AMERICAN STATES INSURANCE COMPANY

INDIANAPOLIS, INDIANA

A STOCK COMPANY

(Hereinafter Called American States)

DOES HEREBY INSURE the person named as the Insured in the Policy Schedule, subject to the provisions, exceptions and limitations herein, against loss to any Covered Person commencing while this policy is in force and resulting from:

(1) accidental bodily injury sustained while this policy is in force (herein called such injury), or

(2) sickness first manifesting itself while this policy is in force (herein called such sickness).

This policy is issued in consideration of the statements contained in the application, a copy of which is attached to and made a part of this policy, and the payment of the First Premium for an initial term equal to the Premium Period commencing on the Policy Date.

10 DAY RIGHT TO EXAMINE POLICY

If, after examination, this policy does not meet the Insured's approval, the policy may be returned for cancellation within ten days after its receipt by the Insured, and any premium paid will be refunded in full. If this policy is returned for cancellation under this provision, the Company shall not be liable for any claim having its origin during such period.

RENEWAL PROVISIONS

This policy is guaranteed renewable during the life of the Insured. It can be renewed by the payment in advance or within the Grace Period of the premium at the Company's premium rates in effect at the time of renewal for all policies of this form number. Any revision in the table of rates shall apply to the Covered Person's original classification, age at entry and sex, and shall apply equally to all policies of this form number, but only after at least 30 days written notice of such change has been mailed to the Insured at his last address as shown on the Company's records. The premium will change for a Covered Person after his Medicare Eligibility Date as defined herein to the rate then applicable to benefits which are in effect when the Covered Person is eligible for Medicare.

DEFINITIONS

The term "Insured" means the person named as the Insured in the Policy Schedule. Should the original Insured cease to be a Covered Person while this policy is in force, the spouse, if then a Covered Person, shall become the Insured, and premiums falling due thereafter will be reduced appropriately. If the Insured's spouse does not survive the Insured, this policy shall terminate as to the Insured when the Insured ceases to be a Covered Person. The policy will terminate as to children at the end of the period for which premium has been accepted.

The term "Hospital" means only an institution which regularly keeps patients overnight, regularly provides twenty-four hour nursing service by graduate nurses (R.N.), has diagnostic and therapeutic facilities under the supervision of a staff of one or more physicians, and except in the case of a hospital primarily concerned with the treatment of chronic sickness, has organized facilities for major surgery. The term "Hospital" does not

MAJOR MEDICAL EXPENSE POLICY

This Policy provides benefits, as stated in the Policy Schedule, for hospital, medical and other specified expenses resulting from accidental bodily injury or sickness to the extent herein provided. This Policy is renewable for life of Insured but subject to the right of the Company to increase premiums on all or classes of this policy form number. The premium charged for and the benefits payable for a Covered Person will change after his Medicare Eligibility Date as defined herein.

include any facility operated by the United States government for the treatment of members or ex-members of the armed forces, unless a charge is made by such facility which the Covered Person is legally required to pay; nor does it include an institution or that part of an institution which is used primarily by a Covered Person as a clinic, nursing, rest or convalescent home or other than incidentally a place for alcoholics or drug addicts.

The term "Convalescent home" shall mean an institution or facility which is legally constituted as a nurs...g home and which provides nursing and convalescent care and facilities for resident patients suffering from injury or sickness and which has the services of a registered nurse or physician on call 24 hours per day. However, such term shall not mean or include an institution which is primarily a facility for the treatment of mental disorders, the aged, drug addicts or alcoholics, or which is a hotel.

The term "Covered Expenses" means the services and supplies listed in part 6 when such services and supplies are recommended by a physician.

The term "Medicare" shall mean Title XVIII of the United States Social Security Act, as amended, or any plan of hospital and medical insurance established by the United States government or any instrumentality thereof.

"Physician" means a physician or a practitioner, other than the Insured or a member of the Insured's immediate family, who is duly licensed by proper governmental authority and who is practicing within the scope of his license; however, physician shall not mean or include a dentist except to the limited extent specifically provided in this Policy or any Rider attached to this Policy.

