[redacted] Insurance Company
[redacted]
[redacted]
1-888[redacted]

COMPREHENSIVE LONG TERM CARE INSURANCE POLICY

NOTICE TO BUYER. This Policy may not cover all of the costs associated with long term care incurred by You during the period of coverage. We advise You to carefully review all Policy limitations.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. It is not intended to replace Your present health insurance. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Us.

THIS IS A TAX-QUALIFIED CONTRACT. This Policy for long term care insurance is intended to be a federally qualified long term care insurance contract and may qualify You for federal and state tax benefits.

GUARANTEED RENEWABLE FOR LIFE. Your Policy renews on Your Policy Anniversary. You have the right, subject to the terms of this Policy, to continue this coverage as long as You pay the required premiums on time. We cannot change any of the terms of Your coverage or benefits without Your consent, except that We may change the premium rates, subject to approval by the California Department of Insurance. Changes in premiums will apply to all members of Your rate class, which constitutes a single risk pool for the purposes of determining any future premium changes. Rate Class means a population segment classified by our actuaries as having similar characteristics, such as issue age, issue year, form number, rate classification, geographic area of residence and selected benefit options.

PREMIUM CHANGES. You cannot be singled out for a rate increase due to a change in Your age or health status. We can, however, change premiums, but only if We change the premiums for all similar policies issued in the same state and on the same form as Your Policy. Any premium changes will be effective on the next Premium Due Date following Our notice to You. We must give You at least 45 days written notice before the effective date of a premium change. If we ever increase Your premium, You will have the option to reduce coverage in order to preserve the premium amount You had previously been paying.

30-DAY FREE LOOK. If for any reason You decide not to keep this Policy, simply return it to Us within 30 days after You receive it. If You return it within the 30 day period, this Policy will be void from the beginning. We will refund any premium paid within 30 days after We receive the returned Policy.

CAUTION: If Your answers on Your Application are misstated or untrue, We may have the right to deny benefits or rescind the Policy. A copy of Your Application is attached to this Policy. If, for any reason, any of Your answers are incorrect, the best time to correct them is now, before a claim arises! Please contact Us at the address shown above.

THIS POLICY IS AN APPROVED LONG TERM CARE INSURANCE POLICY UNDER CALIFORNIA LAW AND REGULATIONS. HOWEVER, THE BENEFITS PAYABLE BY THIS POLICY WILL NOT QUALIFY FOR MEDI-CAL ASSET PROTECTION UNDER THE CALIFORNIA PARTNERSHIP FOR LONG TERM CARE.

FOR INFORMATION ABOUT POLICIES QUALIFTING UNDER THE CALIFORNIA PARTNERSHIP FOR LONG TERM CARE, CALL THE HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM AT THE TOLL-FREE NUMBER: 1 (800) 434-0222.

Secretary [redacted]

President [redacted]

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Refer to the Schedule of Benefits to determine Your benefits, options and applicable coverage details.

Note: *This Policy contains terms that have a special meaning when applied to Your coverage. To help You recognize these terms, the first letter of each word is capitalized wherever it appears throughout the Policy. These terms either: 1) appear in the Glossary (Section 7) with a corresponding definition; and/or 2) appear in a heading or sub-heading within the Policy with accompanying text providing further explanation.*

SECTION 1: LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

The following services and expenses are considered to be covered services and are payable under Your Lifetime Benefit Amount subject to Your Maximum Monthly Benefit. Important words are capitalized in this section for You.

Lifetime Benefit Amount

Your Schedule of Benefits shows the Lifetime Benefit Amount that You have elected. Your Lifetime Benefit Amount represents the lifetime dollar benefit amount available to You under this Policy. Your Lifetime Benefit Amount balance is reduced by all benefit amounts paid to You based on reimbursement for Covered Expenses for Qualified Long Term Care Services

Maximum Monthly Benefit

Your Schedule of Benefits shows the Maximum Monthly Benefit You have elected. Your Maximum Monthly Benefit represents the monthly dollar benefit amount available to You under Your Policy. The original dollar amount, as shown on Your Schedule of Benefits, is calculated as a percentage of Your Lifetime Benefit Amount.

If You are eligible for benefits for fewer than 31 days in any one calendar month period, We will calculate the Maximum Monthly Benefit based on a pro rata amount reflecting the actual number of days You were eligible.

Eligibility Requirements

We will pay benefits described in this Policy when We verify that You meet all of the following conditions:

- You are Chronically Ill;
- You receive any service covered under the Policy, and it is provided pursuant to a written Plan of Care;
- Coverage under this Policy is in force on the date(s) the care is received;
- You have satisfied the applicable Elimination Period, as shown in Your Schedule of Benefits;
- You have not exhausted Your Lifetime Benefit Amount or Your applicable Maximum Monthly Benefit; and
- You meet the additional Policy requirements for the specific Policy benefits You claim.

Chronically Ill means when You have been certified by a Licensed Health Care Practitioner as:

- being unable to perform, without Substantial Assistance from another person, at least two Activities of Daily Living for a period that is expected to last at least 90 consecutive days due to a loss of functional capacity; or
- requiring Substantial Supervision to protect Yourself from threats to health and safety due to a Severe Cognitive Impairment.

You will not meet the definition of Chronically Ill unless within the preceding 12-month period a Licensed Health Care Practitioner has certified that You meet such requirements.

Substantial Assistance means either Hands-on Assistance or Standby Assistance. **Hands-on Assistance** means the physical assistance of another person without which You would be unable to perform the Activities of Daily Living. **Standby Assistance** means the presence of another person, within Your arm's reach, that is necessary to prevent by physical intervention, Your injury while You are performing the Activities of Daily Living.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures or other demonstrations) by another person that is necessary to protect You from threats to Your health or safety (including, but not limited to, such threats as may result from wandering).

Severe Cognitive Impairment is a loss or deterioration in intellectual capacity that is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia and is measured by clinical evidence and standardized tests that reliably measure impairment in the person's:

- short-term or long-term memory;
- orientation as to people, places or time; and
- deductive or abstract reasoning.

