

Massachusetts Mutual Life Insurance Company

Home Office: Springfield, MA 01111-0001

Long Term Care Administrative Office

P.O. Box 4243

Woodland Hills, CA 91365-4243

888.505.8952

Comprehensive Long Term Care Insurance Outline of Coverage for Policy Form MM500-P-2-CA

THIS POLICY IS AN APPROVED LONG TERM CARE INSURANCE POLICY UNDER STATE INSURANCE 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 AND CERTIFICATES QUALIFYING 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.

This contract for long term care insurance is intended to be a federally tax-qualified long term care insurance contract and may qualify You for federal and state tax benefits.

NOTICE TO BUYER: This Policy may not cover all of the costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

Caution: The issuance of this Comprehensive Long Term Care Insurance Policy is based upon the responses to the questions on the Application. A copy of the Application is enclosed. If the responses are misstated or untrue, the Company may have the right to deny benefits or rescind the Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of the responses are incorrect, contact the Company at this address: Massachusetts Mutual Life Insurance Company, P.O. Box 4243, Woodland Hills, CA 91365-4243.

The Policy is an individual Policy of insurance.

PURPOSE OF OUTLINE OF COVERAGE

This outline of coverage provides a very brief description of the important features of the Policy. You should compare this outline of coverage to outlines of coverage for other policies available to You. This is not the insurance contract, but only a summary of coverage. Only the individual Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both You and the Company. Therefore, if You purchase this coverage, or any other coverage, it is important that You READ YOUR POLICY CAREFULLY!

FEDERAL TAX CONSEQUENCES

THE POLICY IS INTENDED TO BE A FEDERALLY TAX-QUALIFIED LONG TERM CARE INSURANCE CONTRACT AS DEFINED UNDER SECTION 7702B(b) OF THE INTERNAL REVENUE CODE OF 1986, as amended, and will be endorsed to conform to changes in that definition. You should consult with Your attorney, accountant, or tax advisor regarding the tax implications of purchasing this long term care insurance.

TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED

RENEWABILITY: THE POLICY IS GUARANTEED RENEWABLE. This means You have the right, subject to the terms of the Policy, to continue the Policy as long as You pay Your premiums on time. Massachusetts Mutual Life Insurance Company cannot change any of the terms of the Policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

Waiver of Premium

Premiums will not be due once We begin paying, and for as long as We continue to pay, benefits for Facility Services or Home Care under the Policy. We will return any unearned premium to You on a pro-rata basis. Premium will again become due when We are no longer paying You because the Insured is no longer receiving Facility Services, or Home Care at least once every week.

For an additional premium payment, an optional Waiver of Premium for Covered Partner Rider is also available, as described below.

TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS

Premiums are subject to change. We can only change the premium for this Policy if We change premiums for everyone in your state with the same class. Any such change must be actuarially justified and approved by Your state. This occurs when the actual experience of the class has been or is anticipated to be different from that assumed in the development of premiums for the class. A class includes persons with the same benefits, issue age, and premium rate class at issue. We will give You at least sixty (60) days written notice at Your last address shown in Our records before We change Your premium.

TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED

If You are not satisfied with the Policy, You may return it to Our agent or Us within thirty (30) days from the date You receive it. We will then refund any premium You have paid within 30 days of our receipt of the Policy and the Policy, all riders and attachments will be considered never to have been in effect. Upon the death of the Insured, We will refund any unearned premium for the Policy on a pro-rata basis. We will make this refund within thirty (30) days of Our receipt of proof of the Insured's death. If You cancel the Policy after thirty (30) days, any unearned premium will be refunded to You on a pro-rata basis.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If the Insured is eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from Us. Neither Massachusetts Mutual Life Insurance Company nor its agents represent Medicare, the federal government or any state government.

LONG TERM CARE COVERAGE

Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, Maintenance or Personal Care Services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

The Policy provides coverage for Qualified Long Term Care Services in the form of an expense incurred benefit for covered long term care expenses, subject to Policy Elimination Periods, Limitations and Exclusions described below.

