Reserve National
INSURANCE COMPANY
601 East Britton Road • Oklahoma City, OK 73114

OUTLINE OF COVERAGE
FOR INDIVIDUAL STANDARD HEALTH BENEFIT POLICY FORM ST-98-OH

I. **Read Your Policy Carefully.** This outline of coverage provides a very brief description of the important features of your policy. 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 your insurance company. It is therefore important that you **READ YOUR POLICY CAREFULLY!**

II. **The Individual Standard Health Benefit Policy** is designed to provide you with coverage for the Covered Expenses specified below, subject to the deductibles, coinsurance provisions and other limitations set forth in the policy.

III. **BENEFITS:**

MAXIMUM LIFETIME BENEFIT (Per Calendar Year).....$1,000,000
CASH DEDUCTIBLE AMOUNT (Per Calendar Year, Per Insured) $750
EMERGENCY ROOM DEDUCTIBLE (Per Visit) $75
PERCENTAGE OF COVERED EXPENSES IN EACH CALENDAR YEAR
70% of Covered Expenses Until Maximum Out of Pocket Expense After Cash Deductible is Met, per Insured
100% thereafter, of Covered Expenses, per Insured
MAXIMUM OUT OF POCKET EXPENSE AFTER CASH DEDUCTIBLE $5,000
MENTAL/NERVOUS DISORDER/ALCOHOLISM/DRUG ADDICTION
Lifetime Maximum per Insured $10,000
Annual Maximum Inpatient Benefit per Insured $2,000
Annual Maximum Outpatient Benefit per Insured $550
Eligible Covered Expense per Visit $50
LIFETIME MAXIMUM ORGAN TRANSPLANT BENEFIT $100,000
SPINAL MANIPULATION .....10 Treatments per Calendar Year
Eligible Covered Expense per Visit $25.00
OUTPATIENT PHYSICAL THERAPY .....20 Treatments per Calendar Year
Eligible Covered Expense per Visit $40
CHILD WELLNESS BENEFIT Calendar Year Maximum Benefit per Insured
Birth to Age 1 .....$500
Age 1 through Age 8 .....$150
MAMMOGRAPHY Calendar Year Maximum Benefit per Insured $85
OUTPATIENT PRESCRIPTION DRUGS Calendar Year Maximum Benefit per Insured $2,500
SPECIALTY CARE FACILITIES Calendar Year Maximum Benefit per Insured $5,000

We will pay the percentage(s), as shown above, of covered expenses, incurred while your coverage is in force, which exceeds the Cash Deductible Amount shown above. You are responsible for satisfying the Cash Deductible Amount for each Insured in each calendar year. All benefits are subject to the limitations stated in the Policy. No benefit will be certified for payment before the expense is actually incurred. No benefit is payable for expenses not deemed Medically Necessary.

Covered expenses are the reasonable and customary fees charged for the following covered services and supplies.

A. HOSPITAL IN-PATIENT BENEFITS - Expenses incurred for a semi-private hospital room, board and general nursing care furnished by the hospital when an Insured is necessarily confined as an overnight bed patient in a hospital, not to exceed the reasonable and customary average semi-private room charge of the hospital. Benefits payable for confinement in intensive care or cardiac care facilities in the hospital will be payable at three (3) times the average semi-private room rate. No benefit will be certified for payment before the expense is actually incurred.

Expenses incurred for medically necessary miscellaneous hospital services and supplies, furnished by the hospital when confined as stated above, for example: operating rooms, recovery room, anesthesia, surgical dressing, central supplies, casts and splints, medicines or drugs used in the hospital, x-ray photographs, laboratory service and oxygen equipment and services.

Charges for personal and convenience items like telephone, radio or television, guest meals or cots, take-home drugs or other items not consumed or used while confined are not covered expenses.

B. SURGEON AND ASSISTANT SURGEON FEE - Expenses incurred for physicians, including necessary assistant surgeons' fees, for surgical procedures performed in a same day surgery facility or when confined as an overnight bed patient in a hospital. (See limitations in the Policy.)

C. BENEFIT FOR ANESTHESIA ADMINISTRATION - Expenses incurred for an anesthesiologist for the administration of anesthesia while undergoing a covered surgical operation.

D. PHYSICIAN'S VISITS - Expenses incurred for services of a licensed physician, subject to the limitations shown above.

E. BENEFIT FOR PATHOLOGIST - Expenses incurred for services of a licensed pathologist while an Insured is confined as an overnight bed patient in a hospital.

F. BENEFIT FOR RADIOLOGIST - Expenses incurred for services of a licensed radiologist while an Insured is confined as an overnight bed patient in a hospital.

G. INPATIENT MENTAL/NERVOUS DISORDERS AND ALCOHOLISM/DRUG ADDICTION - Expenses incurred for treatment of mental/nervous disorders and/or substance abuse on an inpatient basis, up to $50 per visit, and a maximum benefit amount of $2,000 per calendar year. Inpatient and outpatient benefits combined may not exceed the lifetime maximum benefit stated above.