Each of the following functions are **Activities of Daily Living** (ADL)

- **Bathing:** Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
- **Dressing:** Putting on and taking off all items of clothing and any necessary braces; fasteners or artificial limbs.
- **Toileting:** Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- **Transferring:** Moving into or out of a bed, chair or wheelchair.
- **Continence:** The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- **Eating:** Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

A **Plan of Care** is a written individualized plan of services prescribed by a Licensed Health Care Practitioner. The Plan of Care specifies Your long term care needs and the type, frequency, and providers of the services appropriate to meet those needs and the costs, if any, of those services. The Plan of Care will be modified as required to reflect changes in: Your functional or cognitive abilities, Your social situation, and Your care service needs.

Licensed Health Care Practitioner includes any of the following who is not an Immediate Family Member: a Physician (as defined in section 1861(r)(1) of the Social Security Act); registered professional nurse; a licensed social worker; or any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States. A Licensed Health Care Practitioner is responsible for assessing long term care service needs; developing a Plan of Care; coordination of Long Term Care services; implementing the Plan of Care; monitoring and reassessing the Plan of Care as needed.

Physician means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action.

Elimination Period means the total number of days that You remain Chronically Ill before benefits are payable. The Elimination Period begins on the first day that We verify You are Chronically Ill. Days more than 12 months prior to the date You submit Your initial claim request will not count towards meeting the Elimination Period, even if it can be established that You were Chronically Ill at that time. The Elimination Period need only be met once during Your lifetime.

You do not have to be receiving Qualified Long Term Care Services in order to satisfy the Elimination Period. Any day on which We verify that You are Chronically Ill will count toward the Elimination Period.

The Caregiver Training Benefit is available during the Elimination Period.

Qualified Long Term Care Services are necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services and Maintenance or Personal Care Services which are:

- Required by a Chronically Ill individual; and
- Are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Maintenance or Personal Care Services includes assistance with the Activities of Daily Living, including the Instrumental Activities of Daily Living, provided by a skilled or unskilled person under a Plan of Care developed by a Physician or a multidisciplinary team under medical direction.

Instrumental Activities of Daily Living include the activities often performed by a person who is living independently in a community setting during the course of a normal day, such as using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry, and light housekeeping.

How Benefits are Payable

When You are eligible for benefits, as described above, We will reimburse You for Covered Expenses for Qualified Long Term Care Services, up to Your Maximum Monthly Benefit each calendar month.

All benefits, payable to You under this Policy must be pursuant to a written Plan of Care.

COVERED EXPENSES

Facility Care Covered Expenses

Covered Expenses are expenses You incur for Qualified Long Term Care Services during Your stay in a Nursing Facility, Residential Care Facility, or Hospice Care Facility for:

- room and board (including charges to reserve Your bed when You are absent for any reason except discharge);
- ancillary services;
- patient supplies provided by the Nursing Facility, Residential Care Facility, or Hospice Care Facility for care of its residents; and
  Hospice Care services.

Confinement or Confined is a period of time You are a resident in a Nursing Facility or a Residential Care Facility during which a room and board charge is made.

Hospice Care Facility means a facility, unit in a facility, public or private agency unit of a public or private industry that meets federal certification requirements as a Hospice, or is comparably licensed under the laws where it is located, to provide care or management of the terminally ill.

Outside the state of California, a Hospice Care Facility provides a formal Hospice Services program directed by a Physician on an inpatient basis. A Hospice Care Facility must be licensed or certified by the state in which it is located, if such license is required. A Hospice Care Facility may be licensed as a Nursing Facility, Residential Care Facility, or other type of health care facility, except that Hospice Care Facility does not mean a hospital or clinic, a community living center or a place that provides residential care only.

Nursing Facility means a facility or distinct separate part of a hospital or institution that is duly licensed or complies with the state's facility licensing requirements to engage primarily in providing nursing care to inpatients under a Plan of Care prescribed by a Licensed Health Care Practitioner. A Nursing Facility provides 24 hour-a-day nursing care by a Nurse under the supervision of a Registered Nurse (RN). Nursing Facility also means a facility that is licensed as a specialized Alzheimer's Unit in all states where licensure exists.

A Nursing Facility is not: a hospital or clinic; a place which operates primarily for the treatment or rehabilitation for alcoholism or drug addiction, or facility for the treatment of mental illness; a Residential Care Facility; an adult residential care home; a domiciliary care facility; or Your primary place of residence in an area used principally for independent residential living; or a similar establishment. If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as a Nursing Home facility only if it meets all of the above criteria; is authorized to provide nursing care to inpatients; and is engaged principally in providing such nursing care in accordance with that license.

A **Nurse** is someone who is licensed as a Registered Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN) and is operating within the scope of that license.

Residential Care Facility means a facility licensed as a Residential Care Facility for the elderly or a Residential Care Facility as defined in the Health and Safety Code.

Outside of California, eligible providers are facilities that meet applicable licensure standards, if any, and are engaged in primarily providing care and related services sufficient to support needs resulting from impairment in Activities of Daily Living or impairment in cognitive ability; and meet all of the following:

- provides services and care on a 24-hour basis sufficient to support the needs resulting from the inability to perform Activities of Daily Living or from a Severe Cognitive Impairment;
- has trained and ready-to-respond personnel actively on duty in the facility at all times to provide services and care;
- provides three meals a day and accommodates special dietary needs;
- has formal arrangements with a Physician or Nurse to furnish medical care in case of an emergency; and
- has appropriate procedures to provide onsite assistance with prescription medications.

Residential Care Facility also means a facility that is licensed as a specialized Alzheimer's unit in a state where licensure exists.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as a Residential Care Facility only if it is engaged primarily in providing care and services that meet all of the above criteria.

Home and Community Care Covered Expenses

Expenses payable for Qualified Long Term Care Services provided by a Home Health Care Agency or an Independent Provider (including Informal Caregiver services), at-home Hospice Care, or an Adult Day Care Center for:

- Home Health Care Services;
- Personal Care Services;
- Hospice Care Services;
- C are in an Adult Day Care Center;
- Homemaker Services; and
- Respite Care Services.

Covered Expenses for any type of provider do not include the cost of drugs.

Adult Day Care means medical or nonmedical care on a less than 24-hour basis, provided in a licensed Adult Day Care Center outside the residence, for persons in need of personal services, supervision, protection, or assistance in sustaining daily needs, including eating, bathing, dressing, ambulating, transferring, toileting, and taking medications.

