Item Status:	Status Date:
Satisfied - Item: Health - Actuarial Justification	Approved	01/13/2012
Comments:		
Attachment: actu memo OP-1 AR.pdf		

	Item Status:	Status Date:
Satisfied - Item: Outline of Coverage	Approved	01/13/2012
Comments:		
Form OC OP-1 (Option 1) – Outline of Coverage, which will be used in connection with each application for Form OP-1 when the applicant selects the “Option 1” level of indemnity benefits.		

Form OC OP-1 (Option 2) – Outline of Coverage, which will be used in connection with each application for Form OP-1 when the applicant selects the “Option 2” level of indemnity benefits.

These outline of coverage are also attached to the Form Schedule.

Attachments:
OC OP-1 (Option 1).pdf

SERFF Tracking Number: RNIC-127966500 State: Arkansas
 Filing Company: Reserve National Insurance Company State Tracking Number:
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: OP-1 Supplemental Outpatient Fixed Indemnity Policy
 Project Name/Number: OP-1 Supplemental Outpatient Fixed Indemnity Policy/
 OC OP-1 (Option 2).pdf

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved	01/13/2012
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Form PEB-3 (1/11)	Approved	01/13/2012
Comments:	Form PEB-3 (1/11) – Existing Condition Benefit Endorsement, which, in accordance with our underwriting guidelines, may be selected by an applicant for coverage of certain pre-existing conditions after a reduced waiting period of 12 months. This form was previously approved by your office.		

		Item Status:	Status Date:
Satisfied - Item:	Form R-1 (1/11)	Approved	01/13/2012
Comments:	Form R-1 (1/11) – Elimination Rider, which, in accordance with our underwriting guidelines, will be used to permanently eliminate coverage for certain pre-existing conditions. This form was previously approved by your office.		

		Item Status:	Status Date:
Satisfied - Item:	Form RP-A&H	Approved	01/13/2012
Comments:	Form RP-A&H – Notice to Applicant Regarding Replacement, which will be used in replacement situations. This form was previously approved by your office.		

		Item Status:	Status Date:
Satisfied - Item:	Form HDI-Med. Notice	Approved	01/13/2012
Comments:			

SERFF Tracking Number: RNIC-127966500 State: Arkansas
 Filing Company: Reserve National Insurance Company State Tracking Number:
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: OP-1 Supplemental Outpatient Fixed Indemnity Policy
 Project Name/Number: OP-1 Supplemental Outpatient Fixed Indemnity Policy/

Form HDI-Med. Notice – Important Notice to Persons on Medicare, which will be used for each applicant who is eligible for Medicare at the time of application. This form was previously approved by your office.

		Item Status:	Status Date:
Satisfied - Item:	AR-INP (11/09)	Approved	01/13/2012

Comments:

We have included Form AR-INP (11/09) as a supporting document to reflect our compliance with Bulletin 15-2009.

Attachment:

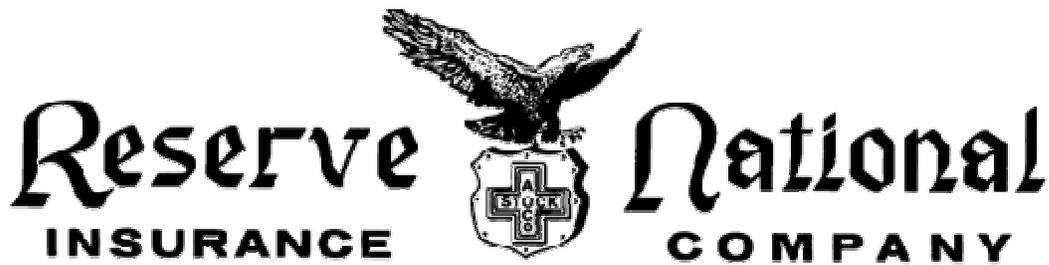
AR-INP (11-09).pdf

		Item Status:	Status Date:
Satisfied - Item:	Explanation of Variable Text	Approved	01/13/2012

Comments:

Attachment:

Arkansas OP-1 Explanation of Variable Text.pdf



601 East Britton Road
OKLAHOMA CITY, OKLAHOMA 73114-

READABILITY CERTIFICATION

FORM NUMBER: Form OP-1 – Supplemental Outpatient Fixed Indemnity Policy

The words, sentences, and syllables of Form OP-1 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:	3030
SENTENCES:	216
SYLLABLES:	3808

This resulted in a Flesch Readability score of **86.255**

A handwritten signature in black ink that reads "Kyle D. Conrad". The signature is written in a cursive, flowing style.

KYLE D. CONRAD
Senior Vice President
and Associate Corporate Counsel

AGENT CODE _____
MGR CODE _____

POLICY NUMBER(S): _____

EFFECTIVE DATE
Month _____ Day _____ Year _____

1. Full Name of Each Applicant

1	2	3	4	First	Middle Initial	Last	Social Security No.	Relation To Proposed Insured	BIRTH DATE			Age	Ht.	Wt.	Sex	
									Mo.	Day	Yr.					
1																
2																
3																
4																

Specified Disease Policy SD-1
 Scheduled Benefit Hospital, Medical, Surgical Expense Policy PS-1

Deductible \$	Daily Room Max. \$	Hospital Misc. Max. \$	Surgery Sch.*
Basic			
App't#	Mthly. Rt.	List Endorsements & Rates	PEB Table
1			
2			
3			
4			
*See the Policy for details.			Total _____

Fixed Indemnity Policy ACS-1 Surgery Schedule* _____
Qualifying Period Before Daily Hospital Indemnity Payable: _____ Days
Daily Hospital Indemnity Amount First 5 Days _____

Scheduled Benefit Accident-Only Policy SA-1
Deductible \$ _____ Daily Room Max. \$ _____

Basic	List Endorsements & Rates	PEB	Total Monthly
App't#	Mthly. Rt.	Table	Premium
1			
2			
3			
4			
*See the Policy for details.			Total _____

Accident Policy
 AP-79 AP-02-79
 AP-91 AP-91-70

App't #	Total Monthly Prem.
1	_____
2	_____
3	_____
4	_____
Total	_____

Dental/Vision Expense Policy
Pol. Yr. Ded. \$ _____
Pol. Yr. Max. \$ _____

App't #	Total Monthly Prem.
1	_____
2	_____
3	_____
4	_____
Total	_____

First Diagnosis Heart Attack / First Major Heart Surgery Indemnity Policy HRT-98
First Diagnosis Heart Attack Benefit (after 30 days) \$ _____
First Major Heart Surgery Benefit (after 30 days) \$ _____

App't #	Total Monthly Prem.	PEB Table
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____
Total	_____	_____

Supplemental Outpatient Policy
 OS-99 OP-2000 Deductible \$ _____
 OP-1 Option 1 _____ Option 2 _____

Basic	List Endorsements & Rates	PEB	Total Monthly
App't#	Mthly. Rt.	Table	Premium
1			
2			
3			
4			
Total			_____

Fixed Indemnity Policy SIP-1* Surgery Schedule** _____
 Hospital Indemnity Policy HDI **See the Policy for details.
Daily Indemnity Amount First 10 Days _____ Next 21 Days _____

Basic	List Endorsements & Rates	PEB	Total Monthly
App't#	Mthly. Rt.	Table	Premium
1			
2			
3			
4			
*Elimination Period Before Daily Indemnity is Payable: _____ Days			Total _____

Home Health Care Indemnity Policy HHC-95

Basic	List Endorsements & Rates	Total Monthly
App't#	Mthly. Rt.	Premium
1		
2		
3		
4		
Total		_____

Cancer Policy
 CFO-95-First Occurrence Cancer Benefit After 180 Days \$ _____
 CC-74 CC-91
App't # | Total Monthly Prem.

1	_____
2	_____
3	_____
4	_____
Total	_____

Cancer Policy ICD-2000
Daily Benefit: First 300 Days _____
Next 200 Days _____

App't #	Total Monthly Prem.
1	_____
2	_____
3	_____
4	_____
Total	_____

Critical Illness and Accidental Death Indemnity Policy CRI
Benefit for 1st Diagnosis Covered Critical Illness (after 180 days)/Accidental Death \$ _____

App't #	Total Monthly Prem.	PEB Table
1	_____	_____
Total		_____

Note: One applicant per policy for CRI.

2. Residence of Proposed Insured _____
Street No. / Rural Route and/or Box Number City State Zip Code

2.(a) Mailing Address of Proposed Insured, if different from above _____

3. Residence Telephone No. area code (_____) No: _____ Business or alternate area code (_____) No: _____

3.(a) E-mail address _____ 3.(b) Name, Address and Telephone No. of payor, if different from above _____

3.(c) Each Applicant's State of Birth _____

4.(a) Proposed Insured's Occupation(s) (state duties) _____ (b) Spouse's Occupation(s) (state duties) _____

5. Full Name of Beneficiary(ies) and Relationship _____

Without a Beneficiary Designation, benefits that are not assigned shall be paid to the Proposed Insured first named above if living, otherwise to the deceased's estate.

6. If submitted for purposes other than a new insurance application, please indicate: Policy Change Conversion Reinstatement:
Policy(ies) Number(s) _____ What benefit(s) are being requested? _____

7. Does any applicant have any Medicare supplement, hospital, medical or surgical insurance in force at the time of this application?
 Yes No If yes, which applicant(s) and details? _____

8. Does any applicant intend the replacement or change of any of his/her existing insurance policy(ies) in connection with this application for insurance? Yes No If yes, which applicant(s), company and amount? _____
(Complete replacement of insurance form.)

9. Has any applicant used any form of tobacco within the past year? Yes No Within the past 3 years? Yes No
If either are yes, which applicant(s)? _____

10. Does any applicant participate or contemplate participating in any type of aviation, other than as a passenger on a regularly scheduled airline? Yes No If yes, which applicant(s) and details? _____

11. In the last 5 years has any applicant participated in or does any applicant contemplate participating in any motorized vehicle racing, scuba or skin diving, sky diving, hang gliding, mountain climbing, rodeos, cliff diving, ballooning, parasailing and/or any professional or semi-professional athletics? Yes No Which applicant(s) and details? _____

12. Has any applicant been convicted of a felony or had his or her drivers license suspended or revoked? Yes No Which applicant(s) and details? _____

13. In the last 5 years, has any applicant had life, disability or health insurance declined, rated, modified, cancelled or not renewed?
 Yes No If yes, which applicant(s) and details? _____

14. Has any applicant ever requested or received a pension, benefits or payment because of an injury, sickness or disability?
 Yes No If yes, which applicant(s) and details? _____

15. Has any applicant applied for or is any applicant currently receiving Social Security disability benefits? Yes No If yes, which applicant(s) and details? _____

16. Does any applicant use a catheter, oxygen, respirator, dialysis machine, walker, wheelchair or similar medical equipment or appliance? Yes No If yes, which applicant(s) and details? _____

17. Is any applicant using any medication or drugs? Yes No If yes, which applicant(s) and name of medication? _____

18. Does any applicant currently have a dental crown or bridge, or wear dentures? Yes No If yes, which applicant(s) _____

19. Has any applicant been advised to have any dental work which has not been completed? Yes No If yes, which applicant(s) and details? _____

20. Does any applicant currently wear eyeglasses or contact lenses? Yes No If yes, which applicant(s) and details? _____

HAVE YOU, OR ANY APPLICANT, EVER HAD OR BEEN TOLD THAT YOU HAD, OR BEEN TREATED BY A PHYSICIAN OR OTHER PRACTITIONER FOR ANY OF THE FOLLOWING? (If "YES" circle the condition(s).)

