American United Life Insurance Company

One American Square, P.O. Box 368, Indianapolis, Indiana 46206-0368

Major Medical Expense Policy

AUL

Name of Insured

Policy Number

Lifetime Maximum Benefit

Basic Deductible

INSURANCE AGREEMENT. American United Life Insurance Company (AUL) will pay you the benefits described in this policy due to injury or sickness. We have issued this policy in consideration of the statements you made in the application and the payment of the first premium. This policy takes effect on the date of issue at 12:01 A.M., local time, where you live.

CONDITIONALLY RENEWABLE. You may keep this policy in force by paying the premiums when due. We will not renew the policy after the policy anniversary following the earlier of your 65th birthday or your eligibility for Medicare. Otherwise, we can refuse to renew this policy only: (1) if all policies issued on this form are non-renewed in the area of jurisdiction where you then live; or (2) in the event of fraud or material misrepresentation in applying for this policy or in filing a claim for policy benefits. In either of these two cases, we must give you at least 31 days written notice that you may not renew.

RENEWAL PREMIUM AMOUNT. The amount of each renewal premium will depend on each covered person's age, sex, place of residence and the table of premiums in effect at the time of renewal. Renewal premiums will increase automatically on each policy anniversary because of an increase in age for each covered person age 26 and older.

WE MAY CHANGE THE TABLE OF PREMIUMS. We may change the table of premiums from time to time. Each change in this table will apply to all policies in force on this form. However, if your policy has been in force for less than 12 months when the change takes place, the change will not apply to your policy until the first anniversary of its date of issue. We will give you at least 31 days written notice of any change in your renewal premium that results from an increase in age or a change of table of premiums.

10 DAY RIGHT TO EXAMINE THIS POLICY. If you decide not to keep this policy, return it to AUL or the agent who sold it within 10 days after receiving it. We will refund any premium you paid and consider the policy to have never been issued.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION. We based our decision to issue this policy on the information entered in your application. Please carefully check the copy of the application attached to this policy. Write to us within 10 days if you find that any information shown is not correct or complete or if any medical history has not been included. Incorrect or omitted information on your application can cause your claim to be denied.

Signed for American United Life Insurance Company by

William R. Brown
Secretary

Jerry D. Semler
President and Chief Executive Officer

A Mutual Company Established 1877

TABLE OF CONTENTS

A copy of the application and any riders listed on page 3 will follow page 14.

INTRODUCTION

In this policy *you* and *your* mean the insured named on page 3. *We, us* and *AUL* refer to American United Life Insurance Company.

Date of Issue means the date that the policy becomes effective. It is shown on page 3. *Policy years* are measured from the date of issue and a *policy anniversary* occurs at the end of each policy year.

The policy takes effect on the date of issue at 12:01 a.m., local time, where the owner lives. The policy will terminate at 11:59 p.m. on the earliest of: (a) the lapse date, (b) the date the owner requests cancellation, or (c) the applicable policy anniversary in accordance with the Termination provision on page 7.

DEFINITIONS

Complications of Pregnancy

Complications of pregnancy means conditions whose diagnoses are distinct from normal pregnancy but are adversely affected by pregnancy or are caused by pregnancy. These include acute nephritis, nephrosis, cardiac decompensation,toxemia, eclampsia, preeclampsia, non-elective abortion, medically necessary caesarean section, and ectopic pregnancy which is terminated.

Complications of pregnancy does not include false labor, occasional spotting, rest prescribed by a physician, morning sickness, or similar conditions which make a pregnancy difficult but do not constitute a medically distinct pregnancy complication. Elective induced abortion and elective caesarean section are also not complications of pregnancy.

Covered Person

A covered person means any person named on page 3, or added by the terms of the policy, whose coverage has not ended.

Doctor

Doctor means a qualified, licensed doctor of medicine or osteopathy, and any other licensed health care provider that state law requires be recognized as a physician and practicing within the scope of his or her license. This includes podiatrists, chiropractors, dentists, optometrists and psychologists with a doctoral degree in psychology.

Home Health Care Agency

Home health care agency means:

- an agency certified to participate as a home health care agency under Medicare; or
- an agency so licensed by the state.

