MUTUAL *of* OMAHA INSURANCE COMPANY
Mutual of Omaha Plaza, Omaha, NE 68175, 402 342 7600

MUTUAL of OMAHA

LONG-TERM CARE INSURANCE POLICY

FEDERAL INCOME TAX EXEMPTIONS: This Policy IS intended to be a tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

STATE MASSHEALTH (MEDICAID) EXEMPTIONS: This policy [IS] {IS NOT} intended to satisfy Massachusetts' minimum long-term care insurance coverage requirements as of the policy's effective date for certain asset and liability exemptions under the Massachusetts MassHealth (Medicaid) Program. Please note that there may be other MassHealth (Medicaid) requirements to qualify for these exemptions.

Please read *Your Options for Financing Long-Term Care: A Massachusetts Guide* for important information about the federal and state exemptions. PLEASE NOTE THAT STATE AND FEDERAL LAWS ARE SUBJECT TO CHANGE AND THAT FEDERAL AND STATE EXEMPTIONS MAY NOT APPLY TO THIS POLICY AT A FUTURE DATE.

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. You are advised to review carefully all policy limitations.

CONSIDERATION. In consideration of the first premium you paid and the application you completed, we have put this policy in force as of the Policy Effective Date. Your application becomes part of your policy.

30-DAY RIGHT TO REVIEW POLICY. You have 30 days from the date of its receipt to review your policy. If during that time you are not satisfied with it, you may return your policy to us or your agent for a prompt refund of all premiums paid. This policy will then be considered never to have been issued.

CHECK YOUR APPLICATION. CAUTION: The issuance of this policy is based upon the responses to questions on your application. A copy of that application is attached. If any of the answers are incorrect or untrue, we have the right to deny benefits or rescind your policy, subject to the Incontestability Period provision. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at the address shown in the Policy Schedule.

GUARANTEED RENEWABLE. This policy is issued on an individual basis and is guaranteed renewable. You have the right to continue this policy in force for as long as you live or until the Maximum Lifetime Benefit is exhausted. Subject to the terms of this policy, we cannot cancel your coverage as long as you pay the required premium when it is due.

PREMIUMS CAN CHANGE. We reserve the right to increase the premium for this policy, but never more than once per year. However, any change in premium must apply to all policies issued to persons of the same Policy Class. That means, except when required by a change in benefits under the policy, premium will not increase due to a change in your age or health or your use of the long-term care coverage. We must give you at least 60 days written notice before we change premium. We will not increase the premium for this policy before the Rate Guarantee Period, if any, shown in the Policy Schedule has expired, except when required by a change in benefits under the policy. Changes in premium rates are subject to the approval of the Massachusetts Commissioner of Insurance.

THIS POLICY PROVIDES LIMITED COVERAGE. PLEASE READ IT CAREFULLY. THIS POLICY DOES NOT CONTAIN ANY PRE-EXISTING CONDITION EXCLUSIONS OR LIMITATIONS.

This policy is a legal contract between you, the Insured, and us, Mutual of Omaha Insurance Company.
READ YOUR POLICY CAREFULLY. THIS IS NOT A MEDICARE SUPPLEMENT POLICY.
If You Are Eligible For Medicare, Review The *Guide To*
***Health Insurance For People With Medicare* Available From Us.**
This policy is not participating and therefore will pay no dividends.

Daniel P. Neary

Chairman of the Board and
Chief Executive Officer

Michael Hurst

Corporate Secretary

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DEFINITIONS

Capitalized terms used in this policy have the meanings assigned to them in this section of the policy.

Activities of Daily Living means the following self-care functions:

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.

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).

Dressing: Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

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.

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.

Adult Day Care means Dementia Day Care or Social Day care.

Adult Day Care Center means a facility that is licensed or certified to provide Adult Day Care by the state in which it operates. If the state does not license or certify such facilities, then it must meet all of the following standards:

(a) it provides Adult Day Care in a protective setting and under appropriate supervision;
(b) it operates on less than a 24-hour basis;
(c) it keeps a written record of services for each person; and
(d) it has established procedures for obtaining appropriate aid in the event of a medical emergency.

Alzheimer's Facility means a specialized facility that is engaged primarily in providing care for persons with Alzheimer's disease or other Severe Cognitive Impairment and has the appropriate state licensure, certification or registration to operate as an Alzheimer's Facility.

Ancillary Services means physical, occupational, speech, and respiratory therapies, wound care, medication management, continence care support, and similar care-related services that support Activities of Daily Living.

Assessment means an evaluation performed by a Licensed Health Care Practitioner to determine or verify that you are Chronically Ill. The Assessment will be based on objective standards of measurement using generally accepted tests to produce verifiable results.

Assisted Living Facility means a facility or distinctly separate part of a facility that has been certified as an assisted living residence by the Massachusetts Executive Office of Elder Affairs or if located in another state is engaged primarily in providing non-skilled long term care. If required by the state in which it is located, an Assisted Living Facility must have the appropriate state licensure, certification, or registration to operate as an Assisted Living Facility.