"Other Medical Expense Coverage" means all coverage provided during a Benefit Period for hospital, surgical, or other medical expenses by any insurance, health, or welfare plan, or prepayment arrangement, or by Medicare or any other program, compulsory or voluntary, established by any federal, state or other governmental law or plan. If coverage is provided on a provision of service basis, the amount of benefits under such coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

The term "Medicare Eligibility Date" shall mean the date on which a Covered Person is first entitled to receive a specified benefit under Medicare, or is first eligible for any benefits under Medicare, if he had enrolled for or if he had applied for entitlement to such benefit under Medicare.

1. **MAXIMUM BENEFIT:** The maximum benefit payable for Covered Expenses incurred by a Covered Person as a result of any one injury or any one sickness shall be the amount shown under Maximum Major Medical Benefit in the Policy Schedule, regardless of whether the Covered Expenses are incurred in one or more Benefit Periods.

2. **MAJOR MEDICAL BENEFIT:** The Company will pay 85% of Covered Expense (except as otherwise provided under 6. Covered Expenses) in excess of the Deductible Amount, incurred by a Covered Person during any Benefit Period, until the Company has paid an amount not to exceed $10,000 as the result of any one accident or sickness. Thereafter the Company will pay 100% of the balance of such Covered Expenses but not exceeding an additional $15,000 for any one accident or any one sickness.

Expenses incurred with respect to care and treatment of mental disease or deficiencies, or psychotic or psychoneurotic disorders will be considered as Covered Expenses only for that amount of expense incurred while the Covered Person is confined as an in-patient in a "Hospital" as defined in "Definitions," except that the maximum that will be paid by the Company during the life of the policy for any one such mental illness or sequels thereof shall be $5,000.

3. **DEDUCTIBLE AMOUNT:** The Deductible Amount shall be the larger of the Minimum Deductible set forth in the Policy Schedule or the amount of benefits provided for Covered Expenses by Other Medical Expense Coverage as defined in Definitions, for any one injury or any one sickness of a Covered Person, and which the Insured must incur within the period specified in the provision "Benefit Period" before any Major Medical Benefit shall be payable under this policy. If injury or sickness shall cause Covered Expenses to be incurred for a Covered Person before that person's Medicare Date, Minimum Deductible (I) shall apply, if incurred after the person's Medicare Date, Minimum Deductible (II) will apply. If the same accident or sickness shall cause Covered Expenses to be incurred for a Covered Person both before and after the person's Medicare Date, only Minimum Deductible (I) shall apply to, and only one Major Medical Maximum shall be payable for, that one accident or sickness. Whenever benefits become payable on behalf of a Covered Person on the basis of a Deductible Amount which is greater than the Minimum Deductible, then the Maximum Benefit shall be increased by an amount equal to three times the difference between the Deductible Amount and the Minimum Deductible but not more than $5000 as to any one Covered Person whether such increases arise from one or more Benefit Periods or one or more sicknesses or injuries. Any such increase in the Maximum Benefit will remain available to the Covered Person to whom it applies and may be used in connection with any Benefit Period established for any sickness or injury until the benefits actually paid on behalf of such person shall have exceeded the limit otherwise available to him by an amount equal to such increase or increases.

If, through the use of the Other Medical Expense Coverage provision, the total amount of benefits paid by the Company and the Other Medical Expense Coverage is not sufficient to pay 100% of the Insured's total Covered

POLICY SCHEDULE

INSURED

FIRST PREMIUM $

POLICY NUMBER

PREMIUM PERIOD

POLICY DATE

MAXIMUM MAJOR MEDICAL BENEFIT $

MINIMUM DEDUCTIBLE (I) $
(BEFORE MEDICARE ELIGIBILITY DATE)

MINIMUM DEDUCTIBLE (II) $
(AFTER MEDICARE ELIGIBILITY DATE)

MAXIMUM DAILY HOSPITAL BENEFIT $

COVERED PERSONS

INSURED

SPOUSE

CHILDREN

Expense, then the Company will add to its benefit payment up to the difference between the Minimum Deductible and the amount paid by the Other Medical Expense Coverage until the Insured has recovered 100% of the total Covered Expense charges incurred by him. However, the total amount payable shall in no event exceed the amount of payment by the Company that the Insured would have normally received in the absence of Other Medical Expense Coverage.

