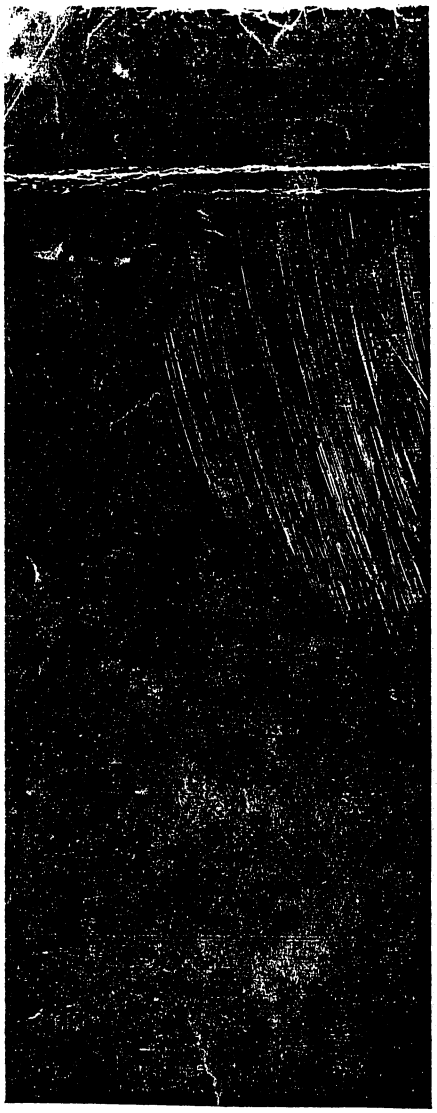

BUSINESS MEN'S ASSURANCE COMPANY OF AMERICA (BMA) WILL PAY the benefits shown in this policy for losses due to sickness or injury that are covered by the policy provisions.

THIS POLICY IS CONDITIONALLY RENEWABLE. BMA may refuse renewal only: 1) if BMA refuses to renew all policies with this form number in force in the state or jurisdiction where the Insured then lives; or 2) if a Covered Person has other coverage in force under an individual, group or government sponsored plan that provides benefits reasonably similar to the benefits provided by this policy during a calendar year. Such non-renewal will: 1) take effect on the next policy anniversary date; and 2) not affect any existing claim except as stated in the "Termination of the Policy" provision. BMA will give 30 days written notice to the Insured, at the last address shown on its records, of any non-renewal. If BMA does not refuse renewal, the Insured may renew this policy by payment of the renewal premium by the end of the Grace Period of any premium due date.

RIGHT TO EXAMINE POLICY: This policy may be returned at any time within 20 days of receipt of this policy by delivering or mailing it to: 1) BMA, P.O. Box 458, Kansas City, Missouri 64141; or 2) the agent through whom it was purchased. Immediately upon such delivery or mailing, this policy will be void from the start and all premium paid will be refunded.

IMPORTANT NOTICE: Please read the copy of the application attached to this policy. Carefully check the application and write BMA at Kansas City, Missouri, within 20 days if: 1) any information shown on it is not correct and complete; or 2) any past medical history has been left out of the application. Material omissions or misstatements in the application could cause an otherwise valid claim to be denied as stated in the "Time Limit On Certain Defenses" provision. This application is a part of this policy. This policy was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

Signed for BMA at Kansas City, Missouri, on the Policy Date.

Secretary

President

MAJOR MEDICAL EXPENSE POLICY

Coverage terminates at age 65 or prior eligibility for Medicare; See the Termination Provisions of this policy.

BMA may change the table of rates by class.

The premium for this policy will change on each policy anniversary date as explained in the "Renewal Premium" provision of this policy.

Business Men's Assurance Company of America

D 7078

THE FOLLOWING INFORMATION PERTAINS TO THE COST CONTAINMENT PROVISION. BEGINNING ON PAGE 4. SINCE THE PREMIUM FOR THIS POLICY ASSUMES THAT THESE COST SAVING PROCEDURES WILL BE FOLLOWED. IF ANY OF THESE PROCEDURES ARE NOT FOLLOWED, THE BENEFITS PROVIDED BY THIS POLICY WILL BE ADJUSTED AS EXPLAINED IN THE COST CONTAINMENT PROVISION.

PRE-CERTIFICATION OF HOSPITAL CONFINEMENT - BEFORE ANY NON-EMERGENCY HOSPITAL ADMISSION, OR ON THE NEXT WORKING DAY AFTER AN EMERGENCY HOSPITAL ADMISSION, BMA'S PRE-CERTIFICATION SERVICE MUST BE CONTACTED AT THIS TOLL FREE NUMBER: 1-800-835-3633. SEE PAGE 5.

REQUIRED SECOND SURGICAL OPINION - FOR FOLLOWING SURGICAL PROCEDURES, A SECOND SURGICAL OPINION IS REQUIRED. SEE PAGE 5.

BUNIONECTOMY (REMOVAL OF A BUNION)
CHOLECYSTECTOMY (REMOVAL OF GALL BLADDER)
GASTRECTOMY (REMOVAL OF ALL OR PART OF STOMACH)
HYSTERECTOMY (REMOVAL OF UTERUS)
LAMINECTOMY (REMOVAL OF VERTEBRAE) OR SPINAL FUSION
MASTECTOMY (REMOVAL OF BREAST)
PROSTATECTOMY (REMOVAL OF ALL OR PART OF PROSTATE GLAND)
TENOTOMY (CUTTING OF TENDON)
THYROIDECTOMY (REMOVAL OF ALL OR PART OF THYROID)
VARICOSE VEIN EXCISION

REQUIRED OUTPATIENT SURGICAL PROCEDURES - THE FOLLOWING SURGICAL PROCEDURES MUST BE PERFORMED ON AN OUTPATIENT BASIS. SEE PAGE 6.