BENEFITS PROVIDED BY THE POLICY

Covered Services

The Policy provides benefits for Qualified Long Term Care Services performed while confined in a nursing facility or residential care facility, Maintenance or Personal Care Services performed while confined in a residential care facility and hospice care provided while confined in a hospice facility. A Prescription Drug Benefit and Bed Reservation Benefit are available if Facility Services are being received in a nursing facility, residential care facility or hospice facility. The Policy provides benefits for Home Care, including benefits for Home Health Care, Personal Care, Homemaker Services, Adult Day Care, Hospice Services and Respite Care. Additional Policy benefits include those for Caregiver Training, an Emergency Response System and Ambulance Services.

Elimination Period

This is the number of days the Insured must receive either Facility Services or Home Care, as defined in the Policy, pursuant to a Plan of Care, while the Policy is in force and the Insured is certified as being Chronically Ill, before We will begin paying benefits. An Elimination Period of thirty (30), sixty (60), ninety (90) or one hundred eighty (180) days may

be chosen. For each day the Insured receives Facility Services or Home Care, We will credit one (1) day toward satisfaction of the Elimination Period. These days do not need to be consecutive. Once the Insured has satisfied the Elimination Period, no future Elimination Period is required. Days may be accumulated under separate claims in order to satisfy the Elimination Period.

For an additional premium payment an Enhanced Elimination Period Rider is available, as described below.

Elimination Period for Coverage Outside of the United States

This is the number of days after the Insured has satisfied the Elimination Period previously described and receives either Facility Services or Home Care Outside of the United States, as defined in the Policy, pursuant to a Plan of Care, while the Policy is in force and the Insured is certified as being Chronically Ill, before We will begin paying benefits for coverage Outside of the United States. Days on which the Insured receives Facility Services and Home Care Outside of the United States will first be used to satisfy the Elimination Period previously described. Once this Elimination Period has been satisfied, We will credit one (1) day towards satisfaction of the Elimination Period for Coverage Outside of the United States. This number of days will be equal to the number of days selected for the Elimination Period previously described. These days do not need to be consecutive; however, days will not be accumulated under separate claims in order to satisfy the Elimination Period for Coverage Outside of the United States. The Insured must first satisfy the Elimination Period before days will count towards satisfaction of the Elimination Period for Coverage Outside of the United States.

Total Benefit Amount

The Total Benefit Amount is determined by multiplying the Daily Benefit Amount chosen by the Benefit Period selected - either 2,190 days (6 Years), 1,825 days (5 Years), 1,460 days (4 Years), 1,095 days (3 Years) or 730 days (2 Years). The result will be the Total Benefit Amount for all benefits payable under the Policy.

Daily Benefit Amount

The initial Daily Benefit Amount will be shown on the Policy Schedule page of the Policy. The current Daily Benefit Amount will be the initial Daily Benefit Amount adjusted to reflect the provisions of any inflation rider attached to the Policy.

Facility Services Benefit

Benefits are payable for Covered Expenses incurred for Qualified Long Term Care Services (including skilled, intermediate or custodial, nursing care), provided in a nursing facility or residential care facility, Maintenance or Personal Care Services performed in a residential care facility and hospice care provided in a hospice facility. Covered Expenses means the actual daily cost of each day's Facility Services received up to the Daily Benefit Amount. Premium rates will vary according to the Daily Benefit Amount selected.

Facility Prescription Drug Benefit

Benefits are payable for Covered Expenses incurred for prescription drugs when the Insured is receiving Facility Services under the Policy. Covered Expenses means the actual monthly cost of the Insured's prescription drugs up to the monthly maximum equal to the Daily Benefit Amount. This benefit is not payable if the Insured is receiving Home Care or the Insured is confined in a hospital.

Facility Bed Reservation Benefit

Benefits are payable if Facility Services are being received in a nursing facility, residential care facility or hospice facility and Covered Expenses are incurred for a Facility Bed Reservation. Covered Expenses means the actual cost charged by the Facility to reserve accommodations for each day the Insured is temporarily absent from the Facility, up to the Daily Benefit Amount. The Policy Year maximum for this benefit is sixty (60) times the Daily Benefit Amount.

Home Care Benefit

Benefits are payable for Covered Expenses for Home Care. Covered Expenses means the actual daily cost of each day's Home Care received up to the Daily Benefit Amount. Benefits include home health care provided through a qualified Home Health Care Agency, in a setting other than a hospital, nursing facility or hospice facility. Home health care includes professional nursing care by or under the supervision of an RN or other licensed nurse; care by a qualified Home

Health Aide; therapeutic care services by or under the supervision of a speech, occupational, physical, or respiratory therapist, licensed or certified under state law, if any; services provided by a registered dietician; or homemaker services. Benefits are also payable for adult day care and hospice care at home.