4. **BENEFIT PERIOD:** A "Benefit Period" of three years shall be established when Covered Expenses in excess of the Deductible Amount are incurred within a period of

1. APPLICABLE BEFORE THE MEDICARE ELIGIBILITY DATE ONLY
   (a) 100 consecutive days when the Deductible Amount is $250; or
   (b) 200 consecutive days when the Deductible Amount is $500; or
   (c) 300 consecutive days when the Deductible Amount is $1000.
2. APPLICABLE AFTER THE MEDICARE ELIGIBILITY DATE ONLY
   (a) 60 consecutive days when the Deductible Amount is $100

as the result of any one injury or any one sickness and are incurred while this policy is in force with respect to the Covered Person. The Benefit Period of three years will begin with the date the first Covered Expenses exceed the Deductible Amount.

5. **SUBSEQUENT BENEFIT PERIODS:** If, at the termination of any Benefit Period, the Maximum Benefit has not been paid, additional Benefit Periods may be established provided the Covered Expenses incurred after the expiration of the previous Benefit Period exceeds 50% of the Deductible Amount within the consecutive day period specified in the above Benefit Period provision.

6. **COVERED EXPENSE:** The following items of expense, subject to any limitations, will apply to the Deductible Amount and for which the Major Medical Benefit will be paid provided such expense (a) is recommended by a physician, (b) is reasonably necessary for the treatment of an injury or sickness, and (c) represents the usual, reasonable and customary charge for the service or supplies in the locality where performed or furnished.

Items A and B of the following covered charges will be paid on the basis of 100% of Covered Expenses.

Items C through J will be paid on the co-insurance factor described in the first paragraph of 2. Major Medical Benefit.

A. Charges for daily room and board for confinement as a patient in a hospital not to exceed the Maximum Daily Hospital Benefit per day stated in the Policy Schedule.

B. Charges for intensive care unit as a patient in a hospital not to exceed twice the Maximum Daily Hospital Benefit per day, except that no part of the combined expense charged for daily hospital room and board and for intensive care unit which is in excess of two times the Maximum Daily Hospital Benefit will apply toward the Deductible Amount or will be considered as Covered Expense under the Major Medical Benefit.

C. Charges by a hospital for medical services, drugs, medicines and supplies.

D. Charges for X-ray, radioactive, laboratory or microscopic tests and other diagnostic services.

E. Charges of a physician, other than members of the Insured's household.

F. Charges of a registered nurse (R.N.) or licensed practical nurse (L.P.N.), other than members of the Insured's household.

G. Charges for drugs and medicines.

H. Charges for professional ambulance service up to 200 miles round trip from the point of departure to the Hospital or Convalescent Home and return.

I. Charges for the rental of therapeutic supplies or other equipment prescribed by a physician.

J. Charges by a convalescent home for room and board and routine care during confinement therein, which within three days follows a period of hospital confinement, but not to exceed 40% of the Maximum Daily Hospital Benefit for any day of confinement in a convalescent home, nor for more than 50 days of confinement.

7. **COMMON ACCIDENT:** If Covered Expenses are incurred for more than one Covered Person as a result of injuries sustained in a common accident, then, as to each such person, a separate Benefit Period will be established beginning on the day the total Covered Expenses of all Covered Persons first exceeds a single Deductible Amount. However, with respect to the Maximum Benefit provision and with respect to any additional Benefit Periods, and the satisfaction of the Deductible Amount for any additional Benefit Periods, Covered Expenses incurred by a Covered Person shall not be combined with those incurred by any other Covered Person. No one Covered Person shall have to incur a greater Deductible Amount as the result of this provision than he would otherwise have had to incur in the absence of said provision.