Adult Day Care Center is a facility that is licensed, registered or certified to provide a planned program of Adult Day Care services by the state in which it operates. If the state does not license such facilities, then it must be operated pursuant to law and meet all of the following standards:

- it provides Adult Day Care services in a protective setting and related supportive services that are designed to meet the needs of functionally or cognitively impaired adults through an individualized service plan;
- it keeps written record of services for each person; and
- it has established procedures for obtaining appropriate aid in the event of a medical emergency.

A **Home** is any residence in which You are living or staying. Home does not include any hospital, Nursing Home Facility, Residential Care Facility or Hospice Care Facility.

Home Health Care Agency refers to an entity that: if licensing or certification is required, is licensed or certified as a Home Health Care Agency under the laws where it is located, or under a public health law or similar law to provide Home Health Care Services; or is recognized as a Home Health Care Agency by Medicare; or meets all of the following:

- be supervised by a qualified professional such as a Registered Nurse (RN), a licensed social worker, or a Physician;
- keep clinical records or care plans on all patients;
- provide ongoing supervision and training to its employees appropriate to the services to be provided.

Home Health Care Services are skilled nursing or other professional services provided in Your Home, including but not limited to:

- part-time or intermittent skilled nursing services;
- physical therapy,
- occupational therapy,
- speech therapy and audiology;
- medical social services by a social worker; or
- assistance with or performance of personal hygiene, Activities of Daily Living, medication management or other related supportive services.

Homemaker Services means assistance with Instrumental Activities of Daily Living that is provided by a skilled or unskilled person under a Plan of Care, developed by a Physician or a multidisciplinary team under medical direction.

Homemaker means a skilled or unskilled person who provides Homemaker Services and whose services are:

- arranged and supervised through a Home Health Care Agency; or
- if not provided through a Home Health Care Agency, are provided pursuant to a written Plan of Care.

Hospice Care Services means outpatient services not paid by Medicare, that are designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a Terminal Illness, and to provide supportive care to the primary caregiver and the family. Care may be provided by a skilled or unskilled person under a Plan of Care developed by a physician or a multidisciplinary team under medical direction.

- **Terminal Illness** means a medical condition resulting from a prognosis of a life expectancy of one year or less, if the disease follows its normal course.

Independent Provider Services include services provided by a home health aide, certified nursing assistant, Nurse, or physical, occupational, respiratory or speech therapist who is working independently and is not affiliated with a Home Health Care Agency. An Independent Provider may also be an Informal Caregiver who is not required to be licensed in the state of California.

Informal Caregiver refers to a person who provides Maintenance or Personal Care services, for which the provider is not licensed. Members of Your Immediate Family are excluded as Informal Caregivers.

Personal Care means assistance with the Activities of Daily Living including the Instrumental Activities of Daily Living, provided by a skilled or unskilled person under a Plan of Care developed by a Physician or a multidisciplinary team under medical direction. **Instrumental Activities of Daily Living** include using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry, and light housekeeping.

Respite Care means short-term care provided in a facility, in the Home, or in a community-based program, that is designed to relieve a primary caregiver.

This policy also provides for the following **Supplemental Covered Expenses**:

Caregiver Training Benefit

Reimbursed up to 1X Your Maximum Monthly Benefit over the life of Your Policy.

Caregiver Training means training for an Informal Caregiver or an Immediate Family Member to perform Maintenance or Personal Care services for You in Your Home. This training can take place while You are Home, or in a hospital, Nursing Facility, Hospice Care Facility or Residential Care Facility, to make it possible for You to return Home and be cared for by the person who received the training.

This Caregiver Training Benefit can be accessed during the Elimination Period.

Immediate Family Member refers to Your spouse/registered domestic partner (RDP), child, parent, or sibling

Home Modification & Supplemental Products Benefit

Reimbursed up to 1 X Your Maximum Monthly Benefit over the life of Your Policy.

Services or Products required pursuant to a Plan of Care that include: Home Modifications, emergency response systems, or Durable Medical Equipment required by a Chronically Ill person in order to live at Home.

Durable Medical Equipment means medical equipment that You buy or rent that is designed to assist You in living at Home. Examples include, but are not limited to, walkers, hospital-style beds, crutches and wheelchairs.

Home Modifications include but are not limited to: building or installing an access ramp to Your Home, widening doorways, installing grab bars in the bathroom or otherwise equipping Your Home for greater safety or access related to Your long term care impairment.

SECTION 2: CONTINGENT NON-FORFEITURE BENEFIT

Note: *This benefit is automatically included in Your coverage as a standard benefit unless You have elected the optional Shortened Benefit Non-Forfeiture Option Rider.*

Contingent Benefit Upon Lapse

This Contingent Non-Forfeiture Benefit will apply to You if, and only if, there is a substantial increase in the premium rates for Your coverage, as described here.

Eligibility for Contingent Benefit Upon Lapse

If there is an increase in premium rates so that the cumulative amount of all premium rate increases is considered to be a substantial increase in premium rates, as determined by the schedule below, We will do the following:

- We will offer to reduce Your current level of coverage without evidence of insurability so that the required premium for Your coverage is not increased.
- We will offer to convert Your coverage to a paid-up status with a lesser Lifetime Benefit Amount. Under this conversion option, the amount of Your revised Lifetime Benefit Amount will be equal to the greater of: (a) one hundred percent (100%) of the sum of all premiums paid, excluding any waived premiums; or (b) one times (1x) Your Maximum Monthly Benefit in effect at the time of conversion. The revised Lifetime Benefit Amount is reduced by the sum of all benefits previously paid to You. Your Maximum Monthly Benefit will remain at the dollar amount in effect at the time of conversion, restricted only by the amount of Your revised Lifetime Benefit Amount. This conversion option may be elected at any time during the 120-day period following the effective date of the premium increase.
- We will notify You that a premium lapse at any time during the 120-day period following the effective date of the premium increase will be deemed to be the election of the preceding offer to convert Your coverage to a paid-up status. A premium lapse is Your failure to pay the required premiums within the 31-day Grace Period.

If You convert Your coverage to the paid-up status in accordance with the provisions above, We will continue to provide coverage, subject to all of the terms and conditions of the Policy in effect at the time of conversion.

Termination of Contingent Non-Forfeiture Benefit

Your coverage under this Contingent Non-Forfeiture Benefit ends when Your Lifetime Benefit Amount has been exhausted.

The following table determines what constitutes a substantial premium increase.

