

**THIS IS A SPECIFIED DISEASE POLICY WITH LIMITED BENEFITS. THE BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES. EXCEPT AS OTHERWISE SPECIFIED, THIS POLICY WILL TERMINATE FOR A COVERED PERSON WHEN THEY REACH AGE 65. 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.**



**Underwritten by Reserve National Insurance Company**

**Administrative Office**

**PO Box 14327 Reading, PA 19612-4327**

**855.521.9366 MedMutualProtect.loomislive.com**

*When we use "we," "us," "Company" 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.*

## **SPECIFIED DISEASE POLICY**

### **INSURING AGREEMENT**

Reserve National Insurance Company agrees to pay benefits as provided herein, for certain specified expenses, subject however, to all the provisions, conditions, exclusions, limitations and other terms of this Policy.

### **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 contact the Company 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.**

In consideration of the payment of the premium in advance and in reliance upon the statements in the application of the Insured, a copy of which is attached and which forms a part of this Policy, the Company hereby insures those persons named on the Insured Schedule, commencing at 12:01 A.M., Standard Time, at the place where the Insured resides, on the Effective Date shown on the Insured Schedule. Upon the expiration of the initial term, as shown on the Insured Schedule, this Policy, subject to the Termination provisions, may be continued in effect by the payment in advance, or within the grace period specified herein, of the premium in effect at the time of such renewal.

### **NOTICE OF TEN-DAY RIGHT TO EXAMINE POLICY**

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

**THIS IS A SPECIFIED DISEASE POLICY. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. SEE THE INSURED SCHEDULE FOR THE COVERED SPECIFIED DISEASES FOR WHICH BENEFITS ARE PAYABLE. NO BENEFITS ARE PAYABLE FOR ANY OTHER CONDITION, ACCIDENT OR SICKNESS.**

**READ THIS POLICY CAREFULLY WITH THE OUTLINE OF COVERAGE.**

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## INSURED SCHEDULE

Policy Number: [00-C2-000000]

Payment Frequency: [Monthly]

Effective Date: [January 1, 2024]

Initial Premium: [\$0.00]

Payment Method: [Method]

Insured: [Jane Doe]

Initial Term Expires: [January 1, 2025]

Agent: [Reserve National Agent]

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### Dependents

[Dependent 1]

[Dependent 2]

[Dependent 3]

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### Policy Benefits and Limitations

**Benefits payable for Covered Specified Diseases are the Benefit Percentage of the Expense Incurred, subject to the Deductible, but not to exceed the maximum benefit amounts shown below. Please note the limitations and refer to the noted page numbers for details.**

Deductible (Applies for each Calendar Year) .....

Benefit Percentage.....

Max. Benefit Amount (Applies for each Calendar Year) .....

Max. Lifetime Benefit.....\$5,000,000

Wellness Benefit

Applies for each Calendar Year Policy Year, \$200 more than 90 days after the Effective Date.

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--HOME OFFICE--

RESERVE NATIONAL INSURANCE COMPANY  
*PO Box 14327 Reading, PA 19612-4327*

## **Covered Specified Diseases**

This Policy provides benefits for **ONLY** (a) the Covered Specified Diseases shown on the Insured Schedule, as listed below; and (b) any condition directly caused or aggravated by one or more of the following Covered Specified Diseases; and (c) qualifying services under the Wellness Benefit. Please refer to the definitions on page 3. No benefits are payable under this Policy for any other condition, accident or sickness.

Addison's Disease

Cancer

Coronary Artery/Cardiovascular Disease

COVID-19

Cushing's Disease

Diabetes

Ebola Virus Disease

End Stage Renal Failure

Gallbladder Disease

Gastrointestinal Disease

Gout

Hyperthyroidism

Hypothyroidism

Major Organ Transplant

Pancreatitis

Pneumonia

Psoriasis

Shingles

Stroke

Viral Hepatitis

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## **Endorsements and Eliminations**

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--HOME OFFICE--  
RESERVE NATIONAL INSURANCE COMPANY  
*PO Box 14327 Reading, PA 19612-4327*

## DEFINITIONS

The following terms in this Policy are defined as follows:

**ADDISON'S DISEASE** means adrenal gland failure due to disease of the adrenal glands with deficiency of cortisol and aldosterone and elevated pituitary hormone adrenocorticotrophic hormone (ACTH) or deficiency of ACTH caused by disorders of the pituitary gland or hypothalamus.

