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

(Hereinafter called the "Company", "We", "Our" or "Us")

INDIVIDUAL STANDARD HEALTH BENEFIT POLICY

This Policy is issued in consideration of the payment of the Initial Premium.

We promise to pay you, the Insured, the benefits provided by this Policy for injuries and sicknesses occurring while this Policy is in force. All benefits are subject to the definitions, provisions, limitations and exclusions of this Policy. All benefits of this Policy are paid directly to you unless you assign them to the hospital or physician.

RENEWABLE AT THE OPTION OF THE INSURED

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 for more details regarding renewability of coverage.

RIGHT TO CHANGE RATES

Premiums are based on each Insured's attained age. Premiums will change as each Insured gets older according to a prearranged schedule. We may also change the amounts of the premiums in the schedule, but only if we change the premium rates on a class basis. My change in your scheduled premiums will take effect on the renewal date of change. We will give you 31 days written notice prior to any nonrenewal or rate change.

TEN DAY FREE LOOK

Carefully read this Policy as soon as you receive it. If you are not satisfied, you may return it to us at our Home Office within 10 days after you receive it. We will then refund all premiums you have paid, and you and the Company will be in the same position as if this Policy had never been issued.

IMPORTANT NOTICE

Please read the copy of the application attached to this Policy. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to the the company at 601 East Britton Rd, Oklahoma city, Oklahoma 73114-7710, within 10 days, if any Information shown on it Is not correct and complete, or if any past medical history has been left out of the application. The application is pan 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.

TABLE OF CONTENTS

INSURED SCHEDULE

Policy Number	42-K4-000000	Renewal Premium:	Direct Bill	Bank Draft
Effective Date	February 24, 1998	Monthly	$ 00.00	$ 00.00
Initial Term Date	February 24, 1998	Quarterly	$ 00.00	$ 00.00
Initial Premium	$00.00	Semi Annual	$ 00.00	$ 00.00
		Annual	$ 00.00	$ 00.00

Insured **JOHN DOE** Agent **RESERVE NATIONAL AGENT**

Insured Dependents

JANE DOE

Policy Benefits

MAXIMUM LIFETIME BENEFIT (Per Insured) $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
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

Endorsements and Eliminations

PART I - DEFINITIONS

For purposes of this Policy, the following terms are defined as follows:

A. YOU, YOUR, YOURS mean the Insured and each Covered Dependent named on the Insured Schedule whose coverage has become effective and has not terminated.

B. ALCOHOLISM OR DRUG ADDICTION means any use of alcohol or a controlled substance which produces as pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

C. COMPLICATIONS OF PREGNANCY means a condition that is distinct from pregnancy, but is adversely affected by pregnancy. This includes but is not limited to: acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar conditions of comparable severity. This also includes emergency non-elective cesarean section, ectopic pregnancy, hyperemesis gravidarum, and spontaneous abortion occurring when a viable birth is not possible. Complications of pregnancy do not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy not constituting a complication distinct from pregnancy.

D. CREDITABLE COVERAGE means with respect to an individual, coverage under any of the following: (a) a group health benefit plan, (b) health insurance coverage, (c) Medicaid or Medicare, (d) Title XIX of the Social Security Act, (e) Chapter 55 of Title 10, U.S. Code, (f) a medical care program of the Indian Health

Service or of a tribal organization, (g) a state health benefits risk pool, (h) a health plan under Chapter,

89, Title 5, U.S. Code, (i) a public health plan, or (j) a plan under the Peace Corps Act. Creditable coverage does not include coverage consisting solely of federally-defined excepted benefits.

E. COVERED DEPENDENT means an Eligible Dependent named on the Insured Schedule whose coverage has become effective and has not terminated.

F. DURABLE MEDICAL EQUIPMENT means equipment that meets all of the following criteria:

1. it can withstand repeated use,
2. It is primarily and customarily used to serve a medical purpose, rather than being primarily for comfort or convenience,
3. It is not customarily useful to a person, in the absence of a Sickness or an injury,
4. It is appropriate for home use,
5. It is related to the Insured's physical disorder, and
6. It is certified in writing by a Physician as being Medically Necessary.