21. Disorder of eyes, ears, nose, throat or glands?.... Yes No

22. Dizzy or fainting spells, seizures or convulsions or recurrent headache?..... Yes No

23. Paralysis, transient ischemic attack, stroke, cerebrovascular disease or insufficiency or hemorrhage, or any residuals thereof?.. Yes No

24. Mental, nervous, psychiatric disorder? Yes No

25. Senility disorder, Alzheimer's disease, organic brain syndrome or disorder, cerebral palsy, muscular dystrophy, multiple sclerosis, Lou Gehrig's disease, neurologic or muscular wasting disease?..... Yes No

26. Persistent shortness of breath, cough, blood spitting, bronchitis, asthma, allergies, emphysema, tuberculosis, pneumonia or other

FOR HOME OFFICE USE

IT IS AGREED THAT ALL STATEMENTS AND ANSWERS CONTAINED IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE AS WRITTEN AND ARE CORRECTLY RECORDED, ARE STATEMENTS AND NOT WARRANTIES, AND THAT: 1. This application and any supplements thereto shall form the basis for and be a part of any insurance issued, and that all statements and answers in this application and any supplements are complete and true to the best of applicant's knowledge and belief. 2. The insurance applied for in this application shall not be considered in force until issued by the Company and the first premium paid. The Company shall have 60 days from the date signed in which to consider and act upon this application which the parties agree is a reasonable time. If within such period insurance has not been received by the applicant, or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company and the Company will return any premium tendered herewith. In connection with an application for insurance currently made to Reserve National Insurance Company, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy related service organization, or other medical or medically related facility, insurance company or MIB, Inc. ("MIB"), that has any health or medical records or knowledge concerning me or any of the members of my family named in said application, to disclose to the Company or its reinsurers any such information upon presentation of this authorization or reproduction thereof.

I understand that (a) an investigative consumer report may be obtained as to my insurability, including, if applicable, information as to character, general reputation, personal characteristics and mode of living; (b) this information will be obtained through personal interviews with my friends, neighbors and associates; and (c) additional information as to the nature and scope of any investigation requested will be furnished to me upon my written request made within a reasonable time after this application is completed. This authorization shall remain valid for a period of 24 months from the date hereof. I understand that I may revoke this authorization at any time by mailing written notice thereof to the Company at 601 East Britton Road, Oklahoma City, OK 73114.

I have paid to Reserve National Insurance Company the sum of \$ _____ which is a Monthly Quarterly Semi-Annual Annual premium, and I hold a receipt for that amount made up without alteration bearing the same date as this application.

If accepted by the Company the applicant requests coverage to be effective: A. Date of application, applicable only on quarterly or longer modes. B. Date of issue C. Other _____

SEND POLICY TO APPLICANT OR AGENT TO DELIVER.

I acknowledge receipt of an outline of coverage for which this application is made..... Yes No

I am 65 years old or older, or eligible for Medicare, and acknowledge receipt of a "Guide to Health Insurance for People with Medicare."..... Yes No

NOTICE: The proposed insured certifies that no person to be covered under the policy applied for is covered by Medicaid or any other Title XIX program. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SPECIAL NOTICE: I UNDERSTAND THAT THE RESERVE NATIONAL INSURANCE COMPANY POLICY I HAVE APPLIED FOR IS NOT DESIGNED TO COVER ALL MEDICAL EXPENSES. IT CONTAINS LIMITS ON THE AMOUNT OF BENEFITS PAYABLE. IT IS NOT CONSIDERED MAJOR MEDICAL COVERAGE BECAUSE OF THESE LIMITS.

Town and State where signed _____ this _____ day of _____, _____.

Signature of Owner (if other than Proposed Insured)

Signature of Proposed Insured/Applicant

The undersigned agent (a) represents Reserve National Insurance Company in connection with the insurance applied for; (b) will receive compensation from the Company if coverage is issued; and (c) may provide services to policyholders on behalf of the Company, subject to the Company's approval. The agent does not have authority to bind the Company.

I certify that I asked each question of the applicant personally and the answers have been accurately recorded hereon. _____

UAP-1 AR (10/11)

Signature of Agent



Another easy way to pay your premium is with your VISA, Mastercard or DISCOVER card.

Please charge to my:



ACCOUNT# AS SHOWN ON CARD

_____-_____-_____-_____

EXPIRATION DATE _____

PLEASE SELECT

Please charge my credit card for the initial premium.

Please charge my credit card for all future renewal premiums. I understand this authorization will remain in effect until revoked by me or until my credit card expires: Monthly Payment Quarterly Payment

Amount authorized \$ _____

NAME OF CARDHOLDER _____
(PLEASE PRINT NAME AS SHOWN ON CARD)

AUTHORIZED SIGNATURE _____
(PLEASE SIGN HERE)

DATE AUTHORIZED _____



THIS IS A SUPPLEMENTAL OUTPATIENT FIXED INDEMNITY POLICY. IT PROVIDES STATED BENEFIT AMOUNTS IN EACH POLICY YEAR WITHOUT REGARD TO THE AMOUNT OF EXPENSES INCURRED.

OUTLINE OF COVERAGE FOR SUPPLEMENTAL FIXED INDEMNITY POLICY FORM OP-1

Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of Supplemental Outpatient Fixed Indemnity Policy Form OP-1. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and Reserve National Insurance Company. It is therefore important that you **Read Your Policy Carefully!**

Supplemental Outpatient Fixed Indemnity Coverage is designed to provide coverage in the form of a stated indemnity benefit for covered outpatient treatment of a covered Injury or Sickness, subject to all the Policy's conditions, limitations and exclusions. Coverage is not provided for any benefits other than the fixed indemnity benefits described below. **THIS IS A LIMITED POLICY. THIS IS NOT MAJOR MEDICAL COVERAGE.**

Benefits, days or visits not used in one Policy Year are not carried forward to any future Policy Year.

I. BENEFITS

(1) Outpatient X-Rays and Lab Tests Indemnity Benefit: If a Covered Person undergoes an Outpatient X-Ray, MRI, CT Scan or a lab test performed or directed by or under the supervision of a Physician as the result of an Injury or Sickness, we will pay indemnity benefits as follows, **limited to the Maximum Aggregate Outpatient X-Rays, and Lab Test Indemnity Benefit of \$2,000.00 for all Outpatient X-Rays, MRIs, CT Scans and lab tests in a Policy Year:**

- (a) X-Rays:** We will pay **\$75.00** for each X-Ray.
- (b) MRIs and CT Scans:** We will pay **\$750.00** for each MRI or CT Scan.
- (c) Lab Tests:** We will pay **\$50.00** for each lab test.

(2) Outpatient Doctor Visits Indemnity Benefit: If a Covered Person receives personal treatment by a Physician in the Physician's office or a clinic, as the result of an Injury or Sickness or for a routine examination, we will pay the Outpatient Doctor Visits Indemnity Benefit of **\$50.00** per visit, **limited to 1 visit per day and 4 visits in a Policy Year.**

(3) Emergency Room Indemnity Benefit: If a Covered Person receives personal treatment by a Physician in a Hospital emergency room as the result of an Injury or Sickness, we will pay the Emergency Room Indemnity Benefit of **\$500.00, limited to 1 visit in a Policy Year.**

(4) Ambulance Indemnity Benefit: If a Covered Person is transported to or from a Hospital as a result of an Injury or Sickness, we will pay the applicable benefit as follows:

- (a) Air Ambulance:** We will pay **\$1,500.00** for air transportation by a licensed ambulance service, **limited to 2 air ambulance trips per Policy Year.**
- (b) Ground Ambulance:** We will pay **\$500.00** for ground transportation by a licensed ambulance service, **limited to 4 ground ambulance trips per Policy Year.**

(5) Prescription Indemnity Benefit: If a Covered Person purchases a Prescription Drug as the result of an Injury or Sickness, we will pay **\$25.00** for each Prescription Drug, **limited to the Maximum Aggregate Prescription Drug Indemnity Benefit of \$500.00 for all Prescription Drugs in a Policy Year.**

(6) Preventive Care Indemnity Benefits: If a Covered Person, who meets the **requirements specified in the Policy**, undergoes one or more of the following types of preventive care performed or directed by or under the supervision of a Physician, we will pay indemnity benefits as follows:

(a) Colonoscopy Indemnity Benefit: For a colonoscopy for a Covered Person who is age 50 or older, to screen for the presence of colon cancer, we will pay the Colonoscopy Indemnity Benefit of **\$500.00, limited to 1 screening colonoscopy every 5 Policy Years.**

(b) Mammogram Indemnity Benefit: For a mammogram for a female Covered Person age 35 or older, and at age intervals specified in the Policy, we will pay the Mammogram Indemnity Benefit of **\$125.00.** See the Policy for details.

(c) Pap Smear Indemnity Benefit: For a Pap Smear for a female Covered Person, we will pay the Pap Smear Indemnity Benefit of **\$100.00, limited to 1 Pap Smear in a Policy Year.**

(d) Diabetes Testing Indemnity Benefit: For a blood test for diabetes, we will pay the Diabetes Testing Indemnity Benefit of **\$50.00, limited to 1 such blood test for diabetes in a Policy Year.**

(e) Prostate Examination Indemnity Benefit: For a Prostate Examination for a male Covered Person who is age 50 or older, we will pay the Prostate Cancer Examination Indemnity Benefit of **\$75.00, limited to 1 Prostate Examination in a Policy Year.**

II. EXCLUSIONS: The Policy does not pay benefits for any Loss 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; (d) intoxication, alcoholism or alcohol related illnesses; (e) mental illness, nervous or emotional disorders; (f) 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; (g) 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 an insured 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; (h) pregnancy or conditions due to pregnancy, **except** that complications of pregnancy shall be covered as any other Sickness; (i) childbirth; (j) participation in a felony or attempted felony, riot or insurrection; (k) rest cures, custodial care, and routine physical examinations, except as specifically provided; (l) surgical sterilization; (m) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet; (n) eye glasses, hearing aids and examination for the prescription or fitting thereof.

III. PRE-EXISTING CONDITIONS LIMITATION: Pre-Existing Conditions are not covered under the Policy until the Policy has been in force for a period of two years; provided, however, that no benefits whatsoever will be payable for Loss from any condition, either pre-existing or otherwise, which is completely excluded from coverage under the Policy by name or specific description on the date of Loss. "Pre-Existing Condition" means a condition that has been diagnosed, or has manifested itself to you within the five-year period immediately preceding the Effective Date of the 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 the Policy.

Coverage for some pre-existing conditions may be included after 12 months for an additional premium payable during the lifetime of your Policy by attachment of the PEB-3 (1/11) endorsement.

IV. _____ (applicant's initials to select) EXISTING CONDITION BENEFIT ENDORSEMENT PEB-3 (1/11): Pre-Existing Conditions disclosed on the application and listed on endorsement Form PEB-3 (1/11) will be covered after 12 months.

V. TERMINATION: Subject to the Policy's Grace Period provision, coverage will immediately terminate at 12:01 A.M., Standard Time, at the place where the Insured resides, on the due date of any premium which is not paid.

VI. RENEWAL SAFEGUARD: The Policy is renewable as follows:

(a) Subject to the Termination provisions of the Policy, we may not decline to renew the Policy except for one or both of the following reasons:

- (1) Renewal premiums are declined on all policies bearing the same form number as the Policy issued to persons in the state where you reside; or
- (2) Failure to correctly report matters inquired of in the application for the Policy.

(b) While the Policy is in effect, we shall not have the right to add any restrictive amendment. There shall be no change in rate classification on account of any physical impairment or on account of any claims incurred.

VII. PREMIUM PAYMENTS/PREMIUMS SUBJECT TO CHANGE:

(a) You have a grace period of 31 days for the payment of each premium which becomes due after the first premium. During this grace period the Policy will continue in force.

(b) Premiums are subject to change. Premiums are based on the attained age of each Covered Person, and 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, the insured's state of residence and/or ZIP code. We will give you 31 days written notice before any such premium change.

THIS IS A LIMITED POLICY.
IT PROVIDES ONLY THE FIXED INDEMNITY BENEFITS DESCRIBED ABOVE.

READ THE POLICY CAREFULLY WITH THIS OUTLINE OF COVERAGE.

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:

- **Form OP-1 provides limited benefits; it is not a major medical policy and is not designed to cover all medical expenses.**
- **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

This Outline of Coverage is to be delivered to the applicant at the time the application for insurance is completed. Supplemental Outpatient Fixed Indemnity Policy Form OP-1 is individually underwritten by Reserve National Insurance Company.