Substantial Premium Increase Schedule
Cumulative premium increase over original premium that will allow the Contingent Non-Forfeiture Benefit to be triggered. (Percentage increase is cumulative from the Policy Effective Date. It does NOT represent a onetime increase.)

Issue Age	Percentage of Increase Over Initial Annual Premium		Issue Age	Percentage of Increase Over Initial Annual Premium
29 and under	200%		72	36%
30 – 34	190%		73	34%
35 – 39	170%		74	32%
40 – 44	150%		75	30%
45 – 49	130%		76	28%
50 – 54	110%		77	26%
55 – 59	90%		78	24%
60	70%		79	22%
61	68%		80	20%
62	62%		81	19%
63	58%		82	18%
64	54%		83	17%
65	50%		84	16%
66	48%		85	15%
67	46%		86	14%
68	44%		87	13%
69	42%		88	12%
70	40%		89	11%
71	38%		90 and older	10%

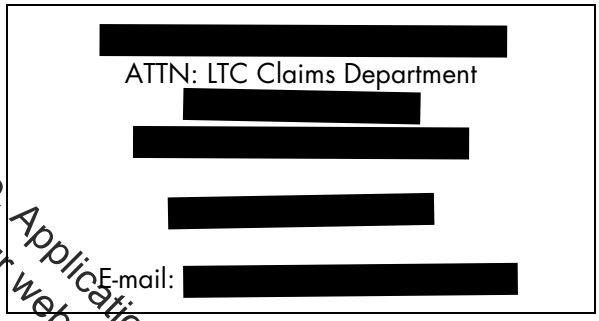
SECTION 3: CLAIM PAYMENTS AND PROCESSING

Note: *This Section describes: when We must be notified of a claim; what to send Us; how We evaluate and pay claims; and other rights and responsibilities under the contract.*

Notice of Claim

Written notice of claim must be given to Us within twenty days, or as soon as reasonably possible, when You first become disabled or when You think You are eligible for benefits under this Policy. We urge You to notify Us even if You are unsure, and We can help You determine whether or not You are eligible for benefits.

To submit a claim request, You or Your Representative must notify Us or any authorized agent of Us. You can notify Us by using the mailing address, phone number or e-mail address as follows:



How Claims are Evaluated

We will collect the information We need to determine Your eligibility for benefits. We may need to contact Your physician or other care provider(s). We may also need to review Your medical records or arrange for an Assessment which will be performed at no cost to You. We will review all such information to determine Your eligibility for benefits as defined in the Eligibility Requirements in Section1.

We will notify You if We determine that You are eligible for benefits. We will also arrange for a Plan of Care to be developed by a Licensed Health Care Practitioner.

Note: Future Assessments may also be required at reasonable intervals to determine Your continued eligibility for benefits. Such Assessments will be at no cost to You.

Claim Form

Upon receipt of a Notice of Claim, We will furnish You with claim form(s). If forms are not furnished within 15 days after giving Notice of Claim, You shall be deemed to have complied with the requirements of this Policy. In some cases, We may also arrange for an in-home Assessment.

Proof of Loss

For claim requests related to Covered Expenses for Qualified Long Term Care Services, written or electronic proof of loss must be given to Us, or to any authorized agent of Us, within 90 days after which such Covered Expense is incurred. Failure to submit proof of claim within this time limit will result in a claim denial unless it is shown that: it was not possible for You to furnish proof within this time and the proof was furnished as soon as reasonably possible, except in the absence of legal capacity, in no event will an expense be considered if proof for that expense is furnished more than 12 months after the date of service.

Written Notification

We will notify You in writing within ten business days of receiving all the required information if Your claim request is denied. We will provide a written explanation of the reasons and make available all information directly related to the denial unless such disclosure is prohibited under state or federal law.

Time Payment of Claims

Once You have met the Elimination Period, benefit payments will be made on a monthly basis following receipt of Your claim requests, or receipt of invoices submitted by You or submitted from providers to whom You have assigned benefits. All benefits payable by this Policy are pursuant to the written Plan of Care prepared for You.

Covered Expenses for Qualified Long Term Care Services are always applied against the Maximum Monthly Benefit for the month when such expenses are incurred – not when the claim is actually paid by Us.

Benefit amounts payable for care provided by an Informal Caregiver will be determined based on Usual and Customary charges for the geographic region where Your care is received. Such amounts payable will also be based on the skill level for the care or services required by You.

Usual and Customary means amounts customarily charged in a given geographic region for similar forms of care, services and/or products which are recognized to effectively support the long term care needs of a Chronically Ill individual, as recommended by a Licensed Health Care Practitioner.

Un-used Maximum Monthly Benefit amounts do not roll over or accumulate month to month; however, all un-used benefit amounts will remain in Your overall Lifetime Benefit Amount balance.

All claims are payable in United State dollars only.

To Whom Benefits Are Payable

All benefits will be payable to You unless otherwise assigned by You or Your Representative, to a Beneficiary named by You. Any other benefits unpaid at Your death will be payable to Your estate. However, We reserve the right to pay up to $2,000 of such benefits otherwise payable to Your estate directly to someone related to You by blood or marriage who is deemed by Us to be justly entitled to the benefits. We will be discharged to the extent of any such payment in good faith.

Appeal Process

If You disagree with Our decision regarding Your claim, You can appeal. You may request in writing or electronically within 60 days of the decision that We reconsider Your claim. You should submit any additional information that You feel We need to review Our decision. You should include the names, addresses, and phone numbers of any care providers You think We should contact to learn more about Your loss. You are responsible for the expense of securing additional information, if applicable, for each instance of reconsideration. We will reconsider Our decision and send You written notification of the results. If We deny Your appeal request, the information related to such denial, will be sent to You within 30 days of receipt of Your appeal request.

Legal Actions

No action may be brought to recover under this Policy until 60 days after proof of loss has been given to Us. No action can be brought more than three years from the date written or electronic proof of loss was required to be given.

Change of Beneficiary

You may change your Beneficiary at any time by giving written or electronic notice to Us. The effective date of the Beneficiary change will be the date the change is received and recorded by Us.

Assignment of Benefits

You may instruct Us to pay benefits due to You under this Policy directly to a Nursing Facility, Residential Care Facility, Hospice Care Facility, Adult Day Care Center or Home Care Agency providing the care for which We are reimbursing expenses. You must notify Us in writing or electronically. The care provider must also agree to the assignment of benefits. No assignment shall be binding upon Us unless a copy is on file at Our office. We do not assume any responsibility for the validity or effect of an assignment.