Hospital

Hospital means an institution which:

1. operates primarily to provide medical care and treatment of sick and injured persons as inpatients;
2. is accredited as a hospital by the Joint Commission on Accreditation of Hospitals or is licensed to operate as a hospital in the state in which it is located;
3. has facilities for diagnosis and major surgery either on its premises or in facilities under the supervision of a physician on a pre-arranged contractual basis.
4. has a doctor in residence or on call at all times; and
5. provides 24-hour nursing care supervised by a registered nurse.

A licensed ambulatory, free-standing, or outpatient surgical center is considered a hospital for this policy.

Hospital does not mean:

- a convalescent, nursing or rest home, or a home for the aged;
- a place providing, other than incidentally, custodial, educational, or rehabilitory care; or
- a facility used, other than incidentally, for treating alcoholism, drug addiction, or chemical dependency.

Immediate Family

Immediate family means spouse, child, brother, sister or parent.

Injury

Injury means accidental bodily injury to a covered person that occurs while this policy is in force.

Intensive Care Unit

Intensive care unit means that part of a hospital which is permanently reserved for confinement of the critically ill or injured and provides constant audiovisual observation. This includes a cardiac care unit.

Medically Necessary

Medically necessary means that a service or supply is essential and appropriate for the diagnosis or treatment of an injury or sickness based on generally accepted current medical practice. The fact that any particular doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply medically necessary. The service or supply must be of medical value to the patient. Also, it must not be experimental, unproven, investigational, educational in nature, or provided for research.

Service or supplies which will not be considered as medically necessary include (but are not limited to) those that:

1. are provided only as a convenience to the covered person or health care provider;
2. are inappropriate for treatment of the covered person's diagnosis or symptoms; or
3. exceed in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.

Medicare

Medicare means Title XVIII of the U.S. Social Security Act of 1965 as amended. It is also known as Health Insurance for the Aged and Disabled.

Mental Illness

Mental illness means neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Nurse

Nurse means a registered nurse, licensed practical nurse, or licensed vocational nurse acting within the scope of his or her license in caring for a sick or injured person.

Pre-Existing Condition

Pre-existing condition means a health condition:

1. for which the covered person received a doctor's advice or treatment within 5 years prior to the covered person's effective date of coverage; or
2. which, in the opinion of a doctor,
   - began prior to the covered person's effective date of coverage, and
   - produced symptoms within 5 years prior to the covered person's effective date of coverage which would have caused an ordinarily prudent person to seek diagnosis or treatment.

Reasonable and Customary Charge

Reasonable and customary charge means the smaller of:

- the customary charge made by the provider (doctor, hospital, etc.) for the service or supply when there is no insurance; or
- the general level of the charges for comparable services or supplies made by other providers in the same county when there is no insurance.

Sickness

Sickness means illness or disease of a covered person that first appears more than 15 days after that person's insurance becomes effective under this policy (except for newborn children). Sickness includes complications of pregnancy.

Skilled Nursing Facility

Skilled nursing facility means a legally operated facility that meets all these conditions:

1. it provides for the care and treatment of persons recovering from a sickness or injury;
2. it provides room, board, and skilled nursing service;
3. it operates under the supervision of a doctor;
4. it has 24-hour nursing service under the supervision of a registered nurse; and
5. it keeps a daily medical record for each patient.

It does not mean a rest home, home for the aged, a place providing mainly custodial care or, other than incidentally, a place for treatment of alcoholism, drug addiction, or chemical dependency.

ELIGIBILITY AND TERMINATION

General Eligibility

You may apply to include any of the following as covered persons under this policy:

- yourself;
- your spouse; and
- each of your unmarried, dependent children under age 23.

Newborn or Adopted Child

Any child born to, or newly adopted by, a covered person while this policy is in force will be covered automatically from birth, or from the date of placement for the purpose of adoption, for 60 days with no additional premium required. Coverage of the newborn or newly adopted child will include coverage of injury, sickness, congenital defects, birth abnormalities, and premature birth. Coverage of the newborn and newly adopted child will also include, but not be limited to, benefits for inpatient or outpatient expenses arising from medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects known as cleft lip and cleft palate.