THIS IS A SUPPLEMENTAL OUTPATIENT FIXED INDEMNITY POLICY. IT PROVIDES STATED BENEFIT AMOUNTS IN EACH POLICY YEAR WITHOUT REGARD TO THE AMOUNT OF EXPENSES INCURRED.

OUTLINE OF COVERAGE FOR SUPPLEMENTAL FIXED INDEMNITY POLICY FORM OP-1

Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of Supplemental Outpatient Fixed Indemnity Policy Form OP-1. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and Reserve National Insurance Company. It is therefore important that you **Read Your Policy Carefully!**

Supplemental Outpatient Fixed Indemnity Coverage is designed to provide coverage in the form of a stated indemnity benefit for covered outpatient treatment of a covered Injury or Sickness, subject to all the Policy's conditions, limitations and exclusions. Coverage is not provided for any benefits other than the fixed indemnity benefits described below. **THIS IS A LIMITED POLICY. THIS IS NOT MAJOR MEDICAL COVERAGE.**

Benefits, days or visits not used in one Policy Year are not carried forward to any future Policy Year.

I. BENEFITS

(1) Outpatient X-Rays and Lab Tests Indemnity Benefit: If a Covered Person undergoes an Outpatient X-Ray, MRI, CT Scan or a lab test performed or directed by or under the supervision of a Physician as the result of an Injury or Sickness, we will pay indemnity benefits as follows, **limited to the Maximum Aggregate Outpatient X-Rays, and Lab Test Indemnity Benefit of \$1,000.00 for all Outpatient X-Rays, MRIs, CT Scans and lab tests in a Policy Year:**

- (a) **X-Rays:** We will pay **\$50.00** for each X-Ray.
- (b) **MRIs and CT Scans:** We will pay **\$500.00** for each MRI or CT Scan.
- (c) **Lab Tests:** We will pay **\$25.00** for each lab test.

(2) Outpatient Doctor Visits Indemnity Benefit: If a Covered Person receives personal treatment by a Physician in the Physician's office or a clinic, as the result of an Injury or Sickness or for a routine examination, we will pay the Outpatient Doctor Visits Indemnity Benefit of **\$25.00** per visit, **limited to 1 visit per day and 4 visits in a Policy Year.**

(3) Emergency Room Indemnity Benefit: If a Covered Person receives personal treatment by a Physician in a Hospital emergency room as the result of an Injury or Sickness, we will pay the Emergency Room Indemnity Benefit of **\$300.00, limited to 1 visit in a Policy Year.**

(4) Ambulance Indemnity Benefit: If a Covered Person is transported to or from a Hospital as a result of an Injury or Sickness, we will pay the applicable benefit as follows:

- (a) **Air Ambulance:** We will pay **\$1,500.00** for air transportation by a licensed ambulance service, **limited to 2 air ambulance trips per Policy Year.**
- (b) **Ground Ambulance:** We will pay **\$250.00** for ground transportation by a licensed ambulance service, **limited to 4 ground ambulance trips per Policy Year.**

(5) Prescription Indemnity Benefit: If a Covered Person purchases a Prescription Drug as the result of an Injury or Sickness, we will pay **\$10.00** for each Prescription Drug, **limited to the Maximum Aggregate Prescription Drug Indemnity Benefit of \$250.00 for all Prescription Drugs in a Policy Year.**

(6) Preventive Care Indemnity Benefits: If a Covered Person, who meets the **requirements specified in the Policy**, undergoes one or more of the following types of preventive care performed or directed by or under the supervision of a Physician, we will pay indemnity benefits as follows:

(a) Colonoscopy Indemnity Benefit: For a colonoscopy for a Covered Person who is age 50 or older, to screen for the presence of colon cancer, we will pay the Colonoscopy Indemnity Benefit of **\$500.00, limited to 1 screening colonoscopy every 5 Policy Years.**

(b) Mammogram Indemnity Benefit: For a mammogram for a female Covered Person age 35 or older, and at age intervals specified in the Policy, we will pay the Mammogram Indemnity Benefit of **\$125.00.** See the Policy for details.

(c) Pap Smear Indemnity Benefit: For a Pap Smear for a female Covered Person, we will pay the Pap Smear Indemnity Benefit of **\$100.00, limited to 1 Pap Smear in a Policy Year.**

(d) Diabetes Testing Indemnity Benefit: For a blood test for diabetes, we will pay the Diabetes Testing Indemnity Benefit of **\$50.00, limited to 1 such blood test for diabetes in a Policy Year.**

(e) Prostate Examination Indemnity Benefit: For a Prostate Examination for a male Covered Person who is age 50 or older, we will pay the Prostate Cancer Examination Indemnity Benefit of **\$75.00, limited to 1 Prostate Examination in a Policy Year.**

II. EXCLUSIONS: The Policy does not pay benefits for any Loss 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; (d) intoxication, alcoholism or alcohol related illnesses; (e) mental illness, nervous or emotional disorders; (f) 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; (g) 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 an insured 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; (h) pregnancy or conditions due to pregnancy, **except** that complications of pregnancy shall be covered as any other Sickness; (i) childbirth; (j) participation in a felony or attempted felony, riot or insurrection; (k) rest cures, custodial care, and routine physical examinations, except as specifically provided; (l) surgical sterilization; (m) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet; (n) eye glasses, hearing aids and examination for the prescription or fitting thereof.

III. PRE-EXISTING CONDITIONS LIMITATION: Pre-Existing Conditions are not covered under the Policy until the Policy has been in force for a period of two years; provided, however, that no benefits whatsoever will be payable for Loss from any condition, either pre-existing or otherwise, which is completely excluded from coverage under the Policy by name or specific description on the date of Loss. "Pre-Existing Condition" means a condition that has been diagnosed, or has manifested itself to you within the five-year period immediately preceding the Effective Date of the 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 the Policy.

Coverage for some pre-existing conditions may be included after 12 months for an additional premium payable during the lifetime of your Policy by attachment of the PEB-3 (1/11) endorsement.

IV. _____ (applicant's initials to select) EXISTING CONDITION BENEFIT ENDORSEMENT PEB-3 (1/11): Pre-Existing Conditions disclosed on the application and listed on endorsement Form PEB-3 (1/11) will be covered after 12 months.

V. TERMINATION: Subject to the Policy's Grace Period provision, coverage will immediately terminate at 12:01 A.M., Standard Time, at the place where the Insured resides, on the due date of any premium which is not paid.

VI. RENEWAL SAFEGUARD: The Policy is renewable as follows:

(a) Subject to the Termination provisions of the Policy, we may not decline to renew the Policy except for one or both of the following reasons:

- (1) Renewal premiums are declined on all policies bearing the same form number as the Policy issued to persons in the state where you reside; or
- (2) Failure to correctly report matters inquired of in the application for the Policy.

(b) While the Policy is in effect, we shall not have the right to add any restrictive amendment. There shall be no change in rate classification on account of any physical impairment or on account of any claims incurred.

VII. PREMIUM PAYMENTS/PREMIUMS SUBJECT TO CHANGE:

(a) You have a grace period of 31 days for the payment of each premium which becomes due after the first premium. During this grace period the Policy will continue in force.

(b) Premiums are subject to change. Premiums are based on the attained age of each Covered Person, and 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, the insured's state of residence and/or ZIP code. We will give you 31 days written notice before any such premium change.

THIS IS A LIMITED POLICY.
IT PROVIDES ONLY THE FIXED INDEMNITY BENEFITS DESCRIBED ABOVE.

READ THE POLICY CAREFULLY WITH THIS OUTLINE OF COVERAGE.

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:

- **Form OP-1 provides limited benefits; it is not a major medical policy and is not designed to cover all medical expenses.**
- **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

This Outline of Coverage is to be delivered to the applicant at the time the application for insurance is completed. Supplemental Outpatient Fixed Indemnity Policy Form OP-1 is individually underwritten by Reserve National Insurance Company.

IMPORTANT NOTICE

Customer Service Department of Reserve National Insurance Company:

601 East Britton Road

Oklahoma City, OK 73114-7710

Telephone # 1-800-654-9106.

If we at Reserve National Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department

Consumer Services Division

1200 West Third Street

Little Rock, Arkansas 72201-1904

Telephone (501) 371-2600



601 East Britton Road ▪ Oklahoma City, OK 73114
www.ReserveNational.com

Explanation of Variable Text

Supplemental Outpatient Fixed Indemnity Policy Form OP-1

In connection with the submission of the above-referenced forms, the following text is variable and is shown in brackets:

1. On the Policy's Insured Schedule, Page 2: The following information will be reflected on an actual policy as issued, depending on the information shown on an insured's application: Policy Number; Effective Date; Initial Term Expires; Insured; Premium for available modes; Agent; Spouse; and Dependents.
2. On the Policy's Insured Schedule, Page 2, Reverse Side, under the heading "Endorsements and Eliminations": Based on underwriting, Existing Condition Benefit Endorsement PEB-3 (1/11), and the description of the condition(s) subject thereto, may be reflected; and/or based on underwriting, Elimination Rider R-1 (1/11), and the description of the condition(s) subject thereto, may be reflected
3. On Existing Condition Benefit Endorsement Form PEB-3 (1/11), if this form is included based on underwriting, the following information will be reflected: Policy No.; Effective Date Endor.; the name of the insured subject to this form; and the description of the condition(s) subject thereto
4. On Elimination Rider Form R-1 (1/11), if this form is included based on underwriting, the following information will be reflected: Policy No.; Effective Date Endor.; the name of the insured subject to this form; and the description of the condition(s) subject thereto

I hereby certify that the foregoing is true and correct to the best of my knowledge, information and belief.

1/9/2012

Date

Kyle D. Conrad
Senior Vice President
and Associate Corporate Counsel

SERFF Tracking Number: RNIC-127966500 State: Arkansas
 Filing Company: Reserve National Insurance Company State Tracking Number:
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: OP-1 Supplemental Outpatient Fixed Indemnity Policy
 Project Name/Number: OP-1 Supplemental Outpatient Fixed Indemnity Policy/

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)
01/12/2012	Form	Supplemental Outpatient Fixed Indemnity Policy	01/13/2012	OP-1_POLICY_ARKANSAS.pdf (Superseded)
01/09/2012	Form	Supplemental Outpatient Fixed Indemnity Policy	01/12/2012	OP-1_POLICY_ARKANSAS.pdf (Superseded)

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. THIS POLICY PAYS FIXED INDEMNITY BENEFIT AMOUNTS FOR COVERED OUTPATIENT TREATMENT, WITH LIMITS ON THE AMOUNTS PAYABLE FOR EACH COVERED TREATMENT AND IN EACH POLICY YEAR. IT IS RENEWABLE AS PROVIDED IN THE RENEWAL SAFEGUARD PROVISION. PREMIUMS ARE BASED ON EACH COVERED PERSON'S ATTAINED AGE. WE HAVE THE RIGHT TO INCREASE PREMIUMS ON A CLASS BASIS BY STATE.



601 East Britton Road ▪ Oklahoma City, OK 73114

When we use "we," "us," or "our" we mean Reserve National Insurance Company. When we use "you" or "your" we mean a Covered Person as defined in this Policy and as named on the Insured Schedule.

Reserve National Insurance Company agrees to indemnify the Covered Person(s) as hereinafter provided, subject, however, to all the provisions, conditions, exclusions, limits of liability and other terms in this Policy.

SUPPLEMENTAL OUTPATIENT FIXED INDEMNITY POLICY INSURING AGREEMENT

In consideration of the payment of the premium in advance and in reliance upon the statements in your application, a copy of which is attached and which forms a part of this Policy, we hereby indemnify the person(s) named on the Insured Schedule, commencing at 12:01 A.M., Standard Time, at the place where you reside, on the Effective Date shown on the Insured Schedule. The initial premium is for the policy term shown on the Insured Schedule. The renewal premium for later policy terms is due on the first day of the next policy term. The coverage provided by this Policy will cease if the renewal premium in effect is not paid when due or within the grace period. Each policy term will begin and end at 12:01 A.M., Standard Time, at the place where the Insured resides.