Notice

You may contact Our Policyholder Services Department with any questions or concerns regarding Your Policy at the phone number and address listed below:

[redacted] Administrative Office
[redacted]
[redacted]
Phone 1-888-[redacted]

If You have questions regarding Your claim You may contact:

[redacted] Administrative Office
ATTN: LTC Claims Department
P.O. Box[redacted]
Pensacola, [redacted]
1.888.[redacted]
E-mail: claims@[redacted]

If You are unsatisfied with Our claim decision or any aspect of Our service and We have failed to resolve any problems You have, You may contact:

California Department of Insurance
Consumer Services Division
300 South Spring Street, South Tower
Los Angeles, CA 90013
1-800-927-4357

SECTION 4: LIMITATIONS AND EXLUSIONS

Exclusions

No benefits will be payable under this Policy for:

- a loss that occurs while this Policy is not in force; or
- an illness, treatment or medical condition that is due to war or act of war, whether declared or not; or
- an illness, treatment or medical condition that results from an attempt at suicide (while sane or insane) or an intentionally self-inflicted injury; or
- treatment related to alcoholism or drug addictions; or
- expenses for services or items to the extent that such expenses are reimbursable under Title XVIII of the Social Security Act (Medicare), or would be so reimbursable but for the application of a deductible or coinsurance amount; or
- care or services, unless otherwise required by law, for which benefits are duplicated or provided under a governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; or
- care or services provided by an Immediate Family Member unless:
  - he or she is a regular employee of an organization which is providing the treatment, service or care; and
  - the organization receives the payment for the treatment, service or care; and
  - he or she receives no compensation other than the normal compensation for employees in his or her job category; or
- care or services for which no charge is made in the absence of insurance; or
- care or services provided outside the United States of America, its territories or possessions, or Canada.

SECTION 5: PAYMENT AND RENEWAL PROVISION

Premium Payments

You will pay premiums to Us or to one of Our authorized agents. Your first premium is due on the Policy Effective Date as shown on Your Schedule of Benefits.

Grace Period

There is a 31 day Grace Period. This means that if a premium is not paid on or before the date it is due, it may be paid during the following 31 days. Your insurance under the Policy will remain in force during the Grace Period, unless We have been advised in writing by You or Your Representative that You want to cancel Your coverage prior to the end of the Grace Period.

Protection Against Unintentional Lapse

You have the right, at the time of Application, to designate at least one person who is to receive notice of termination for non-payment of premium in addition to Yourself. You may change this designation at any time. To do so, You must notify Us in writing or electronically. We will remind You in writing or electronically every two years of this opportunity.

Notification of Termination Due to Non-Payment

If Your premium is due and unpaid at the end of the Grace Period, We will give notice of termination to You and to the person(s) You have designated to receive notice. The notice of termination will be sent at the end of the Grace Period and at least 35 days in advance of termination. This notice will state the amount of unpaid premium, the date by which premium must be paid, and the date the coverage is to terminate. Our notice will be sent prepaid by United States first class mail. We will consider You and Your designated person notified as of five calendar days after the date the notice is mailed by Us. If Your premium remains unpaid on the termination date stated in the notice, Your coverage will terminate as of the end of the Grace Period. Any benefits payable after the last date for which Your premium was paid will be reduced by the premium due from the date the last premium was paid to the date Your coverage under the Policy terminated.

Waiver of Premium

We will waive the payment of premium beginning on the first day You begin receiving benefits. As long as You continue to receive benefits, additional premiums will not be required. Premium payments will again be required after 30 days of not receiving benefits. We will credit or refund, on a pro rata basis, any premiums paid for periods in which Waiver of Premium is in effect. Any such credit will be applied to reduce future premiums that may become due. Any such refund will be made as described in the Refund of Premiums in Certain Cases paragraph below.

Unpaid Premium

When a claim is paid, any premium due and unpaid will be deducted from the claim payment.

Refund of Premiums in Certain Cases

If You die while covered under the Policy or choose to cancel Your Policy, We will refund the pro rata part of any premiums paid for periods beyond Your death or cancellation. In addition, if You become eligible for Waiver of Premium, We will refund any outstanding credit with respect to the Waiver of Premium as described above. In the event of death, any refund will be made within 30 days of Our receipt of Your certified death certificate and will be paid to Your Beneficiary. If there is no named or living Beneficiary on the date of Your death, any refund will be paid to Your estate. In the event of Your cancellation of the Policy, any refund will be paid to You. In the event of an outstanding credit applicable to Waiver of Premium, any such refund will be paid upon the earlier of Your death or Your cancellation of the Policy and will be paid to Your Beneficiary, Your estate or to You in the manner described above. The aggregate amount of all refunds paid upon Your death or cancellation of the Policy cannot exceed the total premiums You paid for Your Policy.

Reinstatement

If the renewal premium is not paid before the Grace Period ends, the Policy will lapse. If We or Our authorized agent accepts the premium without requiring an Application for reinstatement, We will reinstate this Policy. If We or Our agent requires an Application, You will be given a conditional receipt for the premium. If the Application is approved, the Policy will be reinstated as of the approval date. Lacking such approval, the Policy will be reinstated on the 45th day after the date of the conditional receipt unless We had previously written to You 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 You and Us will remain the same, subject to any provisions noted on or attached to the reinstated Policy.

Any premiums We accept for a reinstatement will be applied to a period for which premiums have not been paid. No premium will be applied to any period more than 60 days before the reinstatement date.

Added Protection Against Lapse

If Your coverage is terminated due to non-payment of premiums because You were Chronically Ill before the Grace Period expired, We will provide a reinstatement of coverage based on the conditions specified below. To be eligible for this reinstatement, You must provide Us proof that You were Chronically Ill before the Grace Period expired.

The proof must be in the form of a certification and Assessment from a Licensed Health Care Practitioner which demonstrates that You were Chronically Ill. The proof must be provided to Us within five months of the termination date. You must pay all past due premiums for the coverage that was in force immediately prior to the date of termination. In that event, Your insurance will be reinstated as of the date of that termination without interruption of insurance for that period.