ARTHROSCOPY (EXAMINATION OF JOINT) AND CARTILAGE REMOVAL
BREAST BIOPSY (REMOVAL OF BREAST TISSUE FOR EXAMINATION)
CARPAL TUNNEL (RELIEF OF NERVE PRESSURE IN WRIST)
CATARACT REMOVAL (REMOVAL OF LENS)
CYSTOMETROGRAM (EXAMINATION OF BLADDER FUNCTION)
CYSTOSCOPY (EXAMINATION OF BLADDER)
D&C - DILATATION AND CURETTAGE (SCRAPING OF UTERUS)
EXAMINATION UNDER ANESTHESIA
EXOSTOSIS EXCISION (REMOVAL OF BONY GROWTH)
EYE MUSCLE SURGERY
GANGLION EXCISION (REMOVAL OF MASS OF CYSTIC TUMORS)
HAMMERTOE EXCISION (CORRECTION OF ABNORMALLY BENT TOE)
HYDROCELECTOMY (REMOVAL OF FLUID IN TESTES SAC)
LAPAROSCOPY (EXAMINATION OF ABDOMEN)
NEUROMA OR MORTON'S NEUROMA EXCISION (REMOVAL OF NERVE CELL TUMOR)
PALMER FASCIECTOMY (REMOVAL OF FIBROUS TISSUE OF HAND)
PILONIDAL SINUS (DRAINING OF ABNORMAL SKIN CAVITY AT BASE OF SPINE)
SIMPLE FISTULECTOMY (REMOVAL OF ABNORMAL TUBE-LIKE PASSAGE OF RECTUM
TYMPANOSTOMY WITH INSERTION OF VENTILATORY TUBE (REPAIR OF HOLE IN EARDRUM)
UMBILICAL HERNIA REPAIR (REDUCTION OF PROTRUDING INTERNAL ORGAN AT NAVEL)

Business Men's Assurance Company of America

ACCIDENT EXPENSE

Supplement attached to and forming a part of this policy

ACCIDENT EXPENSE BENEFIT - Benefits will be payable for loss due to expenses incurred as a result of injuries received by a Covered Person while this policy and supplement are in force.

Benefits will be payable provided:

(1) the expenses are Eligible Expenses as defined in this policy;
(2) the expenses are Eligible Expenses incurred while this policy and supplement are in force;
(3) treatment takes place within one year from the date of the accident; and
(4) one or more of the Eligible Expenses was first incurred within 6 months from the date of the accident.

- *Before* any Deductible Amount(s) or Coinsurance Amount(s) have been met, BMA will pay 100% of Eligible Expenses incurred up to the maximum amount payable under this supplement.

- **Maximum Amount** - up to $500 per accident.

  When BMA has paid $500 of Eligible Expenses under this supplement, the Insured must then meet the Deductible Amount(s).

- *After* the Deductible Amount(s) have been met, BMA will pay Eligible Expenses on the same basis as benefits are paid under the "Cost Containment" and/or the "Benefits for Injuries or Sickness" provisions of this policy.

EXCEPTIONS - In addition to the exceptions stated elsewhere in this policy, no benefits will be paid under this supplement for expenses incurred as a result of:

- injuries received while practicing for or engaged in interschool, professional or semiprofessional athletics; and
- any bodily injuries, even though a proximate or precipitating cause of loss is accidental, if the loss is caused or contributed to by, or is a consequence of any of the following excluded risks:
  (1) hernia of any kind;
  (2) a bodily or mental infirmity, illness or disease (except a bacterial infection resulting from an external wound or from accidental ingestion of a contaminated substance); or
  (3) the medical or surgical treatment of a bodily or mental infirmity, illness or disease.

DEFINITIONS - In addition to the definitions listed in this policy, this term is defined to explain its meaning in this supplement.

PROFESSIONAL OR SEMIPROFESSIONAL ATHLETICS - "Professional or Semiprofessional Athletics" are all forms of sports or games for which the Insured:

- competes as an individual or member of a team;
- trains and competes under the guidance of a coach, manager or sponsor;
- complies with a set plan or schedule; and
- is paid (other than prizes).

CONSIDERATION - This supplement is issued in return for:

- the attached application; and
- the payment of the required premium.

It is subject to all the provisions of the policy.

SUPPLEMENT DATE - For benefits under this supplement the Supplement Date, if not the same as the Policy Date, will govern:

- any waiting period shown in the policy; and
- the "Time Limit On Certain Defenses" provision.

Signed for BMA at Kansas City, Missouri, on the Policy Date, unless a different date is shown below.

J. K. Baker
Secretary

Supplement Date, if other
than the Policy Date:

This is your accident and sickness policy that provides benefits for loss due to injury and sickness as defined in the policy.

This policy is a legal contract between the Owner and BMA.

READ THIS POLICY CAREFULLY - This page gives only a brief outline of some of the important features of this policy. Only the policy itself sets forth, in detail, the rights and obligations of both the Insured and BMA. **IT IS THEREFORE IMPORTANT TO READ THIS POLICY CAREFULLY.**

INDEX

(No Text)

BENEFIT PROVISIONS

BMA will pay benefits for the Eligible Expenses listed in this policy that are:

- incurred while this policy is in force and after the effective date of coverage;
- due to injuries that occur or sickness that first manifests itself while this policy is in force and after the effective date of coverage;
- in excess of the Deductible Amount(s);
- incurred during the rest of the Calendar Year after the Deductible Amount(s) are met; and
- medically necessary.

Benefits will be paid subject to all the provisions, terms and conditions of this policy.

DEDUCTIBLE AMOUNT - Subject to the "Cost Containment" provision, the Deductible Amount for each Calendar Year is the larger of:

- the Basic Deductible chosen by the Insured and shown on Page One; or
- the amount of benefits paid by Other Medical Expense Coverage for Eligible Expenses. If a Covered Person has other coverage which pays a benefit more than the Basic Deductible chosen by the Insured, then the amount of that benefit will be used as the Deductible Amount.

For any one Covered Person, the Deductible Amount must be met:

- for each Calendar Year; and
- with Eligible Expenses.

If two or more Covered Persons are treated for injuries due to the same accident, benefits are paid as usual ***except:***

- only one Basic Deductible will apply; and
- the Deductible Amount will be the larger of:
  (1) the Basic Deductible; or
  (2) the amount of benefits provided for Eligible Expenses for all such Covered Persons under the Other Medical Expense Coverage.