To continue coverage for this child, you must:

- give us written notice of the child's birth or adoption; and
- pay any required additional premium within 90 days of the child's birth or the date of placement for adoption.

Termination

Coverage for all covered persons will end when your policy lapses or when you cancel the policy. If your policy does not lapse, coverage for each covered person will end as follows:

1. **Insured.** Your coverage will end on the policy anniversary following the earlier of:
   - your 65th birthday; or
   - your eligibility for Medicare.
2. **Spouse.** Coverage on your spouse will end on the policy anniversary following the earliest of:
   - your spouse's 65th birthday;
   - your spouse's eligibility for Medicare; or
   - the date of dissolution of your marriage.
3. **Child.** Coverage on a dependent child will end on the policy anniversary following the earliest of:
   - the child's 23rd birthday;
   - the date the child marries;
   - the date the child is no longer dependent on you; or
   - the date you and your spouse are no longer covered persons.

   While a child is not capable of self-support due to mental retardation or physical handicap, we will waive the 23-year-old age limit. You must send us proof of the child's incapacity within 31 days of the date coverage would otherwise end and not more often than once a year thereafter.

DEDUCTIBLE

Deductible Amount

The deductible amount means the amount of covered expenses that must be incurred by a covered person each calendar year before we will begin benefit payments. The deductible amount for each covered person during a calendar year will be the greater of:

- the Basic Deductible shown on page 3; or
- the amount of benefits provided by other health insurance coverage for covered expenses incurred during that calendar year by that covered person.

Other Health Insurance Coverage

Other health insurance coverage means any plan which provides insurance, reimbursement or service benefits for hospital, surgical or other medical expenses. This includes: (1) individual or group health insurance policies; (2) non-profit health service plans, including Blue Cross and Blue Shield; (3) health maintenance organization subscriber contracts; (4) self-insured group plans; (5) welfare plans; (6) medical coverage under home-owners or automobile insurance, and (7) service provided or payment received under laws of any national, state or local government such as Medicare. This does not include Medicaid.

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

Common Accident

If 2 or more covered persons are injured in the same accident, only one deductible amount will apply to the covered expenses they incur as a result of that accident. That deductible amount will be the basic deductible or the amount of other health insurance coverage provided for those expenses, whichever is greater.

Maximum Family Deductible

A maximum family deductible equal to 3 times the basic deductible amount will satisfy the deductible requirements for all covered persons in a family during a calendar year.

The common accident deductible for a single accident will be considered as only one basic deductible toward satisfying a family deductible.

Expenses Incurred After September 30

Any covered expenses incurred in a calendar year that are both:

- incurred after September 30; and
- applied to a covered person's basic deductible for that year;

may be applied to that person's basic deductible for the next calendar year.

BENEFITS

Benefits Payable

Each calendar year we will pay a portion of each covered person's covered expenses incurred in that year which exceed that person's deductible amount. The portion we will pay is based on the Benefit Percentage stated on page 3.

Family Maximum Out-of-Pocket

The maximum out-of-pocket expense per calendar year for your family for covered expenses including deductibles will not exceed the amount shown on page 3. Once this family maximum is reached, additional covered expenses for you and your family are paid at the 100% level for the remainder of the calendar year. Covered expenses that are payable at less than the 80% benefit level cannot be applied toward this family maximum out-of-pocket nor are they ever subject to the 100% benefit level.

First Dollar Accident Benefit

If a covered person has an injury while this policy is in force, we will pay related covered expenses according to the First Dollar Accident Benefit shown on page 3. The initial covered expenses must be

incurred within 72 hours after the occurrence of the injury. Subsequent covered expenses must be incurred within 90 days after the day the injury occurred. Payments made under this provision and the coinsurance amount paid by you cannot be used to meet the deductible amount. Covered expenses in excess of the First Dollar Accident Benefit amount or incurred after the 90 days will be covered under the regular benefit provision. This benefit can be applied only once per calendar year per covered person.

Lifetime Maximum Benefit

We will not pay benefits for any covered person greater than the Lifetime Maximum Benefit shown on page 3 (as adjusted below). If in any calendar year the deductible amount exceeds the basic deductible because of benefits paid by other health insurance coverage, then that person's lifetime maximum benefit will be increased. The amount of the increase will be 5 times the excess of the deductible amount over the basic deductible.