SECTION 6: GENERAL PROVISIONS

Coverage Effective Date

You will become covered under the Policy on the Policy Effective Date shown on Your Schedule of Benefits, subject to payment of the required premium.

Coverage Termination Date

Your coverage terminates on the first to occur of:

- the date of Your death; or
- the date coverage is cancelled pursuant to Your request; or
- the date Your Lifetime Benefit Amount is exhausted; or
- the last day of the Grace Period; or
- if You are covered under the Shortened Benefit Period Non-Forfeiture Option or the Contingent Non-Forfeiture Benefit, the date Your revised Lifetime Benefit Amount has been exhausted.

Right to Increase Coverage

You have the right to request to increase Your coverage by requesting a greater Lifetime Benefit Amount. Such increase requests will be subject to underwriting. You will be required to submit a new Application for any increased coverage amount. If approved for the increased Lifetime Benefit Amount, You will have a revised premium. The additional premium associated with the increased Lifetime Benefit Amount will be based on Your current issue age, the rate class at which you were approved for the increased coverage amount, and our premium rate schedule as of the date the coverage increase change is made. Your total revised premium will include this additional premium amount added to your original premium amount.

Right to Reduce Coverage

If You wish to lower Your premiums in the future, You have the right to reduce Your coverage by requesting a lesser Lifetime Benefit Amount. To request a reduction in coverage, You simply notify Us in writing or electronically. Your revised premium will be based on Your original issue age, Your original rate class and Our premium rate schedule as of the date the coverage change is made.

Extension of Benefits

If Your Policy terminates due to failure to pay premium, We will recognize Your basis for a claim for Your Confinement in a Nursing Facility or an Residential Care Facility before the date Your Policy ended in the same manner as if Your insurance was in force. Extension of Benefits stops on the earlier of the date when You no longer meet the Eligibility Requirements for benefits, the date You are no longer Confined in a Nursing Facility or an Residential Care Facility, or the date Your Lifetime Benefit Amount is exhausted.

Entire Contract

The entire contract consists of: the Policy, the Schedule of Benefits, any riders or endorsements to the Policy that are issued by Us, and Your Application.

Contract Changes

Any contract change made by Us must be signed by one of Our executive officers. No agent may modify or waive any of the terms of the contract. No change in the contract is effective until You accept the change in writing or electronically, with the following exceptions: a change in the premiums; a change which is required by law or regulation; or a change which does not reduce or eliminate benefits or coverage. These exceptions do not include an increase in benefits or coverage with a like increase in premium. Any change will be without prejudice to any claim incurred for benefits prior to the date of the change.

Misstatements / Incontestability

In issuing this Policy, We have relied upon information presented by You in Your Application. If Your Policy has been in force for less than six months, We may rescind Your Policy or deny a claim due to a misrepresentation in Your Application that is material to the acceptance for coverage.

If Your Policy has been in force for at least six months, but less than two years, We may rescind Your Policy or deny a claim due to a misrepresentation in Your Application that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

After Your Policy has been in force for two years, We cannot rescind Your Policy or deny a claim due to misrepresentation alone, except in cases where We can show that You knowingly and intentionally misrepresented relevant facts relating to Your health in Your Application.

Misstatement of Age

If Your age was misstated in Your application, We will adjust Your premium to the correct amount for Your insurance at Your correct age as of the Policy effective date.

Conformity With State Statutes

Any provision of Your Policy which, on the Policy effective date, is contrary to the applicable laws of the state where the Policy is delivered is amended to conform to the minimum requirements of such state laws.

Conformity With Internal Revenue Code

If on the Policy effective date, the Policy does not comply with the requirements of Section 7702B (b) of the Internal Revenue Code of 1986, it will be treated as if it had been changed to comply with those requirements. Because the Policy is guaranteed renewable, We will inform You in writing or electronically of any required change in the provisions of this Policy; and You will be given the choice of accepting the change, or retaining the Policy without that change

Time Periods

All time periods start and end at 12:01 a.m. in the time zone in which You reside.

Clerical Error

Clerical error or delays in making entries on the records by Us or Our designees will not void Your coverage if Your coverage would otherwise have been in effect. Such clerical error will not cause You to become insured if You are otherwise not eligible. Such clerical error will also not extend Your coverage if Your coverage would otherwise have ended or been reduced as provided by the Policy. If a clerical error is found, premiums and benefits will be adjusted based on the true facts and the provisions of the Policy.

SECTION 7: GLOSSARY

This Section provides some definitions of words and terms used in the Policy that have a special meaning when applied to Your coverage. To help You recognize these special words and terms, the first letter of each word is capitalized wherever it appears throughout the Policy.

Application — The written or electronic application form provided by Us and completed by You when You apply for coverage.

Assessment — An evaluation done by a Licensed Health Care Practitioner to determine or verify that You are Chronically Ill. The Assessment uses generally accepted tests and instruments that use objective measures and produce verifiable results.

Beneficiary — The person designated by You to receive benefits, if any are payable, under this Policy after your death, or to receive a Refund of Premiums in Certain Cases, if applicable.

Medicare — The "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended, or Title I, Part I of Public Law 89-97, as enacted by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof, or words of similar import.

Mental Disorder — Any neurosis, psychoneurosis, psychopathology, psychosis, or mental or emotional disease or disorder, as classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. If the DSM is discontinued or replaced, the diagnostic manual in use by the American Psychiatric Association as of the date of Your illness will be used.

Policy — The contract between You and Us.

Policy Anniversary — The same month and day as the issue date for each succeeding year this Policy remains In-Force.

Premium Due Date — Each date a premium is due, after the initial premium, in accordance with the terms of this Policy.

Representative — A person or entity legally empowered to represent You.

We, Us, Our — LifeSecure Insurance Company or the administrator it designates.

You, Your or Yourself — The Policyholder named on Your Schedule of Benefits.

LifeSecure Insurance Company
10559 Citation Drive, Suite 300
Brighton, Michigan 48116
1.888.575.8246

Shared Care Rider

This Rider is attached to and made part of Your Policy as of the Effective Date shown on Your Schedule of Benefits. A copy of Your Application is attached. If the provisions of this Rider and those of the Policy do not agree, the provisions of this Rider will apply.

Definitions

Covered Partner means the person named as Your Spouse or Registered Domestic Partner in the Application for Your Policy.

