

SERFF Tracking Number: RNIC-128090333 State: Arkansas
Filing Company: Reserve National Insurance Company State Tracking Number:
Company Tracking Number:
TOI: H10I Individual Health - Dental Sub-TOI: H10I.000 Health - Dental
Product Name: DV-WD-2 Waiver of Deductible
Project Name/Number: DV-WD-2 Waiver of Deductible /

Filing at a Glance

Company: Reserve National Insurance Company

Product Name: DV-WD-2 – Waiver of Deductible SERFF Tr Num: RNIC-128090333 State: Arkansas

TOI: H10I Individual Health - Dental SERFF Status: Closed-Approved- Closed State Tr Num:

Sub-TOI: H10I.000 Health - Dental Co Tr Num: State Status: Approved-Closed
Filing Type: Form/Rate Reviewer(s): Rosalind Minor

Authors: Kyle Conrad, Brenda
Ingram, Mariana Garcia Disposition Date: 02/16/2012

Date Submitted: 02/15/2012 Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: DV-WD-2 – Waiver of Deductible

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Brenda Ingram

Filing Description:

February 15, 2012

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 02/16/2012

State Status Changed: 02/16/2012

Created By: Brenda Ingram

Corresponding Filing Tracking Number:

Mr. Dan Honey

Insurance Deputy Commissioner

Life and Health Division

Arkansas Insurance Department

1200 West Third Street

SERFF Tracking Number: RNIC-128090333 State: Arkansas
Filing Company: Reserve National Insurance Company State Tracking Number:
Company Tracking Number:
TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
Product Name: DV-WD-2 Waiver of Deductible
Project Name/Number: DV-WD-2 Waiver of Deductible /
Little Rock, AR 72201-1904

RE: Reserve National Insurance Company - NAIC # 68462
Form DV-WD-2 – Waiver of Deductible
Form OC DV-1 (3/12) – Outline of Coverage

Dear Mr. Honey:

We are submitting the above-referenced forms, which we request you consider for approval. This is a new filing not previously submitted.

Form DV-WD-2 is an optional rider that will be available with individual Supplemental Dental and Vision Expense Policy Form DV-1 that was approved by your office on 6/29/2010 under SERFF Tracking Number RNIC-126687030. Form DV-WD-2 provides for a waiver of the DV-1 Policy's deductible for "Type 1 Dental Services" (routine dental check-up, including x-rays and cleaning) and eye examinations.

Form OC DV-1 (3/12) is identical to the previously-approved outline of coverage for Policy Form DV-1, except that this new outline has been updated to reflect the availability of Form DV-WD-2.

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") because Form DV-WD-2, and the previously-approved policy this rider will be used with (i.e. Supplemental Dental and Vision Expense Policy Form DV-1) are "excepted benefits."

We anticipate that Form DV-WD-2 will be available to individuals age 0 through 85.

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

SERFF Tracking Number: RNIC-128090333 State: Arkansas
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 Product Name: DV-WD-2 Waiver of Deductible
 Project Name/Number: DV-WD-2 Waiver of Deductible /
 and Associate Corporate Counsel

Company and Contact

Filing Contact Information

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

Filing Company Information

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: AR Filing Fee.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Reserve National Insurance Company	\$100.00	02/15/2012	56380771

SERFF Tracking Number: RNIC-128090333 State: Arkansas
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Project Name/Number: DV-WD-2 Waiver of Deductible /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/16/2012	02/16/2012

SERFF Tracking Number: RNIC-128090333 State: Arkansas
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 Company Tracking Number:
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 Product Name: DV-WD-2 Waiver of Deductible
 Project Name/Number: DV-WD-2 Waiver of Deductible /

Disposition

Disposition Date: 02/16/2012

Implementation Date:

Status: Approved-Closed

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Reserve National Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking Number: RNIC-128090333 State: Arkansas
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	No
Supporting Document	Application	Approved-Closed	No
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	No
Form	Waiver of Deductible	Approved-Closed	No
Form	Outline of Coverage	Approved-Closed	No
Rate	Rates	Approved-Closed	No

SERFF Tracking Number: RNIC-128090333 State: Arkansas
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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/16/2012	DV-WD-2	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Waiver of Deductible	Initial		69.134	DV-WD-2.pdf
Approved-Closed 02/16/2012	OC DV-1 (3/12)	Outline of Coverage	Outline of Coverage	Revised	Replaced Form #: OC DV-1 (7/10) Previous Filing #: RNIC-126687030		OC DV-1 (3-12).pdf

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

**WAIVER OF DEDUCTIBLE
FOR TYPE 1 DENTAL SERVICES AND EYE EXAMINATIONS**

In consideration of the additional premium and effective with the date of issue, coverage under the Policy to which this Rider is attached is amended to include the following:

(1) While the Policy is in force, the **Deductible** provided in the Policy is hereby **waived** for any covered expenses incurred by a Covered Person for:

(A) **Type 1 Dental Services** under the Dental Benefit; and

(B) **Eye Examinations** under the Vision Benefit.

(2) While the Policy is in force, the **Deductible must be satisfied for each Policy Year** as provided in the Policy before any benefits are payable for any covered expenses incurred by a Covered Person for:

(A) **Type 2 Dental Services** under the Dental Benefit; and

(B) **Lenses and Frames** under the Vision Benefit.

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

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


Secretary


President



601 East Britton Road • Oklahoma City, OK 73114

SUPPLEMENTAL DENTAL AND VISION EXPENSE POLICY

THIS POLICY PROVIDES SUPPLEMENTAL BENEFITS FOR STATED DENTAL AND VISION EXPENSES

OUTLINE OF COVERAGE

Reserve National Insurance Company is hereinafter referred to as "we," "us" or "our." The individual(s) covered under the Policy are referred to as "you," "your" or "Covered Person."

NOTE: This policy is NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the Company.

1. READ YOUR POLICY CAREFULLY - This outline of coverage provides a very brief description of the important features of Dental and Vision Expense Policy Form DV-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!**

2. SUPPLEMENTAL DENTAL AND VISION EXPENSE COVERAGE is designed to supplement your existing coverage. Coverage is provided **ONLY** for certain dental and vision expenses as stated in the Policy, subject to all the Policy's conditions, limitations and exclusions. This policy does not cover hospital expenses. **THIS IS A LIMITED BENEFIT POLICY. THIS POLICY IS DESIGNED TO SUPPLEMENT, NOT REPLACE, EXISTING HOSPITALIZATION AND MEDICAL COVERAGE.**

3. DENTAL AND VISION EXPENSE BENEFITS: If you, while the Policy is in force, incur any of the following covered expenses in a Policy Year, we will pay benefits as follows:

(a) First, the **Deductible** you select below must be satisfied for each Policy Year. No benefits are payable for any covered expense making up the Deductible.

_____ (applicant's initials to select) \$ _____ **Deductible**

Each Covered Person must satisfy this Deductible before any benefits are payable to that Covered Person in that Policy Year.

(b) Then, we will pay the **applicable Benefit Percentage** (shown below) of the following items, **limited to the Maximum Policy Year Aggregate Benefit** you select below:

(1) Dental Benefit:

(A) **Type 1 Dental Services:** A routine dental check-up by or under the supervision of a licensed dentist, including X-rays and prophylaxis (cleaning), **limited to a maximum benefit of \$100.00 for each dental check-up and further limited to two dental check-ups in each Policy Year.**

(B) **Type 2 Dental Services:** Services of a licensed dentist other than Type 1 Dental Services, including fillings, root canals, crowns, bridges, onlays and dentures. Replacement or repair of existing fillings, crowns, bridges or dentures will not be covered until after the Policy has been in effect for 12 months or more.