If the state in which it is located does not require an Assisted Living Facility to be licensed, certified, or registered, the facility must meet the following requirements:

(a) provides services and care on a continuous 24-hour basis for persons requiring Substantial Assistance with the Activities of Daily Living or Substantial Supervision due to Severe Cognitive Impairment;
(b) maintains trained staff on duty at all times to provide the services and care;
(c) provides at least three meals a day and accommodates special dietary needs;
(d) provides residential services and Personal Care Services in one location;
(e) maintains formal arrangements with a Physician or Nurse to furnish medical care in case of an emergency; and
(f) maintains appropriate procedures to provide onsite assistance with prescription medications.

An Alzheimer's Facility or a Hospice Care Facility may be an Assisted Living Facility if such facility meets the requirements contained in this definition for an Assisted Living Facility located in a state which does not require licensure, certification, or registration.

Assisted Living Facility does not include a hospital or clinic; a place that operates primarily for the treatment of alcoholism, drug addiction, or Mental or Nervous Disorder; a Nursing Home; a domiciliary care facility; or your primary place of residence in an area used principally for independent residential living; or a similar establishment.

Care Coordinator means a Licensed Health Care Practitioner who is qualified by training and experience to assess and coordinate the overall care needs of a person who is Chronically Ill. The Care Coordinator may provide services independent of, or be employed by or under contract to, an agency. You are not required to use the Care Coordinator designated by us. You may use your own Care Coordinator.

Chronically Ill has the meaning found for such term in the ELIGIBILITY FOR THE PAYMENT OF BENEFITS section of this policy.

Confinement or **Confined** means to be admitted as a resident for a period of time for which a charge is incurred for room and board.

Dementia Day Care means services provided by a dementia day care program operating in accordance with standards issued by the Massachusetts Executive Office of Elderly Affairs, including a structured, secure environment for individuals with cognitive disabilities to maximize the individual's functional capacity, to reduce agitation, disruptive behavior, and the need for psychoactive medication, and to enhance cognitive functioning or a program meeting the requirements of the state in which the dementia care is being provided.

Durable Medical Equipment means equipment which:

(a) is functionally necessary and not just for your convenience;
(b) is designed for repeated and prolonged use;
(c) is suited for use in your Home; and
(d) can enhance your ability to perform Activities of Daily Living.

Durable Medical Equipment includes, but is not limited to, infusion pumps, special hospital-style beds, walkers, or wheelchairs. Durable Medical Equipment does not include any drug, medicine or equipment implanted in your body, temporarily or permanently, modifications to your Home, motorized scooters, or sporting, protective, athletic, or exercise equipment.

Eligible Expenses means expenses you incur for which benefits may be payable under the terms of this policy. Eligible expenses do not include the expenses described in the EXCLUSIONS section of this policy.

Elimination Period means the number of calendar days shown as "Your Elimination Period" in the Policy Schedule to be paid solely by you before this insurance policy begins to pay benefits.

Executive Officer means the chief executive officer, the president, any vice president, the corporate secretary, or any assistant corporate secretary of Mutual of Omaha Insurance Company.

Family Member means your mother, father, son, daughter, brother, sister or Spouse.

Home means the place where you maintain your primary independent residence. Home does not include:

(a) a Nursing Home;
(b) a hospital;
(c) an Assisted Living Facility;
(d) any other institutional setting where you are dependent on others for assistance with Activities of Daily Living; or
(e) the residence of a person providing the Home Care Services or Home Health Care.

Home Care Provider means an entity that provides home care services and meets the provider requirements set forth by the Executive Office of Elder Affairs or a program meeting the requirements of the state in which the home care services are being provided.

Home Care Services means services which provide non-medical assistance with Activities of Daily Living supplied by a Home Care Provider or Home Health Care Agency and which are designed to maintain your ability to live independently. Such services include, but are not limited to: shopping, planning menus, preparing meals, home delivered meals, laundry, and light house cleaning and maintenance including vacuuming, dusting, dry mopping, dishwashing, cleaning the kitchen/bathroom and changing beds.

Home Health Care means medical and non-medical services, provided to ill, disabled or infirm persons in their Homes. Such services include, but are not limited to:

(a) part-time or intermittent skilled services provided by a Nurse;
(b) services to support your compliance with your medication/treatment regimen;
(c) home health aide services;
(d) physical therapy, respiratory therapy, occupational therapy, speech therapy or audiology therapy;
(e) services provided by a specialist in the field of nutrition or the administration of chemotherapy;
(f) nutrition counseling services;
(g) Personal Care Services;
(h) Respite Care; and
(i) Hospice Care.

Home Health Care Agency means an entity that is regularly engaged in providing Home Health Care and Home Care Services for compensation and employs staff who are qualified by training or experience to provide such care. The entity must be certified by the Massachusetts Department of Public Health or, if located in another the state, the entity must:

(a) be supervised by a qualified professional such as a registered nurse (RN), a licensed social worker, or a Physician;
(b) keep clinical records or care plans on all patients;
(c) provide ongoing supervision and training to its employees appropriate to the services to be provided; and
(d) have the appropriate state licensure, accreditation, or certification, where required.

Hospice Care means palliative care to alleviate the physical, emotional, and social discomfort of individuals who are Terminally Ill.

Hospice Care Facility means a facility which provides Hospice Care under the direction of a Physician on an inpatient basis. A Hospice Care Facility must be licensed by the Massachusetts Department of Public Health or certified by the state in which it is located, if such license is required.