Coverage means the long term care insurance in effect under this Policy or under Your Covered Partner's Policy. For purposes of this Rider, Coverage includes the Policy form, Lifetime Benefit Amount, Elimination Period, all applicable Covered Services, Supplemental Coverages, and any Rider(s) purchased.

Eligibility

In order to be eligible for the benefits provided by this Rider:

- Coverage for both You and Your Covered Partner must be identical in all respects, as defined above, for the entire time both Policies are in effect up to the time benefits become payable under this Rider; and
- Both You and Your Covered Partner must have a Shared Care Rider.

This Rider allows Your Covered Partner to receive benefits under Your Policy after the total Lifetime Benefit Amount under Your Covered Partner's Policy has been exhausted. This Rider is part of the Policy to which it is attached if it is included on Your Schedule of Benefits. This Rider provides Coverage as described below.

Benefit

If Your Covered Partner exhausts the Lifetime Benefit Amount under his or her Policy, then he or she may draw from the Lifetime Benefit Amount under Your Policy. We will notify You in writing when Your Covered Partner begins to receive benefits under Your Policy, in accordance with the provisions of this Shared Care Rider. Both You and Your Covered Partner may receive payment for benefits under Your Policy at the same time.

We will pay benefits to Your Covered Partner in accordance with the applicable benefit amounts, terms and conditions in effect under his or her Policy immediately prior to its termination. In no event will the benefits received by Your Covered Partner under Your Policy exceed the Lifetime Benefit Amount under Your Covered Partner's Policy immediately prior to its termination.

In addition, benefits payable to Your Covered Partner under Your Policy will not reduce Your Lifetime Benefit Amount below an amount equal to 12X Your Maximum Monthly Benefit.

Alternatively, if you exhaust the Lifetime Benefit Amount under Your Policy, then You may draw from the Lifetime Benefit Amount under Your Covered Partner's Policy according to the same guidelines and limits outlined above.

Effect on Your Lifetime Benefit

If Your Covered Partner exhausts his or her Lifetime Benefit Amount and then receives benefits under Your Policy, the amount of benefits available to You will be less than You would have had under Your own Policy if You had not purchased this Rider.

Death of Your Covered Partner

In the event of Your Covered Partner's death, the remaining total Lifetime Benefit Amount under his or her Policy will be added to Your Lifetime Benefit Amount. If You are receiving benefits from Your Covered Partner's Policy at the time of Your Covered Partner's death, You will continue to receive benefits under the terms of this Rider until the maximum benefit amount is paid.

Waiver of Premium

We will waive the premium for Your Policy, including the premium for this Rider, if You are eligible for Waiver of Premium under the terms of Your Policy. However, We will not waive premium for Your Policy, including the premium for this Rider, if only Your Covered Partner is receiving benefits under Your Policy.

Cancellation

Either Covered Partner may choose at any time to cancel the Shared Care Rider and maintain their Policy or discontinue both of their Policies and Riders.

1. If Your Covered Partner cancels their Shared Care Rider, the Shared Care Rider for Your Policy is automatically cancelled. In this instance, each Covered Partner can retain their Policy.
2. If Your Covered Partner cancels both their Policy and Shared Care Rider, the Shared Care Rider for Your Policy is automatically cancelled. You may still retain Your Policy.

Limitations

Increases in benefit amounts under the Guaranteed Future Purchase Offer Rider, if applicable, for Your Coverage while Your Covered Partner is eligible for benefits will not be taken into account in determining whether the Coverage remains identical under both Policies. Any other change in benefits under Your Covered Partner's Coverage that is not made to Your Coverage will cause this Shared Care Rider to terminate. This Rider will terminate if Your Coverage and Your Covered Partner's Coverage are no longer identical, with the exception explained above related to the Guaranteed Future Purchase Offer Rider. In order for Your Covered Partner to receive benefits under Your Policy, You must complete the required request form. You may call or email Our Policyholder Services Office to request the required form.

Effective Date

This Rider takes effect on the Rider Effective Date shown below. If this Rider is in effect, it will be set forth on Your Schedule of Benefits.

Termination

This Rider will end on the earlier of:

1. The date We receive Your written request to terminate this Rider; or
2. the date on which Your or Your Covered Partner's Policy ends; or
3. the date on which Your Covered Partner dies; or
4. the date on which the Shared Care Rider on Your Covered Partner's Policy is terminated for any reason except exhaustion of the Lifetime Benefit Amount; or
5. the date on which You or Your Covered Partner change benefits in such a way that Your Policy and Your Covered Partner's Policy are no longer identical.

Premium

The premium for this Rider is shown in the Schedule of Benefits. The premium for this Rider will terminate as of the date this Rider ends. The same conditions that apply to the premium for the Policy will apply to the premium for this Rider.

In all other respects, the provisions and conditions of the Policy remain the same. This Rider is subject to the terms and provisions of the Policy. It is to be attached to and made a part of Your Policy.

Signed for LifeSecure Insurance Company

[redacted]

Secretary

[redacted]

President

[redacted] Insurance Company
[redacted]
1.888.[redacted]

GUARANTEED FUTURE PURCHASE OFFER RIDER

This Rider is attached to and made part of Your Policy if You did not elect the optional 3% Automatic Compound Benefit Increase Option Rider or 5% Automatic Compound Inflation Protection Benefit Rider. The Effective Date is shown on Your Schedule of Benefits. If the provisions of this Rider and those of the Policy do not agree, the provisions of this Rider will apply.

Benefit

Under the Guaranteed Future Purchase Offer Rider, You will be offered the opportunity to increase Your remaining Lifetime Benefit Amount and Maximum Monthly Benefit on Your Policy Anniversary, subject to the conditions listed below.

Each offer to increase will be for 15% of the dollar amount of Your remaining Lifetime Benefit Amount and Your current Maximum Monthly Benefit. This offer will be made on every three years on Your Policy Anniversary. You may elect to increase Your coverage by the amount offered under this feature without submitting evidence of insurability. All increased amounts will be rounded to the nearest whole dollar.

We will notify You in writing or electronically of the offer at least 60 days prior to the anniversary of the Policy Effective Date. You may accept or decline the offer within 60 days after We send the notification. If We do not receive Your acceptance of Our offer within 60 days, We will deem this to be a declination of the offer. You may accept or decline ongoing offers to increase coverage each time an offer is made.