H. OUTPATIENT MENTAL/NERVOUS DISORDERS AND ALCOHOLISM/DRUG ADDICTION - Expenses incurred for treatment of mental/nervous disorders and/or substance abuse on an outpatient basis, up to $50 per visit, with a maximum benefit amount of $550 per calendar year. Inpatient and outpatient benefits combined may not exceed the lifetime maximum benefit stated above.

I. AMBULANCE BENEFIT - Expenses incurred for a professional ambulance service for transportation to a local hospital or the necessary transfer of an Insured from one local hospital to another.

J. DURABLE MEDICAL EQUIPMENT - Expenses incurred for the lesser of the rental or purchase of durable medical equipment incurred as a result of a covered sickness or injury. This equipment is to be for temporary use only, for a period not to exceed six (6) months.

K. MAMMOGRAPHY AND CYTOLOGIC SCREENING - Expenses incurred for an annual screening by mammography for the presence of occult breast cancer, subject to the calendar year maximum benefit shown above and following: (1) A baseline mammogram for women age 35 to 39, inclusive; (2) A mammogram for women age 40 to 49, inclusive, every 2 years or one per year if determined by a physician to have risk factors for breast cancer; and (3) A mammogram every year for women age 50 through 64.

MAMMOGRAM means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

Expenses incurred for cytologic screening for the presence of cervical cancer. Benefits will only be provided for cytologic screenings that are processed and interpreted in a laboratory certified by the College of American Pathologists or in a Hospital.

L. ORGAN TRANSPLANTS - Expenses incurred for the following transplants: 1) cornea, 2) heart, 3) combined heart and lung, 4) kidney, 5) pancreas, 6) bone marrow, 7) liver, and 8) lung, single and bi-lateral.

The covered expenses are initial testing and diagnosis; immunosuppressant drug therapy before and after surgery; complications resulting from surgery; organ rejection or failure; and repeat transplants of the same organ. Benefits are subject to the maximum benefit amount shown above.

M. CHILD WELLNESS BENEFIT - Expenses incurred for child health supervision services from the moment of birth through age eight years. These services will be payable up to the calendar year maximum benefit as stated above.

"Child Health Supervision Services" mean periodic review of a child's physical and emotional status performed by a physician or by a Health Care Professional under the supervision of a physician.

"Periodic Review" means a review performed in accordance .with the recommendations of the American Academy of Pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests.

N. OUTPATIENT PRESCRIPTION DRUGS - Expenses incurred for outpatient prescription drugs and/or medicines, due to a sickness or injury and considered medically necessary, subject to the calendar year maximum benefit shown above.

O. OUTPATIENT PHYSICAL THERAPY - Expenses incurred for outpatient physical therapy on an out-patient basis, subject to the limitations shown above.

P. SPINAL MANIPULATION BENEFITS - Expenses incurred for spinal manipulations, subject to the limitations shown above.

O. SPECIALTY CARE FACILITIES - Expenses incurred for the services provided in the following specialty care facilities subject to the calendar year maximum shown above: nursing home, convalescent home, extended care facility, home health care and hospice.

R. EMERGENCY ROOM BENEFIT - Expenses incurred for the services provided in an emergency room after the satisfaction of the $75 Emergency Room Deductible. This deductible is in addition to the calendar year Cash Deductible Amount and will be deducted with each emergency room service. This deductible can not be applied to the calendar year Cash Deductible Amount. We will waive the Emergency Room Deductible if the emergency room visit results in an admission to the hospital for a covered stay.

S. BENEFIT FOR MATERNITY – The benefits of the Policy will be payable for normal childbirth, normal pregnancy and routine nursery care for the Insured's newborn child, limited to a maximum benefit of $3,000 per pregnancy.

CASH DEDUCTIBLE AND MAXIMUM OUT-OF-POCKET-EXPENSE: The Cash Deductible. Amount shown above will be deducted only once during any one calendar year (January 1-December 31) for each Insured. You are responsible for satisfying the Cash Deductible Amount for. each Insured.

The Maximum Out of Pocket Expense listed above will apply for each Insured during any one calendar year (January 1-December 31). However, once an individual has met their Maximum Out of Pocket Expense in one calendar year, the Policy will cover 100% of covered expenses for the duration of that calendar year for the Insured.