G. ELIGIBLE DEPENDENT means your lawful spouse; your unmarried children, adopted children and children in the custody of the Insured pursuant to an interim court order of adoption, foster children and step-children. A dependent child of the Insured will be covered at least until the end of the calendar year in which the child reaches the age of 25, if (a) the child is dependent upon the Insured for support; and (b) the child is living in the household of the Insured or the child is a full-time or part-time student.

H. FEDERALLY ELIGIBLE INDIVIDUAL means an individual: (a) for whom, as of the date on which the individual seeks coverage, the aggregate of the periods of creditable coverage is 18 or more months and whose most recent creditable coverage was under a group, governmental or church plan, (b) who is not eligible for coverage under a group plan, Medicaid or Medicare, or any state plan, and does not have other coverage, (c) with respect to whom the most recent coverage within the coverage period was not terminated due to fraud or non-payment of premiums, (d) if the individual had been offered continuation coverage under COBRA, elected COBRA coverage, and (e) who, if elected COBRA coverage, has exhausted such coverage.

I. HOME HEALTH CARE means the care of an Insured under a plan of care established, approved in writing and reviewed at least every two months by the attending physician and including one or more of

the following:

1. Part-time or intermittent home nursing care by or under the supervision of a registered nurse,
2. Medically necessary part-time or intermittent Home Health Care services as part of the Home Health Care plan, under the supervision of a registered nurse or medical social worker consisting solely of care for the Insured,
3. Physical, respiratory, occupational or speech therapy,

4. Medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a hospital, if needed under the Home Health Care plan. This is true to the extent such items would be covered under the Policy if the insured had been hospitalized,
5. Nutrition counseling, provided by or under the supervision of a registered dietitian, where such services are Medically Necessary part of the Home Health Care plan,
6. The evaluation of the need for and development of a plan by a registered nurse, physician, extender or medical social worker, for Home Health Care when approved or requested by the attending physician.

J. HOSPITAL means an institution operated pursuant to law for care and treatment of sick or injured persons which:

1. maintains organized facilities for medical, diagnostic and surgical care for sick and injured persons on an in-patient basis for which a charge is made that the Insured is legally obligated to pay in the absence of insurance,
2. maintains a staff of one or more duly licensed physicians, and
3. provides 24 hour nursing care by or under the supervision of a registered graduate professional nurse (R.N.).

The term "Hospital" does not include:

1. any institution which is used principally as a facility for the aged, drug addicts, alcoholics, custodial care, education care, rest or convalescence, or
2. any military, veteran's hospital, soldier's home or any hospital contracted for or operated by the federal government or any agencies thereof for the treatment of members or former members of the armed forces; unless the Insured is legally required to pay for services in the absence of this insurance coverage.

K. INJURY means accidental bodily injury or injuries sustained by an Insured which is the direct cause of the loss independent of disease, bodily infirmity, or any other cause and occurs after the Insured's coverage became effective and while the coverage is in force.

L. INSURED means the Insured or a Covered Dependent under this Policy as named on the Insured Schedule.

M. MEDICALLY NECESSARY means a service, type of care, or procedure that is specified in a plan of care prepared by a physician and is appropriate and consistent with the physician's diagnosis and that could not be omitted without adversely affecting the Insured's illness or condition. Examples of hospitalization and other health care services and supplies that are not Medically Necessary include, but are not limited to:

a. Continued hospitalization of an Insured as a result of a covered pregnancy because the newborn cannot be discharged, or vice versa.
b. Continued hospitalization of an Insured because arrangements for discharge have not been completed.
c. Use of laboratory, x-ray, or other diagnostic testing that has no clear indication, or is not expected to alter the management plan (e.g., repetitive services).
d. Hospitalization because care in the home is unavailable or unsuitable; or hospitalization for any service which could have been provided safely and adequately in an alternate setting (e.g., Hospital outpatient department).
e. Hospitalization for the purpose of custodial care, convalescent care, or any other service primarily for the convenience of the patient and/or his/her family members.

NOTE: The fact that a Provider may prescribe, recommend, approve, or furnish a service or supply, of Itself, neither makes such service or supply Medically Necessary or a Covered Service; nor does it make any charge an Allowed Amount under this contract, whether or not such service or supply is specifically listed as an exclusion.

N. MEDICINES OR DRUGS means those medicines or drugs used in the hospital which can be obtained only upon written prescription of a physician.

PART I – DEFINITIONS (Continued)

O. MENTAL OR NERVOUS DISORDER means a neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

P. PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license; other than a member of the Insured's immediate family.

Q. PRE-EXISTING CONDITION means 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 the 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.