Extension of Benefits

If coverage ends for any covered person, except for non-payment of premium, AUL will continue to pay benefits for an additional 3 months from the date coverage ends for an injury which occurred or sickness which began prior to that date.

Hospital Self Audit

If a covered person detects an overcharge of covered expenses of $25 or more in their hospital bill (inpatient or outpatient), we will reimburse you for 50% of the amount that we are able to recover, up to $500 per hospital stay or visit.

COVERED EXPENSES

Covered expenses means any of the expenses listed below that are:

1. incurred by a covered person while their coverage is in force;
2. incurred for medically necessary care and treatment of an injury or sickness;
3. reasonable and customary;
4. prescribed by a doctor; and
5. not excluded anywhere in the policy.

An expense is incurred on the date the service is performed or the supply is purchased. The following are covered expenses:

1. **Hospital Room and Board.**
   - Charges for room, board and general nursing care while confined in a hospital up to the hospital's most common semi-private room rate.
   - Charges for confinement in an intensive care unit of a hospital.
2. **Miscellaneous Services.** Charges for miscellaneous services, operating rooms and supplies provided by a hospital.
3. **Skilled Nursing Care.** Charges for room, board and general nursing care while confined in a skilled nursing care facility if:
   - the confinement begins within 14 days after a hospital confinement of at least 3 days;
   - the confinement is for the same injury or sickness as the hospital stay; and
   - a doctor certifies that the covered person would have to be confined in a hospital if the skilled nursing care were not provided.

   Covered skilled nursing care charges will be limited to:
   - a daily maximum of 50% of the most common semi-private room rate of the hospital where the covered person was last confined; and
   - charges made during the first 60 days of any one period of skilled nursing care facility confinement.

If a covered person has more than one period of confinement in a skilled nursing care facility for the same or related cause we will consider each as part of the first period of confinement. However, we will not require any additional period of hospital confinement.

4. **Home Health Care Services.** Charges for home health care services if:
   - the charges would have been covered had the services been performed in a hospital;
   - the services are furnished by a home health care agency;
   - a doctor prescribes the services and certifies that the covered person would have to be confined in a hospital or a skilled nursing care facility if the home health care service were not provided; and
   - the services are provided on a part-time or intermittent basis.
5. **Doctor Services.** Charges for the medical and surgical services of a doctor (including second surgical opinions).
6. **Anesthesia.** Charges for anesthesia and its administration but not to exceed 50% of the amount of the doctor's surgical charge that qualifies as a covered expense.
7. **Private Duty Nursing.** Charges for the services of a private duty nurse, but not to exceed $20,000 per calendar year. The private duty nurse cannot be a member of the covered person's immediate family or reside in the same household as the covered person.
8. **Ambulance.** Charges for emergency ambulance service to a local hospital but not to exceed $500 per trip.
9. **Prosthetic Appliances.** Charges for purchase and fitting of necessary prosthetic appliances required for the replacement of natural parts of the body which are lost by a person while insured by this policy and for the necessary subsequent replacement of those appliances but not to exceed $5,000 per appliance.
10. **Physiotherapy.** Charges for outpatient physiotherapy treatments performed by a licensed physical therapist but not to exceed 25 treatments per calendar year. Treatment cannot be performed by a member of the covered person's immediate family.
11. **Occupational Therapy.** Charges for outpatient occupational therapy treatments performed by a licensed occupational therapist but not to exceed 25 treatments per calendar year. Treatment cannot be performed by a member of the covered person's immediate family.
12. **Other Covered Expenses.** Charges for the following care, treatment, services and supplies,if prescribed by a doctor.
    a. x-ray, diagnostic laboratory procedures and radioactive treatment;
    b. blood transfusion including the cost of the blood;
    c. drugs and medicines that are prescribed by a doctor and are dispensed by a licensed pharmacist;
    d. oxygen and other gases and their administration;
    e. casts, splints, trusses, braces (except dental), crutches and other medically necessary supplies; or
    f. rental (or at our option purchase) of hospital type equipment such as a wheelchair, hospital bed, iron lung or other mechanical equipment. The equipment must generally not be useful except for treatment of accidental injury or sickness.
13. **Physical Exams.** Charges for routine physical exams not related to an injury or sickness. Charges are limited to $200 per calendar year per person. This is a covered expense only for you and your spouse (no dependents).