Independent Provider means any of the following individuals who provide services independently of, and are not affiliated with, a Home Health Care Agency: home health aide, certified nursing assistant, Nurse, audiologist, nutritional or chemotherapy specialist, or physical, occupational, respiratory, or speech therapist.

An Independent Provider must be licensed or certified to provide the services such individual provides in the state where the care will be provided. For a home health aide or certified nursing assistant, registration in a government-sponsored nurse aide registry will be an acceptable substitution for licensure or certification.

If licensure or certification is not required in the state where the services will be provided, we will determine, in our sole discretion, if that individual is qualified by training or experience to provide such services. In order for us to make such determination for a home health aide or certified nursing assistant, written proof that such individual has completed an established training course must be provided to us. The training course must include education in safely assisting persons with Activities of Daily Living.

The Independent Provider cannot be a Family Member.

Issue Age means the age shown as the "Issue Age" in the Policy Schedule.

Licensed Health Care Practitioner means any of the following who is not a Family Member: a Physician (as defined in Section 1861(r)(1) of the Social Security Act); a registered nurse (RN); 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.

Maximum Monthly Benefit means the amount shown as "Your Maximum Monthly Benefit" or "MMB" in the Policy Schedule. The Maximum Monthly Benefit may be increased or decreased in accordance with the terms of this policy.

Maximum Lifetime Benefit means the amount shown as "Your Maximum Lifetime Benefit" in the Policy Schedule. The Maximum Lifetime Benefit may be increased or decreased in accordance with the terms of this policy. If the term "Lifetime" is shown in the Policy Schedule, as in the Maximum Lifetime Benefit, there is no limitation on the amount of the Maximum Lifetime Benefit.

Medicaid means the program of medical assistance administered by the Massachusetts Division of Medical Assistance under Title XIX of the federal Social Security Act, 42 USCS section 1396 *et seq.*, and M.G.L. c. 118E.

Medical Alert System means a communication system installed in your Home that is used solely for the purpose of calling for assistance in the event of a medical emergency. A Medical Alert System does not include charges for regular telephone service, or for a home security system, or any other similar service or device.

Medicare means the federal health insurance program under Title XVIII of the federal Social Security Act, 42 USCS subsection 1395 *et seq.*, as amended.

Mental or Nervous Disorder means neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder, as classified in the current edition of 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.

Nurse means 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. Nurse does not include you, a Family Member, or anyone who normally resides in your Home.

Nursing Home means a facility or distinctly separate part of a facility that is engaged primarily in providing nursing care and related services on an inpatient basis under a license issued by the Department of Public Health. If required by the state in which it is located, a Nursing Home must have the appropriate state licensure, certification, or registration to operate as a Nursing Home.

If the state in which it is located does not require a Nursing Home to be licensed, certified, or registered, the facility must meet the following requirements:

(a) provides twenty-four (24) hour-a-day nursing care under the supervision of a licensed practical nurse (LPN), registered nurse (RN), or Physician;
(b) maintains a daily medical record of each inpatient; and
(c) provides nursing care at skilled, intermediate, or custodial levels.

An Alzheimer's Facility or a Hospice Care Facility may be a Nursing Home if such facility meets the requirements contained in this definition for a Nursing Home located in a state which does not require licensure, certification, or registration.

Nursing Home does not include a hospital or clinic; a place which operates primarily for the treatment of alcoholism, drug addiction, or Mental or Nervous Disorders; an Assisted Living 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.

Personal Care Provider means an entity that provides Personal Care Services and meets the provider requirements set forth by the Executive Office of Elder Affairs or a program meeting the requirements of the state in which the Personal Care Services are provided.

Personal Care Services means services provided by a Personal Care Provider or Home Health Care Agency to assist in Activities of Daily Living. Such services include, but are not limited to, assistance with bathing, bedpan routines, foot care, dressing, and care of dentures; shaving and grooming; assistance with eating; and assistance with ambulating and transfers.

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 (as defined in Section 1861 (r) (1) of the Social Security Act) other than you or a Family Member. He or she must be providing services within the scope of his or her license.

Plan of Care means a written plan of services prescribed for you by a Licensed Health Care Practitioner. We reserve the right to discuss your Plan of Care with the Licensed Health Care Practitioner. We have the right to verify that your Plan of Care is appropriate and consistent with generally accepted standards for care of the Chronically Ill. The Plan of Care must specify the type, cost, frequency, and providers of the services you require. The Plan of Care will be modified as required to reflect changes in your functional or cognitive abilities, social situation, and care service needs.

Policy Anniversary Date means any yearly anniversary of the Policy Effective Date while this policy is in effect.

Policy Class means persons who are insured by us under this policy form with the same Issue Age, Rate Classification and benefits similar to the benefits under this policy. Such persons live in the same geographic area of the state as you did on the Policy Effective Date.

Policy Effective Date means the date shown as the "Policy Effective Date" on the Policy Schedule.

Policy Schedule means the pages following this policy that are identified as the "Policy Schedule." The Policy Schedule contains information specific to you and the benefits provided under this policy.

Policy Year means each yearly period commencing on the Policy Effective Date and thereafter each Policy Anniversary Date.

Qualified Long-Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services and maintenance or Personal Care Services which are required by a Chronically Ill person. Maintenance and Personal Care Services mean any care for which the primary purpose is the provision of needed assistance with helping you conduct your Activities of Daily Living while you are Chronically Ill. This includes protection from threats and safety due to Severe Cognitive Impairment.