8. **COMPLICATIONS OF PREGNANCY:** If Covered Expenses are incurred by the Insured, or the Insured's spouse, as a result of complications of pregnancy, and while both the pregnancy and complications thereof commence at least 30 days after the Policy Date and while this policy is in force on both the Insured and spouse, such expense shall be considered as expense from sickness, except that no expense will apply toward the Deductible Amount and no benefits will be paid for expense that would have been incurred had there been no complications. A surgical procedure for delivery, or any abortion or miscarriage, will not of itself be considered a complication of pregnancy.

9. **WAIVER OF PREMIUM:** If total disability of the head of family shall commence while this Policy is in force and before the head of family's Medicare Eligibility Date and if such total disability shall continue without interruption for six months, the Company will waive the payment of each premium thereafter falling due on all Covered Persons during the period of continuous total disability before the head of family's Medicare Eligibility Date and will refund any premium theretofore paid which shall have fallen due and have been paid during such period. Upon the waiver of each premium so falling due, this Policy shall be deemed to be renewed for an additional term period of the same length as the last term period for which premium shall have been paid. In the event of the termination of such total disability before the head of family's Medicare Eligibility Date, the Insured shall have the right to resume the payment of premiums on the next regular premium due date.

For the purposes of this provision, a head of family is defined as one who is, at the time disability commences, (a) engaged in the regular pursuit of an occupation for gain, compensation or profit, (b) a Covered Person, and (c) an adult male Insured, the husband of an adult female Insured, or an unmarried female Insured. A married female Insured may not be deemed the head of family, whether or not her husband is a Covered Person. This waiver of premium provision shall be inapplicable during any period in which no Covered Person meets this definition of head of family.

For the purposes of this provision, total disability means incapacity of the head of family, resulting from sickness or injury as defined in this Policy, which prevents him from performing substantially all the work pertaining to his occupation or any other occupation for which he is or may be suited by education, training or experience.

10. **ADDITIONS:** Persons eligible under the definition of Covered Persons may be added to this policy after its issue, subject to satisfactory evidence of insurability. Any child born to the Insured and his spouse while this policy is in force shall automatically become a Covered Person on the 15th day of age until the end of the Premium Period during which said 15th day of age occurs. Such child shall continue to be a Covered Person on and after such premium due date only if, (1) written notice to include such child as a Covered Person is received by the Company prior to such premium due date, (2) the child is accepted by the Company as a Covered Person, and (3) the policy is renewed by payment of a premium which included the premium charge for such child. However, if such child is born after at least one other child is insured under this policy as a Covered Person, then the new born child shall automatically become a Covered Person on the 15th day of age, at no additional premium, and without the necessity of written notice of such birth to the Company. All provisions of this policy shall apply to such added Covered Persons as of the date such persons are accepted by the Company and the additional premium, if any, is paid.

11. **TERMINATIONS:**

(a) The Insured's spouse shall cease to be Covered Person on the premium due date next following the date the spouse becomes divorced from the Insured.

(b) A dependent child shall cease to be a Covered Person on the premium due date next following the date he attains age 23, marries, or when the Insured ceases to be responsible for his care and support, which ever first occurs. Termination of a dependent child because of age shall not apply to an unmarried child of the Insured who is incapable of self-support due to mental retardation or physical handicap, and who is dependent upon the Insured for support and maintenance, provided however the Company may inquire of the Insured two months prior to attainment by a dependent of age 23, or at any reasonable time thereafter, whether such dependent is in fact a disabled and dependent person and, in the absence of proof submitted within 60 days of such inquiry that such dependent is a disabled and dependent person may terminate coverage of such person at or after attainment of age 23. In the absence of such inquiry, coverage on any disabled or dependent person shall continue through the term of such policy or extension or renewal thereof.

When coverage is terminated for a Covered Person, renewal premiums will be adjusted to apply to those Covered Persons remaining.

Company acceptance of premiums applicable to a period subsequent to the date of termination of a Covered Person's coverage will continue the coverage to the end of the period for which such premium was accepted unless the former spouse has become divorced from the Insured, or the former dependent child has become married or has ceased living in the Insured's household except while attending college, without the Company having been notified (in which event the Company's liability with respect to such person shall be limited to the premium paid for such person for the period such person was not a Covered Person.)