R. REASONABLE AND CUSTOMARY CHARGES, FEES OR EXPENSES means the most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred, so long as those charges are reasonable. The "most common charge" means the lesser of:

1. the actual amount charged by the provider,
2. the negotiated rate, or
3. the charge which would have been made by the provider (Doctor, Hospital, etc.) for a comparable services or supply made by other providers in the same geographic area, as reasonably determined by us for the same service or supply.

S. SAME DAY SURGERY FACILITY means a licensed public or private establishment with an organized staff of physicians and permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures. Such establishment must provide continuous physician services and registered professional nursing services whenever a patient is in the facility. The term "Same Day Surgery Facility" will include facilities operated by a hospital which provided scheduled, non-emergency outpatient surgical care.

T. ROOM AND BOARD CHARGES means the most common average semi-private hospital room rate in the geographic area where service is provided.

U. SICKNESS means sickness or disease of an Insured which first manifests itself after the insured's coverage became effective and while the coverage is in force.

V. SKILLED NURSING FACILITY means a place which: charges the patients for their expense; is legally operated in the state in which it's located, has beds for patients who need medical and skilled nursing care; operates under the supervision of a physician, has continuous 24 hour nursing service under the supervision of a Registered Nurse and keeps complete medical records on each patient. Skilled Nursing Facility also means a wing, area or floor of a Hospital specifically set aside for skilled nursing care.
It doesn't mean: a Hospital; a place that primarily treats the mentally ill, drug addicts or alcoholics, a home for the aged, rest home, community living center or a place that primarily provides domiciliary, residency or retirement care.

PART II - BENEFITS

We will pay the percentage(s), as shown on the Insured Schedule, of covered expenses, incurred while your coverage is in force, which exceed the Cash Deductible Amount shown on the Insured Schedule. You are responsible for satisfying the Cash Deductible Amount for each Insured in each calendar year. All benefits are subject to the limitations shown on the insured Schedule. 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 Part III).

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 on the Insured Schedule.

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 benefit maximum stated on the Insured Schedule.

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 on the Insured Schedule.

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 on the Insured Schedule 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 radio logic 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 cytological screening for the presence of cervical cancer. Benefits will only be provided for cytological 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 charges 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 on the Insured Schedule.

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 in the Insured Schedule.

"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 on the Insured Schedule.

O. OUTPATIENT PHYSICAL THERAPY

Expenses incurred for outpatient physical therapy on an outpatient basis, subject to the limitations shown on the Insured Schedule.

P. SPINAL MANIPULATION BENEFITS

Expenses incurred for spinal manipulations, subject to the limitations shown on the Insured Schedule.

Q. SPECIALTY CARE FACILITIES

Expenses incurred for the services provided in the following specialty care facilities, subject to the calendar year maximum benefit shown on the Insured Schedule: 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.

PART II - BENEFITS (Continued)

S. BENEFIT FOR MATERNITY

The benefits of this 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 listed on the Insured Schedule 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 on the Insured Schedule 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.

PART III - 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

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

OTHER BENEFIT LIMITATIONS

Payment for covered services is limited by payment guidelines currently in effect. These guidelines apply to covered services only and are in addition to all of the other provisions, limitations and exclusions contained in this contract. These guidelines include, but are not limited to, the following:

PART III – EXCLUSIONS AND LIMITATIONS (Continued)

A. Multiple Surgical Procedures are more than one surgical procedure performed on the same or different areas of the body during the same operative session. If Multiple Surgical Procedures are performed, the maximum payment shall be limited to: (a) if two or more procedures are performed through the same incision, payment shall be limited to the amount payable for the procedure having the greater payment; and (b) payments shall be limited to the amount payable for the procedure having the greater payment plus one-half of the amount that would have otherwise been payable for the procedures having the lesser benefit.

B. The benefit for services rendered by a physician acting in a surgical assistant role is limited to 20% of the benefit for the surgical procedure; provided no intern, resident, or other staff physician is available. Surgical assistant services must be rendered by a physician to be eligible for payment.

PART IV - EFFECTIVE DATE OF COVERAGE

You and Your Covered Dependents: Once we have received your application, coverage for you and your covered dependents will begin on the Effective Date shown on the Insured Schedule.