Representative means a person or entity legally empowered to represent you.

Respite Care means the supervision and care of you while Family Members or other individuals who normally provide substantial amounts of unpaid care on a daily basis take short-term leave or rest that provides them with temporary relief from the responsibilities of providing care.

Severe Cognitive Impairment means 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 your:

(a) short-term or long-term memory;
(b) orientation as to people, places or time;

(c) deductive or abstract reasoning; and
(d) judgment as it relates to safety awareness.

Social Day Care means training, counseling, and social services as defined by standards issued by the Executive Office of Elder Affairs (or in accordance with any standards of the state in which care is provided), including assistance with walking, grooming, and eating and planned recreational and social activities suited to the needs of the participants and designed to encourage physical and mental exercise and stimulate social interaction.

Spouse means the person to whom you are legally married.

Substantial Assistance means either Hands-on Assistance or Standby Assistance.

(a) **Hands-on Assistance** means the physical assistance of another person without which you would be unable to perform the Activities of Daily Living.
(b) **Standby Assistance** means the presence of another person, within your arm's reach, that is necessary to prevent, by physical intervention, 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).

Terminally Ill means a medical condition that, with a reasonable degree of medical certainty, will result in your death within six months or less, as certified by a Physician.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

You are eligible for benefits under this policy if you are Chronically Ill. You are Chronically Ill if, within the preceding twelve month period, a Licensed Health Care Practitioner certifies that:

(a) You are 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
(b) You require Substantial Supervision to protect yourself from threats to health and safety due to a Severe Cognitive Impairment.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY OF BENEFITS

Conditions

Except as otherwise provided in this policy, you must incur Eligible Expenses for Qualified Long-Term Care Services in order to receive benefits under this policy. Such Qualified Long-Term Care Services must be specified in a Plan of Care prepared for you by a Licensed Health Care Practitioner. Except for SUPPORTIVE SERVICES, if you are eligible for more than one type of benefit under this policy on a single day, we will pay the benefit which pays the greater amount.

Satisfying the Elimination Period

Except as otherwise provided in this policy, we will not pay benefits for Eligible Expenses incurred during the Elimination Period. The Elimination Period commences on the first day you are eligible for benefits under this policy and on which you:

(a) are Confined to a Nursing Home or an Assisted Living Facility;
(b) receive Home Health Care or Adult Day Care; or
(c) receive long-term care services covered under this policy that are Medicare eligible (for which benefits are not payable under this policy).

Once the Elimination Period has commenced subsequent calendar days will be used to satisfy the balance of the Elimination Period as long as you remain critically ill. Please refer to "Your Elimination Period" in the Policy Schedule for the specific number of calendar days that apply to your policy.

The Elimination Period must be satisfied only once during the term of this policy.

Maximum Lifetime Benefit

Except as otherwise provided in this policy, any benefits paid under this policy will reduce the amount of your Maximum Lifetime Benefit. No additional benefits are payable under this policy once the Maximum Lifetime Benefit has been reduced to zero.

CARE COORDINATION

We will pay the Eligible Expenses made by a Care Coordinator for the following optional services:

(a) assessing your need for long-term care services;
(b) developing your Plan of Care;
(c) coordinating the delivery of long-term care services; and
(d) if you desire, monitoring the delivery of such long-term care services.

You are not required to use a Care Coordinator to receive benefits under this policy. While a Care Coordinator will assist you in identifying qualified providers, you are responsible for choosing your long-term care providers. You are not required to use the providers identified in any Plan of Care developed by a Care Coordinator.

You do not need to satisfy the Elimination Period to receive the services of a Care Coordinator. The Eligible Expenses made by a Care Coordinator will not reduce your Maximum Lifetime Benefit. Care Coordination services provide the fullest coverage only when the Plan of Care is prepared by a Care Coordinator designated by us. However, if you choose to use your own Care Coordinator, we will pay only the covered expenses you incur for your own Care Coordinator to perform an initial Assessment and develop an initial Plan of Care up to a maximum benefit of 1/6th of your Nursing Home Monthly Maximum Benefit.

To request a Care Coordinator, call the toll-free telephone number shown in the Policy Schedule.

Facility Assessment

We will pay the Eligible Expenses made by a Care Coordinator to assess the safety and adequacy of the facility in which you are receiving long-term care. The Care Coordinator must provide you or your Representative with a written report of such facility assessment. We will pay for such assessment no more than once per calendar year.

NURSING HOME BENEFITS

Nursing Home Benefit

We will pay a Nursing Home Benefit if you are Confined to a Nursing Home. The Nursing Home Benefit is equal to the Eligible Expenses made by a Nursing Home each month, up to the Nursing Home Maximum Monthly Benefit.

Eligible Expenses payable under the Nursing Home Benefit are limited to:

(a) room and board;
(b) Ancillary Services; and
(c) patient supplies provided by the Nursing Home for care of its residents.

Eligible Expenses do not include Physician's charges; hospital and laboratory charges; prescription or non-prescription medication; transportation; items and services furnished at your request for comfort, convenience or entertainment, such as televisions, telephones, and beauty care; or guest meals or Spouse charges.