Emergency Response System Benefit

Benefits are payable for Covered Expenses if the Insured is receiving Home Care benefits under the Policy. Covered Expenses means the actual monthly cost of the Insured's Emergency Response System, up to one-half (1/2) of the Daily Benefit Amount.

Ambulance Services Benefit for Respite Care

Benefits are payable for Covered Expenses if the Insured is receiving Home Care benefits under the Policy. Covered Expenses means the actual cost of each day's Ambulance Services up to the Daily Benefit Amount. The Policy Year maximum for this benefit is four (4) times the Daily Benefit Amount.

Caregiver Training Benefit

Benefits are payable for Covered Expenses for training provided by a health care professional approved by Us, to an informal caregiver. Covered Expenses means the actual cost of the Caregiver Training up to the lifetime maximum of five (5) times the Daily Benefit Amount. The Insured is not required to satisfy the Elimination Period for the Policy before We will pay the Caregiver Training Benefit. Receipt of Caregiver Training by the informal caregiver does not count toward satisfaction of the Elimination Period for any other benefits payable under the Policy.

Respite Care Benefit

Benefits are payable for Covered Expenses for Qualified Long Term Care Services provided to the Insured on a short term basis to relieve an informal caregiver in the Insured's Home, a nursing facility, residential care facility or through a community based program. Covered Expenses means the actual cost up to the Daily Benefit Amount. The Policy Year maximum for this benefit is thirty (30) times the Daily Benefit Amount. The Insured is not required to satisfy the Elimination Period for the Policy before We will pay the Respite Care Benefit. Receipt of Respite Care does not count toward satisfaction of the Elimination Period for any other benefits payable under the Policy.

Optional Personal Care Advisor Benefit

The Insured is entitled to the assistance of a Personal Care Advisor. The Insured or the Insured's representative, or a member of the Insured's family are encouraged to contact Our claim office as soon as a claim is anticipated by calling the toll-free number that will be shown on the Policy Schedule page of the Policy. We will then contact the Personal Care Services Provider and instruct them to assign a Personal Care Advisor to the Insured so that the Insured can obtain Personal Care Advisory Services as soon as possible.

If the Insured chooses to utilize the services of the Personal Care Advisor assigned by the Personal Care Advisory Services Provider, the costs of the Personal Care Advisory Services will be billed directly to Us and We will pay the Personal Care Advisory Services Provider directly. The cost of the Personal Care Advisory Services paid by Us will not reduce the Total Benefit Amount under the Policy.

The Insured is not required to satisfy the Elimination Period in order to use the services of a Personal Care Advisor. Use of the Personal Care Advisor does not count towards satisfaction of the Elimination Period. Use of a Personal Care Advisor is completely voluntary. The use or non-use of a Personal Care Advisor does not impact the right to benefits under the Policy.

Coverage Outside of the United States

Benefits are payable for Covered Expenses for Facility Services and Home Care received Outside of the United States. Covered Expenses means the actual cost of each day's Facility Services or Home Care received Outside of the United States, subject to Eligibility for the Payment of Benefits and the Elimination Period for Coverage Outside of the United States, as previously described. Benefits will be payable in United States currency at the conversion rate determined by the United States Treasury as of the date benefits are paid. Benefits will be payable up to one-half (1/2) of the Daily Benefit Amount. A maximum of twenty-five percent (25%) of the Total Benefit Amount is payable under the Policy for this benefit.

While We are paying benefits for Coverage Outside of the United States, the following benefits will not be available: Facility Prescription Drug Benefit, Facility Bed Reservation Benefit, Emergency Response System Benefit, Ambulance Services Benefit, Caregiver Training Benefit or the Respite Care Benefit.

Definitions

Activities of Daily Living:

- **Bathing**, which means 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**, means 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 a catheter or colostomy bag).
- **Dressing**, which means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- **Eating**, which means feeding oneself by getting food in the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
- **Toileting**, which means getting to and from the toilet, getting on or off the toilet, and performing associated personal hygiene.
- **Transferring**, which means the ability to move into or out of bed, a chair, or wheelchair.

Ambulance Services means transportation by ambulance from the Insured's home to a facility, or to and from a facility for purposes of receiving Respite Care.