The Dental Benefit does not include (i) oral hygiene supplies; (ii) cosmetic dental care or treatment, such as bonding or teeth whitening, **unless** it is for treatment of an accidental injury that occurred while this Policy is in force; (iii) orthodontic treatment or dental implants, **unless** it is for treatment of an accidental injury that occurred while this Policy is in force; or (iv) diagnosis or treatment of temporomandibular joint syndrome or craniomandibular joint syndrome.

(2) Vision Benefit:

(A) **Eye Examination:** An eye examination for the purpose of refraction, including any required diagnostic vision services in conjunction with the examination, performed by a Physician, including an ophthalmologist or optometrist, **limited to a maximum benefit of \$100.00 for each eye examination and further limited to one eye examination in each Policy Year.**

(B) **Lenses and Frames:** Eyeglass lenses (and frames) or contact lenses, excluding sunglasses, **limited to an aggregate benefit of \$300.00 in any 24-month period.** Replacement of existing eyeglasses or contact lenses will not be covered until the Policy has been in effect for 12 months or more.

4. BENEFIT PERCENTAGE: For each covered service the applicable Benefit Percentage is as follows:

Dental Benefit:

Type 1 Dental Services..... **80%**
Type 2 Dental Services **60%**

Vision Benefit:

Examination **80%**
Lenses and Frames **80%**

5. MAXIMUM POLICY YEAR BENEFIT: For each Covered Person, the benefits payable in any one Policy Year are limited to the **Maximum Policy Year Aggregate Benefit** you select below:

_____ (applicant's initials to select) \$ _____ **Maximum Policy Year Aggregate Benefit**

(Continued on reverse side)

6. _____ (applicant's initials to select) **OPTIONAL WAIVER OF DEDUCTIBLE FOR TYPE 1 DENTAL SERVICES AND EYE EXAMINATIONS:** For an additional premium, if you select this optional Rider, the Deductible will be waived for any covered expenses incurred by a Covered Person for:

(a) **Type 1 Dental Services** (routine dental check-up by or under the supervision of a licensed dentist, including X-rays and prophylaxis/cleaning), under the Policy's Dental Benefit; and

(b) **Eye Examinations** under the Policy's Vision Benefit.

This waiver does not affect any other benefits under the Policy. The Deductible must continue to be satisfied for each Policy Year as provided in the Policy before any benefits are payable for (A) Type 2 Dental Services under the Policy's Dental Benefit and (B) Lenses and Frames under the Policy's Vision Benefit.

7. EXCLUSIONS: The Policy does not cover any loss caused or contributed to by: (a) war or any act of war (whether war is declared or not); (b) any intentionally self-inflicted injury; (c) drug abuse or drug addiction; (d) intoxication, alcoholism or alcohol related illnesses; (e) participation in a felony or attempted felony, riot or insurrection; (f) charges that a Covered Person is not legally required to pay or that would not have been made if no insurance coverage had existed; (g) treatment received in a United States Government or Veterans facility for which a Covered Person is not required to pay; (h) cosmetic dental care or treatment, **except** that treatment of accidental injury received that occurred while this Policy is in force will be covered subject to the provisions of this Policy; (i) surgery to correct myopia, hyperopia, presbyopia or astigmatism; (j) procedures performed by you or a member of your immediate family ("immediate family" means 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); (k) prescription drugs; (l) expenses incurred to the extent benefits therefor are actually paid by Medicare.

8. PRE-EXISTING CONDITIONS LIMITATION: Pre-Existing Conditions are not covered under the Policy until the Policy has been in force for a period of 12 months; 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 which has been diagnosed, or has manifested itself to you within the 12-month 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 12-month period following the Effective Date of the Policy.

9. 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 date of any premium which is not paid. Additionally, a child's coverage will terminate as provided in the Policy's Coverage for Spouse and Dependent Children provision.