RENEWABILITY

Subject to the Termination provision, coverage under this Policy is renewable as provided in the **Renewal Safeguard** provision. Premiums are subject to change as provided in the Premium Payments provision.

IMPORTANT NOTICE

Please read the copy of the application attached to this Policy. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to the Company at 601 East Britton Road, Oklahoma City, Oklahoma 73114-7710, within 10 days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. The application is part of this Policy, which was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

NOTICE OF 10 DAY RIGHT TO EXAMINE POLICY

You are granted a period of 10 days from the date of delivery of this Policy to examine it. If you are not satisfied for any reason, this Policy may be returned within said 10 days to the Company at its Home Office or to the writing agent. Then the Company shall refund the premium paid, this Policy shall be void from its beginning, and you and Reserve National shall be in the same position as if it had never been issued.

**THIS IS A LIMITED POLICY.
THIS IS AN OUTPATIENT-ONLY POLICY
AND IT DOES NOT PAY BENEFITS FOR SURGERY OR HOSPITALIZATION.**

Read this Policy carefully with the Outline of Coverage.

TABLE OF CONTENTS

Benefits	Pages 4 & 5
Continuation of Coverage Upon Divorce	Page 6
Coverage for Spouse and Dependent Children.....	Page 7
Definitions.....	Page 3
Exclusions	Page 6
Important Notice.....	Page 1
Insured Schedule	Page 2
Insuring Agreement	Page 1
Limitation	Page 6
Notice of 10 Day Right to Examine Policy	Page 1
Policy Provisions	Page 9
Pre-Existing Conditions Limitation	Page 6
Premium Payments	Page 6
Renewability	Page 1
Renewal Safeguard	Page 7
Termination	Page 6
Uniform Provisions	Pages 7 & 8

INSURED SCHEDULE

		<u>Renewal Premium:</u>	Direct Bill	Bank Draft
Policy Number	[00-00-000000]	Monthly	N/A	[\$00.00]
Effective Date	[Feb. 1, 2011]	Quarterly	[\$00.00]	[\$00.00]
Initial Term Expires	[Feb. 1, 2011]	Semi Annual	[\$00.00]	N/A
Initial Premium	[\$00.00]	Annual	[\$00.00]	N/A
Insured	[JOHN DOE]	Agent	[RESERVE NATIONAL AGENT]	

Dependents

Spouse **[JANE DOE]**

- [DEPENDENT 1]**
- [DEPENDENT 2]**
- [DEPENDENT 3]**
- [DEPENDENT 4]**
- [DEPENDENT 5]**

Indemnity Benefits and Limitations for Each Covered Person in Each Policy Year
Benefits or Visits not used in one Policy Year are not carried forward to any future Policy Year.

Outpatient X-Rays and Lab Tests Indemnity Benefit:

- X-Ray Indemnity Benefit\$75.00
- CT Scan/MRI Indemnity Benefit\$750.00
- Lab Test Indemnity Benefit\$50.00
- Maximum Aggregate Outpatient X-Rays and Lab Tests Indemnity Benefit..\$2,000.00 Per Policy Year

Outpatient Doctor Visits Indemnity Benefit..... \$50.00 Per Visit

- This benefit is limited to 1 Visit Per Day and 4 Visits Per Policy Year

Emergency Room Indemnity Benefit.....\$500.00 Per Policy Year

- This benefit is limited to 1 Visit Per Policy Year

Ambulance Indemnity Benefit:

- Air Ambulance Indemnity Benefit\$1,500.00 Per Trip
 *This benefit is limited to 2 Air Ambulance Trips Per Policy Year
- Ground Ambulance Indemnity Benefit\$500.00 Per Trip
 *This benefit is limited to 4 Ground Ambulance Trips Per Policy Year

Prescription Indemnity Benefit:

- Benefit Per Prescription\$25.00
- Maximum Aggregate Prescription Drug Indemnity Benefit \$500.00 Per Policy Year

Preventive Care Indemnity Benefits (see the Policy for specific age and frequency limitations):

- Colonoscopy Indemnity Benefit\$500.00
- Mammogram Indemnity Benefit\$125.00
- Pap Smear Indemnity Benefit \$100.00
- Diabetes Testing Indemnity Benefit\$50.00
- Prostate Examination Indemnity Benefit\$75.00

- Continued on reverse side -

--HOME OFFICE--
 RESERVE NATIONAL INSURANCE COMPANY * 601 EAST BRITTON ROAD * OKLAHOMA CITY, OKLAHOMA 73114

INSURED SCHEDULE

		<u>Renewal Premium:</u>	Direct Bill	Bank Draft
Policy Number	[00-00-000000]	Monthly	N/A	[\$00.00]
Effective Date	[Feb. 1, 2012]	Quarterly	[\$00.00]	[\$00.00]
Initial Term Expires	[Feb. 1, 2012]	Semi Annual	[\$00.00]	N/A
Initial Premium	[\$00.00]	Annual	[\$00.00]	N/A
Insured	[JOHN DOE]	Agent	[RESERVE NATIONAL AGENT]	

Dependents

Spouse **[JANE DOE]**

- [DEPENDENT 1]**
- [DEPENDENT 2]**
- [DEPENDENT 3]**
- [DEPENDENT 4]**
- [DEPENDENT 5]**

Indemnity Benefits and Limitations for Each Covered Person in Each Policy Year
Benefits or Visits not used in one Policy Year are not carried forward to any future Policy Year.

Outpatient X-Rays and Lab Tests Indemnity Benefit:

- X-Ray Indemnity Benefit\$50.00
- CT Scan/MRI Indemnity Benefit\$500.00
- Lab Test Indemnity Benefit\$25.00
- Maximum Aggregate Outpatient X-Rays and Lab Tests Indemnity Benefit..\$1,000.00 Per Policy Year

Outpatient Doctor Visits Indemnity Benefit..... \$25.00 Per Visit

- This benefit is limited to 1 Visit Per Day and 4 Visits Per Policy Year

Emergency Room Indemnity Benefit.....\$300.00 Per Policy Year

- This benefit is limited to 1 Visit Per Policy Year

Ambulance Indemnity Benefit:

- Air Ambulance Indemnity Benefit\$1,500.00 Per Trip
 *This benefit is limited to 2 Air Ambulance Trips Per Policy Year
- Ground Ambulance Indemnity Benefit\$250.00 Per Trip
 *This benefit is limited to 4 Ground Ambulance Trips Per Policy Year

Prescription Indemnity Benefit:

- Benefit Per Prescription\$10.00
- Maximum Aggregate Prescription Drug Indemnity Benefit \$250.00 Per Policy Year

Preventive Care Indemnity Benefits (see the Policy for specific age and frequency limitations):

- Colonoscopy Indemnity Benefit\$500.00
- Mammogram Indemnity Benefit\$125.00
- Pap Smear Indemnity Benefit \$100.00
- Diabetes Testing Indemnity Benefit\$50.00
- Prostate Examination Indemnity Benefit\$75.00

- Continued on reverse side -

--HOME OFFICE--

RESERVE NATIONAL INSURANCE COMPANY * 601 EAST BRITTON ROAD * OKLAHOMA CITY, OKLAHOMA 73114

Endorsements and Eliminations

- [PEB-3 (1/11)] [Applicable to JOHN DOE only, no benefits shall be paid prior to the expiration of 12 months from Feb. 1, 2012, as a result of:
Diabetes, including any complications thereof.]
- [R-1 (1/11)] [Applicable to JANE DOE only, effective Feb. 1, 2012, benefits excluded for:
Pneumonia and/or any disease of the respiratory tract, including any complications thereof.]

DEFINITIONS

The following terms in this Policy are defined as follows:

COVERED PERSON: "Covered Person" means only (a) the Insured, (b) the Insured's spouse and (c) all of the Insured's dependent children, including adopted children; provided such insured, spouse and dependent children are listed by name on the Insured Schedule and the applicable premium is paid. Upon the insured's death, his/her surviving spouse shall become the Insured if such spouse is a Covered Person at the time of the Insured's death.

HOSPITAL: "Hospital" means only a legally constituted institution which operates pursuant to law and is primarily engaged in providing or operating (either on its premises or in facilities available to the hospital on a prearranged contractual basis) facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, for which a charge is made, including facilities for diagnosis and surgery under the supervision of a staff of one or more licensed physicians and which provides 24-hour nursing service by or under the supervision of registered nurses on duty. "Hospital" does not mean convalescent, nursing, rest, or extended care facilities, or facilities operated exclusively for treatment of the aged, or drug or alcohol abuse, whether such facilities are operated as a separate institution or as a section of an institution operated as a Hospital.

INJURY: "Injury" means a Covered Person's accidental bodily injury resulting directly and independently of all other causes from an accident which occurs while a Covered Person whose injury is the basis of a claim is covered under this Policy.

LOSS: "Loss" means the event of a Covered Person's receipt of covered treatment, services or supplies for which a fixed indemnity benefit is payable under this Policy. As used in this Policy, "Loss" does not relate to any economic loss suffered by a Covered Person.

OUTPATIENT: "Outpatient" means covered treatment of a Covered Person's Injury or Sickness performed on an outpatient basis by or under the supervision of a Physician in the Physician's office, a clinic, an independent laboratory or X-ray facility, an outpatient department of a Hospital or a Hospital emergency room.

PHYSICIAN: "Physician" means any legally qualified individual (other than you, your spouse, your or your spouse's parent, grandparent, child, grandchild or sibling, or the spouse of any such individual, or anyone living at your residence) who is duly licensed and practicing the healing arts within the scope of his/her authority and license.

POLICY YEAR: "Policy Year" means each successive 12-month period extending from the Effective Date of this Policy, so that each successive 12-month period constitutes a single Policy Year.

PRE-EXISTING CONDITION: "Pre-Existing Condition" means a condition that has been diagnosed, or has manifested itself to you within the five-year period immediately preceding the Effective Date of this 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 this Policy.

SICKNESS: "Sickness" means a Covered Person's sickness or disease that manifests itself after this Policy's Effective Date and while a Covered Person whose sickness is the basis of a claim is covered under this Policy.

BENEFITS

OUTPATIENT X-RAYS AND LAB TESTS INDEMNITY BENEFIT

If a Covered Person, while this Policy is in force, undergoes an Outpatient X-Ray, MRI, CT Scan or a laboratory test performed or directed by or under the supervision of a Physician as the result of an Injury or Sickness, we will pay indemnity benefits as follows:

- (a) For each such X-Ray, we will pay the X-Ray Indemnity Benefit in the amount shown on the Insured Schedule.
- (b) For each such MRI or CT Scan, we will pay the MRI/CT Scan Indemnity Benefit in the amount shown on the Insured Schedule.
- (c) For each such laboratory we will pay the Lab Test Indemnity Benefit in the amount shown on the Insured Schedule.
- (d) The maximum benefit we will pay for all X-Rays, MRIs, CT Scans and laboratory tests in a Policy Year is limited to the Maximum Aggregate Outpatient X-Rays and Lab Tests Indemnity Benefit shown on the Insured Schedule.

OUTPATIENT DOCTOR VISITS INDEMNITY BENEFIT

If a Covered Person, while this Policy is in force, receives personal treatment by a Physician in the Physician's office or a clinic, as the result of an Injury or Sickness or for a routine examination, we will pay the Outpatient Doctor Visits Indemnity Benefit in the amount shown on the Insured Schedule. This benefit is limited to one visit per day, and not to exceed four visits in a Policy Year.

EMERGENCY ROOM INDEMNITY BENEFIT

If a Covered Person, while this Policy is in force, receives personal treatment by a Physician in a Hospital emergency room as the result of an Injury or Sickness, we will pay the Emergency Room Indemnity Benefit in the amount shown on the Insured Schedule. This benefit is limited to one visit in a Policy Year.

AMBULANCE INDEMNITY BENEFIT

If a Covered Person, while this Policy is in force, is transported to or from a Hospital as a result of an Injury or Sickness, we will pay the applicable indemnity benefit as follows:

- (a) **Air Ambulance:** For air transportation by a licensed ambulance service, we will pay the Air Ambulance Indemnity Benefit in the amount shown on the Insured Schedule, limited to two air ambulance trips in a Policy Year.
- (b) **Ground Ambulance:** For ground transportation by a licensed ambulance service, we will pay the Ground Ambulance Indemnity Benefit in the amount shown on the Insured Schedule, limited to four ground ambulance trips in a Policy Year.