**ATTAINED AGE** means the age of a Covered Person on his/her last birthday.

**BENEFIT PERCENTAGE** means the percentage of covered Expense Incurred for a Covered Specified Disease which are payable under each expense-based benefits provision of this Policy. The Benefit Percentage under this Policy is shown on the Insured Schedule.

**CALENDAR YEAR** means the period beginning on January 1 of any year and ending on December 31 of the same year.

**CANCER:** means one of the disease or conditions listed below for which positive diagnosis is made by a Physician based on diagnostic criteria generally accepted by the medical profession:

A. **Benign Brain Tumor** means a non-malignant mass present within the substance of the brain tissue resulting in permanent deficit to the neurological system.

Benign Brain Tumor does not include cysts, granulomas, meningiomas, malformations of the intracranial arteries or veins and tumors of the cranial nerves, pituitary or spinal cord, unless documented by a legally qualified Physician as causing damage to surrounding neurological tissue; nor any non-malignant mass originally Diagnosed prior to the Effective Date of this Policy.

B. **Cancer In Situ** means a Diagnosis of cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue, except as specifically excluded below. As used herein, stage 0 disease and early prostate cancer requiring medical treatment shall be considered Cancer In Situ.

Cancer In Situ does not include:

1. Premalignant lesions, tumors or polyps;
2. Benign tumors or polyps;
3. Skin Cancer; or
4. Any cancer originally Diagnosed prior to the Effective Date of this Policy or the metastasis of any such cancer.

C. **Life-threatening Cancer** means only those types of cancer manifested by the presence of a malignant neoplasm characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Life-threatening Cancer also includes but is not limited to leukemia, Hodgkin's disease, myeloproliferative and myelodysplastic blood disorders, and invasive melanoma in the dermis or deeper.

Life-threatening Cancer does not include:

1. Premalignant lesions, tumors or polyps;
2. Benign tumors or polyps;
3. Cancer In Situ;
4. Skin Cancer; or
5. Any cancer originally Diagnosed prior to the Effective Date of this Policy or the metastasis of any such cancer.

D. **Skin Cancer** means a type of disease for which malignant cancer cells are found in the outer layer of the skin and which has not been Diagnosed as a malignant melanoma in the dermis or deeper or skin malignancy that has become Life-threatening Cancer, as defined herein.

Skin Cancer does not include:

1. Premalignant lesions, tumors or polyps; or
2. Benign tumors or polyps.

**CORONARY ARTERY/CARDIOVASCULAR DISEASE** means angina pectoris (stable angina), coronary insufficiency (unstable angina), myocardial infarction (heart attack), atherosclerosis, vessel spasms, clots, congestive heart failure or any other dysfunction of the cardiovascular system, including hypertension. Myocardial infarction shall be evidenced by: (a) angina with any EKG changes or (b) elevated Troponin.

**COVERED PERSON** means only (a) the Insured, (b) the Insured's spouse and (c) all of the Insured's dependent children, including adopted children, who are unmarried and under age 26 (see Coverage for Dependent Children provision); 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.

A dependent child of the Insured is automatically covered for 31 days from the moment of birth to the extent of the coverage provided by the Policy for a covered dependent child. We must receive written notice of birth and payment of the applicable premium within 31 days after the child's date of birth in order to have the newborn's coverage continue beyond such 31-day period. If separate Policies have been issued to the Insured and the Insured's spouse, only one of such Policies shall be applicable to a newborn child, i.e., the one providing greater benefits.

A newborn child adopted by the Insured is automatically covered for 31 days from the moment of birth to the extent of the coverage provided by the Policy for a covered newborn dependent child if placement for adoption occurs within 31 days after the child's date of birth. We must receive written notice of birth and payment of the applicable premium within 31 days after the child's date of birth in order to have the newborn adopted child's coverage continue beyond such 31-day period. A child adopted by the Insured who is not a newborn is automatically covered for 31 days from the date of placement for adoption to the extent of the coverage provided by the Policy for a covered dependent child. We must receive written notice of placement for adoption and payment of the applicable premium within 31 days after the date of placement in order to have the adopted child's coverage continue beyond such 31-day period.

The coverage of any child shall be subject to the Coverage for Dependent Children provision.