EXCEPTIONS AND LIMITATIONS

Exceptions

We will not pay benefits for charges due to any of the following. These charges may not be applied toward the deductible amount.

1. Treatment as a result of:
   - intentionally self-inflicted injury or attempted suicide;
   - war or act of war;
   - a covered person's commission of or attempt to commit a felony, or commission of an assault; or
   - a covered person's involvement in an illegal occupation, riot, or insurrection.
2. Services performed by you or by a member of your or your spouse's immediate family.
3. Treatment of an injury or sickness covered by any Workers' Compensation or Occupational Disease Law.
4. Care provided by any government unless the covered person must, by law, pay the charges.
5. Pregnancy (except complications of pregnancy), elective abortion, and routine well-baby care of a newborn child, except as may be covered by attached rider.
6. Cosmetic surgery, but "cosmetic surgery" does not include reconstructive surgery needed because of:
   - injury that occurs while this policy is in force;
   - a birth defect of covered child born to a covered person while this policy is in force; or
   - previous surgery due to injury or sickness performed while this policy is in force;

   nor does "cosmetic surgery" include medical and dental treatment of cleft lip and cleft palate of a newborn or newly adopted child.
7. Rest care, maintenance care, or custodial care.
8. Dental services or oral surgery including dental implants and osseous surgery, except:
   a. as required for treatment to natural teeth within 12 months of an injury or accident; and
   b. for dental treatment of cleft lip and cleft palate of a newborn or newly adopted child.

   Teeth damaged as a result of chewing or biting will not be deemed an injury.
9. Eyeglasses, contact lenses, hearing aids, eye exams, visual therapy, eye refraction, or eye surgery (including radial keratotomy) for correction of refraction error correctable by lenses alone.
10. Treatment of obesity or for weight reduction.
11. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the covered person.
12. Sterilization including, but not limited to, vasectomies and tubal ligations or reversal thereof.
13. Any treatment of impotency, or infertility including in vitro fertilization.
14. Air filters, electronic or otherwise, or any other personal comfort supply or service.
15. Acupuncture or acupressure treatment.
16. Transsexual surgery and counseling, and any related hormone therapy.
17. Music therapy, marriage counseling, and massage therapy.
18. Treatment of learning disabilities (other than mental retardation) including, but not limited to, treatment for scholastic improvement, vocational training, speech development, visual or motor coordination.
19. Experimental or non-FDA approved drugs, vitamins, and food supplements.
20. Artificial hearts, their implantation, or use in an interim period until actual heart transplant.
21. The following organ transplants from one human to another human: heart and lung combined, pancreas, intestines, sclera, bone or cartilage. No organ transplants will be covered if the transplant is from a non-human to a human. Only recipient costs are covered; donor costs are excluded unless the donor is an immediate family member and is insured by us.

22. Services, supplies, or treatment incurred on a Friday, Saturday, or Sunday for inpatient hospital confinements which begin on one of these days unless:
    a. surgery is performed within 24 hours following the covered person's admission to the hospital; or
    b. the covered person is admitted for an acute sickness or injury not requiring surgery.
23. A sickness or physical condition excluded by name or specific description contained herein.

Pre-Existing Condition Limitation

We will not cover charges incurred by a covered person during the first 24 months after his or her coverage becomes effective if the charges are incurred because of a pre-existing condition, including complications and recurrences, that was not disclosed on the application for his or her coverage. Furthermore, these charges may not be applied toward the deductible amount.

Other Limitations

We will pay limited benefits for each covered person for the following items.