This benefit will not be payable for any ambulance trip that is taken for the purpose of convenience.

PRESCRIPTION INDEMNITY BENEFIT

If a Covered Person, while this Policy is in force, purchases a Prescription Drug as the result of an Injury or Sickness, we will pay the Benefit Per Prescription in the amount shown on the Insured Schedule for each such Prescription Drug. The maximum benefit we will pay for all Prescription Drugs in a Policy Year is limited to the Maximum Aggregate Prescription Drug Indemnity Benefit shown on the Insured Schedule. For purposes of this benefit, "Prescription Drug" means a drug or medication which: (a) requires a prescription written by a Physician and (b) is dispensed by a licensed pharmacist.

BENEFITS (Continued)

PREVENTIVE CARE INDEMNITY BENEFITS

If a Covered Person, who meets the requirements specified below, while this Policy is in force, undergoes one or more of the following types of preventive care performed or directed by or under the supervision of a Physician, we will pay indemnity benefits as follows:

(a) **Colonoscopy Indemnity Benefit:** For a colonoscopy for a Covered Person who is age 50 or older, to screen for the presence of colon cancer, we will pay the Colonoscopy Indemnity Benefit in the amount shown on the Insured Schedule, limited to one screening colonoscopy every five Policy Years.

(b) **Mammogram Indemnity Benefit:** For a mammogram for a female Covered Person, we will pay the Mammogram Indemnity Benefit in the amount shown on the Insured Schedule, limited to:

(i) One baseline mammogram examination for each female Covered Person who is at least 35, but less than 40 years of age;

(ii) One mammogram examination every two Policy Years for each female Covered Person who is at least 40, but less than 50 years of age; and

(iii) One mammogram examination every Policy Year for each female Covered Person who is 50 years of age or older.

(c) **Pap Smear Indemnity Benefit:** For a Pap Smear for a female Covered Person, we will pay the Pap Smear Indemnity Benefit in the amount shown on the Insured Schedule, limited to one Pap Smear in a Policy Year. For purposes of this benefit, "Pap Smear" means an examination of the tissues of the cervix of the uterus for the purpose of detecting cancer when performed upon the recommendation of a Physician.

(d) **Diabetes Testing Indemnity Benefit:** For a blood test for diabetes, we will pay the Diabetes Testing Indemnity Benefit in the amount shown on the Insured Schedule, limited to one blood test for diabetes in a Policy Year.

(e) **Prostate Examination Indemnity Benefit:** For a Prostate Examination for a male Covered Person who is age 50 or older, we will pay the Prostate Examination Indemnity Benefit in the amount shown on the Insured Schedule, limited to one Prostate Examination in a Policy Year. For purposes of this benefit, "Prostate Examination" means a digital rectal examination and prostate specific antigen (PSA) test for the purpose of detecting prostate cancer when performed upon the recommendation of a Physician.

LIMITATION

This Policy does not pay any benefit for any diagnosis or treatment of a Covered Person he/she is confined as an inpatient of a Hospital.

EXCLUSIONS

This Policy does not cover any Loss 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 this 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; (d) intoxication, alcoholism or alcohol related illnesses; (e) mental illness, nervous or emotional disorders; (f) 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; (g) 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 an insured 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; (h) pregnancy or conditions due to pregnancy, **except** that complications of pregnancy shall be covered as any other Sickness; (i) childbirth; (j) participation in a felony or attempted felony, riot or insurrection; (k) rest cures, custodial care and routine physical examinations, except as specifically provided herein; (l) surgical sterilization; (m) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet; (n) eye glasses, hearing aids and examination for the prescription or fitting thereof.

PRE-EXISTING CONDITIONS LIMITATION

Pre-Existing Conditions are not covered under this Policy until this Policy has been in force for a period of two years; provided, however, that no benefits whatsoever will be payable for Loss from any condition, either pre-existing or otherwise, which is completely excluded from coverage under this Policy by name or specific description on the date of the Loss.

PREMIUM PAYMENTS

(a) All premiums are payable in advance to the Company at its Home Office. The payment of any premium shall not maintain the insurance under any Policy in force beyond the day immediately preceding the due date of the next premium except as provided in the Grace Period provision.

(b) Premiums are subject to change. Premiums for this Policy are based on the attained age of each Covered Person, and 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, the Insured's state of residence and/or ZIP code. Any change will apply to future premiums for all policies with the same form number issued by us to individuals in the Insured's state of residence. We will give the Insured 31 days written notice before any premium change. No change in premium will be effective before the first policy anniversary.

TERMINATION

Subject to the Grace Period provision, coverage will immediately terminate at 12:01 A.M., Standard Time, at the place where the Insured resides, on the due date of any premium which is not paid.

CONTINUATION OF COVERAGE UPON DIVORCE

If a Covered Person ceases to be covered under this Policy by reason of divorce, such Covered Person may continue his/her coverage under a separate policy identical to this Policy, subject to the following: (a) such Covered Person must give written notice to the Company within 30 days of such divorce of his/her desire to continue coverage; (b) the continuation policy will be issued without evidence of insurability; (c) the premium for the continuation policy will be no more than the premium that would be charged such Covered Person had the divorce not occurred; and (d) any waiting periods will be considered satisfied under the continuation policy to the extent satisfied under the Policy.

COVERAGE FOR SPOUSE AND DEPENDENT CHILDREN

Coverage will be provided for the Insured's spouse and/or dependent children (including adopted children) who are listed by name on the Insured Schedule; provided the applicable premium is paid. If the Insured's spouse and/or dependent children are not covered by this Policy such individual(s) may be added after the Effective Date by submitting a written application and paying the correct premium for his/her coverage. We must approve the application for his/her coverage to be effective.

A newborn child of the Insured is automatically covered for 90 days from the moment of birth. We must receive notice of birth and payment of the applicable premium within 90 days after the child's date of birth or before the next premium due date, whichever is later, in order to have the newborn's coverage continue beyond such 90-day period.

A newborn child adopted by the Insured is automatically covered for 60 days from the moment of birth if the petition for adoption is filed within 60 days after the child's date of birth. We must receive written notice of birth and payment of the applicable premium within 60 days after the child's date of birth in order to have the newborn adopted child's coverage continue beyond such 60-day period.

A child adopted by the Insured more than 60 days after the date of birth is automatically covered for 60 days from the date the petition for adoption is filed. We must receive written notice of the filing of the petition for adoption and payment of the applicable premium within 60 days after the date of placement in order to have the adopted child's coverage continue beyond such 60-day period.

For purposes of this provision, an adopted child includes a minor child under the charge, care and control of the insured, and for whom the Insured has filed a petition to adopt. The coverage of an adopted child will terminate upon the dismissal or denial of the petition for adoption.

RENEWAL SAFEGUARD

This Policy is renewable as follows:

- (a) The Company may not decline to renew this Policy except for one or both of the following reasons:
 - (1) Renewal premiums are declined on all policies bearing the same form number as this Policy issued to persons in the same state in which the Insured resides; or
 - (2) Failure to correctly report matters inquired of in the application for this Policy.
- (b) While this Policy is in effect, the Company shall not have the right to place any restrictive amendment hereon with respect to any coverage in effect hereunder. **There shall be no change in rate classification on account of any physical impairment of a Covered Person or on account of any claims under this Policy.**
- (c) The Company's right to refuse renewal, which is expressly reserved as set forth in (a) above, may be exercised by giving written notice, at least thirty (30) days prior to the expiration of the term for which premium has been paid, to the Insured by either delivery or by mailing to his last address as shown by the records of the Company when, not less than thirty (30) days thereafter, such refusal of renewal shall be effective.

UNIFORM PROVISIONS

1. ENTIRE CONTRACT; CHANGES: This Policy with any endorsements or attachments, is the entire contract of insurance. Only one of our executive officers can approve a change. Such approval must be endorsed on or attached to this Policy. It may not be changed in any way by any agent.

2. TIME LIMIT ON CERTAIN DEFENSES: (a) After three years from the Effective Date of this Policy, no misstatement of a Covered Person, except a fraudulent misstatement made in the application, shall be used to void this Policy. After two years from the Effective Date of the coverage with respect to any claim which is made, no misstatement of any Covered Person eligible for coverage under this Policy, except a fraudulent misstatement contained in a written instrument signed by a Covered Person, shall be used to deny a claim for Loss commencing after expiration of such three years. (b) No claim for Loss that starts after three years from the Effective Date of coverage will be reduced or denied because a Sickness or condition had existed before the Effective Date of coverage. This does not include diseases or physical conditions excluded specifically by name or description on an elimination endorsement or in the Exclusions provision.

UNIFORM PROVISIONS (Continued)

3. GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium falling due after the first premium. During the grace period, the Policy shall continue in force.

4. REINSTATEMENT: This Policy shall lapse if you do not pay the premium before the end of the grace period. If we or any agent authorized by us to accept premium later accepts premium and does not require an application for reinstatement, such acceptance shall reinstate this Policy. If we or such agent require an application for reinstatement and issue a conditional receipt for the premium tendered, this Policy shall be reinstated upon our approval of such application. If we do not approve it, this Policy shall be reinstated on the 45th day after such conditional receipt, unless we give you prior written notice of disapproval. The reinstated Policy shall cover only an Injury caused by an accident occurring after the date of reinstatement or a Sickness beginning more than 10 days from such date. In all other respects you and the Company shall have the same rights under this Policy as were in effect before it lapsed, unless special conditions are added in connection with the reinstatement. Premium accepted in connection with this provision shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement.

5. NOTICE OF CLAIM: You must give us written notice of claim. It must be given within 20 days after a covered Loss occurs or starts, or as soon as you reasonably can. You may give the notice or you may have someone do it for you. Such notice should give your name and Policy number. Notice should be mailed to us at our home office at 601 East Britton Road, Oklahoma City, Oklahoma 73114-7710, or to any authorized agent.

6. CLAIM FORMS: When we receive your notice, we will give or provide you forms for filing proof of Loss. If we do not give or provide them within 15 days, you can meet the proof of Loss requirement by giving us a written statement of what happened. This statement should include the type and extent of your Loss. We must receive this statement within the time given for filing proof of Loss.

7. PROOF OF LOSS: Written proof of Loss must be given within 90 days after such Loss. If it was not reasonably possible to give written proof in the time required, we shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity, the proof required must be given no later than one year from the time specified.

8. TIME OF PAYMENT OF CLAIMS: We will pay benefits immediately upon receipt of due written proof of Loss for benefits provided under this Policy. Any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of due written proof.

9. PAYMENT OF CLAIM: (a) Subject to the Direct Payment of Medical Services provision, benefits will be paid to you. Loss-of-life benefits, if any, are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to your estate. Any other benefits unpaid at death may be paid, at our option, either to your beneficiary or estate. (b) If benefits are payable to your estate or a beneficiary who cannot execute a valid release, we can pay benefits up to \$1,000 to someone related to you or your 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.

10. PHYSICAL EXAMINATION: We, at our expense, may have you examined when and as often as we may reasonably require while a claim is pending.

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

12. CHANGE OF BENEFICIARY: Unless you make an irrevocable designation of beneficiary, only you shall have the right to change the beneficiary. Consent of the beneficiary shall not be required to make any change in this Policy. Also, no such consent shall be required for surrender or assignment of this Policy.

13. CANCELLATION: This Policy may not be cancelled by the Company, nor by you, during a period for which premium has been paid and officially accepted by the Company. The Company may not decline to renew this Policy, except as provided in the Termination provision or the Renewal Safeguard provision.