However, the Maximum Benefit Limit will still apply to each Covered Person separately.

BENEFITS FOR INJURIES OR SICKNESS - Benefits will be payable for the treatment of injuries or sickness as follows:

After the Deductible Amount(s) have been met, BMA will pay:

- 80% (or 75% if required by the "Cost Containment" provision) of Eligible Expenses until the Family Coinsurance Limit has been reached.

FAMILY COINSURANCE LIMIT - Subject to the lifetime Maximum Benefit Limit, BMA will pay 100% of Eligible Expenses for the rest of the Calendar Year after the Insured has incurred $2,500 of out-of-pocket expense for Eligible Expenses for one or more Covered Persons in a Calendar Year. This $2,500 includes any coinsurance amounts.

The $2,500 of out-of-pocket expense paid by the Insured does ***not*** include:

- any Deductible Amount(s) the Insured must pay; and
- any excess expense incurred that is above the usual and customary charge.

COST CONTAINMENT - The premium for this policy is based on factors that assume that the cost saving procedures explained on Pages 5 and 6 will be followed. If a prescribed procedure in Sections I, II and III is ***not*** followed, then the Deductible Amount and the Coinsurance Amount will be adjusted as explained in Sections I, II and III.

BENEFIT PROVISIONS (Continued)

Cost Containment Benefit (Continued)

Section I - **PRE-CERTIFICATION OF HOSPITAL CONFINEMENT** - For any hospital confinement, BMA's Pre-Certification Service must be contacted at the telephone number shown on Page One as follows:

- ***Non-Emergency Admission*** - For a non-emergency admission to the hospital, BMA's Pre-Certification Service must be contacted as soon as possible before admission. In order for the Covered Person to receive the maximum advantage of the pre-certification review, the contact should be made ***10 days before the date of such admission to the hospital.***

  (1) If the contact is ***not*** made ***10 days before the date of admission to the hospital,*** the pre-certification review may not be completed. This means that upon admission to the hospital, the Covered Person may ***not*** know to what extent charges related to the hospital confinement will be considered to be Eligible Expenses; and

  (2) If BMA's Pre-Certification Service is contacted ***less than 2 working days before admission,*** benefits will be adjusted as if the Covered Person ***did not*** follow the cost containment procedures.

- ***Emergency Admission*** - For an emergency admission to the hospital, BMA's Pre-Certification Service must be contacted on the ***first working day after the date of such admission*** to the hospital. If the Covered Person is mentally or physically incapacitated and it is ***not*** reasonably possible for the Insured or another family member to make contact within this period of time, then BMA's Pre-Certification Service must be contacted as soon as reasonably possible after the date of such admission to the hospital.

If the Covered Person follows these procedures, BMA will pay benefits for the Eligible Expenses related to such confinement as outlined in the "Benefits for Injuries or Sickness" provision.

If the Covered Person ***does not*** follow either of these procedures for hospital confinement, benefits payable for Eligible Expenses related to such confinement will be adjusted as follows:

- the Deductible Amount will be increased by $250 for each confinement; and
- the Coinsurance Amount will be increased from 20% to 25% for each confinement until the Family Coinsurance Limit has been reached.

Section II - **SECOND SURGICAL OPINION** - For the surgical procedures listed on Page 1A, BMA requires that the Covered Person obtain a second surgical opinion before incurring any Eligible Expenses for the listed surgical procedure.

If the Covered Person ***does*** obtain a required second surgical opinion, BMA will pay 100% of the usual and customary charge for such second surgical opinion ***before*** any Deductible Amount is applied. All other benefits for the Eligible Expenses related to the surgery will be paid as outlined in the "Benefits for Injuries or Sickness" provision.

If the Covered Person ***does not*** obtain a required second surgical opinion, benefits payable for Eligible Expenses related to that surgery will be adjusted as follows:

- the Deductible Amount will be increased by $250; and
- the Coinsurance Amount will be increased from 20% to 25% until the Family Coinsurance Limit has been reached.

Any second surgical opinions obtained for surgical procedures other than those surgical procedures required by BMA will be considered as an Eligible Expense and paid as outlined in the "Benefits for Injuries or Sickness" provision.

Cost Containment Benefit (Continued)

Section III - OUTPATIENT SURGERY - For the surgical procedures listed on Page 1A, BMA requires that the Covered Person have these surgical procedures performed on an outpatient basis unless BMA receives acceptable certification from the physician that:

- hospital confinement is required for medical reasons; or
- appropriate outpatient surgical facilities are not available within 50 miles of the Covered Person's place of residence.

If the Covered Person ***has*** these surgical procedures performed on an ***outpatient*** basis, BMA will pay benefits for the Eligible Expenses related to such surgery as outlined in the "Benefits for Injuries or Sickness" provision.

If the Covered Person ***has*** these surgical procedures performed on an ***inpatient*** basis, benefits will be:

- payable for charges related to the hospital confinement only to the extent such charges are considered to be Eligible Expenses; and
- adjusted as follows:

  (1) the Deductible Amount will be increased by $250 for each hospital confinement; and
  (2) the Coinsurance Amount will be increased from 20% to 25% until the Family Coinsurance Limit has been reached.

No more than one additional $250 deductible ~~from Sections I, II or III~~ ***will apply to any one confinement.***

BMA's Pre-Certification Service has the authority to ***waive*** the requirements of the "Second Surgical Opinion" and "Outpatient Surgery" provisions.