Nursing Home Bed Reservation Benefit

If you are Confined to a Nursing Home and absent for any reason other than discharge, we will continue to pay the NURSING HOME BENEFIT as if you were still Confined. This Nursing Home Bed Reservation Benefit will be paid only if you have incurred a charge to reserve your place at the Nursing Home. No additional Nursing Home Bed Reservation Benefits are payable in any calendar year once we have paid Nursing Home Bed Reservation Benefits for the maximum number of days shown in the Policy Schedule. Any unused days cannot be carried over to the next calendar year.

The Nursing Home Bed Reservation Benefit is subject to you satisfying the Elimination Period. If the Elimination Period has not been met, we will give the same credit toward the Elimination Period as if you were still Confined.

Benefits paid under this provision will reduce the amount of your Maximum Lifetime Benefit.

ASSISTED LIVING FACILITY BENEFITS

Assisted Living Facility Benefit

We will pay an Assisted Living Facility Benefit if you are Confined to an Assisted Living Facility. The Assisted Living Facility Benefit is equal to the Eligible Expenses made by an Assisted Living Facility each month, up to the Assisted Living Facility Maximum Monthly Benefit.

Eligible Expenses payable under the Assisted Living Facility Benefit are limited to:

(a) room and board for a one-bedroom unit;
(b) Ancillary Services; and
(c) patient supplies provided by the Assisted Living Facility for care of its residents.

Eligible Expenses do not include Physician's charges; hospital and laboratory charges; prescription or non-prescription medication; transportation; items and services furnished at your request for comfort, convenience or entertainment, such as televisions, telephones, and beauty care; or guest meals or Spouse charges.

Assisted Living Facility Bed Reservation Benefit

If you are Confined to an Assisted Living Facility and absent for any reason other than discharge, we will continue to pay the ASSISTED LIVING FACILITY BENEFIT as if you were still Confined. This Assisted Living Facility Bed Reservation Benefit will be paid only if you have incurred a charge to reserve your place at the Assisted Living Facility. No additional Assisted Living Facility Bed Reservation Benefits are payable in any calendar year once we have paid Assisted Living Facility Bed Reservation Benefits for the maximum number of days shown in the Policy Schedule. Any unused days cannot be carried over into the next calendar year.

HOME HEALTH CARE BENEFITS

We will pay a Home Health Care Benefit if you receive Home Health Care or Adult Day Care. The Home Health Care Benefit is equal to the Eligible Expenses incurred by you for Home Health Care or Adult Day Care each month, up to the Home Health Care Maximum Monthly Benefit shown in the Policy Schedule. To be eligible for Home Health Care Benefits, Eligible Expenses incurred by you for Home Health Care must be provided by a Home Health Care Agency or Independent Provider and for Adult Day Care must be provided by an Adult Day Care Center. Home Health Care Benefits include Eligible Expenses incurred by you for transportation to and from an Adult Day Care Center.

This policy shall provide total home health coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy, at the time the covered home health services are being received.

The Home Health Care Benefit is subject to you satisfying the Elimination Period. Benefits paid under this provision will reduce the amount of your Maximum Lifetime Benefit..

RESPITE CARE BENEFITS

In order to provide temporary relief to an unpaid caregiver, you may receive Respite Care during a temporary stay in a Nursing Home or Assisted Living Facility or in your Home or an Adult Day Care Center. When you receive Respite Care, we will pay the Eligible Expenses made by a Nursing Home or Assisted Living Facility or incurred by you for Home Health Care or Adult Day Care each month, up to the Respite Care Maximum Monthly Benefit. Respite Care Benefits will be paid for no longer than the period of time shown in the Policy Schedule. You do not need to satisfy the Elimination Period to receive Respite Care Benefits. The Respite Care Benefits paid will not reduce the amount available under your Maximum Lifetime Benefit.

HOSPICE CARE BENEFITS

If you are Terminally Ill, you may receive Hospice Care during a Confinement to a Nursing Home or Assisted Living Facility or in your Home or Adult Day Care Center. When you receive Hospice Care, we will pay NURSING HOME BENEFITS, ASSISTED LIVING FACILITY BENEFITS and HOME HEALTH CARE BENEFITS, without requiring you to satisfy the Elimination Period. If the Elimination Period has not been met, we will credit the time that you receive HOSPICE CARE BENEFITS toward the Elimination Period.

Benefits paid under this provision will reduce the amount of your Maximum Lifetime Benefit. No additional Hospice Care Benefits are payable if your Physician ceases to certify you as Terminally Ill.

INTERNATIONAL BENEFIT

We will pay an International Benefit if you are Confined to a Nursing Home or Assisted Living Facility or receive Home Health Care or Adult Day Care outside of the United States, its possessions or territories, Canada, or the United Kingdom. The International Benefit is equal to the Maximum Monthly Benefit shown in the Policy Schedule. The International Benefit is paid each month you are eligible to receive the International Benefit. The International Benefit will be paid regardless of whether Eligible Expenses incurred by you in any month are more or less than the Maximum Monthly Benefit. No additional International Benefits are payable under this policy once we have paid International Benefits equal to the International Benefit Lifetime Maximum shown in the Policy Schedule.

All payments of International Benefits will be made in U.S. dollars. We will pay International Benefits only if the care and services received by you occurred in a country where payment is not prohibited by United States Government sanctions, as specified by the United States Department of the Treasury's Office of Foreign Assets Control. In addition, all services must be given by providers who meet the licensing or certification requirements, if any, of the jurisdiction in which the services are received.