1. **Spinal Treatment.** Charges for outpatient, non-surgical services by a physician as a result of or related to distortion, misalignment or sublaxation in the spinal column are limited to $25 per visit and 25 visits per calendar year.
2. **Jaw Joint Treatment.** Treatment for any jaw joint problems including temporomandibular joint syndrome and craniomandibular disorders will be limited to $1,000 per calendar year and $2,000 lifetime. Braces and orthodontia will not be covered.
3. **Transplants.** Charges incurred as a result of a heart transplant or liver transplant will be limited, respectively, to a lifetime maximum of $100,000.
4. **Mental Illness.** Charges for the treatment and care of mental illness for any one covered person will be limited to the Lifetime Maximum Benefit for Mental Illness as shown on page 3. Charges by a doctor for outpatient treatment of mental illness will also be limited in the following ways (as shown on page 3):
    a. the benefit percentage;
    b. the maximum benefit amount per visit; and
    c. the maximum number of visits per calendar year (no more than one visit per day).
5. **Alcoholism, Drug Abuse, and Chemical Dependency.** Charges for the treatment and care of alcoholism, drug abuse, and chemical dependency for any one covered person will be limited to the Lifetime Maximum Benefit for Alcoholism, Drug Abuse, and Chemical Dependency as shown on page 3. Charges for outpatient treatment will also be limited in the following ways (as shown on page 3):
    a. the benefit percentage;
    b. the maximum benefit amount per visit; and
    c. the maximum number of visits per calendar year (no more than one visit per day).

PREMIUMS AND REINSTATEMENT

Premium Payments

Premiums are to be paid to our home office. The first premium is due on the date of issue. After that, premiums may be paid annually, semi-annually, quarterly or, if our rules permit, monthly. A receipt will be given upon request. We will allow you to change the frequency of payment by written request.

Grace Period

After the first premium is paid, any premium can be paid within 31 days after its due date. This 31-day period is called the grace period and your policy will remain in force during this period. If we do not receive your premium payment by the end of the grace period, your policy will lapse.

The grace period does not apply if AUL has given you written notice that we will not renew this policy beyond the period for which the premium has been accepted. This notice must be sent to you at least 31 days before the premium due date. Notice will be mailed to your last known address on our records.

Premium Refund At Death

We will refund that part of any covered person's premium paid for a period beyond the policy month of that person's death.

Reinstatement

If this policy lapses because the premium is not paid by the end of the grace period, you may ask to reinstate the policy. If AUL or an agent authorized by us accepts the overdue premium without requiring a reinstatement application, the policy will be reinstated.

If AUL or our agent requires a reinstatement application, you will be given a receipt for the overdue premium. If the application is approved, the policy will be reinstated as of the approval date. The premium will be refunded if the application is not approved. If AUL does not notify you of approval or disapprovel, the policy will be reinstated as of the 45th day after the date of the premium receipt. The reinstated policy will cover only loss due to:

- injury occurring after the date of reinstatement; or
- sickness that starts more than 10 days after that date.

In all other respects, you and AUL will have the same rights as each had when the policy lapsed. This is subject to any restrictions made a part of the reinstated policy.

CLAIMS

Notice Of Claim

Send written notice of a claim to our home office or to an AUL agent. This notice must be received within 60 days after the expense is incurred or as soon as reasonably possible. Include your name and policy number on the notice.

Claim Forms

When we receive the notice of claim, we will send you forms for filing proof of loss. If we do not send these forms to you within 10 working days, you will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the next provision.

Proof Of Loss

You must furnish us written proof of loss at our home office within 90 days after the date of that loss. If it is not reasonably possible to give written proof in that 90-day period, we will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. However, unless you are legally incapacitated, we will not accept proof of loss later than 1 year after it is due.

Time Of Payment Of Claims

We will pay all benefits under this policy as soon as we receive proper written proof of loss.

Payment Of Claims

We will pay benefits to you. We will pay to your spouse any benefits unpaid at your death; if you have no spouse, we will pay your estate. If benefits are payable to your estate or to a person who cannot give a valid release, we may pay benefits up to $1,000 ($3,000 in Florida) to any member of your immediate family we believe entitled to payment. If we pay such benefits in good faith, we will not have to pay them again.

Physical Examination

We have the right to examine a covered person as often as we may reasonably require while a claim is pending. The examination will be made at our expense.

Legal Actions

No legal action for benefits can be brought against AUL until 60 days after you send the required proof of loss. No legal action against AUL can start more than 3 years (5 years in Kansas, 6 years in South Carolina) after proof of loss is required.