Chronically Ill means within the previous twelve (12) months a Licensed Health Care Practitioner has certified that the Insured:

- is unable to perform, without Substantial Assistance from another person, at least two (2) Activities of Daily Living for a period that is expected to last at least ninety (90) consecutive days due to Loss of Functional Capacity; or
- has a Severe Cognitive Impairment.

Covered Expenses means the amount of benefit payable by Us as a result of the Insured's receipt of Qualified Long Term Care Services. The Covered Expense for each benefit available under the Policy is defined by the specific Benefit provision of the Policy.

Covered Partner means the Insured's spouse or Partner or Domestic Partner who is covered by Us under a policy with the same state policy form number as the Policy.

Domestic Partner means a person named in a valid registration of domestic partnership recognized by the state in which this policy is issued.

Emergency Response System means a personal service the Insured can alert easily (such as pressing a button on a bracelet or pendant) when in distress and in need of help. This does not include a home alarm system.

Facility Services means Qualified Long Term Care Services received by the Insured while Confined in a Facility including:

- room and board;
- Ancillary Services; and
- Hospice Care provided in a Hospice Facility.

Facility Services does not include comfort and convenience items such as televisions, telephone, beauty care and entertainment, or services provided to an individual other than the Insured (e.g. guest meals or spouse charges).

Hands-On Assistance means the physical assistance of another person without which the Insured would be unable to perform the Activity of Daily Living.

Home Care means Qualified Long Term Care Services, provided to the Insured through adult day care, home health care, personal care, homemaker services, hospice services and respite care. Services may be provided by, but are not limited to, an employee of a Home Care Agency, which has the appropriate state licensure or certification, where required, or any skilled or unskilled person who is duly licensed to perform such services, where licensing is required.

Home Care Agency means an entity that is regularly engaged in providing Home Health Care for compensation and employs staff to provide such care. The entity must: keep clinical records or care plans on all patients; provide ongoing supervision and training to its employees appropriate to the services to be provided; and have the appropriate state licensure or certification, where required. If licensure or certification is not required, the entity must be supervised by a qualified professional such as a Registered Nurse (RN), a Licensed Social Worker, or a Physician.

Home Health Aide means a person, licensed or certified to provide medical, speech, audiology, occupational, physical or respiratory therapeutic care services. A Home Health Aide must be duly licensed or certified under state law, if any, and acting within the scope of his or her license or certification at the time the treatment or service is performed.

Immediate Family means the Insured's spouse or Domestic Partner, a parent, sibling or child.

Insured means the person named as the insured on the Policy Schedule page of the Policy.

Licensed Health Care Practitioner means:

- a physician;
- a registered nurse;
- a licensed social worker; or
- other individuals whom the Secretary of the United States Department of the Treasury may prescribe by regulation.

The Licensed Health Care Practitioner must not be a member of the Insured's family.

Loss of Functional Capacity means requiring the Substantial Assistance of another person to perform the prescribed Activities of Daily Living.

Outside of the United States means outside of the United States or its territories, or Canada.

Partner means an adult who is either:

- named along with the Insured, in a valid certificate or license of civil union recognized by the state in which the Policy is issued, including a Declaration of Domestic Partnership filed with the Secretary of State in California; or
- has been living with the Insured for the past three (3) consecutive years in a committed relationship as the Insured's Partner or as a member of the Insured's family; and
 - is committed to sharing basic living expenses with the Insured; and
 - is not married to the Insured, or anyone else; and
 - if related to the Insured, belongs to the same generation of the Insured's family (e.g. brother, sister, or cousin).

Plan of Care means a written individualized plan of services prescribed by a Licensed Health Care Practitioner developed in consultation with the Insured, based upon an assessment that states the Insured is Chronically Ill. The Plan of Care will specify the type, frequency, and providers of the services most suitable to meet the Insured's long term care needs, as well as any providers of formal and informal long term care services and the costs, if any, of those services. The Plan of Care must be updated as the Insured's needs change. At all times We retain the right to verify that the Insured's Plan of Care is appropriate.

Policy means the contract between You and Us.

Policy Anniversary Date means the Policy Anniversary Date as shown on the Policy Schedule page of the Policy.