**COVERED SPECIFIED DISEASE** means only a primary or principal diagnosis, rendered while coverage under this Policy is in force, of one or more of the following, but only as shown on the Insured Schedule: Cancer, Coronary Artery/Cardiovascular Disease, Diabetes, Stroke, Major Organ Transplant, End Stage Renal Failure, Addison's Disease, Cushing's Disease, Ebola Virus Disease, Gastrointestinal Disease, Gout, Hyperthyroidism, Hypothyroidism, Pancreatitis, Psoriasis, Shingles, Viral Hepatitis, COVID-19, Gallbladder Disease, or Pneumonia. Covered Specified Disease shall also be deemed to include all Covered Specified Diseases suffered concurrently.

**COVID-19** means the severe acute respiratory disease called coronavirus disease 2019.

**CUSHING'S DISEASE** means a disease involving the adrenal glands, as evidenced by excessive glucocorticoid hormone levels.

**DEDUCTIBLE** means the amount of covered expenses that must be incurred before any benefits for expense-based benefits are payable. No benefits are payable for covered expenses making up the Deductible. The Deductible under this Policy is shown on the Insured Schedule.

**DIABETES** means diabetes mellitus, which is a group of metabolic disorders that result in hyperglycemia (high blood sugar), and any complications thereof, which include retinopathy, nephropathy, neuropathy and peripheral vascular disease. Diabetes shall be evidenced by elevated hemoglobin A1C (HB A1C).

**EBOLA VIRUS DISEASE** means a viral disease caused by one or more of a distinct species of the filovirus family, confirmed by a definitive pathological diagnosis made in accordance with accepted standards of medical practice and reported by a Physician as Ebola Virus Disease to the United States National Notifiable Disease Surveillance System and/or other United States federal public health authorities.

**EFFECTIVE DATE** means the date on which this Policy becomes effective, as shown on the Insured Schedule.

**END STAGE RENAL FAILURE** means only chronic irreversible failure of the function of both kidneys, which requires dialysis (hemodialysis or peritoneal dialysis) regularly.

**EXPENSE INCURRED** means the charges actually incurred by a Covered Person for covered medical treatment that is prescribed by a Physician, subject to the Maximum Allowable Amount for All Providers provisions. Expense is considered incurred on the date treatment is provided.

**EXPERIMENTAL/INVESTIGATIONAL** means a drug, device or medical care or treatment will be considered Experimental/Investigational if:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is furnished;
2. The informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigative phase, or if such a consent document is required by law;
3. Either the drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;
4. Reliable Evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental study or investigative arm of ongoing Phase III clinical trials; or is otherwise under study to determine the maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;
5. It is an unproven service, or
6. It is not the standard of care as documented by guidelines from appropriate professional organizations or medical societies.

**GASTROINTESTINAL DISEASE** means gastroesophageal reflux, peptic ulcer (duodenal and gastric), inflammatory bowel disease of the small intestine (Crohn's disease) and large intestine, appendicitis, ulcerative colitis, diverticulosis, diverticulitis, gastroenteritis, volvulus, rectal bleeding and irritable bowel syndrome.

**GALLBLADDER DISEASE** means inflammation, infection, stones or blockage of the gallbladder.

**GOUT** means hyperuricemia (high uric acid), a result of either overproduction or underexcretion of uric acid, causing intermittent episodes of acute arthritis.

**HOSPITAL** means only a legally constituted institution which operates pursuant to law having facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, 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. It does not mean convalescent, rehabilitation, 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.

**HOSPITAL SERVICES AND SUPPLIES** means items routinely billed by a Hospital, including: Electrocardiogram, Oxygen, Electroencephalogram, Surgical Dressings, Emergency Room, Medicine, Medical & Surgical Supplies and Equipment, Anesthetics, Drugs, X-rays, I.V. Solution, Laboratory, Transfusions (Blood not included), Antibiotics, Tissue Exam, CT Scan, Physiotherapy Service, Splints, Casts, Magnetic Resonance Imaging, PET Scan, Radiology, Pathology.

**HYPERTHYROIDISM** means a condition caused by excessive production of thyroid hormones.

**HYPOTHYROIDISM** means a condition caused by too little production of thyroid hormones from any cause.

**IMMEDIATE FAMILY** means the parents, spouse, children, or siblings of any Covered Person, or any person residing with a Covered Person.