IV. EXCLUSIONS AND LIMITATIONS no benefits will be paid for charges for: (1) Transportation, except local, to or from a Hospital, by professional ground ambulance services. (2) Normal childbirth, normal pregnancy or routine nursery care (except as provided on the Insured Schedule), elective cesarean section or voluntarily induced abortion. (3) Fertility or infertility studies, diagnostic testing, advice, consultation, examination, medication, or for any treatment related to or connected in any way with the restoration or enhancement of fertility or the inability to conceive or conception by artificial means, including, but not limited to, in-vitro fertilization or embryo transfer. (4) Replacement of artificial limbs and artificial eyes. (5) Blood or blood plasma which has been replaced. (6) Donation of any body organ by an Insured. (7) Services performed by a person who ordinarily resides in the Insured's home or is a close relative of the Insured or by the Insured's employer or partner. (8) Any cosmetic surgery, unless required to restore a part of the body which has been altered as a result of the following events or conditions that occurred while the Insured was insured by the Policy and for which benefits were paid in accordance with the terms of the Policy, (a) Accidental bodily injury; (b) Surgery; or (c) Disease that was first diagnosed while the Insured was insured by the Policy. (9) Custodial care. (10) Expenses applied to a deductible or coinsurance amount under any benefit of the Policy. (11) Services or treatment not prescribed by a doctor or for services or treatment not shown as covered. (12) Expenses due to an illness arising out of, or in the course of, employment for wages or profit. (13) Expenses incurred after the insurance terminates. (14) Treatment or services experimental or investigational in nature. (15) Eye refractions, eye glasses, or contact lens including fitting and examinations, or eye surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring), including, but not limited to radial keratotomy. (16) Treatment, services or supplies furnished by a department or agency of the United States Government. This exclusion will not apply to a non-service connected illness of a veteran of the United States armed forces who does not have a service connected illness. (17) Services and supplies eligible for payment by a government or charitable program, except as required by law. (18) Hearing aids, including fitting and examinations. (19) Expenses which are not necessary to the care or treatment of an illness. (20) Expenses which would not be made if no insurance existed. (21) Recreational or educational therapy or vocational rehabilitation. (22) Except as allowed under covered charges, subject to limitations, speech or occupational therapy and related diagnostic testing if the therapy or testing is in connection with or related in any way to the treatment of a learning disability, speech impediment, or developmental delay even though therapy is recommended due to organic dysfunction, including, but not limited to, congenital deformity or birth trauma. (23) Expenses which the Insured is not legally obliged to pay. (24) Treatment or services which are not generally accepted medical practices in the United

States for a given illness. (25) Treatment of obesity, morbid obesity or for weight reduction purposes. (26) Illness that results from participation in any assault, unlawful act, strike, civil disorder or riot. (27) The treatment of sexual dysfunction or inadequacies including but not limited to, impotence and the implantation of a penile prosthesis. (28) Routine physical or premarital examination except as may be covered under the Child Wellness Benefit. Mammograms and pap smears are covered. (29) A private room in excess of the average semi-private room and board rate. (30) Expenses in excess of reasonable and customary charges. (31) Services or supplies prohibited by law. (32) Sex changes. (33) Sterilization and reversal of sterilization. (34) Expenses resulting from any suicide, attempted suicide or intentionally self-inflicted injury or sickness while sane or insane. (35) Examination, treatment or surgery of the teeth, gums or direct supporting structure, except for repair of injury to sound natural teeth, (including their replacement) as a result of an accidental bodily injury which occurs while the person is insured. Treatment must be given within ninety (90) days of the date of the accident. (36) An illness caused. by any act of war, whether or not declared..(37) Surrogate pregnancy. (38) Surgery of the jaw or for any treatment of temporomandibular joint (TMJ) disorder. Treatment of jaw fractures and removal of tumors of the jaw will not be subject to this exclusion. (39) The treatment of complications arising from or connected in any way with a surgical or medical treatment or procedure that is not a covered expense under the terms of the Policy, whether or not the Insured was insured under the Policy at the time the non-covered treatment or procedure was performed. (40) Foot care due to: a. treatment of weak, strained or flat feet or instability or imbalance of the foot. b. treatment of corn, calluses or the free edge of toenails, except when necessitated for peripheral vascular disease or other illnesses of similar medical seriousness. (41) Contraceptives, infertility drugs and growth hormones.

PRE-EXISTING CONDITIONS: A pre-existing condition is any condition which manifested itself or which was the subject of medical advice or treatment by a health care provider during the six (6) month period immediately preceding the Effective Date of an Insured's coverage. Pregnancy is a pre-existing condition when inception of the pregnancy preceded the Effective Date of the pregnant Insured's coverage regardless of whether the pregnant Insured knew of the pregnancy.

No benefits will be paid for expenses incurred due to a pre-existing condition, as defined above. This limitation relates only to conditions treated during the six months immediately preceding the Effective Date of coverage. Benefits will be paid for expenses incurred for such condition after the end of the period of 12 months while you are insured under the Policy. This exclusion does not apply to federally eligible individuals.
Please see the policy for additional limitations.

V. RENEWABILITY: This plan is guaranteed renewable at the option of the Insured, except for the following reasons: (1) failure to pay premiums; (2) intentional misrepresentation; or (3) we cease to offer health insurance coverage and provide prior notification. Please see the Termination provision of the policy for more details regarding renewability 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 (applicable only if application is taken by an agent)

_____ Applicant's Signature