POLICY PROVISIONS

- 1. MISSTATEMENT OF AGE:** If the age of a Covered Person has been misstated, all benefits payable to that person shall be in the amount the premiums paid would have purchased at the correct age.
- 2. UNPAID PREMIUM:** Any due and unpaid premium for this Policy may be deducted from its benefits then payable.
- 3. ILLEGAL OCCUPATION:** We shall not be liable for any Loss to which a contributing cause was your commission or attempt to commit a felony. We shall not be liable for any Loss to which a contributing cause was your participation in an illegal occupation or illegal activity.
- 4. INTOXICANTS AND NARCOTICS:** We shall not be liable for any Loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic, unless administered on the advice of a physician.
- 5. CONFORMITY WITH STATE STATUTES:** The provisions of this Policy must conform with the laws of the state in which you reside on the date of issue. If any do not, they are hereby amended to conform.
- 6. DIRECT PAYMENT OF MEDICAL SERVICES:** Subject to any written direction of the Insured, the indemnities provided hereunder on account of medical services will be paid directly to the Insured.
- 7. ALTERNATIVE DISPUTE RESOLUTION:** (a) If a dispute arises between a Covered Person and the Company concerning the payment or non-payment of benefits under this Policy, either party may request that the dispute be referred to mediation. Such a request must be submitted to the other party in writing and must include a description of the issue(s) in dispute. The parties will then contact the American Arbitration Association, which will appoint a mediator who is experienced in resolving health insurance disputes. (b) If the decision of the mediator is in favor of the Covered Person, the Company will accept the decision and pay the cost of the mediator and any experts he/she consults with. (c) If the decision of the mediator is in favor of the Company, the Company will pay the cost of the mediator and any experts he/she consults with. (d) This provision will not affect any right of a Covered Person under the Legal Actions provision of this Policy or applicable law.
- 8. INDEPENDENT, NONCOORDINATED FIXED DOLLAR BENEFITS PAYABLE REGARDLESS OF EXPENSES INCURRED:** Each benefit under this Policy is a fixed dollar amount that is payable regardless of the amount of expenses incurred. Each benefit under this Policy is independent of and is not coordinated with the benefits, exclusions or any other provision of any other health insurance coverage or health plan. Each benefit under this Policy is payable with respect to an event without regard to whether benefits are provided with respect to the same event under any other health insurance coverage or health plan. Benefits payable under this Policy will not be reduced on account of any other health insurance coverage or health plan.
- 9. REFUND OF UNEARNED PREMIUM UPON DEATH OF COVERED PERSON:** In the event of a Covered Person's death, any benefits payable to his/her estate shall include any premium paid for any period beyond the date of such Covered Person's death. Said unearned premium shall be paid in a lump sum within 30 days following our receipt of due written proof of death.
- 10. RIDERS OR ENDORSEMENTS:** Except for riders or endorsements which effectuate a request made in writing by you or exercises a specifically reserved right under this Policy, all riders or endorsements added to this Policy after the date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage shall require signed acceptance by you. After the date of Policy issue, any rider or endorsement which increases benefits or coverage with a corresponding increase in premium during the Policy term must be agreed to in writing signed by you, except if the increased benefits or coverage is required by law.

IN WITNESS WHEREOF, Reserve National Insurance Company has caused this Policy to be issued as of the effective date, and to be executed by its President and Secretary at its Home Office at 601 East Britton Road, in the City of Oklahoma City, Oklahoma.


Secretary


President

RESERVE NATIONAL INSURANCE COMPANY
OKLAHOMA CITY, OKLAHOMA

EXISTING CONDITION BENEFIT ENDORSEMENT

Reserve National Insurance Company, in consideration of the payment of the additional premium which has been included in the premium shown in the schedule of the Policy to which this Endorsement is attached, agrees to provide, subject to the hereafter described waiting period, the benefits set forth in the Policy for the following conditions which have manifested themselves to the Covered Person prior to the Effective Date hereof: [February 1, 2012]

Name of Covered Person: [JOHN DOE]

Condition(s): [Diabetes, including any complications thereof.]

WAITING PERIOD: No benefit shall be paid prior to the expiration of 12 months from the Effective Date of this Endorsement as a result of the above-listed condition(s).

All the provisions, conditions and limitations of the Policy to which this Endorsement is attached which are not modified hereby and which are not in conflict herewith shall be applicable to this Endorsement.

IN WITNESS WHEREOF, RESERVE NATIONAL INSURANCE COMPANY has caused this Endorsement to be executed by its President to be effective on the date listed above.


Secretary


President

RESERVE NATIONAL INSURANCE COMPANY
OKLAHOMA CITY, OKLAHOMA

Policy No. [00-00-000000]

Effective Date Endor. [February 1, 2012]

ELIMINATION RIDER

This Policy is attached to and made a part of the above numbered Policy and shall be effective as shown above.

With respect to **[JANE DOE]** named as a Covered
Person hereunder, this Policy is hereby amended to exclude benefits for:

[Pneumonia and/or any disease of the respiratory tract,
including any complications thereof.]

IN WITNESS WHEREOF, **RESERVE NATIONAL INSURANCE CO.** has issued this Policy.


Secretary


President

**ENDORSEMENT(S), IF ANY, AND PHOTOCOPY OF THE APPLICATION
ATTACHED HERETO CONSTITUTE PART OF THE CONTRACT**

THIS SPACE INTENTIONALLY LEFT BLANK



601 East Britton Road ▪ Oklahoma City, OK 73114

SUPPLEMENTAL OUTPATIENT FIXED INDEMNITY POLICY

**This Policy provides fixed indemnity benefit amounts
for covered outpatient treatment
of a Covered Person's Injury or Sickness.**

Read it carefully with the outline of coverage.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. THIS POLICY PAYS FIXED INDEMNITY BENEFIT AMOUNTS FOR COVERED OUTPATIENT TREATMENT, WITH LIMITS ON THE AMOUNTS PAYABLE FOR EACH COVERED TREATMENT AND IN EACH POLICY YEAR. IT IS RENEWABLE AS PROVIDED IN THE RENEWAL SAFEGUARD PROVISION. PREMIUMS ARE BASED ON EACH COVERED PERSON'S ATTAINED AGE. WE HAVE THE RIGHT TO INCREASE PREMIUMS ON A CLASS BASIS BY STATE.



601 East Britton Road ▪ Oklahoma City, OK 73114

When we use "we," "us," or "our" we mean Reserve National Insurance Company. When we use "you" or "your" we mean a Covered Person as defined in this Policy and as named on the Insured Schedule.

Reserve National Insurance Company agrees to indemnify the Covered Person(s) as hereinafter provided, subject, however, to all the provisions, conditions, exclusions, limits of liability and other terms in this Policy.

SUPPLEMENTAL OUTPATIENT FIXED INDEMNITY POLICY INSURING AGREEMENT

In consideration of the payment of the premium in advance and in reliance upon the statements in your application, a copy of which is attached and which forms a part of this Policy, we hereby indemnify the person(s) named on the Insured Schedule, commencing at 12:01 A.M., Standard Time, at the place where you reside, on the Effective Date shown on the Insured Schedule. The initial premium is for the policy term shown on the Insured Schedule. The renewal premium for later policy terms is due on the first day of the next policy term. The coverage provided by this Policy will cease if the renewal premium in effect is not paid when due or within the grace period. Each policy term will begin and end at 12:01 A.M., Standard Time, at the place where the Insured resides.

RENEWABILITY

Subject to the Termination provision, coverage under this Policy is renewable as provided in the **Renewal Safeguard** provision. Premiums are subject to change as provided in the Premium Payments provision.

IMPORTANT NOTICE

Please read the copy of the application attached to this Policy. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to the Company at 601 East Britton Road, Oklahoma City, Oklahoma 73114-7710, within 10 days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. The application is part of this Policy, which was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

NOTICE OF 10 DAY RIGHT TO EXAMINE POLICY

You are granted a period of 10 days from the date of delivery of this Policy to examine it. If you are not satisfied for any reason, this Policy may be returned within said 10 days to the Company at its Home Office or to the writing agent. Then the Company shall refund the premium paid, this Policy shall be void from its beginning, and you and Reserve National shall be in the same position as if it had never been issued.

THIS IS A LIMITED POLICY. IT ONLY PROVIDES SUPPLEMENTAL BENEFITS FOR COVERED OUTPATIENT TREATMENT. IT DOES NOT PROVIDE BENEFITS FOR SURGERY OR HOSPITALIZATION.

Read this Policy carefully with the Outline of Coverage.

TABLE OF CONTENTS

Benefits	Pages 4 & 5
Continuation of Coverage Upon Divorce	Page 6
Coverage for Spouse and Dependent Children.....	Page 7
Definitions.....	Page 3
Exclusions	Page 6
Important Notice.....	Page 1
Insured Schedule	Page 2
Insuring Agreement	Page 1
Limitation	Page 6
Notice of 10 Day Right to Examine Policy	Page 1
Policy Provisions	Page 9
Pre-Existing Conditions Limitation	Page 6
Premium Payments	Page 6
Renewability	Page 1
Renewal Safeguard	Page 7
Termination	Page 6
Uniform Provisions	Pages 7 & 8

INSURED SCHEDULE

		<u>Renewal Premium:</u>	Direct Bill	Bank Draft
Policy Number	[00-00-000000]	Monthly	N/A	[\$00.00]
Effective Date	[Feb. 1, 2011]	Quarterly	[\$00.00]	[\$00.00]
Initial Term Expires	[Feb. 1, 2011]	Semi Annual	[\$00.00]	N/A
Initial Premium	[\$00.00]	Annual	[\$00.00]	N/A
Insured	[JOHN DOE]	Agent	[RESERVE NATIONAL AGENT]	

Dependents

Spouse **[JANE DOE]**

- [DEPENDENT 1]**
- [DEPENDENT 2]**
- [DEPENDENT 3]**
- [DEPENDENT 4]**
- [DEPENDENT 5]**

Indemnity Benefits and Limitations for Each Covered Person in Each Policy Year
Benefits or Visits not used in one Policy Year are not carried forward to any future Policy Year.

Outpatient X-Rays and Lab Tests Indemnity Benefit:

- X-Ray Indemnity Benefit\$75.00
- CT Scan/MRI Indemnity Benefit\$750.00
- Lab Test Indemnity Benefit\$50.00
- Maximum Aggregate Outpatient X-Rays and Lab Tests Indemnity Benefit..\$2,000.00 Per Policy Year

Outpatient Doctor Visits Indemnity Benefit..... \$50.00 Per Visit

- This benefit is limited to 1 Visit Per Day and 4 Visits Per Policy Year

Emergency Room Indemnity Benefit.....\$500.00 Per Policy Year

- This benefit is limited to 1 Visit Per Policy Year

Ambulance Indemnity Benefit:

- Air Ambulance Indemnity Benefit\$1,500.00 Per Trip
 *This benefit is limited to 2 Air Ambulance Trips Per Policy Year
- Ground Ambulance Indemnity Benefit\$500.00 Per Trip
 *This benefit is limited to 4 Ground Ambulance Trips Per Policy Year

Prescription Indemnity Benefit:

- Benefit Per Prescription\$25.00
- Maximum Aggregate Prescription Drug Indemnity Benefit \$500.00 Per Policy Year

Preventive Care Indemnity Benefits (see the Policy for specific age and frequency limitations):

- Colonoscopy Indemnity Benefit\$500.00
- Mammogram Indemnity Benefit\$125.00
- Pap Smear Indemnity Benefit \$100.00
- Diabetes Testing Indemnity Benefit\$50.00
- Prostate Examination Indemnity Benefit\$75.00

- Continued on reverse side -

--HOME OFFICE--
 RESERVE NATIONAL INSURANCE COMPANY * 601 EAST BRITTON ROAD * OKLAHOMA CITY, OKLAHOMA 73114

INSURED SCHEDULE

		<u>Renewal Premium:</u>	Direct Bill	Bank Draft
Policy Number	[00-00-000000]	Monthly	N/A	[\$00.00]
Effective Date	[Feb. 1, 2012]	Quarterly	[\$00.00]	[\$00.00]
Initial Term Expires	[Feb. 1, 2012]	Semi Annual	[\$00.00]	N/A
Initial Premium	[\$00.00]	Annual	[\$00.00]	N/A
Insured	[JOHN DOE]	Agent	[RESERVE NATIONAL AGENT]	

Dependents

Spouse **[JANE DOE]**

- [DEPENDENT 1]**
- [DEPENDENT 2]**
- [DEPENDENT 3]**
- [DEPENDENT 4]**
- [DEPENDENT 5]**

Indemnity Benefits and Limitations for Each Covered Person in Each Policy Year

Benefits or Visits not used in one Policy Year are not carried forward to any future Policy Year.