Covered Persons who are dependent children, and whose coverage is terminated for any reason except failure to pay the required premium, shall have the right to have issued to them, without evidence of medical insurability, a policy which approximates the coverage of this policy, and at the premium rates then in effect for the former Covered Person's attained age, provided (1) application for such policy is made to the Company within 31 days of the date coverage for such person terminates under this policy, and (2) the former Covered Person does not then have medical expense coverage in force which would, according to the standard underwriting practices of the Company, produce a condition of over-insurance.

EXCEPTIONS AND LIMITATIONS: This policy does not cover any loss resulting from (a) war, or any act of war; (b) intentionally self-inflicted injury; (c) mental diseases or deficiencies, psychotic or psychoneurotic disorders, except as provided in Part 2; (d) surgery or treatment on or to the teeth or gums unless made necessary by injury to natural teeth occurring while this policy is in force; (e) cosmetic surgery except surgery occasioned by injury occurring while this policy is in force, or unless performed to correct a congenital anomaly in a child born to the Insured and his spouse while this policy is in force; (f) eye refraction, or the purchase of hearing aids or eyeglasses or contact lenses or the fitting thereof; (g) injury or sickness sustained while in military, naval, or air service of any country. Upon the Covered Person entering such service, a pro rata portion of the premium paid for the Covered Person for any period of such service will be refunded; (h) pregnancy, childbirth or miscarriage except as provided in Part 8; (i) injury or sickness for which benefits are payable under any Workmen's Compensation or Occupation Disease Law or Act; (j) care or treatment furnished or paid for by or through any government, or under any government plan or law, to the extent of such payment.

UNIFORM PROVISIONS

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: (a) After two years from the date the coverage under which claim is made becomes effective for the Covered Person whose injury or sickness is the basis of claim, no misstatements, except fraudulent misstatements, made by the applicant in the application for such coverage shall be used to void the coverage or to deny a claim for loss incurred after the expiration of such two year period. (b) No claim for loss incurred after two years from the date the coverage under which claim is made becomes effective for the Covered Person whose injury or sickness is the basis of claim shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of such Covered Person.

GRACE PERIOD: A grace period of thirty-one days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

REINSTATEMENT: If any renewal premium be not paid within the time granted the Insured for payment a subsequent acceptance of premium by the Company or by any agent duly authorized by the Company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the Company or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the Company or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the Company has previously notified the Insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the Insured and the Company shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within twenty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Insured or the beneficiary to the Company at Indianapolis, Indiana, or to any authorized agent of the Company, with information sufficient to identify the Insured, shall be deemed notice to the Company.

CLAIM FORMS: The Company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

PROOFS OF LOSS: Written proof of loss must be furnished to the Company at its said office within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss will be paid immediately upon receipt of due written proof of such loss.

PAYMENT OF CLAIMS: All indemnities under this policy are payable to the Insured, but any accrued indemnities unpaid at the Insured's death will be paid to the spouse of the Insured, if living, otherwise to the estate of the Insured.

If any indemnity of this policy shall be payable to the estate of the Insured, or to an Insured who is not competent to give a valid release, the Company may pay such indemnity, up to an amount not exceeding $1,000.00, to any relative by blood or connection by marriage of the Insured who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment.

PHYSICAL EXAMINATIONS AND AUTOPSY: The Company at its own expense shall have the right and opportunity to examine the person of the Insured when and as often as it may reasonably require during the pendency of a claim hereunder and make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

MISSTATEMENT OF AGE: If the age of any Covered Person has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

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 Insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

ASSIGNMENT: No assignment of this policy shall be binding on the Company until it is filed with the Company at its Home Office. The Company will assume no responsibility for the validity or sufficiency of any assignment, and any claim thereunder shall be subject to proof of interest and extent thereof.

IN WITNESS WHEREOF, American States Insurance Company has caused this policy to be signed by its President and its Secretary, but the same shall not be binding upon American States unless countersigned by its licensed resident agent.

Secretary

President

Licensed Resident Agent