SUPPORTIVE SERVICES

We will pay the Eligible Expenses for Supportive Services if recommended in a Plan of Care and if mutually agreeable to you and us. Except for the Caregiver Training Benefit, the Plan of Care must recommend that the Supportive Services are a cost effective alternative to benefits otherwise provided by this policy. We will not pay Eligible Expenses incurred prior to the date of mutual agreement.

You can receive Supportive Services at the same time you receive other benefits under this policy. No further Supportive Services will be paid once we have paid an amount equal to the Supportive Services Lifetime Maximum shown in the Policy Schedule. You do not need to satisfy the Elimination Period to receive Supportive Services. Days on which You receive only Supportive Services will not count toward satisfying the Elimination Period. The Supportive Services Benefits paid will not reduce the amount available under your Maximum Lifetime Benefit.

Caregiver Training Benefit

We will pay the Eligible Expenses for training a Family Member or friend to provide care for you in your Home. To be eligible for this benefit, the training must cover the proper use and care of a therapeutic device or an appropriate caregiving procedure by a trainer approved by us. We will not pay to train someone who will be paid to care for you. The training can be received while you are Confined in a hospital, Assisted Living Facility or Nursing Home only if it is reasonably expected that such

training will make it possible for you to return Home where you can be cared for by the person receiving the training.

Durable Medical Equipment Benefit

We will pay the Eligible Expenses for Durable Medical Equipment. Eligible Expenses payable under the Durable Medical Equipment Benefit are limited to the purchase price of the Durable Medical Equipment or, if such Durable Medical Equipment is normally rented on a periodic basis, the rental charge. The decision whether to purchase, as opposed to rent, Durable Medical Equipment will be made by us at our sole discretion.

Home Modification Benefit

We will pay the Eligible Expenses for modifications to your Home which are intended to enhance your ability to perform the Activities of Daily Living and/or allow you to remain in your Home safely. Eligible Expenses payable under the Home Modification Benefit are limited to the expenses incurred by you for labor, equipment, and supplies. The Home Modification Benefit may not be used solely to increase the value of your Home.

Medical Alert System Benefit

We will pay the Eligible Expenses for a Medical Alert System to be installed in your Home. Eligible Expenses payable under the Medical Alert System Benefit are limited to the installation and rental charges for a Medical Alert System.

ALTERNATE CARE BENEFIT

We may pay an Alternate Care Benefit if you receive an alternative type of care, treatment, service or supply for which benefits are not payable under this policy. The amount of any Alternate Care Benefit will be determined by us at the time we approve such care. To be eligible for Alternate Care Benefits, a Plan of Care must recommend the alternative type of care, treatment, service or supply. The Care Coordinator, your Licensed Health Care Practitioner, you or your Representative, and we must all agree that the alternative type of care appropriately meets your needs and is a cost-saving alternative to other benefits provided by this policy.

At the time we approve such care, we will determine whether you must satisfy the Elimination Period to receive Alternate Care Benefits. Upon written notice to you or your Representative, we may discontinue paying you Alternate Care Benefits without affecting your right to other benefits provided by this policy. Benefits paid under this provision will reduce the amount of your Maximum Lifetime Benefit.

EXCLUSIONS

We will not pay benefits under this policy for:

(a) services provided by a Family Member;
(b) services for which no charge would be made in the absence of insurance;
(c) services provided outside of the United States, its possessions or territories, Canada or the United Kingdom (except as provided in the INTERNATIONAL BENEFIT section of this policy);
(d) services provided due to suicide (while sane or insane), attempted suicide or an intentionally self-inflicted injury;

(e) treatment of alcohol or drug detoxification;
(f) treatment of an injury or sickness which would entitle you to benefits under any state or federal workers' compensation program, employer's liability or occupational disease law, or any motor vehicle no-fault law;
(g) services received while this policy is not in force (except as provided in the **Extension of Benefits** section); or
(h) services provided due to an act of declared or undeclared war.

Non-Duplication of Benefits

We will not pay benefits under this policy to the extent that Eligible Expenses are reimbursable under Medicare or would be so reimbursable, except for the application of a deductible or coinsurance amount.

WAIVER OF PREMIUM

We will waive the payment of premium for this policy if you are receiving NURSING HOME BENEFITS, ASSISTED LIVING FACILITY BENEFITS, or HOME HEALTH CARE BENEFITS for, in any month, at least eight days of Home Health Care or Adult Day Care. We will waive premium so long as such benefits are payable. The Elimination Period must be satisfied before we will waive the payment of premium for this policy. Any premium paid for a period for which premiums have been waived will be credited towards future premium payments. When the waiver period ends, premium payments will resume for this policy and must be paid to keep this policy in force.

RIGHT TO REDUCE YOUR COVERAGE AND LOWER PREMIUMS

You may elect at any time to lower the premium for this policy by reducing the Maximum Monthly Benefit or the Maximum Lifetime Benefit or by terminating certain optional benefits to this policy.

The premium following such reduction in policy benefits will be that which we currently charge for persons who would be in your Policy Class following the reduction in benefits for your policy. We will not reduce benefits below the minimum we allow when issuing a new policy. To request a reduction in policy benefits, please contact us at the toll-free number shown in the Policy Schedule.