Outpatient X-Rays and Lab Tests Indemnity Benefit:

- X-Ray Indemnity Benefit\$50.00
- CT Scan/MRI Indemnity Benefit\$500.00
- Lab Test Indemnity Benefit\$25.00
- Maximum Aggregate Outpatient X-Rays and Lab Tests Indemnity Benefit..\$1,000.00 Per Policy Year

Outpatient Doctor Visits Indemnity Benefit..... \$25.00 Per Visit

- This benefit is limited to 1 Visit Per Day and 4 Visits Per Policy Year

Emergency Room Indemnity Benefit.....\$300.00 Per Policy Year

- This benefit is limited to 1 Visit Per Policy Year

Ambulance Indemnity Benefit:

- Air Ambulance Indemnity Benefit\$1,500.00 Per Trip
*This benefit is limited to 2 Air Ambulance Trips Per Policy Year
- Ground Ambulance Indemnity Benefit\$250.00 Per Trip
*This benefit is limited to 4 Ground Ambulance Trips Per Policy Year

Prescription Indemnity Benefit:

- Benefit Per Prescription\$10.00
- Maximum Aggregate Prescription Drug Indemnity Benefit \$250.00 Per Policy Year

Preventive Care Indemnity Benefits (see the Policy for specific age and frequency limitations):

- Colonoscopy Indemnity Benefit\$500.00
- Mammogram Indemnity Benefit\$125.00
- Pap Smear Indemnity Benefit \$100.00
- Diabetes Testing Indemnity Benefit\$50.00
- Prostate Examination Indemnity Benefit\$75.00

- Continued on reverse side -

--HOME OFFICE--

RESERVE NATIONAL INSURANCE COMPANY * 601 EAST BRITTON ROAD * OKLAHOMA CITY, OKLAHOMA 73114

Endorsements and Eliminations

- [PEB-3 (1/11)] [Applicable to JOHN DOE only, no benefits shall be paid prior to the expiration of 12 months from Feb. 1, 2012, as a result of:
Diabetes, including any complications thereof.]
- [R-1 (1/11)] [Applicable to JANE DOE only, effective Feb. 1, 2012, benefits excluded for:
Pneumonia and/or any disease of the respiratory tract, including any complications thereof.]

DEFINITIONS

The following terms in this Policy are defined as follows:

COVERED PERSON: "Covered Person" means only (a) the Insured, (b) the Insured's spouse and (c) all of the Insured's dependent children, including adopted children; provided such insured, spouse and dependent children are listed by name on the Insured Schedule and the applicable premium is paid. Upon the insured's death, his/her surviving spouse shall become the Insured if such spouse is a Covered Person at the time of the Insured's death.

HOSPITAL: "Hospital" means only a legally constituted institution which operates pursuant to law and is primarily engaged in providing or operating (either on its premises or in facilities available to the hospital on a prearranged contractual basis) facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, for which a charge is made, including facilities for diagnosis and surgery under the supervision of a staff of one or more licensed physicians and which provides 24-hour nursing service by or under the supervision of registered nurses on duty. "Hospital" does not mean convalescent, nursing, rest, or extended care facilities, or facilities operated exclusively for treatment of the aged, or drug or alcohol abuse, whether such facilities are operated as a separate institution or as a section of an institution operated as a Hospital.

INJURY: "Injury" means a Covered Person's accidental bodily injury resulting directly and independently of all other causes from an accident which occurs while a Covered Person whose injury is the basis of a claim is covered under this Policy.

LOSS: "Loss" means the event of a Covered Person's receipt of covered treatment, services or supplies for which a fixed indemnity benefit is payable under this Policy. As used in this Policy, "Loss" does not relate to any economic loss suffered by a Covered Person.

OUTPATIENT: "Outpatient" means covered treatment of a Covered Person's Injury or Sickness performed on an outpatient basis by or under the supervision of a Physician in the Physician's office, a clinic, an independent laboratory or X-ray facility, an outpatient department of a Hospital or a Hospital emergency room.

PHYSICIAN: "Physician" means any legally qualified individual (other than you, your spouse, your or your spouse's parent, grandparent, child, grandchild or sibling, or the spouse of any such individual, or anyone living at your residence) who is duly licensed and practicing the healing arts within the scope of his/her authority and license.

POLICY YEAR: "Policy Year" means each successive 12-month period extending from the Effective Date of this Policy, so that each successive 12-month period constitutes a single Policy Year.

PRE-EXISTING CONDITION: "Pre-Existing Condition" means a condition that has been diagnosed, or has manifested itself to you within the five-year period immediately preceding the Effective Date of this 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 this Policy.

SICKNESS: "Sickness" means a Covered Person's sickness or disease that manifests itself after this Policy's Effective Date and while a Covered Person whose sickness is the basis of a claim is covered under this Policy.

BENEFITS

OUTPATIENT X-RAYS AND LAB TESTS INDEMNITY BENEFIT

If a Covered Person, while this Policy is in force, undergoes an Outpatient X-Ray, MRI, CT Scan or a laboratory test performed or directed by or under the supervision of a Physician as the result of an Injury or Sickness, we will pay indemnity benefits as follows:

- (a) For each such X-Ray, we will pay the X-Ray Indemnity Benefit in the amount shown on the Insured Schedule.
- (b) For each such MRI or CT Scan, we will pay the MRI/CT Scan Indemnity Benefit in the amount shown on the Insured Schedule.
- (c) For each such laboratory we will pay the Lab Test Indemnity Benefit in the amount shown on the Insured Schedule.
- (d) The maximum benefit we will pay for all X-Rays, MRIs, CT Scans and laboratory tests in a Policy Year is limited to the Maximum Aggregate Outpatient X-Rays and Lab Tests Indemnity Benefit shown on the Insured Schedule.

OUTPATIENT DOCTOR VISITS INDEMNITY BENEFIT

If a Covered Person, while this Policy is in force, receives personal treatment by a Physician in the Physician's office or a clinic, as the result of an Injury or Sickness or for a routine examination, we will pay the Outpatient Doctor Visits Indemnity Benefit in the amount shown on the Insured Schedule. This benefit is limited to one visit per day, and not to exceed four visits in a Policy Year.

EMERGENCY ROOM INDEMNITY BENEFIT

If a Covered Person, while this Policy is in force, receives personal treatment by a Physician in a Hospital emergency room as the result of an Injury or Sickness, we will pay the Emergency Room Indemnity Benefit in the amount shown on the Insured Schedule. This benefit is limited to one visit in a Policy Year.

AMBULANCE INDEMNITY BENEFIT

If a Covered Person, while this Policy is in force, is transported to or from a Hospital as a result of an Injury or Sickness, we will pay the applicable indemnity benefit as follows:

- (a) **Air Ambulance:** For air transportation by a licensed ambulance service, we will pay the Air Ambulance Indemnity Benefit in the amount shown on the Insured Schedule, limited to two air ambulance trips in a Policy Year.
- (b) **Ground Ambulance:** For ground transportation by a licensed ambulance service, we will pay the Ground Ambulance Indemnity Benefit in the amount shown on the Insured Schedule, limited to four ground ambulance trips in a Policy Year.

This benefit will not be payable for any ambulance trip that is taken for the purpose of convenience.

PRESCRIPTION INDEMNITY BENEFIT

If a Covered Person, while this Policy is in force, purchases a Prescription Drug as the result of an Injury or Sickness, we will pay the Benefit Per Prescription in the amount shown on the Insured Schedule for each such Prescription Drug. The maximum benefit we will pay for all Prescription Drugs in a Policy Year is limited to the Maximum Aggregate Prescription Drug Indemnity Benefit shown on the Insured Schedule. For purposes of this benefit, "Prescription Drug" means a drug or medication which: (a) requires a prescription written by a Physician and (b) is dispensed by a licensed pharmacist.

BENEFITS (Continued)

PREVENTIVE CARE INDEMNITY BENEFITS

If a Covered Person, who meets the requirements specified below, while this Policy is in force, undergoes one or more of the following types of preventive care performed or directed by or under the supervision of a Physician, we will pay indemnity benefits as follows:

(a) **Colonoscopy Indemnity Benefit:** For a colonoscopy for a Covered Person who is age 50 or older, to screen for the presence of colon cancer, we will pay the Colonoscopy Indemnity Benefit in the amount shown on the Insured Schedule, limited to one screening colonoscopy every five Policy Years.

(b) **Mammogram Indemnity Benefit:** For a mammogram for a female Covered Person, we will pay the Mammogram Indemnity Benefit in the amount shown on the Insured Schedule, limited to:

(i) One baseline mammogram examination for each female Covered Person who is at least 35, but less than 40 years of age;

(ii) One mammogram examination every two Policy Years for each female Covered Person who is at least 40, but less than 50 years of age; and

(iii) One mammogram examination every Policy Year for each female Covered Person who is 50 years of age or older.

(c) **Pap Smear Indemnity Benefit:** For a Pap Smear for a female Covered Person, we will pay the Pap Smear Indemnity Benefit in the amount shown on the Insured Schedule, limited to one Pap Smear in a Policy Year. For purposes of this benefit, "Pap Smear" means an examination of the tissues of the cervix of the uterus for the purpose of detecting cancer when performed upon the recommendation of a Physician.

(d) **Diabetes Testing Indemnity Benefit:** For a blood test for diabetes, we will pay the Diabetes Testing Indemnity Benefit in the amount shown on the Insured Schedule, limited to one blood test for diabetes in a Policy Year.

(e) **Prostate Examination Indemnity Benefit:** For a Prostate Examination for a male Covered Person who is age 50 or older, we will pay the Prostate Examination Indemnity Benefit in the amount shown on the Insured Schedule, limited to one Prostate Examination in a Policy Year. For purposes of this benefit, "Prostate Examination" means a digital rectal examination and prostate specific antigen (PSA) test for the purpose of detecting prostate cancer when performed upon the recommendation of a Physician.

LIMITATION

This Policy does not pay any benefit for any diagnosis or treatment of a Covered Person he/she is confined as an inpatient of a Hospital.

EXCLUSIONS

This Policy does not cover any Loss 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 this 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; (d) intoxication, alcoholism or alcohol related illnesses; (e) mental illness, nervous or emotional disorders; (f) 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; (g) 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 an insured 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; (h) pregnancy or conditions due to pregnancy, **except** that complications of pregnancy shall be covered as any other Sickness; (i) childbirth; (j) participation in a felony or attempted felony, riot or insurrection; (k) rest cures, custodial care and routine physical examinations, except as specifically provided herein; (l) surgical sterilization; (m) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet; (n) eye glasses, hearing aids and examination for the prescription or fitting thereof.

PRE-EXISTING CONDITIONS LIMITATION

Pre-Existing Conditions are not covered under this Policy until this Policy has been in force for a period of two years; provided, however, that no benefits whatsoever will be payable for Loss from any condition, either pre-existing or otherwise, which is completely excluded from coverage under this Policy by name or specific description on the date of the Loss.

PREMIUM PAYMENTS

(a) All premiums are payable in advance to the Company at its Home Office. The payment of any premium shall not maintain the insurance under any Policy in force beyond the day immediately preceding the due date of the next premium except as provided in the Grace Period provision.

(b) Premiums are subject to change. Premiums for this Policy are based on the attained age of each Covered Person, and 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, the Insured's state of residence and/or ZIP code. Any change will apply to future premiums for all policies with the same form number issued by us to individuals in the Insured's state of residence. We will give the Insured 31 days written notice before any premium change. No change in premium will be effective before the first policy anniversary.

TERMINATION

Subject to the Grace Period provision, coverage will immediately terminate at 12:01 A.M., Standard Time, at the place where the Insured resides, on the due date of any premium which is not paid.