Policy Year means the period from the Policy effective date to the first Policy Anniversary Date or the period from one Policy Anniversary Date to the next 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 the Insured when Chronically Ill, and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Maintenance or personal care services means any care the primary purpose of which is the provision of needed assistance with helping the Insured conduct Activities of Daily Living while Chronically Ill. This includes protection from threats to the Insured's health and safety due to a Severe Cognitive Impairment.

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

- short or long term memory;
- orientation as to person (such as the person's identity), place (such as the person's location) and time (such as day, date and year); and
- deductive or abstract reasoning.

Single Claim Period means a claim for benefits under the Policy that is not interrupted by a period of one hundred eighty (180) consecutive days. If the Insured does not meet the requirements of Eligibility for the Payment of Benefits under the Policy because the Insured is no longer Chronically Ill and no benefits are paid under the Policy for a period of one hundred eighty (180) consecutive days or longer, a new Single Claim Period will be established.

Stand-By Assistance means the presence of another person within arm's reach of the Insured that is necessary to prevent, by physical intervention, injury to the Insured while performing the Activity of Daily Living.

Substantial Assistance means Hands-On or Stand-By Assistance.

Substantial Supervision means continual supervision by another person to protect a person with a Severe Cognitive Impairment or others from threats to health or safety (such as may result from wandering). Such supervision may include cueing by verbal prompting, gestures, or other similar demonstrations.

Total Benefit Amount means the remaining amount of benefits that may be paid under the Policy. The initial Total Benefit Amount is shown on the Policy Schedule page of the Policy. The Total Benefit Amount after Policy issue will be decreased by benefits paid under the Policy. The Total Benefit Amount after Policy issue will be increased in accordance with the provisions of any riders attached to the Policy and any additional benefits resulting from the crediting of dividends.

We, Us, Our means Massachusetts Mutual Life Insurance Company.

You, Your means the owner of the Policy as indicated in Our records. The owner is the Insured unless otherwise provided in the application or changed by written request.

Eligibility for the Payment of Benefits

Subject to all the terms and provisions of the Policy, We will pay the Covered Expenses for benefits described in the Policy when We verify that the Insured meets all of the following conditions:

- the Insured is Chronically Ill;
- the Qualified Long Term Care Services the Insured receives are covered under the Policy and are provided pursuant to the Plan of Care;
- coverage under the Policy was in force on the date(s) the Qualified Long Term Care Services were received by the Insured;
- unless otherwise indicated within the Policy, the Insured has satisfied the Policy's Elimination Period;
- any daily, monthly, annual, or lifetime limits on the specific benefit(s) being claimed under the Policy or any attached riders to the Policy have not been exhausted;
- the Insured meets all additional requirements indicated in the Policy for the specific benefit(s) under the Policy;
- the requirements under the FILING A CLAIM section of the Policy have been satisfied; and
- the claim is not subject to the Limitations and Exclusions contained in the Policy.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR THE PAYMENT OF BENEFITS

Non-Eligible Facilities

A nursing facility does not include a hospital, clinic, rest home or residential care facility, a convalescent home, an adult residential care facility, a domiciliary and retirement care facility, a training center or any other facility where the patient is not required to pay, or the Insured's primary place of residence in an area used principally for independent residential living, or a similar establishment. A residential care facility does not include a hospital, a nursing facility, an individual residence, or an independent living unit.

No benefits will be paid under the Policy for confinement in:

- non-eligible facilities; or
- an unlicensed facility (if licensing is required in your state).

Limitations and Exclusions

No benefits will be paid and the Elimination Period will not be satisfied for any confinement, care, treatment or service(s):

- provided to the Insured by a member of the Insured's Immediate Family;
- provided Outside of the United States except as described previously under Coverage Outside of the United States;
- for which You or the Insured have no financial liability or that is provided at no charge in the absence of insurance;
- provided for the treatment of drug addiction or alcoholism;
- provided in a government or veteran facility or any other facilities where the patient is not required to pay; or
- provided for the medical treatment of mental illness, including but not limited to inpatient or outpatient psychiatric care.

Non-Duplication of Benefits

Benefits are not payable under the Policy for: (a) expenses incurred to the extent that such expenses are reimbursable under Medicare or would be so reimbursable but for the application of a deductible or coinsurance amount; or (b) any other state or federal workers' compensation plan, or other governmental program (except Medi-Cal or Medicaid).