GENERAL PROVISIONS

Contract

The entire contract consists of the basic policy, the attached copy of your application and any attached riders or endorsements.

Any change in this policy must be approved by AUL's Chairman, President, Vice-President or Secretary in writing. This written 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

After a person has been covered under this policy for 2 years, misstatements in the application may not be used to void that person's coverage or deny that person's claim for loss incurred after the 2-year period unless the misstatements are fradulent.

We will not deny or reduce any claim for loss incurred after this 2-year period because a sickness or physical condition existed before that person's effective date of coverage. This does not apply to any sickness or physical condition excluded by name or specific description contained herein.

Misstatement Of Age Or Sex

If the age or sex of a covered person has been misstated, we will:

- refund all excess premiums paid; or
- charge you for all underpayments.

If the correct age at issue exceeded our then current issue age limit or if the correct age now is greater than our renewal age limit, we will refund all premiums paid for the period not covered, and we will not pay any claims incurred during that period.

Conformity With State Statutes

Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which you reside on that date is amended to conform to the minimum requirements of such laws.

Assignment

We will not honor any assignment of this policy unless it is in writing and filed with us at our home office. It is up to you to make sure the assignment is valid.

Unpaid Premium

When a claim is paid, we have the right to subtract any due and unpaid premium from the claim payment.

Dividends

Each year while this policy is in force, we will determine its share of divisible surplus, if any. That share will be credited as a dividend.

Dividends may be paid in cash or may reduce an annual, semi-annual or quarterly premium. If you do not elect an option, dividends will be paid in cash.

Conversion Privilege

When coverage on your spouse or your dependent children ends, they may be eligible for a similar policy, without proof of good health, under certain circumstances. For your spouse to qualify for this conversion privilege, coverage must end because of dissolution of your marriage. For your dependent children to qualify, coverage must end because you and your spouse are no longer covered persons.

The eligible spouse or child may purchase a conversion policy provided:

- the person's application and first premium are sent to us within 31 days after coverage under this policy ends;
- the person is living in a state in which we offer similar coverage; and
- the person is not then insured under any other policy providing similar benefits.

Any restrictions that apply to the covered person converting will also be applied to the conversion policy.

POLICY DATA

DATE OF ISSUE	Dec. 15, 1989		
AGE AT ISSUE	35 Nearest Birthday		
INSURED'S SEX	Male		
NAME OF INSURED	JOHN Q. PUBLIC	3 329 212	POLICY NUMBER
LIFETIME MAXIMUM BENEFIT	$2,000,000	$1,000	BASIC DEDUCTIBLE

Benefit Percentage: 80% of the first $5,000 and 100% of the excess

Family Maximum Out-of-Pocket: $4,000

First Dollar Accident Benefit: 80% of the first $400

Mental Illness:

Lifetime Maximum Benefit: $25,000
Outpatient Benefit Percentage: 50%
Maximum Benefit Per Visit: $40
Maximum Number of Visits Per Calendar Year: 50

Alcoholism, Drug Abuse, and Chemical Dependency:

Lifetime Maximum Benefit: $5,000
Outpatient Benefit Percentage: 50%
Maximum Benefit Per Visit: $25
Maximum Number of Visits Per Calendar Year: 50

COVERED PERSONS (OTHER THAN INSURED): Jane Public

SCHEDULE OF BENEFIT AND PREMIUMS

FORM NUMBER	DESCRIPTION OF POLICY PLAN AND ATTACHED AGREEMENTS	INITIAL ANNUAL PREMIUM*
H-73	Major Medical Expense Policy	$1,526.40
	Total Annual Premium At Date of Issue	$1,526.40

***The Annual Premium for each subsequent policy year depends on each covered person's age, sex, place of residence and table of premiums then in effect.**

NOTICE OF ANNUAL MEETING

By-law, Art. III, Sec. 1: The regular annual meeting of the members of this corporation shall be held at its principal place of business on the third Thursday in February of each year at the hour of 10:00 o'clock a.m.; Elections for directors shall be held at such annual meeting.

AUL

American United Life Insurance Company
Indianapolis, Indiana