Newborn Children: Your newborn children will be provided coverage effective from the moment of birth for 31 days. Coverage during the 31 days will not be subject to any evidence of eligibility and will include coverage for congenital birth defects, birth abnormalities and premature birth. After the initial 31 day period, coverage will continue only if we have received: (1) written notice of birth from you during the initial 31 day period; (2) any required additional premium for such dependent by the end of the initial 31 day period; and (3) evidence of eligibility and insurability satisfactory to us.

Adopted Children: Adopted children shall be treated the same as newborn children and shall be eligible for coverage on the same basis upon placement in the adoptive home, regardless of whether a final decree of adoption has been entered; provided that a petition for adoption has been duly filed and is pursued to a final decree of adoption.

Addition of Dependents: You may add additional dependents by providing evidence of eligibility satisfactory to us and upon payment of the premium required for such additional dependents. The acceptance of new covered dependents will be shown by endorsement and the date of the endorsement will be the effective date of coverage for the new covered dependents.

PART V - PREMIUMS

Payment of Premiums: Premiums are payable to us at our Home Office. The premium is payable monthly, quarterly, semiannually or annually. Payment of any premium will not maintain the Policy in force beyond the next premium due date, except as provided by the grace period. Any indebtedness of the Insured to us arising out of prior claims may be deducted in any settlement under this Policy.

Grace Period: A grace period of 31 days, measured from the premium due date, will be allowed for payment of all premiums due, other than the first. During this time, the coverage will remain in force, unless we receive previous written notice that the coverage is to be terminated prior to the grace period.

Premiums Subject to Change: Premiums are based on each Insured's attained age. Premiums will change as each Insured gets older according to a prearranged schedule. We may also change the amounts of the premiums in the schedule, but only if we change the premium rates on a class basis. Any change in your scheduled premiums will take effect on the renewal date of the change. We will give you 31 days written notice prior to any nonrenewal or rate change.

PART VI - TERMINATION OF COVERAGE

This Policy shall remain in effect until terminated by either party in a manner consistent with this contract.

A. Voluntary Cancellation by You; Non-Cancellation by Us: You may cancel this Policy at any time by written notice delivered or mailed to us, effective upon receipt or on such later date as specified in such notice. In the event of cancellation, we will return promptly the unearned portion of any premium paid. The earned premium shall be computed by use of the short-rate table last filed with the state official having supervision of insurance in the state where the Insured resided when this Policy was issued. Cancellation shall not affect any claim originating prior to the effective date of cancellation. We may not cancel this Policy during any period for which premiums have been paid.

PART VI - TERMNATION OF COVERAGE (Continued)

B. Termination for Cause: This Policy is guaranteed renewable at the option of the Insured, except for one or more of the following reasons:

1. The Insured failed to pay premiums or contributions in accordance with the terms of the Policy or we have not received timely premium payments,
2. The Insured has made an intentional misrepresentation of material fact under the terms of the Policy, or
3. We cease to offer coverage in the individual market in accordance with this section.

If we elect to discontinue offering all health insurance coverages in the individual market, we will provide notice to each individual and to the Ohio Department of Insurance at least 180 days prior to the date of expiration of coverage.

C. Termination of a Covered Dependent's Coverage: A Covered Dependent's coverage under this contract will terminate as follows:

1. on the date this contract terminates;
2. on the date specified by the Company that the dependent's coverage is terminated by the Company for cause;
3. on the date specified by the primary Insured that the dependent's coverage terminates; or
4. if a Covered Dependent has made an intentional misrepresentation of material fact under the terms of this Policy.

D. Continuation of Coverage: A covered spouse will become the primary Insured under this Policy if the Insured dies or becomes eligible for Medicare. Coverage of the remaining Insureds will not change as a result of such continuation of coverage. The continuation of coverage is subject to the renewability provisions of this Policy.

E. Conversion Privilege: Subject to the renewability provisions of this Policy, if a Covered Dependent's coverage terminates due to divorce, annulment or dissolution of marriage, or the legal separation of a covered spouse from the primary Insured, that Covered Dependent may apply for a Conversion policy. If that Covered Dependent makes written application and pays the required premium within 31 days after termination, we will issue the Covered Dependent a new policy. The new policy will (1) be a policy then available which is most comparable to this Policy and (2) be based on attained age and where that Covered Dependent lives. The new policy will not require evidence of insurability.