10. RENEWABILITY: Subject to the Policy's Termination provision, the Policy is **guaranteed renewable** at your option. We reserve the right to change premiums in accordance with the Policy's Premium Payments provision.

11. 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 an Insured's sex, attained age, smoking status and/or state (or other geographic classification) of residence. We will give you 31 days notice before any such premium change.

THIS IS A LIMITED BENEFIT POLICY.

IT ONLY PROVIDES BENEFITS FOR STATED DENTAL AND VISION EXPENSES. THIS POLICY IS NOT DESIGNED TO COVER ALL EXPENSES ASSOCIATED WITH YOUR DENTAL AND VISION NEEDS.

READ THE POLICY CAREFULLY WITH THIS OUTLINE OF COVERAGE.

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.

The undersigned applicant hereby acknowledges receipt of a copy of this Outline of Coverage.

Dated this _____ day of _____, year _____. Signed at _____,

State of _____.

Agent's Signature

Applicant's Signature

[This Outline of Coverage is to be delivered to the applicant at the time the application for insurance is completed.]
Dental and Vision Expense Policy Form DV-1 is individually underwritten by Reserve National Insurance Company.

SERFF Tracking Number: RNIC-128090333 State: Arkansas
 Filing Company: Reserve National Insurance Company State Tracking Number:
 Company Tracking Number:
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: DV-WD-2 Waiver of Deductible
 Project Name/Number: DV-WD-2 Waiver of Deductible /

Rate Information

Rate data applies to filing.

Filing Method: SERFF
Rate Change Type: Neutral
Overall Percentage of Last Rate Revision: 0.000%
Effective Date of Last Rate Revision:
Filing Method of Last Filing:

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Reserve National Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking Number: RNIC-128090333 State: Arkansas
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 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: DV-WD-2 Waiver of Deductible
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Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 02/16/2012	Rates	DV-WD-2	New		DV-WD-2 rates AR.pdf

EXHIBIT I

Reserve National Insurance Company, NAIC# 68462
Policy Form DV-WD-2 (DV-1 Rider)
Attained Age Monthly Premium
Arkansas

Attained Age	Regular Monthly	Bank Draft Monthly	Quarterly	Semi-Annual	Annual
0-18	\$5.45	\$5.00	\$16.00	\$31.70	\$60.15
19-64	\$5.45	\$5.00	\$16.00	\$31.70	\$60.15
65-99	\$5.45	\$5.00	\$16.00	\$31.70	\$60.15

Monthly Bank Draft = Monthly Rate x .92

Semi-Annual Rate = Monthly Rate x 5.82

Quarterly Rate = Monthly Rate x 2.94

Annual Rate = Monthly Rate x 11.04

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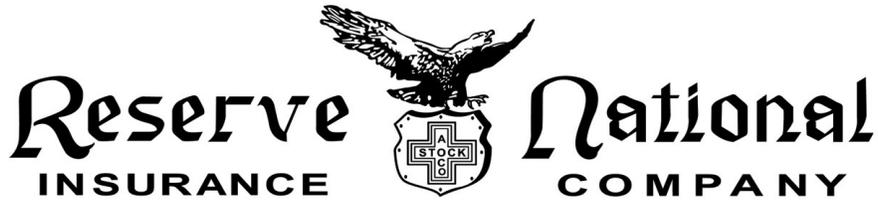
Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	02/16/2012
Comments:		
Attachment: DV-WD-2- Readability Certification.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved-Closed	02/16/2012
Bypass Reason: N/A		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Health - Actuarial Justification	Approved-Closed	02/16/2012
Comments:		
Attachment: Act Mem DV-WD-2 AR.pdf		

	Item Status:	Status Date:
Satisfied - Item: Outline of Coverage	Approved-Closed	02/16/2012
Comments:		
Attachment: OC DV-1 (3-12).pdf		



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

READABILITY CERTIFICATION

FORM NUMBER: **Form DV-WD-2 – Waiver of Deductible**

The words, sentences, and syllables of Form DV-WD-2 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:	113
SENTENCES:	7
Syllables:	162

This resulted in a Flesch Readability score of **69.134**.