If your policy is about to lapse due to non-payment of premium, we will notify you of your option to lower premiums by reducing policy benefits, and give you 30 days in which to exercise this option.

COVERAGE PROVISIONS

Term of Coverage

If you have paid the initial premium due under this policy, your coverage begins on the Policy Effective Date. Your coverage will continue so long as you pay the premium for this policy.

Policy Termination

This policy will terminate on the earliest of:

(a) the date we receive your written or verbal request to cancel this policy (in which case the grace period will not apply);
(b) the date of your death;

(c) the date the Maximum Lifetime Benefit is reduced to zero; or
(d) the date this policy lapses for nonpayment of premium.

Termination will not affect any claim made under this policy while it was in force.

Extension of Benefits

If your policy lapses for nonpayment of premium while you are continuously Confined in a Nursing Home or Assisted Living Facility, benefits will be continued under this policy.

CLAIM PROVISIONS

Notice of Claim

If you think you are Chronically Ill, you should contact us. This notice should be given to us within 30 days of the onset of being Chronically Ill, or as soon as is reasonably possible. You or your Representative may give the required notice. The notice should include your name and policy number as shown in the Policy Schedule. Notice can be mailed to, or you may call, us at the address and phone number shown in the Policy Schedule.

How Claims Are Evaluated

When notice of claim is received, we will collect the information we need to document whether you are Chronically Ill. We reserve the right, as part of the review, to arrange for you to undergo an Assessment at no cost to you. We may need to contact your Physician or other care provider and to review your medical records. We will then review this information to confirm your qualifications for benefits. We will not pay benefits until your eligibility for benefits is verified and a Plan of Care has been developed. If you are eligible for benefits, you may choose your own Licensed Health Care Practitioner or Care Coordinator to develop the Plan of Care.

Claim Forms

When we receive notice of claim, we will send you a claim form. If we do not send such form within 15 days after we receive your notice, you can send us proof of loss by giving us a written statement of your claim.

Proof of Loss

For reimbursement of Eligible Expenses your proof of loss must include the provider's bill. In case of a loss for which this policy provides a periodic payment, written proof of loss must be given within 90 days after the end of each period for which we are liable. In case of a claim for any other loss, written proof must be given to us within 90 days after the date of the loss. If it was not reasonably possible to give us timely written proof, we will not reduce or deny the claim for this reason if the proof is supplied as soon as reasonably possible. In any case, proof must be furnished no later than 12 months from the time otherwise specified, except in the absence of legal capacity.

Time of Payment of Claims

We will make periodic payments for benefits which have accrued for more than one month. Subject to our receipt of written proof of loss, accrued benefits for such loss will be paid at the end of each month. Any balance unpaid when our liability for such loss ends will be paid immediately upon our receipt of written proof. Benefits for any other covered loss will be paid immediately once we receive written proof of loss.

Proration of Benefits

If you are eligible to receive NURSING HOME BENEFITS, ASSISTED LIVING FACILITY BENEFITS, HOME HEALTH CARE BENEFITS, or RESPITE CARE BENEFITS under this policy for less than the entire month, we will adjust such benefits for that month. Such benefits will be prorated based on the number of days you are confined to a Nursing Home or Assisted Living Facility that month, or the number of days which remain in the month after you first receive Home Health Care or Adult Day Care. We will assume that each of such months consist of 30 days regardless of the actual number of days in such month.

Payment of Claims

All benefits will be paid to you, if you are living, unless you have authorized us to pay benefits directly to a care provider.

Any accrued benefits unpaid at your death will be paid to your estate. At our option, any portion of the accrued benefits unpaid at your death, up to $1,000 may, as an accommodation, be paid to an alternative payee deemed by us to be entitled to the payment. We will be fully discharged to the extent of any payment made in good faith under this paragraph.

Written Notification of Claim Denial

You will be notified in writing whether or not you are eligible for benefits. We will notify you within 10 days of receiving all the required information. If we deny benefits, you may request that we provide you the basis for our denial. Unless prohibited by state or federal law, we will notify you within 60 days of our receipt of your written request.

Appealing a Claims Decision

If you disagree with our decision regarding any claim, you may request in writing that we reconsider the claim. Such request must be made within 60 days of the date we notify you of our decision. 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 condition. You are responsible for the expense of securing additional information. We will reconsider our decision and send you written notification of the results. If we deny your appeal request, you may request that we provide you the basis for our denial. We will notify you within 60 days of our receipt of your written request.

Assignment of Benefits

You may instruct us to pay policy benefits directly to the provider responsible for providing your care. You must provide such instructions to us in writing. The care provider must also agree to the assignment of benefits. We do not assume any responsibility for the validity or effectiveness of any assignment.

Right of Recovery

If we pay benefits in a total amount which is, at any time, in excess of the benefits payable under this policy, we will have the right to recover such excess from you or from any providers to whom such payments were made. We may withhold future benefit payments in order to recover such excess benefit payments.

PREMIUM AND REINSTATEMENT PROVISIONS

Payment of Premiums

You will pay premiums to us to keep this policy in force. Your first premium is due on the Policy Effective Date. The frequency of payment you selected is shown as the premium mode in the Policy Schedule. You may change the premium mode by giving us prior written or verbal notice. We must receive your request at least 30 days prior to any premium payment date.