**INSURED** means the Covered Person listed on the Insured Schedule.

**MAJOR ORGAN TRANSPLANT** means only definitive evidence of the failure of the Covered Person's **liver, kidney, lung, entire heart or pancreas** which requires the malfunctioning organ to be replaced with an organ from a human donor under generally accepted medical procedures, **and surgery to transplant the replacement organ into the Covered Person is actually performed** in the United States. Major Organ Transplant shall be evidenced by: (a) the Covered Person's registration with the United Network of Organ Sharing (UNOS) or similar network and (b) surgery actually performed in the United States to transplant a human liver, kidney, lung, entire heart or pancreas into the Covered Person by a Physician who is board certified to perform such surgery.

Major Organ Transplant does not include transplantation of any other organ or tissue, or replacing any human organ with a mechanical device or with an organ or tissue from an animal. Major Organ Transplant does not include, with respect to the heart, the transplant of a heart valve or anything less than the entire heart. Major Organ Transplant does not include removal of any organ from any donor. No benefits are payable under this Policy for any Expense Incurred by or for a donor in connection with a Covered Person's Major Organ Transplant.

**MEDICALLY NECESSARY** means a health care service, supply, or drug provided for the purpose of preventing, evaluating, diagnosing, or treating an illness or injury, or its symptoms, that is determined by us or in consultation with an appropriate medical professional to be all of the following:

- A. In accordance with generally accepted standards of medical practice.
- B. Clinically appropriate, in terms of type, frequency, extent, site, and duration and considered safe and effective for the covered person's illness or injury or their symptoms.
- C. Not provided mainly for the covered person's convenience or that of the covered person's doctor or other health care provider.
- D. Not furnished solely to promote athletic achievement, a desired lifestyle, or to improve the covered person's environmental or personal comfort.
- E. As cost effective as any established alternative service, supply, or drug that is as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the covered person's illness or injury or their symptoms.

A health care service, supply, or drug will not meet this definition based solely on the fact that a doctor or health care provider of a covered person performs, provides, prescribes, orders, recommends, or approves that service, supply or drug.

**NEGOTIATED RATE** means the amount we will pay for services pursuant to an agreement between us and an individual provider for an individual customer's services.

**OUTPATIENT SURGERY CENTER/AMBULATORY SURGERY CENTER** means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an outpatient/ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services, when operating within the scope of such license.

**OUTPATIENT SURGERY SERVICES AND SUPPLIES** means items routinely billed by an Outpatient Surgery Center/Ambulatory Surgery Center, including: Oxygen, Surgical Dressings, Medicine, Medical & Surgical Supplies and Equipment, Anesthetics, Drugs, X-rays, I.V. Solution, Laboratory, Transfusions (Blood not included), Antibiotics, Tissue Exam, CT Scan, Physiotherapy Service, Splints, Casts, Magnetic Resonance Imaging, PET Scan, Radiology, and Pathology.

**PANCREATITIS** means an inflammatory process involving the pancreas and which involves elevation of the serum amylase and serum lipase. Benefits are not payable for Pancreatitis that is the result of alcohol abuse or alcoholism.

**PHYSICIAN** means a person, other than the Covered Person, a member of the Covered Person's Immediate Family, or a business associate of the Covered Person, who is duly licensed, and who is legally qualified to diagnose and treat Sickness and injuries. He or she must be providing services within the scope of his or her license and must be a board-certified specialist where required under this Policy.

**PNEUMONIA** means an infection of the lungs that causes the air sacs, or alveoli, of the lungs to fill with fluid caused by bacteria, viruses, or fungi.

**PRE-EXISTING CONDITION** means a condition which has been diagnosed, or for which treatment, advice, medication or consultation was received, or that has manifested itself to the Covered Person, within the five-year period immediately preceding the Effective Date of this Policy by a sign or symptoms, whether the specific condition has been medically diagnosed or not.

**PSORIASIS** means a disease of the skin with well demarcated inflammatory plaques and papules usually covered by thickened silvery scales, and includes psoriatic arthritis. Psoriasis must be definitively diagnosed by a skin biopsy.

**REQUIREMENTS OF DIAGNOSIS** means that we must be furnished in writing a diagnosis of conditions by a Physician licensed in the United States. This diagnosis must include documentation supported by clinical, radiological, histological or laboratory evidence of the condition. We may require at our expense an additional examination by a Physician of our choice.