A handwritten signature in black ink that reads "Kyle D. Conrad".

KYLE D. CONRAD
Senior Vice President
and Associate Corporate Counsel



601 East Britton Road • Oklahoma City, OK 73114

SUPPLEMENTAL DENTAL AND VISION EXPENSE POLICY

THIS POLICY PROVIDES SUPPLEMENTAL BENEFITS FOR STATED DENTAL AND VISION EXPENSES

OUTLINE OF COVERAGE

Reserve National Insurance Company is hereinafter referred to as "we," "us" or "our." The individual(s) covered under the Policy are referred to as "you," "your" or "Covered Person."

NOTE: This policy is NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the Company.

1. READ YOUR POLICY CAREFULLY - This outline of coverage provides a very brief description of the important features of Dental and Vision Expense Policy Form DV-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!**

2. SUPPLEMENTAL DENTAL AND VISION EXPENSE COVERAGE is designed to supplement your existing coverage. Coverage is provided **ONLY** for certain dental and vision expenses as stated in the Policy, subject to all the Policy's conditions, limitations and exclusions. This policy does not cover hospital expenses. **THIS IS A LIMITED BENEFIT POLICY. THIS POLICY IS DESIGNED TO SUPPLEMENT, NOT REPLACE, EXISTING HOSPITALIZATION AND MEDICAL COVERAGE.**

3. DENTAL AND VISION EXPENSE BENEFITS: If you, while the Policy is in force, incur any of the following covered expenses in a Policy Year, we will pay benefits as follows:

(a) First, the **Deductible** you select below must be satisfied for each Policy Year. No benefits are payable for any covered expense making up the Deductible.

_____ (applicant's initials to select) \$ _____ **Deductible**

Each Covered Person must satisfy this Deductible before any benefits are payable to that Covered Person in that Policy Year.

(b) Then, we will pay the **applicable Benefit Percentage** (shown below) of the following items, **limited to the Maximum Policy Year Aggregate Benefit** you select below:

(1) Dental Benefit:

(A) **Type 1 Dental Services:** A routine dental check-up by or under the supervision of a licensed dentist, including X-rays and prophylaxis (cleaning), **limited to a maximum benefit of \$100.00 for each dental check-up and further limited to two dental check-ups in each Policy Year.**

(B) **Type 2 Dental Services:** Services of a licensed dentist other than Type 1 Dental Services, including fillings, root canals, crowns, bridges, onlays and dentures. Replacement or repair of existing fillings, crowns, bridges or dentures will not be covered until after the Policy has been in effect for 12 months or more.

The Dental Benefit does not include (i) oral hygiene supplies; (ii) cosmetic dental care or treatment, such as bonding or teeth whitening, **unless** it is for treatment of an accidental injury that occurred while this Policy is in force; (iii) orthodontic treatment or dental implants, **unless** it is for treatment of an accidental injury that occurred while this Policy is in force; or (iv) diagnosis or treatment of temporomandibular joint syndrome or craniomandibular joint syndrome.

(2) Vision Benefit:

(A) **Eye Examination:** An eye examination for the purpose of refraction, including any required diagnostic vision services in conjunction with the examination, performed by a Physician, including an ophthalmologist or optometrist, **limited to a maximum benefit of \$100.00 for each eye examination and further limited to one eye examination in each Policy Year.**

(B) **Lenses and Frames:** Eyeglass lenses (and frames) or contact lenses, excluding sunglasses, **limited to an aggregate benefit of \$300.00 in any 24-month period.** Replacement of existing eyeglasses or contact lenses will not be covered until the Policy has been in effect for 12 months or more.