ELIGIBLE EXPENSES - BMA will consider as Eligible Expenses the usual and customary charge for the following services and supplies that are medically necessary:

- the most prevalent semi-private room rate of a hospital;
- confinement in an Intensive Care Unit or Cardiac Care Unit of a hospital;
- services of a physician for medical care, consultation or surgery ***except*** for services of a physician for manipulative treatments, heat treatments or ultra sound;
- medical or surgical services or supplies normally provided by a hospital including ambulatory surgical centers and outpatient units of a hospital;
- charges for drugs and medicines that:
  (1) require a physician's written prescription; and
  (2) are dispensed by a licensed pharmacist;
- services of a licensed physiotherapist or speech therapist that are authorized by a physician. These services are ***not*** covered if the physiotherapist or speech therapist is a member of a Covered Person's immediate family or one who normally lives with the family;
- oxygen and rental of equipment for its administration;
- X-ray and laboratory examinations;
- dental X-rays and services if required:
  (1) for removal of tumor or cyst; or
  (2) by injuries to natural teeth if services are performed within 6 months of the accident;
- radioactive and X-ray therapy;
- anesthetic materials and the services of an anesthesiologist;
- blood and blood plasma;
- local ambulance service as deemed necessary by a physician;
- rental, not to exceed purchase price, of wheelchair, hospital-type bed or iron lung;
- casts, splints, trusses, crutches, surgical dressings and braces ***except*** dental braces; covered complications of pregnancy;

BENEFIT PROVISIONS (Continued)

Eligible Expenses (Continued)

- cosmetic surgery, if required:
  (1) by injury; or
  (2) as reconstructive surgery:
    - due to or that follows surgery resulting from trauma, infection or other diseases of the involved part; or
    - due to congenital malformation or birth abnormalities of a covered newborn child dependent.
- rental or the first purchase of a prosthetic device when medically required because of a covered sickness or injury.
  Covered devices are:
  (1) heart pacemakers;
  (2) braces for support or augmentation of a natural function;
  (3) artificial limbs;
  (4) artificial eyes, intraocular lens implant or the first contact lenses or glasses following cataract surgery;
  (5) breast implants after removal due to disease and the first external breast prosthesis;
  (6) kidney dialysis equipment that is not payable under Medicare;
  (7) replacement of the devices listed above if due to:
    - progression of a disease or injury; or
    - growth of an insured child.

  These devices are ***not*** covered:
  (1) glasses and contact lenses ***except*** as listed above;
  (2) braces, spacers, retainers, artificial teeth or denture crowns, bridges and other dental prosthesis;
  (3) hearing aids;
  (4) support hose, corsets and other body support garments;
  (5) wigs, hair pieces and hair transplants;
  (6) breast augmentation;
  (7) shoes, arch supports or other such items;
  (8) replacement of a prosthesis due to loss, damage, wear or obsolescence;

Subject to the maximum limits as shown, BMA will consider as Eligible Expenses the usual and customary charge for the following services and supplies that are medically necessary:

- private duty nursing services that are:
  (1) authorized by a physician; and
  (2) provided outside of a hospital.
  Maximum Number of Days - 30 days for each Calendar Year.

- services of a physician for manipulative treatments, heat treatments and ultra sound.
  Maximum Number of Visits - 18 visits for each Calendar Year, subject to $1,000 benefit limit for each Calendar Year.

- confinement in a skilled nursing facility.
  Maximum Number of Days - 60 days for each Calendar Year.

  Confinement in a skilled nursing facility must:
  (1) follow a period of hospital confinement of at least 3 days in a row;
  (2) start before the Covered Person has been out of the hospital for 14 days; and
  (3) be for the purpose of continuing medical treatment for the conditions which caused hospital confinement.

Eligible Expenses (Continued)

- home health care services.
  Maximum Number of Days - 60 days for each Calendar Year, allowing one home health care visit per day.

  Services will be covered if such services:
  (1) are provided by a home health care agency;
  (2) would be covered if received during confinement in a hospital or skilled nursing facility;
  (3) are received in lieu of hospital or skilled nursing facility services;
  (4) are prescribed by a physician as medically necessary for the care and treatment of sickness or injuries; and
  (5) begin within 14 days after a period of confinement:
  - of at least 3 days in a row in a hospital; or
  - in a skilled nursing facility for which benefits are payable under this policy.

  Covered services are:
  (1) nursing services;
  (2) physical or speech therapy;
  (3) medical supplies, prescription drugs and lab services;
  (4) home health aide services that are mainly of a medical or therapeutic nature;
  (5) nutritional services; and
  (6) the evaluation of the need for and the developing of a home health care plan.

  Services ***not*** covered are services:
  (1) of a person who usually lives in the Insured's home or is a Covered Person;
  (2) or supplies mainly to aid in normal activities of daily living;
  (3) received for any period when the Covered Person is not under the continuing care of a physician; or
  (4) furnished outside the Covered Person's home.

- hospice care provided by a hospice as part of a hospice care program.
  Lifetime Maximum Amount Per Person - up to $3,000, subject to a maximum of 30 days inpatient hospice care for the terminally ill Covered Person.
  This benefit will not duplicate benefits payable under any other benefit provision.

- treatment of mental illness or substance dependency as follows:
  (1) ***Inpatient Benefit*** - For hospital room, board and nursing services
  Maximum Number of Days - 30 days for each Calendar Year.
  (2) ***Outpatient Treatment Facility Benefit*** - Facility charges for treatment received in an Outpatient Treatment Facility.
  Maximum Number of Visits - 30 visits for each Calendar Year, one visit per day.
  (3) ***Psychotherapy Benefit*** - Physician's charges for psychotherapy on an inpatient or outpatient basis.
  Maximum Number of Visits - 50 visits for each Calendar Year, one visit per day.

MAXIMUM BENEFIT LIMIT - $1,000,000. This amount is the total payable for Eligible Expenses for each Covered Person's lifetime.

When a Deductible Amount, other than the $250 Deductible Amount that may be required by the "Cost Containment" provision, is used for any Covered Person that is greater than the Basic Deductible chosen by the Insured, the Maximum Benefit Limit is increased as follows:

- the Maximum Benefit Limit which would otherwise apply to that Covered Person is increased by $3.00 for each $1.00 by which the Deductible Amount used exceeds the Basic Deductible; and
- the total increase in the Maximum Benefit Limit for each Covered Person's life will not exceed $100,000.