Diagnosis of a Heart Attack must be established by all of the following three criteria:

- (a) a clinical picture of a myocardial infarction;
- (b) electrocardiographic findings consistent with a myocardial infarction; and
- (c) elevation of cardiac enzymes above standard laboratory levels of normal (in the case of CPK, a CPK-MB measurement must be used).

**SHINGLES** means the latent varicella zoster virus that is reactivated in the sensory ganglia and moves down the sensory nerve to the skin and may also involve the eyes. "Shingles" does not include the primary infection known as chicken pox.

**STROKE** means a cerebrovascular accident within brain tissue caused by hemorrhage, embolism or thrombosis. Stroke shall be evidenced by: (a) documented measurable neurological deficit that persists for at least 72 hours following the occurrence of the Stroke and (b) neuroimaging studies that confirm the diagnosis.

Stroke does not mean transient ischemic attack (TIA), reversible neurological deficit, migraine, cerebral injury resulting from trauma, or vascular disease affecting the eye, optic nerve or vestibular functions or other cerebral events.

**URGENT CARE FACILITY** means a licensed and certified freestanding medical facility offering unscheduled medical services for more than 8 consecutive hours that is operated by a staff of Physicians, with at least one Physician on call at all times and a licensed Physician as the facility's full-time administrator. An Urgent Care Facility is not an emergency room or outpatient department of Hospital.

## BENEFITS

### EXPENSE-BASED BENEFITS

This Policy provides expense-based benefits for ONLY (a) the **Covered Specified Diseases** shown on the Insured Schedule and (b) any **condition directly caused or aggravated by** one or more of the Covered Specified Diseases shown on the Insured Schedule. No benefits are payable under this Policy for any other condition, accident or sickness.

(a) First, the **Deductible** must be **satisfied**. No benefits are payable for covered medical services making up the Deductible shown on the Insured Schedule.

(b) Then, we will pay the Benefit Percentage of the Expense Incurred for the following expenses, subject to the limitations below and not to exceed the Maximum Benefit Amount and Maximum Lifetime Benefit shown on the Insured Schedule:

**INPATIENT BENEFITS:** The following expenses, if billed by a Hospital for services while the Covered Person was a resident inpatient:

1. Daily room and board
2. Daily room or accommodation charge in a Hospital Intensive Care Unit
3. Use of operating, treatment or recovery room.
4. Hospital Services and Supplies routinely billed by the Hospital.
5. Treatment provided by a Physician or nursing services.
6. Expenses for the primary surgeon when a surgical operation is performed by a Physician. Expenses for a Physician or Physician Assistant who assists the primary surgeon are covered but not to exceed 25% of the benefit payable for the primary surgeon for the surgical procedure.
7. Expenses for the administration of anesthesia by a Physician for a surgical procedure are covered , but not to exceed 25% of the benefit payable for the primary surgeon for the surgical procedure.
8. Expenses for a prosthesis (a replacement part or device, whether organic or inorganic, implanted in the body to perform or augment a bodily function, including artificial limbs or eyes, casts, splints, trusses or braces).

Only the services and supplies shown above are covered under this benefit.

**EMERGENCY ROOM BENEFITS:** Expenses for treatment in a Hospital emergency room are covered if treatment is caused by a Covered Specified Disease, for which treatment is received.

**OUTPATIENT SURGERY BENEFITS:** The following expenses if billed by an Outpatient Surgery Center/Ambulatory Surgery Center for:

1. Expenses for the primary surgeon when a surgical operation is performed by a Physician. Expenses for a Physician who assists the primary surgeon are covered but not to exceed 25% of the benefit payable for the primary surgeon for the surgical procedure.
2. Expenses for the administration of anesthesia by a Physician for a surgical procedure are covered, but not to exceed 25% of the benefit payable for the primary surgeon for the surgical procedure.
3. Outpatient Surgery Services and Supplies routinely billed by the Outpatient Surgery Center/Ambulatory Surgery Center
4. This benefit does not include office-visit surgeries.