For purposes of satisfying the Elimination Period, days on which the Insured meets the requirements of Eligibility for the Payment of Benefits, but coverage is excluded due to the Non-Duplication of Benefits, will count toward satisfaction of the Elimination Period.

Grace Period

Except for the first premium, You will have thirty-one (31) days after each due date to pay the premium due. The Policy remains in force during the Grace Period.

Unintentional Lapse

If the premium is not paid by the thirtieth (30th) day of the Grace Period, We will provide written notice to You and the Insured, if different, and any individuals designated by You or the Insured, if different, to receive notice of non-payment of premium. Notice will be sent at least thirty (30) days before cancellation of Your coverage. If the premium is not paid within thirty-five (35) days after notice is sent, the Policy will lapse for non-payment of premium.

THE POLICY MAY NOT COVER ALL EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the costs of long term care services will likely increase over time, You should consider whether and how the benefits of this plan may be adjusted. The benefit levels of the basic Policy will not increase over time. For an additional premium payment, You may purchase the optional Inflation Protection Rider described below.

ALZHEIMER'S DISEASE AND MENTAL ILLNESS

Subject to Eligibility for the Payment of Benefits and any Limitations and Exclusions described above, the Policy provides coverage for long term care expenses which are caused by Alzheimer's Disease, dementia and mental illness.

PREMIUM

Long Term Care Insurance Policy

Covered Partner Discount (two applicants) Partner Discount (one applicant)

Elimination Period: 30 Days 60 Days 90 Days 180 Days

Daily Benefit (\$50 - \$400): \$ _____

Benefit Period: 2,190 Days (6 Years) 1,825 Days (5 Years) 1,460 Days (4 Years)
 1,095 Days (3 Years) 730 Days (2 Years)

The following are the Annual Premiums for the coverage You have applied for:

Comprehensive coverage is Facility and Residential Care Facility plus Home Care (HC)

	Premium
Comprehensive Long Term Care Insurance Policy	\$ _____
Inflation Protection Rider (may select only one)	
<input type="radio"/> 5% Compound Inflation Protection	\$ _____
<input type="radio"/> 3% Compound Inflation Protection	\$ _____
Elimination Period Riders (may select only one)	
<input type="radio"/> Enhanced Elimination Period	\$ _____
<input type="radio"/> HC Waiver of the Elimination Period	\$ _____
Other Riders	
<input type="radio"/> HC Monthly Benefit	\$ _____
<input type="radio"/> Shortened Benefit Period Nonforfeiture	\$ _____
<input type="radio"/> Restoration of Benefits	\$ _____
Covered Partner Riders (if applying as Covered Partners, both must select any of the following riders)	
<input type="radio"/> Waiver of Premium for Covered Partner	\$ _____
<input type="radio"/> Paid-Up Survivor Benefit	\$ _____
<input type="radio"/> Shared Care (Covered Partner coverage must be identical) <i>(available with 2 Year or 3 Year Benefit Period only)</i>	\$ _____
TOTAL ANNUAL PREMIUM	\$ _____

ADDITIONAL FEATURES

Medical Underwriting

The Insured's insurability for the Policy will be determined by the answers given in the Application and any other authorized medical information We obtain regarding the Insured's current state of health.

Dividends

While the Policy is in force, We may credit it with dividends. Dividends are based on divisible surplus, if any, as We apportion at the end of each Policy Year. Dividends credited to the Policy will be used to reduce the future premiums for the Policy. If the Policy is not in premium paying status, the dividends will be used to increase the future benefits of the Policy. Dividends, if any, are not anticipated to be credited before the later of (a) the Policy Anniversary Date after the Insured attains sixty-five (65) years of age, or (b) the tenth (10th) Policy Anniversary Date.

OPTIONAL RIDERS (available for an additional premium payment)

Shortened Benefit Period Nonforfeiture

The rider provides a benefit when the Policy lapses, after being in force for at least three (3) years, due to the non-payment of premium. The Policy will become paid-up with modified coverage based on the Daily Benefit Amount in effect immediately prior to the date of lapse. The Total Benefit Amount payable under the rider will be reduced to the greater of: (a) the total of all premiums paid prior to the date of lapse for the Policy and all riders or (b) ninety (90) times the Daily Benefit Amount in effect immediately prior to the date of lapse of the Policy.