EXCEPTIONS

No benefits will be paid for:

- loss caused by act of declared or undeclared war;
- loss suffered while in the armed forces. BMA will return any premium paid past the time of entry into the armed forces when notice is received;
- loss when there are benefits due under Workmen's/Workers' Compensation or Occupational Disease Law;
- the cost of care, service or supplies that are covered under any national, state or other government plan ***except*** Medicaid;
- services for which no charge is normally made in the absence of insurance. This includes Veterans' hospitals;
- loss due to pre-existing conditions ***except*** that after 2 years from the date a person becomes covered, a claim for a pre-existing condition will not be denied unless that condition is excluded by name or specific description. Coverage will not be denied for those conditions fully disclosed in the application and not specifically excluded by a signed endorsement;
- loss due to mental illness or substance dependency ***except*** as allowed under the "Benefits for Injuries or Sickness" provision;
- circumcision or immunization for a child;
- loss due to pregnancy or childbirth ***except*** for covered complications of pregnancy;
- loss caused by committing or attempting to commit an assault or felony;
- loss due to intentional self-inflicted injuries;
- expenses incurred for services or supplies considered to be experimental, investigational or for research purposes in the diagnosis or treatment of the injury or sickness for which claim is made;
- cosmetic surgery ***except*** as allowed under the "Benefits for Injuries or Sickness" provision;
- dental X-rays or services ***except*** as allowed under the "Benefits for Injuries or Sickness" provision;
- expenses incurred for a sterilization operation or procedure;
- expenses incurred for a radial keratotomy surgical procedure unless certified as medically necessary by BMA's Pre-Certification Service;
- loss in the first 6 months after the effective date of coverage, ***except*** treatment on an emergency basis, for:
  (1) hernia of any kind;
  (2) hemorrhoids;
  (3) removal of tonsils and/or adenoids; or
  (4) disorder of the reproductive organs;

- hospital care or confinement in an institution or that part of an institution that is primarily for:
  (1) nursing, rest or convalescent care;
  (2) custodial, educational or rehabilitory care;
  (3) the care of the aged; or
  (4) the care of the mentally ill, drug addicts or alcoholics ***except*** as allowed under the "Benefits for Injuries or Sickness" provision.

- confinement in a skilled nursing facility that is primarily for:
  (1) custodial, educational or rest care;
  (2) the care of the aged; or
  (3) the care of the mentally ill, drug addicts or alcoholics;

- expenses incurred for:
  (1) services or supplies that are ***not*** medically necessary in the diagnosis or treatment of the injury or sickness;
  (2) a checkup or physical exam;
  (3) preventive services;
  (4) pediatric exams, tests or other services for a child unless required due to:
    - injuries;
    - sickness;
    - congenital malformation or birth abnormalities; or
    - prematurity.

DEFINITIONS

These terms are defined in order to make their meaning clear as far as this policy is concerned.

AMBULATORY SURGICAL CENTER - An "ambulatory surgical center" is a lawfully operated establishment, public or private, that:

- has an organized staff of physicians;
- has permanent facilities that are equipped and operated mostly for performing surgery;
- has continuous physician's services and registered professional nursing services when a patient is in the facility; and
- does not have services for an overnight stay.

BASIC DEDUCTIBLE - The "Basic Deductible", as chosen by the Insured, is the amount of Eligible Expenses incurred for a Covered Person that the Insured must pay each Calendar Year. It is subject to the "Deductible Amount" provision and is shown on Page One of this policy.

CALENDAR YEAR - A "Calendar Year" is a period of one year which starts on January 1 and ends December 31.

COINSURANCE - "Coinsurance" is the percentage applied to the excess of Eligible Expenses that the Insured must pay after the Deductible Amount(s) have been met.

COMPLICATIONS OF PREGNANCY - "Complications of Pregnancy" are covered as any other sickness subject to the following:

- Complications of Pregnancy ***does mean*** involuntary complications such as:
  - eclamptic toxemia;
  - hyperemesis gravidarum;
  - placenta praevia;
  - ectopic pregnancy;
  - puerperal infection;
  - eclampsia;
  - Caesarean Section delivery;
  - miscarriage; and
  - anemia of pregnancy.
- Complications of Pregnancy ***does not*** mean:
  - false labor;
  - occasional spotting;
  - physician prescribed rest during the pregnancy; or
  - other conditions which are not a distinct complication of pregnancy, even though they may be connected with management of a difficult pregnancy.

CONFINEMENT - "Confinement" is a necessary stay as an inpatient in a hospital or skilled nursing facility that is:

- due to injury or sickness; and
- authorized by a physician.

Each "day" of confinement includes an overnight stay for which a charge is customarily made.

COVERED PERSON - A "Covered Person" is:

- the Insured; or
- an eligible dependent who is included for coverage under this policy.

No person will be considered to be a "Covered Person" after such person's coverage terminates.

ELIGIBLE EXPENSES - "Eligible Expenses" are the usual and customary charges for the services and supplies listed in this policy that are medically necessary. Eligible Expenses shall be considered to be incurred as of the date the services are rendered or the purchases are made.

EMERGENCY ADMISSION - An "emergency admission" only applies to the "Pre-Certification of Hospital Confinement" provision. It means entering the hospital for a sickness or injury that requires immediate treatment to prevent loss of life or impairment of body functions.

DEFINITIONS (Continued)

EXPERIMENTAL, INVESTIGATIONAL OR FOR RESEARCH PURPOSES - "Experimental, Investigational or for Research Purposes" means services or supplies not recognized or proven to be effective treatment of sickness or injury in accordance with generally accepted standards of medical practice. BMA will consult an appropriate source to determine whether a service or supply is considered to be experimental, investigational or for research purposes.

HOME HEALTH CARE - "Home health care" is care and treatment of a Covered Person under a plan of care established, approved in writing and reviewed at least every 2 months by the attending physician unless it is determined that a longer span of time will suffice between reviews. "Home health care" includes one or more of the home health care services listed in the "Benefits for Injuries or Sickness" provision.

HOME HEALTH CARE AGENCY - A "home health care agency" is a public or private agency or its subdivision operated by law that:

- is chiefly engaged in providing skilled nursing services and other therapeutic services;
- has policies set by a group of professionals, including one or more physicians and one or more registered nurses, to govern the services that it provides;
- has services supervised by a physician or registered nurse; and
- keeps a medical record on each patient.