**ADDITIONAL OUTPATIENT BENEFITS:** If a Covered Person, incurs expenses for Outpatient Services for a Covered Specified Disease, while this Policy is in force, we will pay benefits as follows:

- (1) **Outpatient Doctor Visits:** expenses for personal treatment by a Physician;
- (2) **Outpatient Medical Imaging and Lab Tests:** expenses for Outpatient X-Ray, MRI, CT scan, EKG, Echocardiograms, nuclear medicine, EEG, EMG, PET scans, ultrasounds, MRA's or a laboratory test performed or directed by or under the supervision of a Physician;
- (3) **Urgent Care Services:** expenses for personal treatment by a Physician in an Urgent Care Facility;
- (4) **Ambulance Services:** expenses for ground or air ambulance transportation to or from a Hospital by a licensed ambulance service.;
- (5) **Physical Therapy Services:** expenses for physical therapy;
- (6) **Prosthesis:** expenses for a prosthesis (a replacement part or device, whether organic or inorganic, implanted in the body to perform or augment a bodily function, including artificial limbs or eyes, casts, splints, trusses or braces).

**MAXIMUM CALENDAR YEAR BENEFIT:** The maximum aggregate benefits payable for all Covered Services for each Covered Person under this Policy is limited to \_\_\_\_\_ per Calendar Year.

**TOTAL LIFETIME MAXIMUM OUTPATIENT BENEFIT:** The total lifetime maximum amount of benefits payable in the aggregate for all covered Outpatient Services expenses for each Covered Person under this Policy are limited to \$1,000,000.

**MAXIMUM LIFETIME BENEFIT:** The total lifetime maximum amount of benefits payable in the aggregate for all Covered Services for each Covered Person under this Policy is limited to \$5,000,000.

**WELLNESS BENEFIT:** After 90 days from the Effective Date, excluding vaccinations, benefits are payable for the following categories of preventive services:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force
- With respect to Covered Persons who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Service Administration (HRSA).
- Other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.

Examples of preventive services that fall within the above categories are:

- Preventive Gynecological Services
- Preventive Physical Examinations
- Preventive Screenings
- Women's preventive services
- Routine Testing

For a comprehensive list of recommended preventive services, please visit:  
[www.healthcare.gov/coverage/preventive-care-benefits](http://www.healthcare.gov/coverage/preventive-care-benefits)

## **MAXIMUM ALLOWABLE AMOUNT FOR ALL PROVIDERS**

Covered charges will be limited to what We determine to be the maximum allowable amount. A Covered Person may be billed by the provider for the portion of the bill We do not cover, in addition to any other applicable fees including, but not limited to, any coinsurance, copayment, Deductible, and any portion above the Maximum Benefit Amount.

For goods and services provided by a provider, facility or supplier including, but not limited to, professional, inpatient and outpatient claims, the maximum allowable amount is the lesser of:

1. Billed charges; or
2. The negotiated rate; or
3. If a negotiated rate is not available, in accordance with the following methodologies:

Two and half times the amount, as would be allowed to the facility or provider by Medicare, or an equivalent of what Medicare would allow based on the use of Medicare data and independent relative value unit or other data, for the goods and services reported on the claim, established utilizing the most currently available Medicare, provider-specific or facility-specific orthopedic schedules and methodologies, or available industry data sources.

## **EXCLUSIONS**

This Policy does not cover any loss caused by, resulting from, relating to or contributed to by:

- a. any condition, accident or sickness that is not a Covered Specified Disease specifically named on the Insured Schedule or that is not caused or aggravated by a Covered Specified Disease specifically named on the Insured Schedule;
- b. alcoholism or drug addiction;
- c. dental care or treatment;
- d. cosmetic or elective surgery, except that excluded cosmetic surgery shall not include breast reconstruction in connection with mastectomy, including reconstructive surgery on a non diseased breast to establish symmetry with a diseased breast on which reconstructive surgery has been performed;
- e. a Covered Specified Disease covered by any worker's compensation act or occupational diseases law;
- f. rest cures, custodial care, and routine physical examinations not covered under the Wellness Benefit;
- g. expenses incurred to the extent benefits are actually paid by Medicare;
- h. charges that a Covered Person is not legally required to pay or that would not have been made if no insurance coverage had existed;
- i. treatment received in a U.S. Government or Veterans hospital for which a Covered Person is not required to pay;
- j. eye glasses, hearing aids and examination for the prescription or fitting thereof;
- k. any expense incurred for the acquisition, purchase, harvesting or transportation of human or animal organs used in transplant procedures;
- l. a Covered Specified Disease sustained while serving in the military or auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer (we will return the pro-rata premium for any period not covered by this Policy while you are in such service or engaged in such work);
- m. Experimental or Investigational treatment;
- n. any services rendered outside of the United States;
- o. non-emergency air ambulance;
- p. ambulance services provided for a Covered Person's comfort or convenience;
- q. treatment, services or supplies that are not Medically Necessary as determined by us;

- r. services performed by a member of the Covered Person's Immediate Family;
- s. treatment, services or supplies provided at no cost to the Covered Person; or
- t. any amount in excess of the Maximum Allowable Amount;
- u. a covered Person being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician;
- v. participation in a felony riot or insurrection;
- w. participation in an illegal job.