PART VII - GENERAL PROVISIONS

Entire Contract; Changes: The Policy and any endorsements, including the enrollment application, is the entire contract. Only an officer of the Company has the power on our behalf to execute or change the contract. No other person will have the authority to bind us in any manner. Any change in the coverage will be made by amendment approved and signed by us.

The written statements made in the application by the Insured are deemed, in the absence of fraud, to be representations and not warranties.

Notice of Claim: Written notice of claim must be given us as soon as possible. The notice may be given to us at our home office or to the agent. Notice should include the name of the Insured and the policy number.

Claim Forms: Upon receipt of written notice of claim, we will furnish the forms we require for filing proof of loss. If we do not send the forms within 15 days, you can meet our requirements by giving us a written statement. This statement should include the nature and extent of the claim and be sent to us within 15 days, you can meet our requirements by giving us a written statement. This statement should include the nature and extent of the claim and be sent to us within the time stated in the Proof of Loss provision.

Proof of Loss: Written proof of loss must be furnished to us within 90 days after the date for which claim is made. If it is shown that it is not reasonably possible to furnish written proof of loss within that time, the claim will not be invalidated or reduced as long as we receive such proof as soon as reasonably possible and in no event, in the absence of legal incapacity, later than one year from the time proof is otherwise required.

Time of Payment of Claims: We will pay all benefits due, promptly upon receipt of due proof of loss.

PART VII – GENERAL PROVISIONS (Continued)

Assignment of Claims: All benefits payable will be paid to the Insured unless a written assignment of benefits is filed with us at our Home Office. We will not be responsible for the legal effect of any assignment.

Payment of Claims: All benefits are payable to you unless you have otherwise assigned the benefits to a medical provider. If any such benefits remain unpaid at your death, or, if you are, in the opinion of the Company, incapable of giving a legally binding receipt for payment of any benefit, we may. at our option, pay such benefit to any one or more of the following relatives: your spouse, mother, father, child or children, brother or brothers, sister or sisters. Any payment so made will constitute a complete discharge of our obligations to the extent of such payment.

Physical Examination: We will, at our own expense, have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of a claim when and as often as we may reasonably require during the pendency of a claim.

Legal Actions: No legal action may be brought to recover on this Policy within 60 days after written proof of loss has been given as required by this Policy. No such action may be brought after the expiration of the applicable statute of limitations from the time written proof of loss is required to be given.

Misstatement of Age: If the age of any Insured has been misstated, our records will be changed to show the correct age. The benefits provided will not be affected if the Insured continues to be eligible for coverage at the correct age. However, premium adjustments will be made so that we receive the premiums due for the correct age.

Time Limit on Certain Defenses: 1. After two years from the effective date of an Insured's coverage under the Policy, no misstatements, except fraudulent misstatements made by the applicant in the application for the coverage, will be used to void the coverage. 2. No claim for loss incurred after one year from the effective date of an Insured's coverage will be reduced or denied on the grounds that a disease or physical condition had existed prior to the effective date of the Insured's coverage.

Conformity with State Statutes: Any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which the policyholder resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Reinstatement: If any renewal is not paid within the time granted for payment, a subsequent acceptance of premium by us or by any agent duly authorized by us to accept such premium, without requiring an application for reinstatement shall reinstate the coverage; provided, however, that if we or any agent duly authorized by us requires an application for reinstatement and issues a conditional receipt for the premium, this coverage will be reinstated upon approval of such application by us; or lacking such approval, on the 45th day after the date of such conditional receipt unless we previously notify you, in writing, of our disapproval of the application. The reinstated coverage shall cover only loss resulting form injury that is sustained after the date of reinstatement and sickness that begins more than 10 days after such date.

In all other respects, both you and we shall have the same rights as we had under this Policy immediately before the due date of the defaulted premium. This is subject to any provisions endorsed on or attached to this Policy in connection with the reinstatement.

IN WITNESS WHEREOF**,** Reserve National Insurance Company has caused this policy to be signed by its President and attested by its Secretary as of the Date of Issue at its Home Office at 601 East Britton Rd, in the City of Oklahoma City, Oklahoma.

Secretary

President

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

601 East Britton Road ▪ Oklahoma City, OK 73114

INDIVIDUAL STANDARD HEALTH BENEFIT POLICY

ST-98-OH