Enhanced Elimination Period

The rider modifies the previously described Elimination Period and provides that if the Insured receives at least one (1) day of Facility Services or Home Care within a seven (7)-day period (Sunday through Saturday), We will credit seven (7) days toward satisfaction of the Elimination Period.

Home Care Waiver of Elimination Period

The rider will waive the requirement to satisfy the Elimination Period for purposes of receiving benefits under the Home Care Benefit. Days for which a Home Care Benefit is paid for under the rider are credited towards the satisfaction of the Elimination Period for other benefits under the Policy. However, no days will be credited toward satisfaction of the Elimination Period for Coverage Outside of the United States.

Waiver of Premium for Covered Partner

The rider will waive the premium payments for the Policy to which the rider is attached during any period in which the premium payments for the Covered Partner's policy are waived. A Waiver of Premium for Covered Partner must be issued with and remain attached to the Covered Partner's policy. Both the Policy, including the rider and the Covered Partner's policy, including the rider, must remain in force. If both policies or the rider do not remain in force, the rider will terminate and the premium for the rider will end.

Home Care Monthly Benefit

The rider replaces the Home Care daily reimbursement limit with a monthly reimbursement limit. We will pay a benefit equal to Covered Expenses incurred. Covered Expenses means the actual cost of Home Care received during a calendar month, up to the Monthly Benefit Amount. The Monthly Benefit Amount for a given calendar month is equal to the Daily Benefit Amount times thirty-one (31), less any Facility Services Benefits received during that calendar month.

Restoration of Benefits

The rider will restore the Total Benefit Amount selected to its original amount and then adjust for the effects of an inflation protection rider, if any, attached to the Policy, if We pay benefits under the Policy and the Insured subsequently Recovers. Under the rider, Recovers means that the Insured has not exhausted the Total Benefit Amount and for a period of one hundred eighty (180) consecutive days prior to the date the benefits are restored the following three (3) conditions are satisfied: (a) the Policy is in force and premiums are not waived; (b) the Insured is no longer Chronically Ill; and (c) We have not paid benefits under the Policy during the one hundred eighty (180) consecutive days. Benefits may be restored more than once. However, the rider will terminate and the premium for the rider will no longer be due when the total of all amounts, adjusted for the effects of an inflation protection rider, if any, attached to the Policy, restored over the lifetime of the rider is equal to the original Total Benefit Amount. The rider will terminate when the Total Benefit Amount of the Policy is exhausted. In the event You cancel or the Policy lapses due to non-payment of premium, the rider will also terminate.

Paid-Up Survivor Benefit

The rider provides that the Policy to which the rider is attached will be paid-up and no further premium payments required after both of the following have occurred: (a) the tenth (10th) Policy Anniversary Date; and (b) the date of the Covered Partner's death. If the Covered Partner dies before the tenth (10th) Policy Anniversary Date, the premium for the Policy must continue to be paid, including the rider, until the tenth (10th) Policy Anniversary Date, unless waived under the Policy, at which point the Policy will be paid-up and no further premium payments will be required. A Paid-Up Survivor Benefit Rider must be issued with and remain attached to the Covered Partner's policy. Both the Policy, including the

rider and the Covered Partner's policy, including the rider, must remain in force. If both policies, or the rider do not remain in force, the rider will terminate and the premium for the rider will end. In the event You cancel or the Policy lapses due to non-payment of premium, the rider will terminate.