Grace Period

This policy has a 70-day grace period. This means that if a premium is not paid in full by the date it is due, it may be paid during the 70-day period following that date. During the grace period, this policy will stay in effect.

This policy will not lapse for nonpayment of premium unless we have given notice to you and any person(s) designated by you in the application, at the address provided by you for purposes of receiving notice of lapse. Notice will not be mailed until 30 days after the premium due date for a premium that is due and unpaid. Notice will be given by United States first-class mail. You will have at least 40 calendar days from the date of the notice of lapse to pay all premiums that are due. Notice will be considered to have been given as of 10 days after the date of the mailing. If the overdue premiums remain unpaid, this policy will lapse as of the premium due date.

Reinstatement

If your policy lapses for nonpayment of premium, you may request reinstatement of the policy by writing to us. You may be asked to complete an application for reinstatement. We have the right to require evidence of insurability. You will be required to pay the cost of any records that may be necessary to provide such evidence of insurability.

If a reinstatement application is required, and we or our agent issues a conditional receipt for the premium received, the policy will be reinstated upon approval of the application by us. If the application is approved and payment of all past due premium is received by us, the policy will be reinstated as of the last premium due date. Lacking such approval, the policy will be reinstated upon the 45th day following the date of the conditional receipt unless we have previously notified you in writing of the application disapproval. If we fail to inform you, this policy will be reinstated on the 45th day following the date of the application. If we accept the payment of all past due premium, without requiring an application for reinstatement, this policy will be reinstated as of the last premium due date.

The reinstated policy only covers loss due to an injury sustained or physical or mental condition that begins after the date of reinstatement. In all other respects, you and we have the same rights under this policy as were in effect before it lapsed, unless special conditions are added in connection with the reinstatement.

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 lapse or termination for nonpayment of premiums, in addition to yourself. You may change this designation at any time. To do so, you must notify us in writing. We will remind you in writing every two years of this opportunity.

If this policy lapses due to nonpayment of premiums because you were Chronically Ill, you may request, within five months of the date of lapse, that we reinstate this policy without requiring an application.

You must undergo an Assessment by a Licensed Health Care Practitioner and obtain a certification that you became Chronically Ill on or before the date of lapse. Upon payment of all past due premiums, your policy will be reinstated as of the lapse date.

Refund of Unearned Premiums

Upon receipt of notice that you cancelled your policy or that you have died, we will refund the portion of the premium paid for the period between the date of cancellation or death and the next premium due date. We will pay the refund to you or, upon your death, your Spouse, if living, or to your estate.

Unpaid Premiums

When benefits are paid for a claim under this policy, any premium then due and unpaid may be deducted from the benefits payable.

GENERAL POLICY PROVISIONS

Entire Contract and Changes

This policy is a contract between you and us. The entire contract is:

(a) this policy;
(b) the attached signed application;
(c) any supplemental applications made part of this policy;
(d) any riders; and
(e) any endorsements and amendments.

All statements made in the application will, in the absence of fraud, be considered representations and not warranties. We will not use any statement in defense of a claim or to contest this policy unless it is in a written application.

Any change made to this policy requires an Executive Officer's written consent. An agent does not have authority to change this policy or waive any of its terms.

Address for Notices and Requests

If, under this policy, you are required to provide notice or make a request to us, such notices or requests must be given to us at our Long-Term Care Service Center. The address and phone number for our Long-Term Care Service Center is shown on the first page of the Policy Schedule. If such address or phone number changes in the future, we will send you a revised Policy Schedule or otherwise notify you of such change.

Change of Beneficiary

Unless you make an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to you. Consent of the beneficiary or beneficiaries will not be required for surrender or assignment of benefits under this policy or to make any change of beneficiary or beneficiaries, or to make any other changes in this policy.

Time Limit on Certain Defenses

In issuing this policy, we have relied upon the information presented in your application. We may rescind your policy or deny a claim due to a misrepresentation in your application that is material to our

acceptance of you for coverage if your policy has been in force for less than six months following the Policy Effective Date.

If this 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 our acceptance of you for coverage and pertains to the condition for which benefits are sought.

After this policy has been in force for two years, this policy is incontestable, except for relevant facts relating to your health that you knowingly and intentionally misrepresented or failed to disclose.

Clerical Error

Clerical errors or delays in making entries on our records will not void your coverage if your coverage would otherwise have been in effect. Clerical error will also not extend your coverage if your coverage would otherwise have ended or been reduced as provided by this policy. If a clerical error is found, premiums and benefits will be adjusted accordingly.

Physical Examinations

We, at our expense, may require you to under go a physical examination by a Physician when and as often as is reasonable while a claim is pending.

Misstatement of Age

If your age has been misstated in the application, all benefits payable will be those which the premium paid would have purchased at the correct age.

Legal Actions

No legal action can be brought to recover under this policy until at least 60 days after we have been given satisfactory written proof of loss. Legal action cannot be brought after the expiration of three years from the date proof of loss is required.

Nonparticipating

This policy will not pay dividends nor share in any of our surplus or earnings.

Conformity with Internal Revenue Code

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

Compliance with Law

We reserve the right to make any change to the provisions of this policy to comply with, or give you the benefit of, any federal or state statute, rule, or regulation.

Conformity With State Statutes

If any provision of this policy conflicts with the laws of the state where you reside on that provision's effective date, it is amended to the minimum requirements of those laws.