HOME HEALTH CARE VISIT - A "home health care visit" is a period of up to 4 hours under the home health care plan, evaluating the need for or developing such a plan, will be a home health care visit.

HOSPICE - A "hospice" is an agency that:

- as its main purpose, provides a hospice care program;
- has been licensed by or obtained the approval of the appropriate state or governmental agency as required by law;
- is under the overall direction of a licensed physician;
- has services supervised by a patient care coordinator who is either a physician or registered nurse;
- has hospice care services available 24 hours a day, 7 days a week; and
- keeps a medical record on each patient.

HOSPICE CARE PROGRAM - A "hospice care program" is a coordinated program of home and inpatient care which treats the terminally ill persons and their family as a unit. The program provides care to meet the special physical, psychological, spiritual and social needs of the family unit during the terminal illness and bereavement.

HOSPITAL - A "hospital" is an institution for medical care of sick or injured persons:

- on an inpatient basis;
- operating on a 24-hour basis:
  - (1) with facilities for medical care, diagnosis and major surgery; or
  - (2) with such facilities available on a prearranged basis and under the supervision of one or more physicians;
- providing 24-hour nursing services; and
- licensed by the appropriate state licensing body.

A "hospital" as it applies to mental illness or substance dependency is an institution that:

- provides 24-hour medical, therapeutic and psychiatric care for the treatment of mental illness or substance dependency;
- has facilities available on a prearranged basis and under the supervision of one or more physicians;
- provides 24-hour nursing services; and
- is licensed by the appropriate state licensing body.

A "hospital" does ***not*** mean an institution or that part of an institution that is primarily for:

- nursing, rest or convalescent care;
- custodial, educational or rehabilitory care; or
- the care of the aged.

IMMEDIATE FAMILY - "Immediate Family" is the Insured's spouse and the children, brothers, sisters and parents of the Insured and of the Insured's spouse.

INJURIES - "Injuries" are bodily injuries that:
- are caused by accident;
- are received while this policy is in force; and
- result in loss directly and independently of all other causes.

Blood poisoning or septicemia due to accidental bodily injuries is included in the term "injuries".

INTENSIVE CARE UNIT - An "intensive care unit" is a unit in a hospital that is:
- set aside from the rest of the hospital facilities;
- set aside for critically and seriously ill or injured patients when the attending physician prescribes constant observation; and
- a place where the following are available on an immediate and standby basis;
  (1) room and board;
  (2) specialized registered nurse and other nursing services; and
  (3) special equipment and supplies.

MANIPULATIVE TREATMENT - "Manipulative Treatment" means the diagnosis, analysis and adjustment of spinal subluxations and diagnosis, manipulative therapy and the related treatment of the musculoskeletal structure for other than fractures and dislocations of the extremities.

MEDICALLY NECESSARY - "Medically Necessary" means that the service or supply is required to diagnose or treat an injury or sickness and must:
- be performed and/or prescribed by a physician;
- be consistent with the diagnosis and treatment of such sickness or injury;
- be in accordance with generally accepted standards of medical practice; and
- not be solely for the convenience of the Covered Person or the physician.

MEDICARE - "Medicare" means the Health Insurance for the Aged Act under the Title XVIII of the United States Social Security Act of 1965, as then constituted or as later amended.

MENTAL ILLNESS OR SUBSTANCE DEPENDENCY -

"Mental Illness" is a mental disorder that requires psychiatric treatment. It means:
- all psychoneuroses (such as but not limited to neurasthenia, psychasthenia or hysteria);
- all psychoses (such as but not limited to symptomatic psychosis, schizophrenia, dementia praecox, manic depressive psychosis, paranoia or paranoid conditions); and
- suicide or attempt at suicide (whether sane or insane).

"Substance Dependency" is a condition such as alcoholism or drug addiction in which the Covered Person suffers social and/or occupational impairment and where there is evidence of ***tolerance*** or ***withdrawal.***

- **Tolerance** means:
  (1) when markedly increased amounts of the substance are required to get the desired effects; or
  (2) when there is markedly reduced effect with regular use of the same dose.

- **Withdrawal** means when the regular intake of a substance used to induce a physiological state of intoxication or addiction is stopped or reduced and results in a substance-specific syndrome.

MOST PREVALENT SEMI-PRIVATE ROOM RATE - The "most prevalent semi-private room rate" is the rate that applies to the greatest number of semi-private rooms in the hospital where services are rendered. If a hospital has no semi-private room rate, the most prevalent semi-private room rate in the area is used.

DEFINITIONS (Continued)

NURSING SERVICES - "Nursing Services" are services that are provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.) or a licensed vocational nurse (L.V.N.) who is:

- acting within the scope of that person's license;
- authorized by a physician; and
- not a member of the Insured's immediate family or one who normally lives with the family.

OTHER MEDICAL EXPENSE COVERAGE - "Other Medical Expense Coverage" means:

- coverage for hospital, surgical or other medical expenses by:
  - (1) any other insurance plan;
  - (2) welfare plan;
  - (3) prepayment plan (including Blue Cross and Blue Shield); or
- services provided or payments made under laws of any national, state or other government.

If coverage is given on a service basis, the amount of benefits under such coverage will be taken as the amount the services given would have cost in the absence of such coverage.

OUTPATIENT TREATMENT FACILITY - An "outpatient treatment facility" as it applies to mental illness or substance dependency is a place that:

- provides therapeutic and/or psychiatric care for the treatment of mental illness or substance dependency;
- has an organized medical staff; and
- is accredited by the Joint Commission on Accreditation of Hospitals or is licensed by the appropriate state licensing body.

PHYSICIAN - A "physician" is any duly qualified person licensed under an appropriate statute. To consider benefits for payment:

- the services given must be covered by this policy;
- the person giving the service must be authorized to perform the service;
- the person giving the service must be practicing within the scope of his or her license; and
- the person giving the service must not be a member of the Insured's immediate family or one who normally lives with the family.