No further offers will be made if Your Policy is terminated, or if coverage is continuing in effect under:

- the Extension of Benefits;
- the Shortened Benefit Period Non-Forfeiture Option Rider, if any; or
- the Contingent Non-Forfeiture Benefit, if any.

No further offers will be made:

- once You have attained age 84;
- during the Elimination Period; or
- if You meet the Eligibility Requirements for benefits, as described in the Policy.

If You recover so that You no longer meet the Eligibility Requirements for benefits, You will again be eligible for Guaranteed Future Purchase Offers when they occur, subject to the above restrictions.

Premium

There is an additional premium for this Rider shown on your Schedule of Benefits. The additional premium for the increased amount of coverage provided by this Rider will be based on Your attained age, Your original rate class and Our premium rate schedule as of the date the benefit increase offer is made to You and accepted by You.

Termination

This Rider will terminate and coverage for this Rider will end on the earliest of:

- the date We receive Your written request to terminate this Rider;
- the date of Your death;
- the date Your Policy terminates.

Signed for [redacted] Insurance Company

[redacted] Secretary

[redacted] President

[redacted] Insurance Company
[redacted]
1.888.[redacted]

SHORTENED BENEFIT NON-FORFEITURE OPTION RIDER

This Rider is attached to and made part of Your Policy as of the Effective Date shown on Your Schedule of Benefits. A copy of Your Application is attached. If the provisions of this Rider and those of the Policy do not agree, the provisions of this Rider will apply.

Benefit

If Your coverage terminates due to non-payment of premium on or after the third anniversary of this option and before Your Lifetime Benefit Amount has been exhausted, the Shortened Benefit Non-Forfeiture Option will provide a paid-up continuation of Your coverage with a lesser Lifetime Benefit Amount. The amount of Your revised Lifetime Benefit Amount will be equal to the greater of: (a) one hundred percent (100%) of the sum of all premiums paid, excluding any waived premiums; or (b) one times (1x) Your Maximum Monthly Benefit in effect at the time of lapse. Your Maximum Monthly Benefit will remain at the dollar amount in effect at the time of lapse, restricted only by the amount of Your revised Lifetime Benefit Amount.

We will continue to provide coverage, subject to all of the terms and conditions of the Policy in effect at the time of lapse. Your coverage under this option ends when the Lifetime Benefit Amount has been exhausted.

Premium

There is an additional premium for this Rider shown on your Schedule of Benefits. If this Rider terminates prior to the Policy termination, Your Premium will be adjusted to reflect that change.

Termination

This Rider will terminate at the earliest of:

- the date We receive Your written request to terminate this Rider;
- the date of Your death;
- the date Your Policy terminates.

Note: This Shortened Benefit Non-Forfeiture Option cannot be triggered until Your Policy has been in effect for three full years.

Signed for [redacted] Insurance Company

[redacted]
Secretary

[redacted]
President

[redacted] Insurance Company
[redacted]
1.888.[redacted]

5% AUTOMATIC COMPOUND INFLATION PROTECTION BENEFIT RIDER

This Rider is attached to and made part of Your Policy as of the Effective Date shown on Your Schedule of Benefits. If the provisions of this Rider and those of the Policy do not agree, the provisions of this Rider will apply.

Benefit

We will increase the dollar amount of Your Lifetime Benefit Amount, un-reduced by any benefits paid, and Your current Maximum Monthly Benefit by 5% each year.

All increased amounts will be rounded to the nearest whole dollar.

These increases in benefits will not be determined by the actual amount of future inflation. The actual increases in benefits under Your Policy may be greater or less than the amount of inflation.

If this Rider is added after the Policy Effective Date, all increases will be added on the annual anniversary dates following the addition of the benefit to Your Policy.

Benefit Increases Effective Date

The increase will become effective on each anniversary of the Policy Effective Date even if You are receiving benefits.

Premium

There is an additional premium for this Rider shown on your Schedule of Benefits. Your premium rate will not change as a result of the annual benefit increases. However, Your Premium may change subject to the terms of the Policy. See Premium Changes section of the Policy. If this Rider terminates prior to the termination of the Policy, Your Premium will be adjusted to reflect the removal of this Rider.

Termination

This Rider will terminate at the earliest of:

- the date Your coverage is continuing in effect under the Extension of Benefits Provision; the Shortened Benefit Non-Forfeiture Option Rider (if any); or the Contingent Non-Forfeiture Benefit; or
- the date We receive Your written request to terminate this Rider;
- the date of Your death;
- the date Your Policy terminates.

Signed for [redacted] Insurance Company

[redacted]
Secretary

[redacted]
President

LS-0128B CA 09/09

[redacted] Insurance Company
[redacted]
1.888[redacted]

3% AUTOMATIC COMPOUND BENEFIT INCREASE OPTION RIDER

This Rider is attached to and made part of Your Policy as of the Effective Date shown on Your Schedule of Benefits. If the provisions of this Rider and those of the Policy do not agree, the provisions of this Rider will apply.

Benefit

We will increase the dollar amount of Your Lifetime Benefit Amount, un-reduced by any benefits paid, and Your current Maximum Monthly Benefit by 3% each year.

All increased amounts will be rounded to the nearest whole dollar.

These increases in benefits will not be determined by the actual amount of future inflation. The actual increases in benefits under Your Policy may be greater or less than the amount of inflation.

If this Rider is added after the Policy Effective Date, all increases will be added on the annual anniversary dates following the addition of the benefit to Your Policy.

Benefit Increase Effective Date

The increase will become effective on each anniversary of the Policy Effective Date even if You are receiving benefits.

Premium

There is an additional premium for this Rider shown on Your Schedule of Benefits. Your premium rate will not change as a result of these annual benefit increases. However, Your Premium may change subject to the terms of the Policy. See Premium Changes section of the Policy. If this Rider terminates prior to the termination of the Policy, Your premium will be adjusted to reflect that change.

Termination

This Rider will terminate at the earliest of:

- the date Your coverage is continuing in effect under the Extension of Benefits Provision; the Shortened Benefit Non-Forfeiture Option Rider (if any); or the Contingent Non-Forfeiture Benefit; or
- the date We receive Your written request to terminate this Rider;
- the date of Your death;
- the date Your Policy terminates.

Signed for [redacted] Insurance Company

[redacted]
Secretary

[redacted]
President