## **TERMINATION**

A Covered Person's Policy will terminate upon the earlier of:

- a. At 12:01 A.M., Standard Time, at the place where the Insured resides, at the end of the 31-day grace period following the due date of any premium for that Covered Person which is not paid;
- b. For a dependent child, the date provided in the Coverage For Dependent Children provision; or
- c. The date we receive a request from you to terminate this policy or any later date stated in your request; or
- d. The date there is fraud or a material misrepresentation made by or with the knowledge of a Covered Person in filing a claim for policy benefits.
- e. On the earlier, the day a Covered Person reaches age 65 or becomes eligible under Medicare. Any acceptance of premium after such date shall be for the remaining persons who qualify as Covered Persons under the Policy and any excess premium will be refunded.
- f. The circumstances specified in Continuation Of Coverage Conversion For Spouse provision, if the Covered Person is the Insured's spouse.
- g. The date you reach the amount specified under the MAXIMUM LIFETIME BENEFIT provision.

## **CONTINUATION OF COVERAGE FOR SPOUSE**

If the Insured's spouse is a Covered Person, such spouse's coverage will terminate the day before the premium due date following the date of divorce, annulment, dissolution, or legal separation (where recognized) from the Insured. If coverage for the Insured's spouse terminates due to this paragraph the spouse will have the right to: (1) make written request, within 31 days of such termination, that a new policy be issued naming the spouse as the Insured; and (2) have a new policy issued without requiring evidence of insurability. The new policy will be effective on the date of the written request subject to our receipt of the applicable premium. The new policy will be one which: (A) is then currently utilized by the Company; and (B) contains benefit and renewability provisions at least as favorable as those contained in this Policy. For purposes of the Time Limit on Certain Defenses provision, the Effective Date of coverage under the new policy will be the same as that for this Policy.

## **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.

## PRE-EXISTING CONDITIONS LIMITATIONS

Any Covered Specified Disease which is a Pre-Existing Condition, as defined herein, is not covered under this Policy until this 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 not shown on this Policy's Insured Schedule on the date of the loss.

## PREMIUM PAYMENTS

(a) All premiums are payable in advance to Us. 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 hereinafter provided in the Grace Period provision.

(b) Premiums may be changed. Premiums for this Policy are based on the Attained Age of each Covered Person, and each Covered Person's premium will 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 Attained Age, and the Insured's state of residence. We will give you 31-day notice before any such premium change.

## COVERAGE FOR DEPENDENT CHILDREN

(a) The coverage on any dependent child shall cease on the child's 26<sup>th</sup> birthday or upon the child's marriage, whichever occurs first. Our acceptance of premium after such date shall be for the remaining persons who qualify as Covered Persons under this Policy and any excess premium will be refunded.

(b) Coverage may be continued for any covered dependent child regardless of age who: (1) is incapable of self-sustaining employment by reason of mental incapacitation or physical handicap; (2) became so incapacitated prior to age 26; and (3) is dependent on the Insured for support and maintenance. You must furnish us proof of such incapacity and dependency within 30 days of the child's 26<sup>th</sup> birthday. After the two-year period following the child's 26<sup>th</sup> birthday, proof of continued incapacity and dependency must be furnished at our request, but no more often than annually.

## UNIFORM PROVISIONS

**1. ENTIRE CONTRACT; CHANGES:** This Policy together with the application, endorsements, benefit agreements, riders and attached papers, if any, is the entire contract of insurance. No change in the Policy shall be valid until approved in writing by a Vice President, the Secretary or the President of the Company, and signed at our Home Office. Such approval must be noted on or attached to this Policy. No agent may change this Policy, and no agent may waive any of its provisions.

**2. TIME LIMIT ON CERTAIN DEFENSES:** 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, except a fraudulent misstatement contained in a written instrument signed by a Covered Person, shall be used to deny a claim for loss incurred commencing after expiration of such two years.