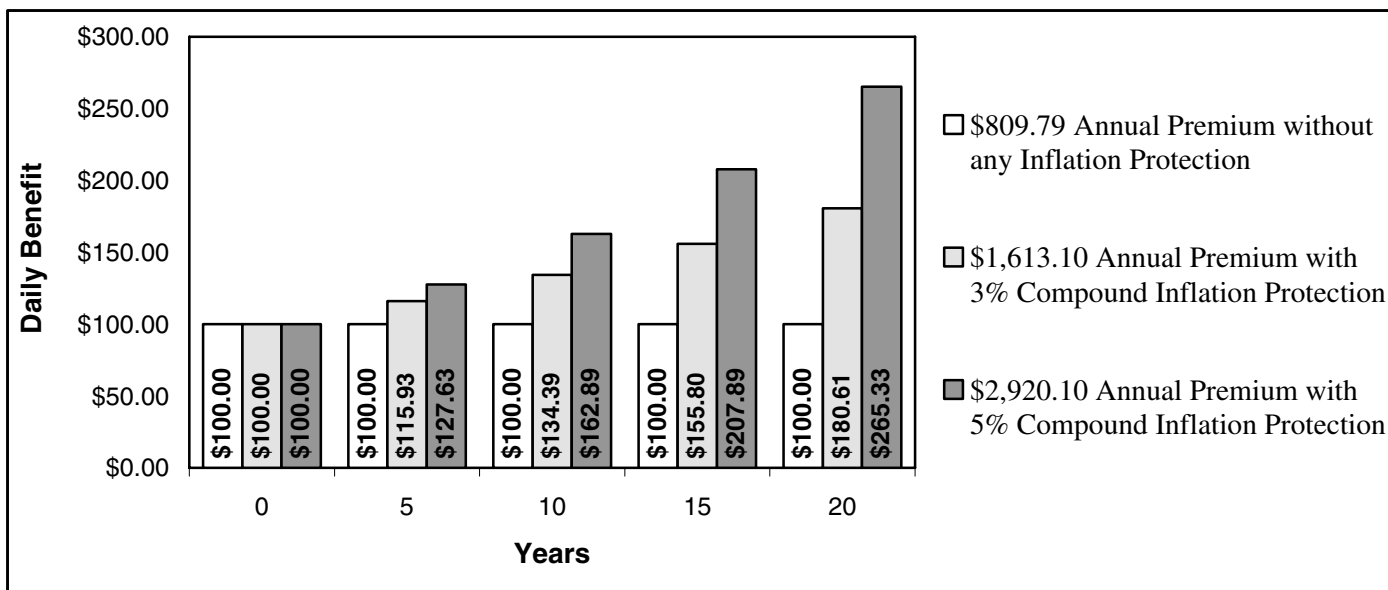
Shared Care

The rider provides for a Shared Total Benefit Amount for Covered Partners in the event that the Total Benefit Amount for the Policy has been exhausted, the Policy will remain in force and We may continue to pay benefits in accordance with the provisions of the Policy until the Shared Total Benefit Amount has also been exhausted. The Policy will terminate on the date that both the Total Benefit Amount and the Shared Benefit Amount are exhausted. The Shared Benefit Amount will be reduced by benefits paid under the Policy and by benefits paid under the Shared Care Rider attached to the Covered Partner's policy. The Shared Benefit Amount will be increased in accordance with any inflation protection rider attached to the Policy. If the Covered Partner dies, the Shared Total Benefit Amount will remain available for as long as the Policy including the rider remain in force. The Policy and the Covered Partner's policy must be identical at the time of purchase and remain in force as identical policies (policy form, Total Benefit Amount, Elimination Period, Daily Benefit Amount, and all attached riders and endorsements). If identical policies do not remain in force, the rider will terminate and the premium for the rider will end. In the event the Policy lapses due to non-payment of premium, the rider will terminate.

Inflation Protection

The rider provides that on each Policy Anniversary Date, while the Policy to which the rider is attached remains in force, including while We are paying benefits, We will increase the Daily Benefits. The Compound Inflation Protection Rider increases the Daily Benefit Amount and the Daily Limit for Coverage Outside of the United States, as well as the Total Benefit Amount and the Lifetime Limit for Coverage Outside of the United States, by either three percent (3%) or five percent (5%).

The following graph compares the benefits and premiums between a policy with the five percent (5%) Compound Inflation Protection Rider, a policy with the three percent (3%) Compound Inflation Protection Rider and a policy without any rider. For purposes of illustration, the sample shown is for a policy with a 1,095-day (3-Year) Benefit Period for Facility Services and Home Care, issued at age fifty-five (55), a ninety (90) day Elimination Period, and a one hundred dollar (\$100.00) Daily Benefit Amount.



INFORMATION AND COUNSELING

The California Department of Insurance has prepared a Consumer Guide to Long Term Care Insurance. This guide can be obtained by calling the Department of Insurance toll-free number. This number is 1-800-927-HELP. Additionally, the Health Insurance Counseling and Advocacy Program (HICAP), administered by the California Department of Aging, provides long term care insurance counseling to California senior citizens. Call the HICAP toll-free telephone number 1-800-434-0222 for a referral to your local HICAP office. **A specimen individual policy form offered in California is available upon request.**

Information pertaining to your local HICAP office is provided below.

County: _____

Agency: _____

Phone: _____