4. BENEFIT PERCENTAGE: For each covered service the applicable Benefit Percentage is as follows:

Dental Benefit:

Type 1 Dental Services..... **80%**
Type 2 Dental Services **60%**

Vision Benefit:

Examination **80%**
Lenses and Frames **80%**

5. MAXIMUM POLICY YEAR BENEFIT: For each Covered Person, the benefits payable in any one Policy Year are limited to the **Maximum Policy Year Aggregate Benefit** you select below:

_____ (applicant's initials to select) \$ _____ **Maximum Policy Year Aggregate Benefit**

(Continued on reverse side)

6. _____ (applicant's initials to select) **OPTIONAL WAIVER OF DEDUCTIBLE FOR TYPE 1 DENTAL SERVICES AND EYE EXAMINATIONS:** For an additional premium, if you select this optional Rider, the Deductible will be waived for any covered expenses incurred by a Covered Person for:

(a) **Type 1 Dental Services** (routine dental check-up by or under the supervision of a licensed dentist, including X-rays and prophylaxis/cleaning), under the Policy's Dental Benefit; and

(b) **Eye Examinations** under the Policy's Vision Benefit.

This waiver does not affect any other benefits under the Policy. The Deductible must continue to be satisfied for each Policy Year as provided in the Policy before any benefits are payable for (A) Type 2 Dental Services under the Policy's Dental Benefit and (B) Lenses and Frames under the Policy's Vision Benefit.

7. EXCLUSIONS: The Policy does not cover any loss caused or contributed to by: (a) war or any act of war (whether war is declared or not); (b) any intentionally self-inflicted injury; (c) drug abuse or drug addiction; (d) intoxication, alcoholism or alcohol related illnesses; (e) participation in a felony or attempted felony, riot or insurrection; (f) charges that a Covered Person is not legally required to pay or that would not have been made if no insurance coverage had existed; (g) treatment received in a United States Government or Veterans facility for which a Covered Person is not required to pay; (h) cosmetic dental care or treatment, **except** that treatment of accidental injury received that occurred while this Policy is in force will be covered subject to the provisions of this Policy; (i) surgery to correct myopia, hyperopia, presbyopia or astigmatism; (j) procedures performed by you or a member of your immediate family ("immediate family" means 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); (k) prescription drugs; (l) expenses incurred to the extent benefits therefor are actually paid by Medicare.

8. PRE-EXISTING CONDITIONS LIMITATION: Pre-Existing Conditions are not covered under the Policy until the Policy has been in force for a period of 12 months; 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 which has been diagnosed, or has manifested itself to you within the 12-month 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 12-month period following the Effective Date of the Policy.

9. 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 date of any premium which is not paid. Additionally, a child's coverage will terminate as provided in the Policy's Coverage for Spouse and Dependent Children provision.

10. RENEWABILITY: Subject to the Policy's Termination provision, the Policy is **guaranteed renewable** at your option. We reserve the right to change premiums in accordance with the Policy's Premium Payments provision.

11. 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 an Insured's sex, attained age, smoking status and/or state (or other geographic classification) of residence. We will give you 31 days notice before any such premium change.

THIS IS A LIMITED BENEFIT POLICY.

IT ONLY PROVIDES BENEFITS FOR STATED DENTAL AND VISION EXPENSES. THIS POLICY IS NOT DESIGNED TO COVER ALL EXPENSES ASSOCIATED WITH YOUR DENTAL AND VISION NEEDS.

READ THE POLICY CAREFULLY WITH THIS OUTLINE OF COVERAGE.

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.

The undersigned applicant hereby acknowledges receipt of a copy of this Outline of Coverage.

Dated this _____ day of _____, year _____. Signed at _____,

State of _____.

Agent's Signature

Applicant's Signature

[This Outline of Coverage is to be delivered to the applicant at the time the application for insurance is completed.]
Dental and Vision Expense Policy Form DV-1 is individually underwritten by Reserve National Insurance Company.