CONTINUATION OF COVERAGE UPON DIVORCE

If a Covered Person ceases to be covered under this Policy by reason of divorce, such Covered Person may continue his/her coverage under a separate policy identical to this Policy, subject to the following: (a) such Covered Person must give written notice to the Company within 30 days of such divorce of his/her desire to continue coverage; (b) the continuation policy will be issued without evidence of insurability; (c) the premium for the continuation policy will be no more than the premium that would be charged such Covered Person had the divorce not occurred; and (d) any waiting periods will be considered satisfied under the continuation policy to the extent satisfied under the Policy.

COVERAGE FOR SPOUSE AND DEPENDENT CHILDREN

Coverage will be provided for the Insured's spouse and/or dependent children (including adopted children) who are listed by name on the Insured Schedule; provided the applicable premium is paid. If the Insured's spouse and/or dependent children are not covered by this Policy such individual(s) may be added after the Effective Date by submitting a written application and paying the correct premium for his/her coverage. We must approve the application for his/her coverage to be effective.

A newborn child of the Insured is automatically covered for 90 days from the moment of birth. We must receive notice of birth and payment of the applicable premium within 90 days after the child's date of birth or before the next premium due date, whichever is later, in order to have the newborn's coverage continue beyond such 90-day period.

A newborn child adopted by the Insured is automatically covered for 60 days from the moment of birth if the petition for adoption is filed within 60 days after the child's date of birth. We must receive written notice of birth and payment of the applicable premium within 60 days after the child's date of birth in order to have the newborn adopted child's coverage continue beyond such 60-day period.

A child adopted by the Insured more than 60 days after the date of birth is automatically covered for 60 days from the date the petition for adoption is filed. We must receive written notice of the filing of the petition for adoption and payment of the applicable premium within 60 days after the date of placement in order to have the adopted child's coverage continue beyond such 60-day period.

For purposes of this provision, an adopted child includes a minor child under the charge, care and control of the insured, and for whom the Insured has filed a petition to adopt. The coverage of an adopted child will terminate upon the dismissal or denial of the petition for adoption.

RENEWAL SAFEGUARD

This Policy is renewable as follows:

- (a) The Company may not decline to renew this Policy except for one or both of the following reasons:
 - (1) Renewal premiums are declined on all policies bearing the same form number as this Policy issued to persons in the same state in which the Insured resides; or
 - (2) Failure to correctly report matters inquired of in the application for this Policy.
- (b) While this Policy is in effect, the Company shall not have the right to place any restrictive amendment hereon with respect to any coverage in effect hereunder. **There shall be no change in rate classification on account of any physical impairment of a Covered Person or on account of any claims under this Policy.**
- (c) The Company's right to refuse renewal, which is expressly reserved as set forth in (a) above, may be exercised by giving written notice, at least thirty (30) days prior to the expiration of the term for which premium has been paid, to the Insured by either delivery or by mailing to his last address as shown by the records of the Company when, not less than thirty (30) days thereafter, such refusal of renewal shall be effective.

UNIFORM PROVISIONS

1. ENTIRE CONTRACT; CHANGES: This Policy with any endorsements or attachments, is the entire contract of insurance. Only one of our executive officers can approve a change. Such approval must be endorsed on or attached to this Policy. It may not be changed in any way by any agent.

2. TIME LIMIT ON CERTAIN DEFENSES: (a) After two years from the Effective Date of this Policy, no misstatement of a Covered Person, except a fraudulent misstatement made in the application, shall be used to void this Policy. After two years from the Effective Date of the coverage with respect to any claim which is made, no misstatement of any Covered Person eligible for coverage under this Policy, except a fraudulent misstatement contained in a written instrument signed by a Covered Person, shall be used to deny a claim for Loss commencing after expiration of such two years. (b) No claim for Loss that starts after two years from the Effective Date of coverage will be reduced or denied because a Sickness or condition had existed before the Effective Date of coverage. This does not include diseases or physical conditions excluded specifically by name or description on an elimination endorsement or in the Exclusions provision.

UNIFORM PROVISIONS (Continued)

3. GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium falling due after the first premium. During the grace period, the Policy shall continue in force.

4. REINSTATEMENT: This Policy shall lapse if you do not pay the premium before the end of the grace period. If we or any agent authorized by us to accept premium later accepts premium and does not require an application for reinstatement, such acceptance shall reinstate this Policy. If we or such agent require an application for reinstatement and issue a conditional receipt for the premium tendered, this Policy shall be reinstated upon our approval of such application. If we do not approve it, this Policy shall be reinstated on the 45th day after such conditional receipt, unless we give you prior written notice of disapproval. The reinstated Policy shall cover only an Injury caused by an accident occurring after the date of reinstatement or a Sickness beginning more than 10 days from such date. In all other respects you and the Company shall have the same rights under this Policy as were in effect before it lapsed, unless special conditions are added in connection with the reinstatement. Premium accepted in connection with this provision shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement.

5. NOTICE OF CLAIM: You must give us written notice of claim. It must be given within 20 days after a covered Loss occurs or starts, or as soon as you reasonably can. You may give the notice or you may have someone do it for you. Such notice should give your name and Policy number. Notice should be mailed to us at our home office at 601 East Britton Road, Oklahoma City, Oklahoma 73114-7710, or to any authorized agent.

6. CLAIM FORMS: When we receive your notice, we will give or provide you forms for filing proof of Loss. If we do not give or provide them within 15 days, you can meet the proof of Loss requirement by giving us a written statement of what happened. This statement should include the type and extent of your Loss. We must receive this statement within the time given for filing proof of Loss.

7. PROOF OF LOSS: If the Policy provides for periodic payment for a continuing Loss, written proof of Loss must be given to us within 90 days after the end of each period for which we are liable. For any other Loss, written proof must be given within 90 days after such Loss. If it was not reasonably possible to give written proof in the time required, we shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity, the proof required must be given no later than one year from the time specified.

8. TIME OF PAYMENT OF CLAIMS: We will pay benefits immediately upon receipt of due written proof of Loss for benefits provided under this Policy. However, a benefit that is payable by periodic payments, subject to due written proof of Loss, shall be paid monthly. Any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of due written proof.

9. PAYMENT OF CLAIM: (a) Subject to the Direct Payment of Medical Services provision, benefits will be paid to you. Loss-of-life benefits, if any, are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to your estate. Any other benefits unpaid at death may be paid, at our option, either to your beneficiary or estate. (b) If benefits are payable to your estate or a beneficiary who cannot execute a valid release, we can pay benefits up to \$1,000 to someone related to you or your 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.

10. PHYSICAL EXAMINATION: We, at our expense, may have you examined when and as often as we may reasonably require while a claim is pending.

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

12. CHANGE OF BENEFICIARY: Unless you make an irrevocable designation of beneficiary, only you shall have the right to change the beneficiary. Consent of the beneficiary shall not be required to make any change in this Policy. Also, no such consent shall be required for surrender or assignment of this Policy.

13. CANCELLATION: This Policy may not be cancelled by the Company, nor by you, during a period for which premium has been paid and officially accepted by the Company. The Company may not decline to renew this Policy, except as provided in the Termination provision or the Renewal Safeguard provision.

POLICY PROVISIONS

1. MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated, all benefits payable to that person shall be in the amount the premiums paid would have purchased at the correct age.

2. UNPAID PREMIUM: Any due and unpaid premium for this Policy may be deducted from its benefits then payable.

3. ILLEGAL OCCUPATION: We shall not be liable for any Loss to which a contributing cause was your commission or attempt to commit a felony. We shall not be liable for any Loss to which a contributing cause was your participation in an illegal occupation or illegal activity.

4. INTOXICANTS AND NARCOTICS: We shall not be liable for any Loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic, unless administered on the advice of a physician.

5. CONFORMITY WITH STATE STATUTES: The provisions of this Policy must conform with the laws of the state in which you reside on the date of issue. If any do not, they are hereby amended to conform.

6. DIRECT PAYMENT OF MEDICAL SERVICES: Subject to any written direction of the Insured, the indemnities provided hereunder on account of medical services will be paid directly to the Insured.

7. ALTERNATIVE DISPUTE RESOLUTION: If a dispute arises between a Covered Person and the Company concerning the payment or non-payment of benefits under this Policy, either party may request that the dispute be referred to mediation. Such a request must be submitted to the other party in writing and must include a description of the issue(s) in dispute. The parties will then contact the American Arbitration Association, which will appoint a mediator who is experienced in resolving health insurance disputes.

If the decision of the mediator is in favor of the Covered Person, the Company will accept the decision and pay the cost of the mediator and any experts he/she consults with.

If the decision of the mediator is in favor of the Company, the Company will pay the cost of the mediator and any experts he/she consults with.

This provision will not affect any right of a Covered Person under the Legal Actions provision of this Policy or applicable law.

8. INDEPENDENT, NONCOORDINATED FIXED DOLLAR BENEFITS PAYABLE REGARDLESS OF EXPENSES INCURRED: Each benefit under this Policy is a fixed dollar amount that is payable regardless of the amount of expenses incurred. Each benefit under this Policy is independent of and is not coordinated with the benefits, exclusions or any other provision of any other health insurance coverage or health plan. Each benefit under this Policy is payable with respect to an event without regard to whether benefits are provided with respect to the same event under any other health insurance coverage or health plan. Benefits payable under this Policy will not be reduced on account of any other health insurance coverage or health plan.

9. REFUND OF UNEARNED PREMIUM UPON DEATH OF COVERED PERSON: In the event of a Covered Person's death, any benefits payable to his/her estate shall include any premium paid for any period beyond the date of such Covered Person's death. Said unearned premium shall be paid in a lump sum within 30 days following our receipt of due written proof of death.

IN WITNESS WHEREOF, Reserve National Insurance Company has caused this Policy to be issued as of the effective date, and to be executed by its President and Secretary at its Home Office at 601 East Britton Road, in the City of Oklahoma City, Oklahoma.


Secretary


President

RESERVE NATIONAL INSURANCE COMPANY
OKLAHOMA CITY, OKLAHOMA

EXISTING CONDITION BENEFIT ENDORSEMENT

Reserve National Insurance Company, in consideration of the payment of the additional premium which has been included in the premium shown in the schedule of the Policy to which this Endorsement is attached, agrees to provide, subject to the hereafter described waiting period, the benefits set forth in the Policy for the following conditions which have manifested themselves to the Covered Person prior to the Effective Date hereof: [February 1, 2012]

Name of Covered Person: [JOHN DOE]

Condition(s): [Diabetes, including any complications thereof.]

WAITING PERIOD: No benefit shall be paid prior to the expiration of 12 months from the Effective Date of this Endorsement as a result of the above-listed condition(s).

All the provisions, conditions and limitations of the Policy to which this Endorsement is attached which are not modified hereby and which are not in conflict herewith shall be applicable to this Endorsement.

IN WITNESS WHEREOF, RESERVE NATIONAL INSURANCE COMPANY has caused this Endorsement to be executed by its President to be effective on the date listed above.


Secretary


President

RESERVE NATIONAL INSURANCE COMPANY
OKLAHOMA CITY, OKLAHOMA

Policy No. [00-00-000000]

Effective Date Endor. [February 1, 2012]

ELIMINATION RIDER

This Policy is attached to and made a part of the above numbered Policy and shall be effective as shown above.

With respect to **[JANE DOE]** named as a Covered
Person hereunder, this Policy is hereby amended to exclude benefits for:

[Pneumonia and/or any disease of the respiratory tract,
including any complications thereof.]

IN WITNESS WHEREOF, **RESERVE NATIONAL INSURANCE CO.** has issued this Policy.


Secretary


President

**ENDORSEMENT(S), IF ANY, AND PHOTOCOPY OF THE APPLICATION
ATTACHED HERETO CONSTITUTE PART OF THE CONTRACT**

THIS SPACE INTENTIONALLY LEFT BLANK



601 East Britton Road ▪ Oklahoma City, OK 73114

SUPPLEMENTAL OUTPATIENT FIXED INDEMNITY POLICY

**This Policy provides fixed indemnity benefit amounts
for covered outpatient treatment
of a Covered Person's Injury or Sickness.**

Read it carefully with the outline of coverage.