PRE-EXISTING CONDITION - A "pre-existing condition" is:

- the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a 5 year period prior to the effective date of coverage of the Covered Person; or
- a condition for which medical advice or treatment was advised by or received from a physician within a 5 year period prior to the effective date of coverage of the Covered Person.

Those conditions fully disclosed in the application and not specifically excluded by a signed endorsement are not considered "pre-existing conditions."

SECOND SURGICAL OPINION - A "second surgical opinion" is an opinion by a consulting physician who examines the patient to evaluate the necessity that the patient undergo the proposed surgery. The second surgical opinion must be obtained:

- if the surgical procedure is shown on Page 1A;
- after one surgeon has proposed to perform the surgery on the patient but prior to the time the surgery is performed; and
- by a board certified physician, who has regularly performed the proposed surgical procedure and is not professionally or financially associated with the first surgeon.

SICKNESS - A "sickness" is a disease that first manifests itself after the effective date of this policy and while this policy is in force. A disease is said to first manifest itself when symptoms are such that, if they were disclosed to a physician, a diagnosis could be made at that time.

SKILLED NURSING FACILITY - A "skilled nursing facility" is a lawfully operated, licensed institution or convalescent hospital or that part of a hospital that:

- is a place primarily for giving skilled nursing care to a sick or injured person;
- is on a resident inpatient basis at the patient's expense;
- operates continuously under supervision of a registered nurse; and
- requires that:
  (1) patients be under the constant personal supervision of a physician;
  (2) patients be attended on a regular basis;
  (3) medicine be given only on the order of a physician; and
  (4) a medical record be kept each day for each patient.

It is ***not*** a place primarily for:

- custodial, educational or rest care;
- the care of the aged; or
- the care of the mentally ill, drug addicts or alcoholics.

STERILIZATION OPERATION OR PROCEDURE - "Sterilization Operation or Procedure" means any operation or procedure that alters the human body (male or female) for the purpose of temporary or permanent prevention of pregnancy.

USUAL AND CUSTOMARY - "Usual and Customary" means a charge that is not more than the normal level of charges made by providers in the area where the service is performed. BMA will use factors such as:

- the amount of charges as certified by BMA's Pre-Certification Service; and
- similar training and experience to determine the normal level of charges. BMA will determine the size of the area needed to get an accurate cross section of data.

RENEWAL PREMIUM

The initial premium for this policy is shown on Page One. Premiums for this policy will increase on each Policy Anniversary Date based on:

- the Attained Age of the Insured and spouse, if any. Attained Age means the age as of the last birthday on the Policy Anniversary Date.
- where the Insured then lives; and
- the table of premiums then in effect. BMA may change the table of premium rates by class in the state or jurisdiction where the Insured then lives.

BMA will give 30 days written notice to the Insured, at the last address shown on its records, of a change in premium.

EXTENSION OF COVERAGE TO DEPENDENTS

ELIGIBLE DEPENDENTS - Members of the Insured's family who are eligible to become Covered Persons are the Insured's:

- spouse;
- own unmarried dependent children, including adopted children, up to 19 years of age who are supported by the Insured;
- stepchildren and foster children up to 19 years of age if the children:
  (1) are permanently living with the Insured in a regular parent-child relationship; and
  (2) receive more than one-half of their support from the Insured.

- newborn children. These children are covered at birth for 45 days. For this coverage to continue, the Insured must:
  (1) notify BMA of the birth within the 45 day period; and
  (2) pay any required premium from the date of birth. ***BMA must receive this payment no later than 15 days after notice of the amount due.***

A child may be added as a Covered Person to only one policy if the Insured and the Insured's spouse are covered under separate policies that:
(1) are reasonably similar in the benefits provided; and
(2) provide for automatic addition of newborn children.

- unmarried dependent children from the age of 19 years to 24 years including step or foster children if they are:
  (1) full-time students of an accredited junior college or four year college or university; and
  (2) supported by and live with, if not living at a college or university, the Insured.

Dependents Covered On The Policy Date - Coverage is given on the Policy Date only to dependents:

- specified on page One of this policy;
- named in the application; and
- accepted by BMA.

Dependents Added After The Policy Date - A dependent, who is eligible after the Policy Date, may be added if:

- BMA's underwriting standards are met;
- BMA accepts the application made by the Insured; and
- the required premium, if any, is paid.

When accepted, BMA will issue a supplement to this policy which names the dependent and shows the effective date of coverage.

NOTICE TO BMA - The following will change the coverage and may change the premium. Notify BMA as soon as:

- any Covered Person becomes eligible for Medicare;
- an insured child reaches age 19, or age 24 if a full-time student of an accredited junior college or four year college or university;
- an insured child marries;
- an insured child ceases to be dependent on the Insured;
- there is a divorce of the Insured and the insured spouse;
- a child is born to the Insured or insured spouse if the Insured wants to add the child to this policy; or
- any Covered Person becomes eligible for other insurance that provides coverage with reasonably similar benefits provided under this policy.

TERMINATION OF COVERAGE

The Insured's coverage terminates, with proper change in premium, on the day before the earlier of:
- the 65th birthday of the Insured; or
- the date the Insured first becomes eligible for benefits under Medicare.

The insured ***spouse's*** coverage terminates, with proper change of premium, on the day before the earliest of:
- the premium due date that follows the date of divorce from the Insured;
- the 65th birthday of the spouse; or
- the date the spouse first becomes eligible for benefits under Medicare.

A ***child's*** coverage terminates, with proper change of premium, on the day before the premium due date that follows the earliest of such child's:
- 19th birthday or 24th birthday if a full-time student;
- marriage;
- termination of dependency on the Insured; or
- the date the child first becomes eligible for benefits under Medicare.

Coverage for an insured child may be continued only so long as coverage is in force for the Insured or for the Insured's spouse.

Mentally or Physically Handicapped Children - This policy will continue to insure any child who is mentally or physically incapable of earning his or her own living if:
- termination is called for because of age;
- proof of such incapacity is received by BMA within 31 days of the termination date;
- this policy stays in force; and
- the incapacity continues.