**3. GRACE PERIOD:** There will be a grace period of 31 days for payment of each premium falling due after the first premium. This Policy will stay in force during the grace period.

**4. REINSTATEMENT:** This Policy will lapse if you do not pay the premium before the end of the grace period. 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 of such conditional receipt, unless we give you prior written notice of disapproval. The reinstated Policy shall cover only loss due to a Covered Specified Disease occurring after the date of reinstatement. 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 or to any authorized agent.

**6. CLAIM FORMS:** When we receive your notice, we will send you forms for filing proof of loss. If we do not send 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 of and extent of the loss you incurred. We must receive this statement within the time given for filing proof of loss.

**7. PROOF OF LOSS:** You must give us written proof of your loss within 90 days after the date of loss or as soon as you reasonably can. Proof must, however, be furnished within 12 months except in the absence of legal capacity.

**8. TIME OF PAYMENT OF CLAIMS:** We will pay you 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 CLAIMS:** (a) Subject to the Direct Payment of Hospital, Medical Services provision, benefits will be paid to the Insured. Any other benefits unpaid at death may be paid, at the Company's option, either to the Insured's beneficiary or estate. (b) If benefits are payable to the Insured's estate or a beneficiary who cannot execute a valid release, we can pay benefits up to \$1,000 to someone related to the Insured or 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 AND AUTOPSY:** We, at our expense, may have you or your dependent examined when and as often as we may reasonably require while a claim is pending. We may also have an autopsy performed at our expense unless prohibited by law.

**11. LEGAL ACTIONS:** No action at law or in equity 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 three 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.

## **POLICY PROVISIONS**

**1. MISSTATEMENT OF AGE:** If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age. If a Covered Person's age has been misstated on the Covered Person's application for coverage under this policy, any future premiums will be adjusted and past premiums will be refunded or owed to us based on the Covered Person's correct age. If a Covered Person's age has been misstated and we would not have issued coverage for that Covered Person, we will refund the premium paid minus any benefit amounts paid by us, and coverage would be void from the effective date.

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

**3. 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.

**4. INCENTIVES:** We may furnish, or partner with other organizations that furnish, applicants for coverage or covered persons that meet common criteria determined by Us or our partners with programs where premiums and fees will be discounted, credited, refunded, waived or otherwise adjusted, or where other items of value may be offered or provided to You at no charge or a discount.

## **ADDITIONAL PROVISIONS**

**A. DIRECT PAYMENT OF HOSPITAL, MEDICAL SERVICES:** Benefits shall be payable to the Insured unless they are assigned to a health care provider. Any notice of assignment of benefits must be in writing. Notice of assignment of benefits received from a health care provider will be sufficient to cause Covered Expenses to be paid to the provider. You may revoke an assignment of benefits at any time by providing

written notice of the revocation to us. Any revocation shall be valid as to You and the health care provider.

**B. 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 as binding 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 medical experts it consults with.

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

**C. CANCELLATION:** The Policyowner may cancel this policy at any time. The Policyowner's request must be in writing and sent to Us. Cancellation will become effective on the day We receive the request, or on a later date specified in Your request. In the event of cancellation, We will promptly return the unearned portion of any Premium paid. This will be calculated using the pro-rata portion of any Premium paid. If any claim originated prior to the effective date of cancellation, We will pay the appropriate benefits due. We cannot cancel this policy for any reason other than nonpayment of Premium.

**D. COOPERATION PROVISION:** When a loss occurs, each Covered Person or their representative must promptly:

1. Sign, date and deliver to us an authorization which may be needed to obtain relevant information from doctors, hospitals and other third parties;
2. Answer any relevant questions, under oath, which we may ask about the loss;
3. Furnish a copy of any relevant document that pertains to the loss; and
4. Furnish any other assistance which we may reasonably require to process the claim.

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 E Britton Rd, in the City of Oklahoma City, Oklahoma.

*Patricia B. DeCangi*

Secretary

*Charles R. Stahl*

President

**ENDORSEMENTS, IF ANY, AND PHOTOSTAT OF APPLICATION ATTACHED  
HERETO CONSTITUTE PART OF THE CONTRACT**

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**Underwritten by Reserve National Insurance Company**

*Administrative Office*

*PO Box 14327 Reading, PA 19612-4327*

*855.521.9366 [MedMutualProtect.loomislive.com](http://MedMutualProtect.loomislive.com)*

**SPECIFIED DISEASE POLICY**