Death Of The Insured - If the Insured dies while this policy is in force and:
- if the spouse ***is*** a Covered Person then:
  (1) the spouse becomes the "Insured"; and
  (2) a change in premium is made.
- if the spouse is ***not*** a Covered Person, all coverage will terminate on the day before the next premium due date.

Divorce Of The Insured - Upon divorce from the Insured, coverage for the Covered Person will be subject to the following:

Coverage provided by this policy may be converted to a new policy. If the premium continues to be paid by or for the former spouse, coverage under the original policy will continue until BMA has notified the former spouse of the conversion right.
Once the former spouse has been notified, BMA must receive within 31 days:
- a written request for conversion; and
- the payment of the first premium.

The new policy will be:
- an individual policy with coverage reasonably similar to the terminated coverage;
- issued without requiring evidence of insurability; and
- with the option to include dependent children previously covered.

Any probationary or waiting periods in the new policy will be considered as being met to the extent such limitations have been met under the prior policy.

CONVERSION PRIVILEGE

This policy may be converted if coverage terminates according to the "Termination of Coverage" provision.

Within 31 days of such termination, BMA must receive:
- a written request for conversion; and
- the payment of the first premium.

The new policy will be:
- an individual policy in use for conversion on the date request is made; and
- issued without requiring evidence of insurability.

TERMINATION OF THE POLICY

This policy terminates at the earliest of these dates:
- the date when coverage has terminated for both the Insured and the insured spouse under the "Termination of Coverage" provision;
- the date a renewal premium is due and the premium has not been paid, subject to the Grace Period;
- the date this policy expires if BMA does not renew; or
- the date specified for cancellation in a written request by the Insured. The pro rata portion of the premium will be returned.

Such termination will not affect the payment of any benefits due for Eligible Expenses incurred but not reimbursed prior to the date of termination.

In the event BMA does not renew this policy:

- As limited below, benefits will be extended for a Covered Person for Eligible Expenses incurred for continuous treatment of a sickness or injury that caused Eligible Expenses to be incurred prior to the termination of this policy.

- Benefits will be extended until one of the following occurs first:

  (1) 12 months from the termination date of this policy; or
  (2) the maximum benefit payable has been paid.

All terminations of coverage will take effect at 11:59 p.m. local time at the residence of the Insured on the specified date of termination.

PREMIUM PAYMENTS

Premiums must be ***paid to*** the Home Office or an authorized agent. The Insured may request a receipt.

Premiums may be paid at 12,6,3 or ***one*** month intervals. This depends on:
- what the Insured chooses;
- BMA's current minimum premium rules;
- BMA's currently accepted methods of payment; and
- the date coverage terminates if coverage terminates ***before*** a premium due date as explained below.

Each premium after the first ***is due*** on the premium due date. The premium due date is the first day of the term to which each premium applies.

If the premium is ***not*** paid by the end of the Grace Period, this policy will lapse at the end of the period for which the premium was paid.

If the date specified in this policy for termination of any coverage occurs ***during*** a premium term, the last premium will be billed only to the date of termination. If BMA accepts a premium for a period of time past the date coverage should terminate, coverage will stay in force until the end of the period which the premium was accepted.

GENERAL PROVISIONS

CONSIDERATION - This policy is issued in return for the attached application and the payment of the required premium.

EFFECTIVE DATE AND TERM - This policy will be effective at 12:01 a.m. local time at the residence of the Insured either:

- as soon as it is accepted by the owner and the first premium has been paid. This has to take place while the health and occupation of the proposed Insured(s) stay the same as shown in the application; or
- on the date provided by a conditional coverage receipt issued in exchange for the payment of the first premium.

Premiums continue this policy in force as follows: a monthly premium for the term of one month; a quarterly premium for the term of 3 months; a semiannual premium for the term of 6 months; and an annual premium for the term of one year. The term is measured from the Policy Date.

ENTIRE CONTRACT; CHANGES - This policy, with the application and attached papers, is the entire contract between the Insured and BMA. No change in this policy will be effective until approved by a BMA officer. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES:

Misstatements In The Application - After 2 years from the date a person becomes covered, only fraudulent misstatements in the application may be used to void this policy or deny any claim for loss incurred or disability that starts after the 2 year period.

Pre-Existing Conditions Limitations - No claim for loss incurred or disability that starts after 2 years from the date a person becomes covered will be reduced or denied because a sickness or physical condition (not excluded by name or specific description before the date of loss) had existed before the effective date of coverage.

MISSTATEMENT OF AGE OR SEX - If any Covered Person's age or sex has been misstated, the benefits will be those the premium paid would have purchased at the correct age or sex.

GRACE PERIOD - This policy has a 31 day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. The Grace Period will not apply if, at least 30 days before the premium due date, BMA has delivered or mailed to the Insured's last address shown in its records written notice of BMA's intent not to renew this policy. During the Grace Period, this policy will stay in force. If the renewal premium is not paid by the end of the Grace Period, this policy will lapse at the end of the period for which the premium was paid.

REINSTATEMENT - If the renewal premium is not paid before the Grace Period ends, this policy will lapse. Later acceptance of the premium by BMA (or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate this policy.

If BMA or its agent requires an application, the Insured will be given a conditional receipt for the premium. If the application is approved, this policy will be reinstated as of the approval date. Lacking such approval, this policy will be reinstated on the 45th day after the date of the conditional receipt unless BMA has previously written the Insured of its disapproval.

The reinstated policy will cover only:

- loss that results from an injury sustained after the date of reinstatement; or
- sickness that starts more than 10 days after such date.

In all other respects, the rights of the Insured and BMA will remain the same, subject to any provisions noted on or attached to the reinstated policy.

Business Men's Assurance Company of America

Amendment attached to and forming a part of this policy

This amendment changes the policy as follows:

The **MAXIMUM BENEFIT LIMIT** is changed to $2,000,000.

All other provisions, conditions and limitations of this policy remain the same.

Signed for BMA at Kansas City, Missouri, on the Policy Date, unless a different date is shown below.

O. R. Kh

Secretary

Amendment Date, if other
than the Policy Date: