TID:
211063428_5/20/2020_18590968

COMPANY/MO:
TLIC / MO 021

GMCPROD-ID:
U2CTPX3

REQUESTOR:
NB
UHS?87

SERVICE GROUP:
NONE

POLICY NUMBER & INSURED NAME:
211063428 - JOHN DOE

JURISDICTION:
CT

DRA-PARTNERSHIP:
NO

GMCPROD-ID:
UNI2NIC_MASTERPOLICY

HOME OFFICE: CEDAR RAPIDS, IOWA
Long Term Care Administrative Office
P.O. Box 869090 Plano, TX 75086-9090

JOHN DOE
123 MAIN ST
CITY, CT 12345

TRANSAMERICA®
LIFE INSURANCE COMPANY

HOME OFFICE: CEDAR RAPIDS, IOWA
Long Term Care Administrative Office
P.O. Box 869090
Plano, TX 75086-9090
1-(800) 227-3740

CONGRATULATIONS AND WELCOME!

Thank you for selecting Transamerica Life Long Term Care Coverage. Welcome to our large and growing family of Transamerica Life policyholders.

We recognize that Long-Term Care insurance is an important part of your financial planning. This product provides you and your family the added security of knowing that should you be faced with the very high costs commonly associated with Long Term Care, you will have financial and referral resources available to better support you in making the right choices for your needs. And, it helps to protect the financial future that you and your family have worked so hard to build.

This policy has been approved by the Connecticut Partnership for Long Term Care. As a result, the State of Connecticut guarantees that when you receive benefits under this policy, you can protect an amount of your assets equal to the amount of benefits your policy paid in case you need to apply to Connecticut's Medicaid program. Even if the Medicaid program changes, your assets will continue to be protected.

Asset Protection is a valuable part of this policy. In order to be able to use it, you must have all of your records related to this policy. If you use the benefits of this policy, Transamerica Life is required to send you quarterly reports detailing how much Asset Protection you've earned. Therefore, **it is important that you keep this policy, the Asset Protection reports and all of your other records related to it together, so that you will have all of your information if you need to apply to Connecticut's Medicaid program in the future.**

You can be referred to a Connecticut Partnership – approved Access Agency by calling the following toll-free number: 1-866-745-3543. Claim forms and benefit information may be obtained by calling the same toll-free number, and asking to speak with a nurse care advisor. A nurse care advisor will be happy to discuss your care needs and set up an on-site visit with an Access Agency.

We are pleased to enclose your Policy, which is the contract between us that describes in detail each benefit that you purchased. When you applied for this Policy, you were provided with a marketing brochure and an Outline of Coverage. During your 30-day Free Look Period, you should carefully review your. Application and Policy to be certain that you are satisfied with the coverage that has been issued to you.

As a reminder, your policy is Guaranteed Renewable, which means that as long as the premium is paid when due, we cannot cancel your policy. However, this does not mean that premium rates are guaranteed to remain at their present level. Although we cannot single you out for a rate increase, we can change your premium if we change premiums for all policyholders of this policy form; subject to approval by the Connecticut Department of Insurance. Because many factors can influence the need for premium increases, you should be prepared for the possibility of increased premium rates over the life of your policy.

We have included on the back of this letter a copy of the Company's Notice of Privacy Policy for your reference. This notice is informational and does not require a response.

If you have any questions or desire to review the terms of your coverage, you may contact one of our Customer Service Representatives at the toll free number listed above.

A WORD OF CAUTION: Beware of anyone who encourages you to replace this coverage without allowing you time to carefully investigate the replacement proposal. Insist on time to review the proposal, and I encourage you to contact your insurance producer who can help you to review the proposal.

We look forward to serving you for the many years to come. And again, welcome to our family.

Sincerely,

Tonya L Ulery

Tonya L Ulery
VP Claims and Customer Service, Transamerica Life

Effective August 5, 2019, LTCG, a licensed Third Party Administrator, began administering long term care insurance policies (in other words, handling day-to-day customer service requests) and processing claims.

TRANSAMERICA®

Revised April 29th, 2019

NOTICE OF PRIVACY PRACTICES TRANSAMERICA COMPANIES

This Notice is provided to you by the Transamerica companies listed at the end of this Notice. We value our customers and your trust in us, especially when you share your personal information with us. We understand that the privacy and security of that personal information is important to you. We call this information "data". This Notice describes the data we collect and how we use, share and protect such data. The types of data we collect and share depend on the type of product or service you have with us. Also, Transamerica websites' and applications' Terms of Use and Privacy Statements provide additional detail on the treatment and handling of data when interacting with these sites or applications. If your relationship with us ends, we will continue to handle your data in accordance with this Notice.

Data That We Collect: We collect the following types of data:

Data	Typical Data Sources
Name, email and physical address, age, social security and driver's license numbers, employment, financial and health data and history.	• You directly, when you submit applications and forms and engage in communications with us • Employers, healthcare providers, other insurance companies and other authorized entities
Data about your transactions with us. Data about your transactions with unaffiliated third parties ("Third Parties") that is shared with Transamerica. Transactional data collected as part of your interaction with Transamerica or provided by Third Parties can include, but is not limited to, account balances, accrued benefits, coverages, premiums, payment and claims history, financial transactions, and medical or health data.	• Our affiliates (companies under common ownership) • Third Parties • Transamerica's websites, digital platforms, and applications • Assistive technologies, mobile or wearable devices, or other similar technology
Credit history, employment information and other information about your creditworthiness, medical care and health.	• Consumer reporting agencies and other service providers we use such as third party data suppliers • Your employers, healthcare providers, other insurance companies and other authorized entities
Data about products and services you obtain or in which you might be interested.	• You • Third Parties with whom we have joint marketing arrangements • Other Third Parties as allowed
Data you provide to Third Parties when you have authorized the Third Party to share such data with other parties. This includes data collected through Third Party applications, websites, or other digital interfaces, data you share with us, data you have authorized us to receive, or data you have authorized Third Parties to share with us.	• Third Party applications, websites, or other digital interfaces where you have agreed to share your data • Assistive technologies, mobile or wearable devices, or other similar technology

How We Use Your Data: We use data to provide our services and for purposes allowed by law, this includes use authorized by you. For example, we may use your data to:

- Process claims and transactions,
- Research, develop, and market products and services,
- Prevent and prosecute fraud or criminal activities,
- Support online customer experiences, digital platforms, and/or applications you elect to participate in
- Maintain your accounts,
- Comply with applicable laws and for security purposes,
- Maintain, operate, and market our business, or

Sharing Data: We may share your data with Third Parties and affiliates as permitted or required by law, or when you authorize us to do so. In certain situations, our ability to share information is limited by other restrictions, such as certain contractual agreements with plan sponsors or similar arrangements. **We will honor those restrictions to the extent they conflict with the terms of this Notice.**

We may also share your data with Third Parties in certain circumstances, such as:

- Those who provide services to support our business, including processing claims, account maintenance, and marketing and sales,
- Credit bureaus,
- Insurance regulators, law enforcement, governmental
- Health care professionals, including to verify coverage or to provide information relating to a medical condition,
- Governmental agencies so they can decide if you are eligible for public benefits,

authorities and other Third Parties in response to legal process or required by law,
- Other insurance companies (including successor insurers), agents and insurance support organizations to coordinate your benefits or in connection with insurance transactions involving you,
- Group policyholders, for example, regarding claims experience or to support service audits,
- Certificate or policyholders regarding the status of an insurance transaction,
- Those who have a legal or beneficial interest in your assets (such as creditors with a lien on your account),
- Other financial companies in connection with joint marketing efforts,
- Your employer or plan sponsor as needed to support the administration of employee accounts (but only as permitted by law and only if you have established an account in connection with your employer),
- Your representatives and lawyers,
- To prevent and prosecute fraud or criminal activities,
- To conduct actuarial or research studies, and
- In connection with the sale or merger of all or part of our business.

Our affiliates include a broad range of companies who provide financial services. These include insurance companies and agencies, and investment advisors. They also include agencies and broker/dealers who may not be included in the scope of this Notice. If we serve you through one of these professionals not covered under the Notice, you may contact them directly for information regarding their privacy practices. Specific contact information for these professionals can be found on your statements and other correspondence from them. We do not share information about your creditworthiness among our affiliates. The Transamerica affiliated companies with whom we may share your other information may include our companies with a Transamerica or Stonebridge name. For example, we may share your data with our affiliates:

- For their everyday business purposes;
- So they can tell you about products and services they offer;
- So they can determine which of their products and services may be of interest to you;
- So they can provide various services to us to support our business, such as claims processing, maintaining your account, and marketing products and services to you; or
- So they can audit themselves or their agents

Your Choice to Limit Marketing by Transamerica Affiliates: You may limit our affiliates' use of certain types of data to market their own products and services to you ("Opt Out"). To do this, choose one of the Opt Out methods set forth below. This data relates to your transactions and experiences with us. For example, this may include the products you own and your account history. Your choice to limit marketing offers from our affiliates will apply for at least 5 years from when you Opt Out. Once that period expires, we will send you a renewal Notice. That renewal Notice will allow you to continue to limit marketing offers from our affiliates for at least another 5 years. If you have already Opted Out of marketing offers from our affiliates, you do not need to Opt Out again until you receive a renewal Notice. If you hold a policy or account jointly with someone else, your Opt Out elections will apply to everyone on the account. When you are no longer our customer, we will continue to share your data as described in this Notice (including your Opt Out, if applicable). However, you may contact us at any time to elect to Opt Out.

To Opt Out: To limit our sharing of data with affiliates for marketing by affiliates as described above, you may:

- Call us at **877-257-4690** and our menu will prompt you through your choice(s), or
- Visit us online at **www.transamerica.com/optout**.

Your Right of Access and Correction: You have a right of access and correction with respect to data we collect except data that relates to and is collected in connection with a claim or criminal or civil lawsuit involving you. You must make your request to us in writing listing the account or policy numbers with the data you are requesting to access. If you tell us of an error in the data, we will review it and if we agree, we will correct our records. If we don't agree, you may dispute our findings in writing and send your statement to us. We will include your statement whenever we provide your disputed information to anyone outside Transamerica. This is a summary of your rights. For a copy of our more detailed Notice of Insurance Information Practices as applicable to your product or service, please send a written request to 6400 C St. SW Cedar Rapids, IA 52499-0001.

Protecting Your Data: We maintain appropriate controls to limit access to data to persons who need access to it in order to do their jobs or to provide products and services to you. We train our workforce in the proper handling of data. In addition, we maintain other physical, technical, and administrative or procedural safeguards to protect your data.

Other Privacy Protections for Vermont Residents only. We will not share data we collect about you with Third Parties, except as permitted by Vermont law or authorized by you. We may still share data about our transactions or experiences with you with our affiliates. **For California Residents only.** If you are a California resident, you will receive a separate notice with additional choices.

We may revise this Notice. If we make material changes, we will notify you as required by law. This Notice is provided by the following Transamerica companies and any separate accounts established for products they offer:

Transamerica Advisors Life Insurance Company
Transamerica Capital, Inc
Transamerica Casualty Insurance Company
Transamerica Financial Life Insurance Company
Transamerica Investors Securities Corporation
Transamerica Life Insurance Company
Transamerica Premier Life Insurance Company
Transamerica Retirement Advisors, LLC
Transamerica Retirement Solutions, LLC
Stonebridge Benefit Services, Inc

TRANSAMERICA®
LIFE INSURANCE COMPANY

HOME OFFICE: CEDAR RAPIDS, IOWA
Long Term Care Administrative Office
P.O. Box 869090
Plano, TX 75086-9090
1-(800) 227-3740

This is a Precertified Long Term Care Insurance Policy
That Provides Medicaid Asset Protection under
The Connecticut PARTNERSHIP FOR LONG-TERM CARE™

THIS IS A LONG TERM CARE INSURANCE POLICY. PLEASE READ IT CAREFULLY.

We are pleased to issue this Policy to You. It has many important features. We urge You to read it carefully. It is issued in exchange for Your application and payment of the first premium.

This Policy is intended to be a federally tax-qualified long term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended. If a change to Your Policy is required as a result of future IRS rulings, You will be given a choice of accepting the change or keeping the Policy without change as a non-tax qualified contract.

THIS POLICY IS GUARANTEED RENEWABLE FOR LIFE OR UNTIL THE POLICY MAXIMUM AMOUNT HAS BEEN EXHAUSTED

Your timely payment of premiums is all that is needed to keep this Policy in force until the Policy Maximum Amount has been exhausted. We cannot cancel this Policy if the required premium payments are paid on a timely basis. To continue this Policy during the Premium Paying Period, You must pay any premium due on or before the Premium Due Date. It must be received by Us at Our Administrative Office before the end of the Grace Period.

WE HAVE A RIGHT TO CHANGE PREMIUMS

We can change Your premiums, subject to approval by the Connecticut Insurance Department. Any change in premiums will apply to all policies issued in Your state in the same premium class as Yours. Any change in premium can occur only during the Premium Paying Period shown on the Schedule. We must give You at least 60 days written notice before We change Your premiums. Your premiums will not increase due to a change in Your age or health.

30-DAY RIGHT TO REVIEW YOUR POLICY

You have 30 days from the day You receive this Policy to review it and return it to Us if You decide not to keep it. You do not have to tell Us why You are returning the Policy. Within 30 days of when You receive it, simply return it to Us at Our Administrative Office or to the agent/insurance producer through whom it was purchased. We will refund the full amount of any premium paid within 30 days after Our receipt of the returned Policy. The Policy will be void as if it had never been issued.

IMPORTANT CAUTION ABOUT THE APPLICATION

We have issued this Policy based on the answers to the questions on the application. A copy of the application is attached. If any answers are incorrect or untrue, We may have the right to deny benefits or rescind this Policy. The best time to clear up any question is now, before a claim arises! If, for any reason, any of the answers are incorrect or untrue, contact Us at Our Administrative Office. Our address is shown above and the toll-free number is shown above and on the Schedule page.

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

THIS POLICY 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.

COORDINATION WITH OTHER BENEFITS NOTICE: Benefits provided under this Policy may be reduced to the extent that similar benefits are payable under any other plans or programs to which You are entitled (including Medicare). Please refer to the Coordination With Other Benefits provision of this Policy for a full explanation. This provision will NOT reduce the Policy Maximum Amount payable under this Policy.

Jay Orlandi
Secretary

Blake Bostwick
President

TABLE OF CONTENTS

SCHEDULE

Policy Number: 211063428
Insured: JOHN DOE

Effective Date: 6/1/2020
Insured's Issue Age: 55

Premium Paying Mode: Annual
First Annual Premium: $7,573.11

Premium Paying Period: Lifetime
First Modal Premium: $7,573.11

Our toll free number for Customer Service: (800) 227-3740

Early notification to Our Claims Department will help Us make a timely review of Your claim. Please let Us know immediately, or in advance whenever possible, when You need care or services covered by this Policy. Please call the Claims Department at (866) 745-3544.

Note: The benefits shown on this Schedule are those that You elected and which became effective on the Effective Date of this Policy. Any changes to Your coverage will be shown by endorsement. This includes any benefits You add or delete and their respective effective dates.

The First Annual Premium is the total amount You will pay per year only if You choose the Annual Premium Paying Mode. It will be exceeded if You pay premiums more frequently than once a year (for example - Semi-Annually, Quarterly or Monthly). See the Modal Premium Disclosure section.

BENEFITS

Policy Maximum Amount*	$300,000.00
Elimination Period	60 Days

The Home Care and Adult Day Care Benefit, Long Term Care Facility Benefit, the Long Term Care Facility Bed Reservation Benefit and the Alternate Plan of Care Benefit are subject to the Elimination Period.

Home Care and Adult Day Care Benefit*	Included
Initial Maximum Daily Benefit	$285.00
Care Coordination Benefit	Included
Maximum	Unlimited
Remain At Home Benefit*	Included
Maximum Benefit	$17,100.00
Long Term Care Facility Benefit*	Included
Initial Maximum Daily Benefit	$285.00
Long Term Care Facility Bed Reservation Benefit	Included
Number of Days Per Calendar Year	60 Days
Respite Care Benefit*	Included
Number of Days Per Calendar Year	30 Days
Initial Maximum Daily Benefit	$285.00
Waiver of Premium Benefit	Included
Hospice Care Benefit*	Included
Initial Maximum Daily Benefit	$285.00
Alternate Plan of Care Benefit	Included

Compound Benefit Increase	Included
Percentage	3%
Contingent Nonforfeiture Benefit Endorsement	Included
Return of Premium To Age 67 Endorsement	Included

*Subject to increases due to inflation.

OPTIONAL BENEFITS

Shared Care Benefit Rider	Elected-Premium $1,091.45
Monthly Benefit Rider*	Elected-Premium $203.49
Maximum Monthly Benefit for Long Term Care Facilities	Number of days in the Calendar Month X LTC Facility Initial Maximum Daily Benefit
Maximum Monthly Benefit for Home Care and Adult Day Care	Number of days in the Calendar Month X Home Care and Adult Day Care Initial Maximum Daily Benefit
Full Restoration of Benefits Rider	Elected-Premium $368.59
Joint Waiver of Premium Rider	Elected-Premium $141.27
Nonforfeiture Benefit Rider	Elected-Premium $542.89
TOTAL PREMIUM FOR INCLUDED BENEFITS	$5,225.42
TOTAL PREMIUM FOR OPTIONAL BENEFITS	$2,347.69
TOTAL PREMIUM FOR ALL BENEFITS	$7,573.11

MODAL PREMIUM DISCLOSURE

You may choose to pay Your premium annually (once a year), semi-annually (2 times a year), quarterly (4 times a year), monthly (12 times a year) or in some cases, by payroll deduction at the frequency determined by Your employer. The premiums may be paid monthly in 12 payments only by electronic funds transfer or list bill. You may change Your mode of premium payment by sending a written request to Our Administrative Office.

Please note that the more often You pay, the higher Your total premium amount will be per year. Additional premium charges are included for all premium payment periods other than annual. These charges are called "modal factor charges". These charges are based upon modal factors that are used to determine the premium amount for all payment options. The modal factors are 1.00 for annual, .52 for semi-annual, .265 for quarterly, and .09 for monthly.

Cost Comparison of Premium Paying Modes				
Premium Paying Mode	Number of Premium Payments Per Year	Amount of Each Modal Premium Payment	Total of Modal Premium Payments per Year	Total Additional Payment per Year
Annual	01	$7,573.11	$7,573.11	$0.00
Semi-Annual	02	$3,938.00	$7,876.00	$302.89
Quarterly	04	$2,006.87	$8,027.48	$454.37
Monthly	12	$681.58	$8,178.96	$605.85

To calculate the total amount of premiums You will pay in a year based on Your current premium payment selection:

(1) multiply the First Annual Premium shown on this Schedule by the factor for Your chosen Premium Paying Mode; and then

(2) multiply that result by the number of premium payments per year based on Your chosen Premium Paying Mode.

GENERAL INFORMATION

This Policy uses terms that have certain meanings within this Policy. Defined terms are shown with capital letters to help You better identify them. Most of the definitions are in the General Definitions section at the end of this Policy. Definitions related to eligibility for benefits are in the Eligibility Definitions section. We suggest that You closely read the facility and care provider definitions.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

We will pay for the Qualified Long Term Care Services covered by this Policy if:
(1) You are a Chronically Ill Individual; and
(2) The Qualified Long Term Care Services are prescribed for You in a written Plan of Care by a Licensed Health Care Practitioner.

You will be considered a Chronically Ill Individual when one of the following criteria is met:
(1) You are unable to perform, without Substantial Assistance from another individual, at least 2 out of the 6 Activities of Daily Living (ADLs) for an expected period of at least 90 days due to a loss of functional capacity; or
(2) You require Substantial Supervision to protect Yourself from threats to health and safety due to Severe Cognitive Impairment.

A Licensed Health Care Practitioner must certify that You are a Chronically Ill Individual. The certification must be submitted to Us and must be renewed at least every 12 months.

All of the services covered by this Policy are intended to be Qualified Long Term Care Services.

This Policy provides coverage for Qualified Long Term Care Services which are needed due to mental and nervous conditions, including Alzheimer's disease, Parkinson's disease and senile dementia as long as You are certified by a Licensed Health Care Practitioner as being a Chronically Ill Individual as defined in this Policy. Benefits are subject to the Elimination Period, provisions, exclusions and limitations of this Policy.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

Conditions
In order for benefits to be payable under this Policy:

- You must satisfy the Eligibility for the Payment of Benefits provision;
- all Qualified Long Term Care Services must begin while Your coverage is in force;
- all charges must be incurred for services rendered or goods provided while the applicable benefit is in force;
- You must satisfy the Elimination Period if it applies to the benefits You are receiving; and
- all care and services must be consistent with Your current Plan of Care. You must provide Us with both an acceptable Plan of Care and Proof of Loss documentation.

The Elimination Period, benefits, benefit limits and Policy Maximum Amount are shown on the Schedule. The Schedule and the benefit sections indicate if the Elimination Period is applicable to each Benefit.

Limitations
All benefits are subject to the Policy Maximum Amount of this Policy, except for the Care Coordination Benefit. We will not pay benefits during the Elimination Period, except as noted in this Policy. Benefits are subject to the General Exclusions and Limitations and the Coordination with Other Benefits provisions of this Policy.

NOTE: If more than one type of covered care or service is received on the same day, only the daily benefit providing the largest payment will be payable, unless otherwise stated in the Benefits section of this Policy.

We will not pay for: Physician's charges; hospital or laboratory charges; prescription or non-prescription medications; medical supplies; durable medical equipment (except as provided under the Remain At Home Benefit); payments in-kind; transportation; or personal expenses, such as items and services furnished at Your request for comfort, convenience, beautification or entertainment.

ELIGIBILITY DEFINITIONS

Chronically Ill Individual
Any individual who has been certified by a Licensed Health Care Practitioner as:
(1) being unable to perform, without **Substantial Assistance** from another individual, at least 2 out of the 6 **Activities of Daily Living (ADLs)** for an expected period of at least 90 days due to a loss of functional capacity; or
(2) requiring **Substantial Supervision** to protect You from threats to health and safety due to **Severe Cognitive Impairment**.

Substantial Assistance
Hands-on Assistance or Standby Assistance.

(1) Hands-on Assistance
The physical assistance (minimal, moderate or maximal) of another person without which You would be unable to perform the Activity of Daily Living.

(2) Standby Assistance
The presence of another person within arm's reach that is necessary to prevent, by physical intervention, injury to You while You are performing the Activity of Daily Living (such as being ready to catch You if You fall while getting into or out of the bathtub or shower as part of bathing, or being ready to remove food from Your throat if You choke while eating).

Activities of Daily Living (ADLs)
Each of the following six (6) functional areas is considered an Activity of Daily Living (ADL):

(1) Bathing: The ability to wash oneself by sponge bath; or in either a tub or shower, including the task of getting into and out of the tub or shower.

(2) 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 a catheter or colostomy bag).

(3) Dressing: The ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.

(4) Eating: The ability to feed oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

(5) Toileting: The ability to get to and from the toilet, to get on and off the toilet, and to perform associated personal hygiene.

(6) Transferring: The ability to move into and out of a bed, chair or wheelchair.

Substantial Supervision
Continual supervision by another person that is necessary to protect You as a Severely Cognitively Impaired person from threats to Your health or safety (such as may result from wandering). This includes cuing by verbal prompting, gestures, or other demonstrations.

Severe Cognitive Impairment (including the term "Severely Cognitively Impaired")
A severe loss or deterioration in intellectual capacity that is measured by standardized tests and scores as prescribed in Connecticut regulation by the Connecticut Partnership for Long-Term Care as part of an evaluation that reliably measures impairment in Your:
(1) short-term or long-term memory;
(2) orientation as to people, places or time; and
(3) deductive and abstract reasoning.

BENEFITS

The following sections describe the coverage available for care and services under this Policy. Please read the benefit provisions carefully. Each of the Benefits of this Policy is subject to all applicable requirements and limitations of this Policy.

Certain Benefits of this Policy require Care Coordination. In order for Home and Community Care benefits and the Alternate Plan of Care Benefit to be payable, You must be using the Care Coordination Benefit.

Home and Community Care includes the following Benefits:
(1) Home Care and Adult Day Care;
(2) the Remain At Home Benefit;
(3) Respite Care if received somewhere other than in a Long Term Care Facility; and
(4) Hospice Care if received somewhere other than in a Long Term Care Facility.

HOME CARE AND ADULT DAY CARE BENEFIT
Home Care Services, Home Health Care Services and/or Adult Day Care must be included in a Plan of Care developed and approved by a Licensed Health Care Practitioner employed by an Access Agency. These benefits will not be payable on any day that You are confined as an inpatient in a hospital or Long Term Care Facility.

We will pay You for the Out of Pocket Expenses for each day You receive Home Care Services, Home Health Care Services, or Adult Day Care. Payment is subject to:
(1) satisfaction of the Eligibility for the Payment of Benefits provision;
(2) the Home Care and Adult Day Care Maximum Daily Benefit;
(3) the Policy Maximum Amount; and
(4) the Elimination Period, if Your Schedule indicates that it applies to this benefit.

Home Care Services must be provided by or through a Home Care Agency or a Homemaker-Home Health Aide Agency (in the state of Connecticut) in Your Home. Home Health Care Services must be provided by or through a Home Care Agency. Adult Day Care must be provided by and at an Adult Day Care Center.

CARE COORDINATION BENEFIT
We will pay for the Care Coordinator to provide the following services. This is in addition to any other benefits paid under this Policy. We will pay for the Care Coordinator to provide Care Coordination services as long as You are certified as meeting the requirements in the Eligibility for the Payment of Benefits provision.

(1) a comprehensive face-to-face assessment of Your functional and cognitive capacity;
(2) development, completion, approval and implementation of a Plan of Care;
(3) coordination, and monitoring of the delivery, of services included in the Plan of Care on an as needed basis;
(4) completion of a comprehensive reassessment of a Plan of Care, as needed; and
(5) a transition plan when the services of the Plan of Care are no longer necessary.

Claims for benefits will be referred by Us to an Access Agency who will contact You to arrange for an assessment. There will be no charge to You for the covered Care Coordination services of the Care Coordinator. No amount will be subtracted from the Policy Maximum Amount.

The Care Coordination Benefit is not subject to, nor will it be applied toward the satisfaction of, the Elimination Period.

REMAIN AT HOME BENEFIT

Services described below must be included in a Plan of Care developed and approved by a Licensed Health Care Practitioner employed by an Access Agency. To qualify for this benefit, We must agree to the provider selected by You, as well as the labor, equipment and/or supplies in advance.

While You are living in Your Home, the Remain At Home Benefit can be used to pay for the following Qualified Long Term Care Services:
(1) Home Modification;
(2) Caregiver Training for a Volunteer Caregiver;
(3) Therapeutic Device or Technology; and
(4) Medical Alert System.

We will pay You for the Out of Pocket Expenses for care or services You receive under the Remain At Home Benefit. Payment is subject to:
(1) satisfaction of the Eligibility for the Payment of Benefits provision;
(2) the Remain At Home Maximum Benefit; and
(3) the Policy Maximum Amount.

The care or services provided under the Remain At Home Benefit must be consistent with Your care needs and provided according to a Plan of Care. The Remain At Home Benefit is available even if You are receiving the Home Care and Adult Day Care Benefit at the same time. The Remain At Home Benefit is not subject to, nor will it be applied toward the satisfaction of, the Elimination Period.

RESPITE CARE BENEFIT

If You are being cared for by Your Volunteer Caregiver on a continuous basis, We will pay You for the Out of Pocket Expenses for Respite Care. Payment is subject to:
(1) satisfaction of the Eligibility for the Payment of Benefits provision;
(2) the Respite Care Maximum Daily Benefit;
(3) the Policy Maximum Amount; and
(4) Respite Care must be provided in a Long Term Care Facility or in Your Home.

The Respite Care Benefit is available for up to the Number of Days Per Calendar Year shown on the Schedule. Benefits for Respite Care are not subject to, nor will they be applied toward the satisfaction of, the Elimination Period. Respite Care provided in Your Home must be included in a Plan of Care developed and approved by a Licensed Health Care Practitioner employed by an Access Agency.

LONG TERM CARE FACILITY BENEFIT

We will pay You for the Out of Pocket Expenses for each day You are confined as an overnight bed patient in a Long Term Care Facility. This includes room and board and Qualified Long Term Care Services. Payment is subject to:

(1) satisfaction of the Eligibility for the Payment of Benefits provision;
(2) the Elimination Period;
(3) the Long Term Care Facility Maximum Daily Benefit;
(4) the Policy Maximum Amount; and
(5) care and services provided while You are confined as an overnight bed patient in a Long Term Care Facility as defined in this Policy.

We will not pay more than the charge for a one-bedroom unit.

EXTENSION OF THE LONG TERM CARE FACILITY BENEFIT

If Your Policy Lapses while You are receiving the Long Term Care Facility Benefit, benefits will be continued until the earliest of the following: You no longer qualify for benefits; You are discharged from the Long Term Care Facility; You exhaust the Policy Maximum Amount; or You die. No other Policy benefits or benefits added by rider or endorsement to this Policy will be continued under this benefit.

LONG TERM CARE FACILITY BED RESERVATION BENEFIT

When You are absent for any reason during a Long Term Care Facility confinement, We will pay You for the Out of Pocket Expenses while the room in the Long Term Care Facility is being reserved. We will pay You for each day of Your absence, up to the Long Term Care Facility Maximum Daily Benefit.

You must have satisfied the Elimination Period before the Bed Reservation Benefit is available. The Bed Reservation Benefit is available for up to the Number of Days Per Calendar Year shown on the Schedule. It is subject to the Eligibility for the Payment of Benefits provision and the Policy Maximum Amount.

WAIVER OF PREMIUM BENEFIT

We will automatically change Your Premium Paying Mode to monthly and not require the payment of Your monthly premium when You qualify for the Waiver of Premium Benefit.

To qualify for the Waiver of Premium Benefit, You must:

(1) meet the requirements in the Eligibility for the Payment of Benefits provision;
(2) satisfy the Elimination Period, if it applies to the benefits You are receiving; and
(3) be confined as an overnight bed patient and receiving the Long Term Care Facility Benefit;
(4) be receiving the Home Care and Adult Day Care Benefit; or
(5) be receiving the Hospice Care Benefit.

We will stop waiving the premium when You no longer qualify for the Waiver of Premium Benefit. The Waiver of Premium Benefit will end on the date the Policy Maximum Amount has been exhausted.

To keep Your Policy in force when the Waiver of Premium Benefit ends or after You no longer qualify for the Waiver of Premium Benefit, premiums must be paid as they become due. Any unearned premiums paid which apply to the period that premiums are being waived will be refunded to You following the Policy monthly anniversary on which the waiver of premium began.

If benefits are added while the premium is being waived, the premium for those added benefits must continue to be paid.

If You are receiving any benefits other than those specified in numbers (3), (4) and (5) above, the Waiver of Premium Benefit will not apply.

HOSPICE CARE BENEFIT

We will pay You for the Out of Pocket Expenses for each day You receive Hospice Care. Payment is subject to:

(1) satisfaction of the Eligibility for the Payment of Benefits provision;
(2) a certification that You are Terminally Ill;
(3) the Hospice Care Maximum Daily Benefit;
(4) the Policy Maximum Amount; and
(5) Hospice Care must be provided by a Hospice Care Provider.

Benefits for Hospice Care are not subject to, nor will they be applied toward the satisfaction of, the Elimination Period.

Benefits for Hospice Care will not be payable when other benefits are payable under this Policy, except for the Care Coordination Benefit. Hospice Care that is provided somewhere other than in a Long Term Care Facility must be included in a Plan of Care developed and approved by a Licensed Health Care Practitioner employed by an Access Agency.

ALTERNATE PLAN OF CARE BENEFIT

Your Policy provides coverage for a wide range of long term care services. Because there may be new and evolving long term care services that We could not anticipate at the time Your Policy was issued, the Alternate Plan of Care Benefit gives Us the discretion to consider whether We may want to cover alternate Qualified Long Term Care Services not otherwise expressly covered by this Policy. Except for the Care Coordination Benefit, the Alternate Plan of Care Benefit will not be paid when any other benefits for care and services are being provided under this Policy. The services to be received under the Alternate Plan of Care Benefit must be included in a Plan of Care developed and approved by a Licensed Health Care Practitioner employed by an Access Agency.

We will consider paying benefits to You based on the Out of Pocket Expenses You incur for services requested under an Alternate Plan of Care only if:

(1) You are currently receiving benefits under this Policy; and
(2) You request in writing, prior to receipt of such alternative services, that We consider payment for services not identified in this Policy; and
(3) We determine that You satisfy and continue to satisfy the requirements under the Eligibility for the Payment of Benefits provision of this Policy; and
(4) the cost of services under the Alternate Plan of Care You request is less expensive than the amount We would otherwise pay for Qualified Long Term Care Services; and
    - the services are clearly specified in Your Plan of Care; and
    - the Alternate Plan of Care Benefit amount is agreed to in a written Alternate Plan of Care agreement that is signed by You and Us.

We have the sole discretion to determine the amount, if any, We are willing to pay toward the cost of such services. Any benefits paid under this provision will reduce Your Policy Maximum Amount. Days on which You receive alternative Qualified Long Term Care Services on or after the effective date of the Alternate Plan of Care agreement may count toward satisfaction of the Elimination Period. If so, We will not pay this benefit until Your Elimination Period has been satisfied, depending on what the alternative services are. You will qualify for a waiver of premium under this benefit only if the benefits You are currently receiving qualify for a Waiver of Premium Benefit.

The Alternate Plan of Care Benefit may not be used to pay for any charges for services described in the General Exclusions and Limitations, or the Coordination with Other Benefits provisions of this Policy. The Alternate Plan of Care Benefit will not extend any benefit listed in this Policy that You have exhausted. The Alternate Plan of Care Benefit may not be used to pay for services at any type of facility that is

otherwise excluded from coverage under the terms of this Policy.

An Alternate Plan of Care agreement will specify an agreement effective date and an agreement termination date. We reserve the right to review and develop a new Alternate Plan of Care agreement with You at the agreement termination date of the current Alternate Plan of Care agreement. However, You may choose to discontinue the use of the Alternate Plan of Care Benefit at any time. Our consideration and/or payment of the Alternate Plan of Care Benefit does not waive any of Your or Our rights under this Policy.

INFLATION PROTECTION COVERAGE

The following inflation protection coverage is available with this Policy form. **See Your Schedule page for which benefit below applies to Your Policy.**

COMPOUND BENEFIT INCREASE

On each anniversary of the effective date of this Policy, We will increase Your current Maximum Daily Benefits. They will increase without regard to claims paid. Those benefits will increase by 3% or 5%. The percentage You chose is shown on the Schedule.

We will also increase the Policy Maximum Amount by 3% or 5%, the same percentage as for the Maximum Daily Benefit. It is calculated based on the Policy Maximum Amount on Your last Policy anniversary, minus any claims paid since the last Policy anniversary. The Remain At Home Maximum Benefit will increase in the same way.

For example 5%:

Previous Anniversary's Policy Maximum Amount:	$400,000
Claims Paid During Last Policy Year:	$ 50,000
Benefit Increase for Current Year:	$ 17,500 (= [$400,000 - $50,000] x 5%)
Remaining Policy Maximum Amount:	$367,500 (= $400,000 - $50,000 + $17,500)

For example 3%:

Previous Anniversary's Policy Maximum Amount:	$400,000
Claims Paid During Last Policy Year:	$ 50,000
Benefit Increase for Current Year:	$ 10,500 (= [$400,000 - $50,000] x 3%)
Remaining Policy Maximum Amount:	$360,500 (= $400,000 - $50,000 + $10,500)

These increases will continue as long as this Policy is in force, even if You are receiving benefits on the date of the increase.

If You add to Your benefits after the effective date of this Policy, those added benefits will not increase until the amount of the additional coverage has been in effect one full year.

If You increase or decrease Your Policy's benefits after Your Policy was issued, the above calculations will be based on the new benefit amounts. Those new benefit amounts will be shown on an endorsement to Your Policy.

This benefit ends on the earliest of:
(1) the date the Policy ends; or
(2) when the Policy is continued under any nonforfeiture or contingent nonforfeiture benefit.

DAILY BENEFIT COMPOUND INCREASE

On each anniversary of the effective date of this Policy, We will increase Your current Maximum Daily Benefits. They will increase without regard to claims paid. Those benefits will increase 5%.

Until the Policy anniversary following Your 65th birthday, We will also increase the Policy Maximum

Amount by 5%. It is calculated based on the Policy Maximum Amount on Your last Policy anniversary, minus any claims paid since the last Policy anniversary. The Remain At Home Maximum Benefit will increase in the same way.

For example:

Previous Anniversary's Policy Maximum Amount:	$400,000
Claims Paid During Last Policy Year:	$ 50,000
Benefit Increase for Current Year:	$ 17,500 (= [$400,000 - $50,000] x 5%)
Remaining Policy Maximum Amount:	$367,500 (= $400,000 - $50,000 + $17,500)

On the Policy anniversary following Your 65th birthday, the Policy Maximum Amount will cease to increase, and it will remain at its attained level. This means that the Policy Maximum Amount will not increase over time and the Maximum Daily Benefits will continue to increase according to this Policy. This will result in the Policy Maximum Amount being depleted at a faster rate as Your Maximum Daily Benefits continue to increase. You should be aware that if Your Policy Maximum Amount does not increase over time, it might not provide all of the Medicaid Asset Protection that You need.

The Remain At Home Maximum Benefit will cease to increase on the Policy anniversary following Your 65th birthday in the same way as the Policy Maximum Amount.

These increases will continue as stated above, even if You are receiving benefits on the date of the increase.

If You add to Your benefits after the effective date of this Policy, those added benefits will not increase until the amount of the additional coverage has been in effect one full year. If You add to Your Policy Maximum Amount, any amount added will continue to increase, along with the base Policy Maximum Amount until the Policy anniversary following Your 65th birthday.

If You increase or decrease Your Policy's benefits after Your Policy was issued, the above calculations will be based on the new benefit amounts. Those new benefit amounts will be shown on an endorsement to Your Policy.

This benefit ends on the earliest of:
(1) the date the Policy ends; or
(2) when the Policy is continued under any nonforfeiture or contingent nonforfeiture benefit.

GENERAL EXCLUSIONS AND LIMITATIONS

This Policy will not pay benefits when You are eligible for confinement, care or services:
(1) resulting from alcoholism or drug addiction, unless as a result of medication prescribed by a Physician;
(2) resulting from or arising out of attempted suicide or intentionally self-inflicted injury;
(3) provided in a government facility (unless otherwise required by law), services for which benefits are paid or payable under Medicare, or would be payable except for application of a deductible or coinsurance amount (this does not apply when expenses are reimbursable under Medicare solely as a secondary payer), or other governmental program (except Medicaid);
(4) due to participation in a felony or insurrection;
(5) for which no charge is normally made in the absence of insurance;
(6) received outside the fifty (50) United States and the District of Columbia, or Canada;
(7) paid or payable under any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; or
(8) performed by a member of Your Immediate Family. Your Immediate Family member can provide covered care or services if he or she is a regular employee of an organization that is engaged in providing the Qualified Long Term Care Services. The organization he or she works for must receive

the payment for the care or service. Your Immediate Family member must receive no compensation other than the normal compensation for employees in his or her job category.

We will not pay for any confinement, care or service that is not included in Your Plan of Care. We will not pay for anything that is prohibited by state or federal law, including any law governing economic and trade sanctions.

A government facility includes a facility administered, covered or reimbursed by the Veteran's Administration.

COORDINATION WITH OTHER BENEFITS

The benefits of this Policy are designed to supplement NOT duplicate other benefits.

If You have any health insurance plan or non-Partnership long term care plan and You are entitled to benefits under those plans that would also be covered services under this Policy, You are required to obtain payment for those benefits first, prior to using benefits under this Policy.

Examples of health insurance plans include, but are not limited to, basic hospital, health maintenance organization (HMO), medical/surgical, major medical plan, Medicare, Medicare managed care plan, and Medicare supplemental programs.

If You are eligible to receive benefits under this Policy and any other Partnership-approved long term care plans, then the plan with the earliest Effective Date shall be deemed to be the primary coverage and the other Partnership-approved plans shall be deemed the secondary coverage, in order by Effective Date, from earliest to latest.

Any benefit amounts that You are entitled to receive under this Policy will be reduced by any benefits payable by these other plans. This provision will NOT reduce the Policy Maximum Amount payable under this Policy.

CLAIMS INFORMATION

This section informs You of: when to notify Us of a claim; what to send to Us; where to send it; how We pay benefits; and other claims-related rights and obligations under this Policy.

Notifying Us of a Claim

Notice of Claim: Early notification to Our Claims Department will help Us make a timely review of Your claim. Please let Us know immediately, or in advance whenever possible, when You need care or services covered by this Policy. Please see Your Schedule page for the toll-free number for the Claims Department. You may choose to send Us written notice instead.

Notice must be received by Us at Our Administrative Office within 60 days of the date the covered loss starts or as soon as is reasonably possible. The notice should include at least: Your name, Policy Number, and the address to which the claim form should be sent. You may authorize someone else to act for You in filing a claim.

How to File a Claim

Claim Forms: When We receive notice of a claim, We will send out a claim form to be used to file Proof of Loss. We will send the claim form to You within 15 days of notice of a claim.

The claim form has instructions on how to fill it out and where to send it. Please read the form carefully. Answer all questions and send all required information to the address on the form. You may choose to have someone else complete the information for You as Your representative.

If You do not get the claim form within 15 days, Proof of Loss can be filed without it by sending Us a letter. The letter needs to describe the occurrence, the nature, and the extent of the loss for which claim is being made. That letter must be sent to Us within the time period stated in the Proof of Loss section. At a minimum, the description should tell Us such things as:

- Your name, address, social security number, and policy number;
- the type of benefits for which claim is being made;
- the names and addresses of the medical professionals and care providers who are aware of Your condition or have provided care covered by this Policy;
- the diagnosis; and
- the time periods for which benefits are being claimed.

Assessment of Your Condition:

A. For Home and Community Care benefits and the Alternate Plan of Care Benefit, before We approve a claim for benefits under this Policy, an assessment may be performed by a Licensed Health Care Practitioner employed by an Access Agency. This assessment may be performed in person. The Licensed Health Care Practitioner employed by an Access Agency will assess Your condition and prognosis for recovery.

   To continue payments, We may require a Licensed Health Care Practitioner employed by an Access Agency to reassess Your condition and to update the prognosis for recovery. We will pay the costs of the initial assessment and all reassessments. We may require a reassessment at least once every 12 months while benefits are being paid. We may require a reassessment more often, but not more often than every 90 days.

B. For all other benefits, before We approve a claim for benefits under this Policy, an assessment may be performed by a Licensed Health Care Practitioner We select. This assessment may be performed in person. The Licensed Health Care Practitioner will assess Your condition and prognosis for recovery.

To continue payments, We may require a Licensed Health Care Practitioner to reassess Your condition and to update the prognosis for recovery. We will pay the costs of the initial assessment and all reassessments. We may require a reassessment at least once every 12 months while benefits are being paid. We may require a reassessment more often, but not more often than every 90 days.

When to File a Claim

Proof of Loss: You must give Us written Proof of Loss within 90 days after the end of the Elimination Period in order to satisfy the Elimination Period requirements. You must send the Proof of Loss to Our Administrative Office. We will require a certification by a Licensed Health Care Practitioner that You were a Chronically Ill Individual during the Elimination Period. It must include documentation that during the Elimination Period, You received services from covered providers for which You incurred a charge.

In order to help Us determine Your eligibility for the payment of benefits, We may require that You provide Us with any combination of documents, such as, but not limited to:

(1) claim forms and authorizations to obtain Proof of Loss;
(2) Physician's orders;
(3) medical records;
(4) copies of licensure of any facility, provider or for any bed to which You are assigned;
(5) itemized daily or monthly billing statements;
(6) records of the care or services You received;
(7) Explanation of Benefits (EOBs) that You have received from other sources for the same services. This includes: other health insurance or long term care insurance policies; the Veteran's Administration; and Medicare;
(8) provider's Plan of Care or provider assessment/reassessment records or similar documents; and

(9) provider's residence agreements, disclosures, life care contracts or similar documents.

For Home and Community Care benefits and the Alternate Plan of Care Benefit, We reserve the right to have an Assessment of Your Condition conducted by an Access Agency before We approve a claim for benefits under this Policy. For all other benefits, We reserve the right to conduct an Assessment of Your Condition before We approve a claim for benefits under this Policy.

We must receive written Proof of Loss within 90 days after the end of each month for which benefits may be paid. If it is not reasonably possible to give Us written proof in the time required, We will not reduce or deny a claim for being late if the Proof of Loss is sent to Us as soon as is reasonably possible. Unless You are not legally capable, the required Proof of Loss must always be given to Us no later than one year from the time specified.

How and When Claims are Paid

Time of Payment of Claim: Benefits under this Policy are payable after services have been rendered and charges have been incurred for such services. We will not pay benefits based on Advance Bills.

A. Within 30 business days after We receive notice of claim and Proof of Loss, We will either: pay the claim, if We have received all of the required information and determine that the claim is payable; or send You a written notice acknowledging the date of receipt of the claim. If We do not pay the claim, We will let You know: We are declining to pay all or part of the claim and the specific reason(s) for denial; or that additional information is necessary to determine if all or any part of the claim is payable and the specific additional information that is necessary.

B. Within 30 business days after We receive the requested additional information, We will either: pay the claim; or We will let You know that We are declining to pay all or part of the claim and the specific reason(s) for denial.

If We fail to follow the process outlined above, We will pay interest at the rate of 1% per month on the amount of the claim that should have been paid but that remains unpaid 45 business days after:
(1) the receipt of the claim with respect to subsection A above; or
(2) all requested additional information is received with respect to subsection B above.

The interest payable will be included in a late claim payment without the requirement to file an additional claim for such interest.

Payment of Claims: All benefits will be paid in U.S. dollars.

You may request that the payment of benefits to be made to someone other than You. This assignment of benefits must be sent to Us in writing. You should make this assignment of benefits no later than at the time Proof of Loss is filed. We will assume no liability for the payment of benefits to an assigned party that was paid based on the assignment of benefits in Our file at the time of payment.

Benefits unpaid at Your death will be paid to Your estate. We may pay such benefits to any relative by blood or marriage that we deem to be entitled to the benefits if they would otherwise be paid to Your estate. We may pay such benefits to any other person who has cared for or looked after Your affairs and who is deemed by Us to be justly entitled to the benefits. We may pay up to $1,000 under this provision. We will be discharged to the extent of any such payment made in good faith.

How to Appeal a Claim

Claims Appeal Process: We evaluate a claim based on the provisions of this Policy and the information We obtain or that is given to Us. If You do not agree with a claim decision, You may ask for an appeal. Your request must be in writing to Us. It needs to include all of the following information: the names, addresses and phone numbers of the providers who You think We should contact to learn more about Your

health and the care received; the Physicians and other health care professionals who treated You; and the facilities that provided the care or services. No special form is needed. Your request must be sent to Our Administrative Office within 1 year of the time of filing written Proof of Loss. You may authorize someone else to act for You under this appeal process. You or Your authorized representative may submit additional information of any kind that You think will help with Your appeal.

After We receive Your appeal and the necessary supporting documents, We will reexamine the information regarding Your claim and any additional information provided to Us. Within 30 days after We receive all of the necessary information, We will complete Our review. We will send You and Your authorized representative, if any, Our decision in writing. If Our decision is to pay the claim, We will pay it promptly. If the appeal is denied, We will clearly state Our reasons and make information directly relating to the denial available to You.

Right of Recovery

We have the right to recover any overpayment made because of an error in the processing of a claim. We may offset any amounts that have not been previously recovered from any future benefit payment.

Subrogation: If You become a Chronically Ill Individual as a result of an act or omission of someone else and receive covered care or services, We shall provide benefits to You, subject to the terms of this Policy. Acceptance of such benefits will mean You consent to the provisions of this section.

If We make any payments for benefits under this Policy, We shall be subrogated, to the extent of such payments, to all rights of recovery You have against any person or entity as permitted by law. You shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to Us.

We shall have a lien on all funds received by You up to the amount of benefits provided to You. We may give notice of that lien to any party who may have caused or contributed to the loss. All funds received shall be deemed to be for benefits paid by Us to or for Your account, regardless of the characterization of such funds. In the event that You receive funds on which We have a lien, such funds shall be held in trust by You until paid over to Us.

If We so decide, We may be subrogated to Your rights to the extent of the benefits received under this Policy. This includes Our right to bring suit against a third party in Your name. After giving You 30 days written notice, We or Our designee shall have the right to bring suit and take such action as necessary in Your name to recover the amount of benefits paid under this Policy. We can only do this if You or anyone acting on Your behalf has not taken action against such third party to obtain a judgment, settlement, or other recovery. Any action taken without Your consent shall be without prejudice to You.

You must take all actions, provide such information and assistance, and execute all instruments as We may require to help in the enforcement of Our rights under this provision. You shall take no action prejudicing Our rights and interests under this provision.

ASSET PROTECTION

When Benefits Will Earn Medicaid Asset Protection

Benefits paid to You, or a provider of long term care services on Your behalf, under this Policy can count towards Medicaid Asset Protection for purposes of eligibility for Connecticut's Medicaid program or any other state's Medicaid program that has a reciprocal agreement with Connecticut's Medicaid program. In order for benefit payments to count towards Medicaid Asset Protection, the conditions in Items 1, 2, and 3 that follow must be met:

(1) You have met one of the following insured events:

- You have a documented need for Substantial Assistance, with 2 or more of the following Activities of Daily Living: Dressing, Bathing, Eating, Toileting, Transferring and Continence; or

- You have been assessed and found to have a Severe Cognitive Impairment based on tests and scores prescribed by the Connecticut Partnership for Long-Term Care.

(2) The benefits are paid under this Partnership-approved Policy; and

(3) All Home and Community Care benefits and the Alternate Plan of Care Benefit must be provided in accordance with a written Plan of Care developed and approved by an Access Agency (the Access Agency must be approved by the Connecticut Partnership for Long-Term Care).

How to Stay Qualified for Medicaid Asset Protection Under the Partnership

(1) Each year Your Maximum Daily Benefit amounts must equal or exceed the minimum inflation-adjusted daily benefit specified by the Connecticut Insurance Department. The inflation-adjusted Maximum Daily Benefit amount increase provided to You each year under the compound inflation feature that You have selected will allow You to keep pace with the Department's minimum requirements.

(2) You were a resident of Connecticut when You applied for and subsequently were issued this Partnership-approved long term care insurance.

(3) All Home and Community Care benefits and the Alternate Plan of Care Benefit that are covered by this Policy count toward Medicaid Asset Protection only when an Access Agency (the Access Agency must be approved by the Connecticut Partnership for Long-Term Care) developed and approved the written Plan of Care.

(4) You can accumulate Medicaid Asset Protection wherever Your Policy pays benefits. If you need to access Medicaid to pay for Your care and You want to utilize the Medicaid Asset Protection You have earned, You must apply to Connecticut's Medicaid program or to any other state Medicaid program that has a reciprocal agreement with Connecticut. You must be a resident of and receive care in the state where you apply to Medicaid.

GENERAL PROVISIONS

This section describes: the documents that form this contract; the importance of a truthful application; and other basic rights and obligations.

The Contract

Entire Contract: The entire contract between You and Us will consist of:

(1) this Policy;

(2) the application; and

(3) any riders, endorsements or amendments made a part of this Policy.

No agent/insurance producer has authority to change or waive any part of this Policy. To be valid, any change or waiver must be:

(1) in writing;

(2) approved by one of Our executive officers and the Connecticut Department of Insurance, if necessary; and

(3) endorsed on or attached to this Policy.

Misstatement of Age

If Your age has been misstated, the benefits payable will be those that the premium paid would have purchased at Your correct age. If Your correct age is greater than the maximum age at which We would have issued this Policy, Our liability will be limited to the refund of all premiums paid for this Policy.

Contesting Coverage

Time Limit on Certain Defenses: When Your coverage has been in force less than 6 months, We may rescind the coverage or deny an otherwise valid claim upon a showing of misrepresentation that is material to Our decision to issue You the coverage.

When Your coverage has been in force for at least 6 months but less than 2 years, We may rescind the coverage or deny an otherwise valid claim upon a showing of misrepresentation that is both material to Our decision to issue You the coverage and which pertains to the condition for which benefits are sought.

After Your coverage has been in force for 2 years or more, Your coverage is incontestable except for nonpayment of premium.

Correction of Mistakes
When We discover a mistake or You bring one to Our attention, We reserve the right to correct it. We reserve the right to correct any mistakes We make whether: in the premium calculation and collection process; in the policy issue process; in the benefit payment process; or in some other part of Our contractual relationship. The benefit selections You made on the application and the premiums You have paid will be used to determine the coverage of Your Policy.

Other Provisions
Nonparticipating: This Policy does not participate in Our profits or surplus earnings.

No Cash Values, Borrowing, or Use as Collateral: This Policy does not provide for a cash surrender value, or other money that can be: borrowed; or paid, assigned or pledged as collateral for a loan.

Conformity with Law: If anything in this Policy does not comply with a law to which it is subject on its Effective Date, that provision is amended to conform to such law.

Time Periods: All time periods begin and end at 12:01 A.M. Standard time at Your Home.

Legal Actions: You cannot bring suit against Us until at least 60 days after written Proof of Loss has been given to Us. You cannot bring suit against Us after 3 years from the time written Proof of Loss is required to be given.

EFFECTIVE DATE, PREMIUM AND TERMINATION PROVISIONS

The Policy Taking Effect
Effective Date and Consideration: This Policy is issued based on Your answers to the questions on the application and payment of the First Modal Premium. It takes effect on the Effective Date shown on the Schedule, provided the First Modal Premium is paid. The Schedule will show only the benefits and benefit amounts We initially issued. Any benefits You delete or add later will be shown by endorsement to this Policy. All policy and benefit provisions and the Elimination Period will be calculated from the effective date of any increase in benefits.

Paying Premiums
After payment of the first premium, each additional premium, if any, is due at the end of the period for which the prior premium was paid. Premiums for this Policy must be paid when due in order for the coverage to remain in force. The Premium Paying Mode shown on the Schedule states how often premiums are to be paid per year. The Premium Paying Period shown on the Schedule states how long premiums are to be paid. Premiums are to be paid to Us at Our Administrative Office. The Premium Paying Mode You selected will impact Your overall cost of insurance.

What Happens When Premiums Are Not Paid
Grace Period: This Policy has a 65-day Grace Period. If a premium other than the first premium is not paid within 30 days from the Premium Due Date, We will send written notice of the nonpayment of the premium to You and the person or persons You named to receive such notice. We will send the notice to the addresses You provided to Us. You have an additional 35 days to pay the premium after We have mailed

this notice. You may choose to change Your benefits as described below in **Your Right to Reduce Benefits** in order to reduce Your premium. During the Grace Period, this Policy will stay in effect. If We do not receive the premium payment before the end of the Grace Period, this Policy will Lapse.

You may have named a person or persons to receive notice of nonpayment of premium on Your application. The person or persons You named are not responsible for paying the premium. You may change the person or persons named at any time while this Policy is in effect. Please note that You must tell Us if any of the addresses change. You must send the information in writing to Our Administrative Office. We will provide You with a reminder of Your right to change the person or persons named at least every two years.

Your Right to Reduce Benefits
You may request that We reduce Your benefits at any time while this Policy is in force. This request must be in writing.

You may choose to:
(1) reduce only the Policy Maximum Amount;
(2) reduce the Maximum Daily Benefit resulting in a reduced Policy Maximum Amount; or
(3) reduce other benefits consistent with Our administrative processes.

The premium for the Policy containing the reduced benefits will be based on: the age used to determine the premium for the coverage then currently in force; and the reduced amount of coverage elected. We will not allow You to lower Your Maximum Daily Benefit amount to an amount that is lower than the minimum daily benefit amount that is required by the Connecticut Partnership for Long-Term Care for a partnership-approved long term care insurance policy.

Reduced Benefit Offer
In the event Your Policy is about to Lapse, We will offer You the option to reduce Your Policy Maximum Amount and reduce Your premium. You will have no less than 30 days to consider the offer. Notice will be sent 30 days after the premium is due. The premium for the new Policy Maximum Amount will be based upon Your age at the time Your Policy was originally issued, and no underwriting will be required. It will be Your responsibility to continue to promptly pay this new reduced premium before the end of each Grace Period.

The reduced Policy Maximum Amount will take into account any increases in coverage that have accumulated due to any inflation adjustment, along with any decreases due to claims paid. For example, if You purchase a $100,000 Policy Maximum Amount, which has increased to $200,000, the reduction must be taken from the $200,000 amount.

The daily benefit amounts (and any monthly benefit amounts, if applicable) will NOT be reduced and will continue to reflect any inflation adjustments. For example, if Your Long Term Care Facility Maximum Daily Benefit grew from $200 to $400, then after any reduction under this provision the Long Term Care Facility Maximum Daily Benefit would still be $400 and will continue to increase annually. All other provisions in Your Policy will remain the same.

We will make such offer whenever Your Policy is about to Lapse during the first year it is in force, and at least once after the Policy has been in force for one year. We will NOT make the Reduced Benefit Offer to You if the balance of Your Policy Maximum Amount (after any claims have been paid) would provide for the equivalent of one year of coverage or less; or Your Policy was issued with the equivalent of one year of coverage.

Putting This Policy Back In Force
Reinstatement: Once this Policy Lapses, We may or may not put it back in force (reinstate) at Our option. Within 90 days of Your last Premium Due Date, You may request that We reinstate this Policy. We will require an application for reinstatement, but We will not require any premium at that time. If the application is approved by Us, You must then pay all past-due premiums. This Policy will be put back in

force as of the Lapse date.

Your reinstated Policy will cover only losses that begin after the date of reinstatement. In all other respects, Your rights and Our rights will be the same as before this Policy Lapsed. If there are any new provisions that apply to the reinstatement, they will be endorsed on or attached to the reinstated Policy.

Unintentional Lapse: If Your Policy Lapses unintentionally, We will reinstate Your coverage only if:
(1) We receive the request for reinstatement in Our Administrative Office within 180 days of the last Premium Due Date; and
(2) We receive a Licensed Health Care Practitioner's written certification that You were diagnosed, using generally accepted medical diagnostic methods and tests, as being a Chronically Ill Individual at the time this Policy Lapsed; and
(3) We receive all past-due premiums for the benefits that were in force at the time this Policy Lapsed.

Any claim incurred during the 180-day period will be considered for benefits subject to all other Policy provisions.

When the Policy Terminates
We will not cancel or otherwise end this Policy because of Your age or a change in Your mental or physical health.

Termination: This Policy and all benefits will end on the earliest of the following:
(1) the date this Policy Lapses;
(2) the date of Your death;
(3) the date the Policy Maximum Amount has been exhausted; or
(4) Our receipt of Your written request to cancel this Policy. If You do not specify a date to cancel this Policy, it will end on the next Policy monthly anniversary following Our receipt of the request. If You name a future cancellation date in Your written request, it will end on Your requested future cancellation date.

If You send Us a written notice to cancel Your Policy and You have named a person or persons in addition to Yourself to be notified regarding premium payments, We will send a notice to that person or persons that You have requested that We cancel Your Policy.

Payment of benefits for covered charges incurred before this Policy ends will not be affected.

Refund of Premiums
If this Policy terminates due to Your death, We will refund the portion of the modal premium paid for the period after the monthly anniversary following Your death up to the next Premium Due Date. This refund will be made only if Your Policy is still in its Premium Paying Period and is in force at the time of Your death. Any premiums paid for the time following the next Policy monthly anniversary after Your death will be refunded. The refund will be made within 30 days of Our receipt of written notice of Your death. It will be paid to Your estate.

If We receive a written request from You to cancel this Policy, We will refund any premiums paid for the period after Your cancellation. This refund will be made only if Your Policy is still in its Premium Paying Period and in force at the time We receive Your written cancellation. If You do not specify a date to cancel this Policy, We will refund any premiums paid from the next Policy monthly anniversary following Our receipt of the request. If You name a future date to cancel this Policy, We will refund any premiums paid from Your requested future cancellation date forward. The refund will be made within 30 days of Our receipt of written notice of cancellation. It will be paid to You.

GENERAL DEFINITIONS

Access Agency
An organization that provides Care Coordination services, including assessments and reassessments, Plan of Care development, and coordination and monitoring of all Home and Community Care benefits and the Alternate Plan of Care Benefit and has been approved as an Access Agency by the state of Connecticut as meeting the requirements for such agency defined in Section 17b-342 of the Connecticut General Statutes.

Adult Day Care
A program for six (6) or more individuals of social and health-related services provided during the day in a community group setting. The purpose of the program is to support frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

Adult Day Care Center
A facility or organization that is licensed, registered or certified to provide Adult Day Care, if required by the state in which it is located.

If licensure, registration, or certification is not required by the state, it is that part (or separate center) of a facility that provides Adult Day Care and meets all of the following requirements:
(1) it operates at least 5 days a week for a minimum of 4 hours per day and is not an overnight facility;
(2) it maintains a daily written record for each client, which includes a Plan of Care and a record of all services provided;
(3) it has established procedures for obtaining appropriate aid in the event of a medical emergency; and
(4) its staff includes all of the following: (a) a full-time director; and (b) one or more nurses in attendance during operating hours.

Advance Bill(s)
Bills for services that are prebilled or billed prior to the services actually being provided. Benefits under this Policy are not eligible for payment until after covered services are received. For example: A bill or invoice may be created one month by a Long Term Care Facility for residency or services that it anticipates will be provided in the next month. This is considered an Advance Bill. It will not be accepted as Proof of Loss and is not eligible for payment. Only services that have been provided and received are eligible for payment.

Assisted Living Services
Nursing services and assistance with Activities of Daily Living provided to residents living within a Managed Residential Community having supportive services that encourage residents primarily age fifty-five (55) or older to maintain a maximum level of independence. Routine household services may be provided as Assisted Living Services by the Assisted Living Services Agency or by the Managed Residential Community. These services provide an alternative for elderly persons who require some help or aid with Activities of Daily Living or nursing services in order to remain in their private residential units within the Managed Residential Community.

Assisted Living Services Agency
An entity that provides Assisted Living Services.

Calendar Month
A period beginning on the first day through and including the last day of any of the 12 months of a year. For example: January 1st through January 31st.

Care Coordination
The following services provided by an Access Agency:
(1) a comprehensive face-to-face assessment of Your functional and cognitive capacity;
(2) development, completion, approval and implementation of a Plan of Care;

(3) coordination, and monitoring of the delivery, of services included in the Plan of Care on an as needed basis;
(4) completion of a comprehensive reassessment of a Plan of Care, as needed; and
(5) a transition plan when the services of the Plan of Care are no longer necessary.

Care Coordinator
A person who is a Licensed Health Care Practitioner employed by an Access Agency provided to You by Us. There is no charge to You for his or her services. The Care Coordinator may gather objective information specific to Your circumstances; use the information gathered to help develop the Plan of Care; and identify providers that can deliver the needed care and services. He or she may assist You in identifying Your long term care needs and matching those needs with available service providers and resources.

Care Coordinators are normally familiar with care providers in Your area. There usually is a wide range of providers available. They vary greatly from skilled professionals to unskilled caregivers, based on the type of care needed. The Care Coordinator may help find providers to work with You and Your family. You are responsible for choosing the actual providers to be used. You may ask for another provider to be identified if for any reason You are not satisfied with a Care Coordinator or a care provider.

A Care Coordinator does not include anyone who: (1) has an ownership interest in; (2) is on contract with; or (3) is an employee of any provider of the services received. A Care Coordinator cannot be a member of Your Immediate Family.

Caregiver Training
Appropriate training and instruction provided by a person approved by the Care Coordinator to provide the knowledge and skills necessary for:
(1) the proper use and care of a Therapeutic Device and/or disposable medical aids, including but not limited to catheters; ostomy bags; or suctioning tubes; or
(2) the performance of appropriate caregiving procedures, such as changing of wound dressings; repositioning a patient in bed; or giving injections.

Civil Union Partner
An adult who is not related to You by blood or marriage under the laws of the state in which he or she resides; and with whom You have entered into a formal civil union according to the legal requirements of the state in which You both reside.

Connecticut Partnership for Long-Term Care
The program authorized under Section 17b-252 of the Connecticut General Statutes.

Domestic Partner
An adult who is not related to You by blood or marriage under the laws of the state in which this Policy was delivered; who has resided with You continuously for at least 2 years prior to the Policy's Effective Date; and both of You hold Yourselves out to the public as life partners. Domestic Partner is used to describe this relationship, regardless of the term used by Your state or jurisdiction.

Domestic Partner does not include any person who is married to anyone else (whether by civil or religious ceremony or common-law marriage), nor any roommate or friend of Yours.

Elimination Period
The number of days that You must be confined as an overnight bed patient or receiving care or services before We will pay benefits for those services that are subject to the Elimination Period. The care or services must be for which benefits would be payable under this Policy if there were no Elimination Period. No such benefits will be paid until You have: (1) satisfied the Eligibility for the Payment of Benefits; and

(2) incurred Out of Pocket Expenses for the number of days shown on the Schedule. You will be responsible for the expenses for those days. Days used to satisfy the Elimination Period do not have to be consecutive and can accumulate over time after You have met the Eligibility for the Payment of Benefits. Once satisfied, You will not have to satisfy the Elimination Period again.

The Elimination Period is shown on the Schedule.

Only confinement, care and services received that are subject to the Elimination Period can be used to satisfy the Elimination Period.

We will give You credit toward the Elimination Period for days of confinement, care or services covered under this Policy, even though they are paid or payable by Medicare or other health insurance. Credit toward the Elimination Period is given only for those services that are subject to the Elimination Period under this Policy.

Days of confinement in a hospital or rehabilitation hospital/facility cannot be used to satisfy the Elimination Period, even if they are paid or payable by Medicare or other health insurance.

Home
Any place where You reside other than: a Long Term Care Facility; a rehabilitation hospital/facility; a hospital; or other acute care facility.

Home Care Agency
An entity that provides care and services in Your Home and meets all of the following criteria:
(1) it is, where required, licensed, certified or accredited as a Home Health Care Agency, Home Care Agency, Homemaker-Home Health Aide Agency (in the state of Connecticut) or Nurse Registry (in states where Nurse Registries exist);
(2) it provides Home Health Care Services or Home Care Services;
(3) it is, where required by its licensure, certification or accreditation, supervised by a Registered Nurse or a licensed social worker;
(4) it keeps written Plan of Care records on all patients. This includes Physician's orders where appropriate; and
(5) if providing Home Health Care Services, it also keeps daily written clinical records on all patients.

Placement agencies, employment agencies and similar entities do not qualify as Home Care Agencies.

Home Care Services
Services that are provided by skilled or unskilled persons who work under the supervision of a Home Care Agency or Homemaker-Home Health Aide Agency (in the state of Connecticut). These services are provided in Your Home. Home Care Services include the following:
(1) Personal Care Attendant Services;
(2) reporting changes in Your condition and needs, and completing appropriate records; and
(3) Homemaker Services.

Home Health Care Services
A program of part-time or intermittent professional, para-professional or skilled care provided through a Home Care Agency to You in Your Home. Home Health Care Services include nursing services provided by a: Nurse; physical therapist; respiratory therapist; speech therapist; occupational therapist; infusion therapist; or nutritional specialist.

Homemaker-Home Health Aide
An unlicensed person who has successfully completed a training and competency evaluation program for the preparation of homemaker-home health aides approved by the Connecticut Department of Public Health.

Homemaker-Home Health Aide Agency
A Connecticut agency that is responsible for the Homemaker-Home Health Aide services furnished to patients and for the implementation of the Plan of Care.

Homemaker Services
Support services that are secondary to assistance with the Activities of Daily Living or because of a Severe Cognitive Impairment. These services must be included in Your Plan of Care. They include one or more of the following, required so that You can remain at Home: meal preparation; laundry; and light housekeeping. Light housekeeping means: vacuuming; dusting; dry mopping; dishwashing; cleaning the kitchen and bathroom; and changing beds.

Home Modification
Modifications to Your Home that are being made to improve Your ability to perform the Activities of Daily Living and allow You to live safely and independently in Your Home. Examples of Home Modification include: installing a lift system; installing a ramp for wheelchair access; widening doorways; installing grab bars in Your bathroom; and similar changes to improve accessibility.

Home Modification does not include things such as: home maintenance or repair; cosmetic changes; elevators; exercise rooms; remodeling; installation of a hot tub or swimming pool; or any similar modification. We will not pay for the purchase of any tools. We will not pay for the removal or reversal of any Home Modification that was previously covered under this Policy.

Hospice Care
A coordinated, interdisciplinary program for meeting the special needs of Terminally Ill individuals. This includes the physical, emotional, social and spiritual needs of such individuals. Hospice Care provides palliative and supportive services during the terminal illness to individuals who have no reasonable prospect of cure.

Hospice Care Facility
A facility that is licensed or certified by the state in which it is located to provide Hospice Care.

Hospice Care Provider
A Long Term Care Facility, Home Care Agency, Hospice Care Facility or other provider that is licensed to provide Hospice Care. It does not include a hospital.

Immediate Family
Your Spouse/Partner and anyone who is related to You or Your Spouse/Partner (including adopted, in-law and step-relatives). This includes a parent, grandparent, child, grandchild, brother, sister, aunt, uncle, first cousin, nephew or niece.

Lapse
The termination of Your Policy as of the last Premium Due Date if Your premium is not paid before the end of the Grace Period.

Licensed Health Care Practitioner
A Physician, registered professional nurse (RN), licensed social worker, or other individual who meets such requirements as may be prescribed by the U.S. Secretary of the Treasury. A Licensed Health Care Practitioner may not be a member of Your Immediate Family.

Long Term Care Facility
A health care facility that is licensed, certified, or registered by the appropriate authority in the state in which it is located to provide inpatient care for persons who are in need of assistance with Activities of

Daily Living or are Severely Cognitively Impaired. The facility must charge a fee for the inpatient care at the time the care is provided.

A Long Term Care Facility must:
(1) provide personal care by on-site facility staff. It must also make available 3 meals a day and can accommodate special diets;
(2) have procedures in place establishing appropriate protocol for medication management and the handling and administration of drugs and biologicals;
(3) provide an emergency call system and on-site facility staff able to respond to emergencies. The staff's duties must include supervision of safety, security and awareness of the whereabouts of the residents at all times;
(4) have a Physician or Registered Nurse on site or on contract to provide nursing services specified in case of an emergency; and
(5) have on-site facility staff that provide Qualified Long Term Care Services to residents on a 24-hour-a-day basis.

Regardless of name, any properly licensed, certified, or registered facility providing the services shown above will qualify as a Long Term Care Facility. This includes, for example: nursing homes; skilled nursing facilities; nursing care facilities; assisted living facilities; adult foster care facilities; congregate care facilities; basic care facilities; residential care facilities; family and group assisted living facilities; boarding care homes; domiciliary care homes; personal care homes; and hospice care facilities. In the state of Connecticut, a Managed Residential Community providing Assisted Living Services to You through a licensed Assisted Living Services Agency will qualify as a Long Term Care Facility.

In those states where licensure, certification or registration is not required for a particular facility, such as an assisted living facility, a facility must meet all of the requirements in items # 1-5 listed above. In addition, it must meet all of the following requirements in order to qualify as a Long Term Care Facility:
(6) the following information must be provided in writing to each resident:
  a) a tenant services contract or agreement in place for each resident; and
  b) admission and transfer/discharge requirements; and
(7) provides a minimum of 10 beds.

Long Term Care Facility does not mean a facility or part of a facility that is operated mainly for the treatment and care of: mental, nervous, psychotic or psychoneurotic deficiencies or disorders; tuberculosis; drug addiction; or rehabilitation or occupational therapy. A Long Term Care Facility is not a rehabilitation hospital/facility.

A Long Term Care Facility is not a hospital. It may be a separate and distinct wing or section of such an institution, if such wing or section, including Your assigned bed, is appropriately licensed, certified, or registered to provide the level of care defined above. Also, a Long Term Care Facility is not: an independent living apartment or unit; hotel; motel; retirement home; or any dwelling similar to these.

Maintenance or Personal Care Services
Any care the primary purpose of which is to provide needed assistance with any of the disabilities that cause You to be a Chronically Ill Individual (including the protection from threats to health or safety due to Severe Cognitive Impairment).

Managed Residential Community
A facility consisting of private residential units that provides a managed group living environment, including housing and services primarily for persons age fifty-five (55) or older.

Medicaid Asset Protection
The right extended by Sections 17b-252 and 17b-253 of the Connecticut General Statutes to a person who

purchases a Partnership-approved long term care insurance policy to retain an amount of assets equal to the sum of qualifying insurance payments made on their behalf in determining eligibility for the Connecticut Medicaid program.

Medical Alert System
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. We will not pay for any charges for: normal telephone service; a home security system; or any other similar service or device.

Medicare
The "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Nurse
A person who is duly licensed as either:
(1) a Registered Nurse (RN);
(2) a Licensed Practical Nurse (LPN); or
(3) a Licensed Vocational Nurse (LVN).

The term Nurse does NOT include:
(1) You; or
(2) a member of Your Immediate Family.

Our Administrative Office
The Long Term Care Division located at the address shown on the front of Your Policy.

Out of Pocket Expenses
This Policy will pay You for the actual charges You incur and are legally obligated to pay for covered services after You receive those covered services. Benefits are payable up to the policy maximums shown on the Schedule. Advance Bills are not eligible for payment. Only covered services that have been provided and received are eligible for payment.

As a condition to receiving benefits, You must submit the care provider's bill or invoice showing all of the following:
(1) Your name;
(2) the name, address and tax identification number of the provider who rendered the covered service(s);
(3) the date(s) of each covered service including the month, day and year;
(4) each type of covered service rendered each day; and
(5) the actual charge for which You are legally obligated to pay for each covered service.

The covered service(s) must have been included in Your current written Plan of Care and must be provided within the frequency specified in the Plan of Care.

As part of Our review of Your claim, We reserve the right to require that You provide Us with documentation demonstrating to Our satisfaction that You have paid and fully satisfied the Out of Pocket Expenses for each covered service, except where You have assigned benefits directly to a provider. Such documentation may include cancelled checks or bank statements and, if requested, must be provided before any benefits will be paid to You. If You have assigned benefits directly to a provider, We will not require documentation from You that You paid the benefits. However, We reserve the right to request documentation or perform audits to assure Us that there is no duplication of payments, refunds, discounts, or rebates from the provider to You or any other entity.

Partner
A Domestic Partner or a Civil Union Partner.

Personal Care Attendant Services
Care or assistance that is necessary to protect Your health and safety while allowing You to remain at Home. This includes services such as assistance with Activities of Daily Living, medication management, mobility, and personal hygiene. Personal Care Attendant Services are not services that are primarily for personal convenience or companionship, nor do they include transportation services.

Physician
A person who is legally qualified and licensed by a jurisdiction within the 50 United States and District of Columbia, or Canada as a Medical Doctor (M.D.) or a Doctor of Osteopathy (D.O.) and who is operating within the scope of that license.

The term Physician does not include:
(1) You;
(2) a member of Your Immediate Family; or
(3) anyone who has a financial interest in, or is an employee of, a facility, agency, or center administering the Plan of Care.

Plan of Care
A written, face-to-face, systematic, standardized and comprehensive assessment of Your physical and cognitive abilities by a Licensed Health Care Practitioner. The Plan of Care must specify the type, frequency and providers of all the services that You require. The services also must be consistent with the assessment done to develop the Plan of Care. The Plan of Care may include services not covered by Your Policy. No more than one Plan of Care may be in effect at a time.

The Plan of Care must include the date, if any, by which You are expected to recover from Your illness or injury. The Plan of Care must be prescribed, approved and signed by a Licensed Health Care Practitioner. Unless otherwise stated in this Policy, it must be updated or confirmed in writing at least once every 12 months or more frequently at the discretion of the Company. We will not require an update or written confirmation more frequently than once each 90 days. We reserve the right to discuss the Plan of Care with the Licensed Health Care Practitioner to verify that the Plan of Care is appropriate and consistent with generally accepted standards of care for a Chronically Ill Individual.

If possible, a copy of the Plan of Care should be sent to Us before the care and services are received. Otherwise, it must be provided to Us at the time the first claim under the Plan of Care is submitted. Unless otherwise stated in this Policy, the Plan of Care must be submitted no later than 90 days after the care and services begin. It must document by assessment that You met the requirements in the Eligibility for the Payment of Benefits provision during that 90-day period.

A Plan of Care must be approved by a Licensed Health Care Practitioner who: (1) does not have a financial interest in; (2) is not on contract with; and (3) is not an employee of the facility, agency, center or provider administering all or any part of such Plan of Care.

For Home and Community Care benefits and the Alternate Plan of Care Benefit, the Plan of Care must be developed and approved by a Licensed Health Care Practitioner employed by an Access Agency.

Policy
This contract between You and Us.

Policy Maximum Amount
The total dollar amount payable for all benefits of this Policy, except for the Care Coordination Benefit. The Policy Maximum Amount is shown on the Schedule. When the Policy Maximum Amount has been exhausted, no further benefits will be payable.

Premium Due Date
After the first premium, each date a premium is due, subject to the terms of this Policy.

Premium Paying Mode
As shown on the Schedule, how often premiums are to be paid.

Proof of Loss
Information or documents satisfactory to Us that We require to determine whether benefits are payable under Your Policy. We are able to pay benefits only after We have received all necessary Proofs of Loss. You must either provide Us with this information or authorize its release to Us.

Qualified Long Term Care Services
Necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and Maintenance or Personal Care Services, which:
(1) are required by a Chronically Ill Individual; and
(2) are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Only Qualified Long Term Care Services are covered under this Policy.

Please Note: To be eligible for payment under this Policy, it is not enough for services simply to be Qualified Long Term Care Services. These services must also:
(1) be services that are otherwise eligible to be paid under this Policy; and
(2) satisfy all other requirements of this Policy.

Qualified Long Term Care Services do not include charges for items or services unrelated to assistance with the Activities of Daily Living or Severe Cognitive Impairment. The following are examples of items or services that are not covered. These include, but are not limited to: dry cleaning; personal care items such as toothbrushes, toothpaste, mouthwash, deodorant, hair brushes, denture cleaning materials, tissues, razors, etc.; beauty and barber shop services; tobacco and smoking supplies; newspapers and periodicals; stationery, postage and writing implements; radio, telephone, television, cable, satellite and internet services; dental services and dentures; glasses; and hearing aids.

Respite Care
Respite or relief for Your Volunteer Caregiver. Respite Care is provided so that the Volunteer Caregiver who normally provides Your care may take short-term leave or take a rest to provide him or her with temporary relief from the responsibilities of caregiving. Respite Care covers short-term care provided: in a Long Term Care Facility; in a community-based program such as Adult Day Care; or care received in Your Home.

Spouse
A legal spouse.

Terminally Ill
A person who has been certified in writing by his or her Physician as having a life expectancy of 6 months or less.

Therapeutic Device or Technology
Equipment or technology that is designed to assist You in performing the Activities of Daily Living or help with Your Severe Cognitive Impairment. It must be appropriate for Your condition and used in Your Home. Examples of a Therapeutic Device or Technology include:
(1) hospital-style beds;
(2) crutches;
(3) wheelchairs;

(4) infusion pumps;
(5) walkers;
(6) smart home monitoring or “wander mats”; or
(7) tracking systems like “smart shoes” with GPS (global positioning system).

Therapeutic Device does not mean any drug or medical equipment implanted in Your body, temporarily or permanently. It also does not include: CPAP machines; backup generators; oxygen; hearing aids; artificial limbs; teeth; medical supplies; motorized scooters; sporting, protective, athletic or exercise equipment.

Volunteer Caregiver
The unpaid person who has the primary responsibility of caring for You in Your Home. A person who is paid to care for You is not a Volunteer Caregiver.

We, Us, Our, the Company
Transamerica Life Insurance Company.

You, Your, Yours, Yourself
The Insured named on the Schedule.

TRANSAMERICA®
LIFE INSURANCE COMPANY

HOME OFFICE: CEDAR RAPIDS, IOWA
Long Term Care Administrative Office
P.O. Box 869090
Plano, TX 75086-9090
1-(800) 227-3740

ENDORSEMENT

ATTACHED TO AND MADE A PART OF POLICY NO. 211063428

ANYTHING IN SAID POLICY TO THE CONTRARY NOTWITHSTANDING, THIS ENDORSEMENT SHALL EXPIRE CONCURRENTLY WITH SAID POLICY UNLESS OTHERWISE TERMINATED.

THIS ENDORSEMENT IS EFFECTIVE AS OF THE EFFECTIVE DATE SHOWN ON THE SCHEDULE OF YOUR POLICY.

THE ABOVE REFERENCED POLICY IS HEREBY AMENDED AND MODIFIED AS FOLLOWS:

The definition of **Physician** in your policy is hereby deleted and replaced by the following:

Physician means a doctor of medicine or osteopathy as set forth in Section 1861(r)(1) of the Social Security Act, as amended, who is legally authorized to practice medicine and surgery within the United States by the jurisdiction in which he or she performs such function or action.

The term Physician does not include:
1. You;
2. a member of Your Immediate Family; or
3. anyone who has a financial interest in, or is an employee of, a facility, agency, or center administering the Plan of Care.

IN WITNESS THEREOF, TRANSAMERICA LIFE INSURANCE COMPANY HAS ISSUED THIS AMENDMENT TO THE POLICY.

Jay Orlandi
Secretary

Blake Bostwick
President

TRANSAMERICA®
LIFE INSURANCE COMPANY

HOME OFFICE: CEDAR RAPIDS, IOWA
Long Term Care Administrative Office
P.O. Box 869090
Plano, TX 75086-9090
1-(800) 227-3740

CONTINGENT NONFORFEITURE BENEFIT ENDORSEMENT

This Endorsement is made a part of the Policy to which it is attached. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy. The Effective Date of this Endorsement will be the Effective Date of Your Policy. If this Endorsement is added after Your Policy was issued, the Effective Date is shown below.

If We increase Your premium rates to a level which results in a cumulative increase of the annual premium equal to or greater than the percentage of Your initial annual premium in the chart below and You are unable to afford the increased premium, then You may choose one of the two Options below.

We will give You at least 60 days written notice prior to the due date of the premium rate increase.

Options

We will notify You that You may elect to:

(1) reduce Your current Policy benefits so that the required premium payments are not increased. You may not reduce Your benefits to less than an amount that is currently available; or

(2) change Your coverage as shown below under the Shortened Benefit Period. You have 120 days after the due date for the rate increase to choose this option. If Your Policy Lapses during this 120-day period, the Shortened Benefit Period will automatically take effect.

No underwriting is required.

Your initial annual premium is based on Your age when the Policy was issued. Please note that if the cumulative increase is less than the percentage set forth below, the Shortened Benefit Period option is not available to You.

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

Shortened Benefit Period
Your coverage will continue on a limited basis if it would have otherwise Lapsed because You stopped paying premiums.

The daily benefit amounts available will be the same amounts in effect at the time Your Policy would have Lapsed. The maximum benefit amount in force will be equal to all of the premiums paid for all of Your coverage combined. This amount will exclude any waived premiums.

The minimum Policy Maximum Amount will be equal to 30 times the Long Term Care Facility Maximum Daily Benefit at the time the coverage would have Lapsed. Combined benefits under Your Policy and this Endorsement will not be more than the maximum amount payable for each benefit. Nor will they be more than the total benefits that would have been payable under Your Policy if You had continued to pay the premiums.

All of the requirements of the Policy that applied in order for You to be eligible for the payment of benefits at the time Your coverage would have Lapsed will continue to apply. To the extent that any of the requirements were satisfied under Your Policy at the time it would have Lapsed, they will also be satisfied under this Endorsement.

All optional coverage, including any riders, will end when Your coverage is continued under this Endorsement. In addition, no inflation adjustment will be made while the Policy is in effect under this benefit.

At the time Your coverage would have Lapsed, if You have a benefit in force that allows coverage to become paid-up or premium to be waived for life at some future date, this Endorsement will only apply if: (1) Your coverage would have Lapsed before the date when coverage would otherwise have become paid-up; or (2) Your coverage would have Lapsed before the date when the waiver of premium for life under a survivorship rider, if applicable, would have applied. This Endorsement will end on the date coverage becomes paid-up or premium is waived for life under any such provision.

At the time Your coverage would have Lapsed, if You had a return of premium benefit that was in force: (1) the return of premium benefit will end; and (2) no return of premium benefit will be paid under this Endorsement.

Once the maximum benefit amount in force under this Endorsement has been paid, no further benefits will be payable and all coverage will end.

Endorsement Effective Date: _____

Jay Orlandi
Secretary

Blake Bostwick
President

TRANSAMERICA®
LIFE INSURANCE COMPANY

HOME OFFICE: CEDAR RAPIDS, IOWA
Long Term Care Administrative Office
P.O. Box 869090
Plano, TX 75086-9090
1-(800) 227-3740

RETURN OF PREMIUM TO AGE 67 ENDORSEMENT

This Endorsement is made a part of the Policy to which it is attached. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of the Policy. The Effective Date of this Endorsement will be the Effective Date of Your Policy as shown on the Schedule.

NOTE: If You are younger than age 67 at the time of Your death, this Benefit is available to You.

BENEFIT
Subject to any provision to the contrary, if this Endorsement has been continuously in force, a benefit will be paid if You die when You are younger than age 67. No benefit will be paid if You are age 67 or older.

The amount of this benefit will be the sum of all premiums paid less the amount of any benefits paid pursuant to the terms of the Policy, from the Effective Date of the Policy up to the date of Your death. The sum of all premiums paid will exclude any waived premiums and will be accumulated without interest.

Payment of the benefit will be made in one lump sum to Your beneficiary. Your beneficiary will be the person listed in Your application unless later changed by You.

You may change Your beneficiary at any time by sending written notice to Us. The effective date of the beneficiary change will be the date the change is received and recorded by Us. If You die before We receive the request, the change will not be effective.

If there is no named or living beneficiary on the date of Your death, this benefit will be paid to Your estate.

Jay Orlandi
Secretary

Blake Bostwick
President

TRANSAMERICA®
LIFE INSURANCE COMPANY

HOME OFFICE: CEDAR RAPIDS, IOWA
Long Term Care Administrative Office
P.O. Box 869090
Plano, TX 75086-9090
1-(800) 227-3740

SHARED CARE BENEFIT RIDER

This Rider allows Your Spouse/Partner to access the available benefits under Your Policy once the Policy Maximum Amount under his/her own policy has been exhausted.

This Rider is made a part of Your Policy. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy which do not conflict with this Rider. In case of conflict between the Policy and this Rider, the provisions of this Rider will control.

The additional premium amount for this Rider is shown on the Schedule. The effective date of this Rider also is shown on the Schedule. If this Rider has been added after Your Policy was issued, the effective date of this Rider is shown below. The premium for this Rider is then shown in the endorsement attached to this Rider.

Eligibility
You have named Your Spouse/Partner as the Shared Care covered person under Your Policy. This will allow Your Spouse/Partner to access benefits under Your Policy if and only if:

- You and Your Spouse/Partner both purchase and maintain identical Long Term Care Insurance Policies issued by Transamerica Life Insurance Company; and
- You and Your Spouse/Partner both have identical Shared Care Benefit Riders attached to Your Policies; and
- the Policy Maximum Amount of Your Spouse/Partner's own Transamerica Life Insurance Company policy has been exhausted; and
- Your Policy has at least some of its Policy Maximum Amount still available; and
- We receive a signed consent form from You allowing Your Spouse/Partner to receive benefits under Your Policy Maximum Amount.

Impact on Medicaid Asset Protection When a Policy Covers Both You and Your Spouse/Partner
The amount of assets You can protect under a Partnership-approved Policy is equal to the amount of benefits paid for Your care. Please note that Medicaid Asset Protection is only available to the individual actually receiving the benefits. This means that if You receive benefits under this Policy, the specific dollar amount of assets You can protect is dependent upon (limited to) the amount of coverage You, as an individual, use for Your Qualified Long Term Care Services.

If Your Spouse/Partner is accessing benefits under this Policy, You will NOT receive Medicaid Asset Protection for that care. Medicaid Asset Protection is NOT transferable between Spouses/Partners. In addition, continued access by one Spouse/Partner to this Policy's benefits could lead to the exhaustion of the Policy Maximum Amount. In such an event, this Policy will terminate.

Definition
Spouse/Partner means the Spouse/Partner who is named in the application for this Rider.

Benefit
If Your Spouse/Partner exhausts the Policy Maximum Amount under his/her own Transamerica Life Insurance Company policy, We will continue Your Spouse/Partner's coverage under Your Policy. Your Spouse/Partner's coverage is subject to all of the terms and the Policy Maximum Amount of Your Policy as long as You keep Your Policy and this Rider in force. You may keep this Rider in force by the timely payment of the Rider premium.

In order for Your Spouse/Partner to access benefits under Your Policy:

- Your Spouse/Partner must have already exhausted the Policy Maximum Amount under his/her own policy; and
- Your Policy must have at least some of its Policy Maximum Amount still available; and
- Your Spouse/Partner must have already satisfied the Elimination Period under his/her own policy, if the benefits used under his/her policy were subject to the Elimination Period; or
- Your Spouse/Partner must satisfy the Elimination Period under Your Policy, if the benefits he/she receives are subject to the Elimination Period.

You and Your Spouse/Partner both may receive benefits under Your Policy at the same time. We will not pay benefits that exceed the Policy Maximum Amount of both policies combined.

All of the benefits of Your Policy are available for Your Spouse/Partner to access through this Rider, except as noted below.

Waiver of Premium

The Waiver of Premium Benefit contained in Your Policy or in any Rider attached to it will apply only if You are receiving benefits under Your Policy. We will not waive Your Policy's premiums because Your Spouse/Partner is receiving benefits under Your Policy.

Restoration of Benefits

The Full Restoration of Benefits Rider, if it is attached to Your Policy, only applies to benefits that You have used under Your Policy. No benefits used by Your Spouse/Partner will be restored under Your Policy.

Death of Your Spouse/Partner

If Your Spouse/Partner dies while this Rider is in effect, We will increase Your Policy Maximum Amount by the amount of the remaining Policy Maximum Amount under Your deceased Spouse/Partner's Policy, if any. We must receive written proof of the death of Your Spouse/Partner. We will provide You with written notice of the new Policy Maximum Amount and Your new premium. No further premiums for this Rider will be required.

Termination

Termination of this Rider will not affect the Policy to which it is attached. Any benefits paid under this Rider will be subtracted from the Policy Maximum Amount.

This Rider ends on the earliest of:

(1) the date the Policy ends;
(2) the date the Policy is continued under any nonforfeiture or contingent nonforfeiture benefit;
(3) the date the Shared Care Benefit Rider on Your Spouse/Partner's policy ends for any reason other than because benefits under that policy were exhausted;
(4) the date the Policy Maximum Amount is exhausted under both Your Policy and Your Spouse/Partner's policy;
(5) the date You or Your Spouse/Partner elects to change either of Your policies so that the policies are no longer identical; or
(6) the date We receive written request from You to cancel this Rider or Your Policy.

Rider Effective Date: _____

Jay Orlandi
Secretary

Blake Bostwick
President

TRANSAMERICA®
LIFE INSURANCE COMPANY

HOME OFFICE: CEDAR RAPIDS, IOWA
Long Term Care Administrative Office
P.O. Box 869090
Plano, TX 75086-9090
1-(800) 227-3740

MONTHLY BENEFIT RIDER

This Rider is made a part of Your Policy. It is subject to all provisions, definitions, conditions, maximums, exceptions and limitations of Your Policy which do not conflict with this Rider. In case of conflict between the Policy and this Rider, the provisions of this Rider will control.

The additional premium amount for this Rider is shown on the Schedule. The effective date of this Rider is the Policy's Effective Date shown on the Schedule.

Benefits payable under this Rider are based on Your Out of Pocket Expenses. We will not pay benefits based on Advance Bills. In order for benefits to be payable, all of the requirements of the Policy must be met.

LONG TERM CARE FACILITY MAXIMUM MONTHLY BENEFIT

Instead of paying the Long Term Care Facility Benefit on a daily basis, We will pay You for the Out of Pocket Expenses for Long Term Care Facility confinement based on services received during each Calendar Month. This means that the daily limit for the benefits listed no longer applies. Instead, benefits are paid based on the total services received during the month.

The Maximum Monthly Benefit for Long Term Care Facilities can also be used for: Bed Reservation; Respite Care; or Hospice Care. You must be confined in a Long Term Care Facility (or in a Hospice Care Facility, in the case of Hospice Care).

The maximum benefit payable during each Calendar Month will be calculated by multiplying the Long Term Care Facility Maximum Daily Benefit by the number of actual days in the month. In no case will the Maximum Monthly Benefit exceed Your Out of Pocket Expenses for the Calendar Month.

Prorate: If You meet the Eligibility for the Payment of Benefits requirements and We receive a Plan of Care for only part of a Calendar Month, We will prorate the Maximum Monthly Benefit. Prorate means We will divide the Maximum Monthly Benefit by the actual number of days in the month, then multiply by the number of days in that month that You meet the Eligibility for the Payment of Benefits requirements and for which We receive a Plan of Care.

HOME CARE AND ADULT DAY CARE MAXIMUM MONTHLY BENEFIT

Instead of paying the Home Care and Adult Day Care Benefit on a daily basis, We will pay You for the Out of Pocket Expenses for Home Care Services, Home Health Care Services and Adult Day Care based on services received during each Calendar Month. This means that the daily limit for these benefits no longer applies. Instead, benefits are paid based on the total services received during the month. This may allow You to receive multiple services on the same day that would otherwise exceed your Home Care and Adult Day Care Maximum Daily Benefit.

The Maximum Monthly Benefit for Home Care and Adult Day Care can also be used for Respite Care or Hospice Care received in Your Home.

The maximum benefit payable during each Calendar Month will be calculated by multiplying the Home Care and Adult Day Care Maximum Daily Benefit shown on the Schedule by the number of actual days in

the month. If You meet the Eligibility for the Payment of Benefits requirements and We receive a Plan of Care for only part of a Calendar Month, We will prorate the Maximum Monthly Benefit. See the Prorate paragraph above for details. In no case will the Maximum Monthly Benefit exceed Your Out of Pocket Expenses for the Calendar Month.

This Rider ends on the date that the Policy ends.

Jay Orlandi
Secretary

Blake Bostwick
President

TRANSAMERICA®
LIFE INSURANCE COMPANY

HOME OFFICE: CEDAR RAPIDS, IOWA
Long Term Care Administrative Office
P.O. Box 869090
Plano, TX 75086-9090
1-(800) 227-3740

FULL RESTORATION OF BENEFITS RIDER

This Rider is made a part of Your Policy. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy which do not conflict with this Rider. In case of conflict between the Policy and this Rider, the provisions of this Rider will control.

The additional premium amount for this Rider is shown on the Schedule. The effective date of this Rider is the Effective Date shown on the Schedule.

When We have paid claims under the Policy, those Policy benefits can be restored under this Rider. This Rider is subject to the Requirements below. The Eligibility for the Payment of Benefits provision does not apply to this Rider. If You have completely exhausted Your benefits under the Policy, this Rider will not apply.

We will restore the Policy Maximum Amount to the amount that it would have been if no benefits had been paid under the Policy. We will restore the Remain At Home Maximum Benefit in the same way. This includes any inflation adjustments made while the Policy is in effect. The restored amount can be used only for confinement or care that is subject to the Policy Maximum Amount.

The Policy Maximum Amount will be restored only one time during the life of the Policy. We will restore the Remain At Home Maximum Benefit one time during the life of the Policy as well.

Requirements For Full Restoration of Benefits

- You must not meet the definition of a Chronically Ill Individual for 180 consecutive days.
- You may not receive any Qualified Long Term Care Services during that time.
- You must notify Us that a Licensed Health Care Practitioner has certified that You are no longer a Chronically Ill Individual.
- You must file that certification with Us.

The 180 consecutive day period begins when Your condition is verified by Us through an Assessment of Your Condition.

We will not accept a back-dated certification. The Policy and this Rider must remain in force during this period.

This Rider ends on the earliest of:
(1) the date benefits are restored under this Rider;
(2) the date the Policy ends; or
(3) when the Policy is continued under any nonforfeiture or contingent nonforfeiture benefit.

Jay Orlandi
Secretary

Blake Bostwick
President

TRANSAMERICA®
LIFE INSURANCE COMPANY

HOME OFFICE: CEDAR RAPIDS, IOWA
Long Term Care Administrative Office
P.O. Box 869090
Plano, TX 75086-9090
1-(800) 227-3740

JOINT WAIVER OF PREMIUM RIDER

This Rider is made a part of Your Policy. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy which do not conflict with this Rider. In case of conflict between the Policy and this Rider, the provisions of this Rider will control.

The additional premium amount for this Rider is shown on the Schedule. The effective date of this Rider also is shown on the Schedule. If this Rider has been added after Your Policy was issued, the effective date of this Rider is shown below. The premium for this Rider is then shown in the endorsement attached to this Rider.

BENEFIT
We will waive all premiums for Your Policy for the same months that We are waiving the premiums for Your Spouse/Partner's policy under the Waiver of Premium Benefit. We will stop waiving the premiums for Your Policy under this Rider when We are no longer waiving the premiums for Your Spouse/Partner's policy.

Eligibility for Joint Waiver of Premium: This benefit is only available if:
(1) both You and Your Spouse/Partner have identical individual long term care policies in force with Us under the same policy form series which includes this Joint Waiver of Premium Rider; and
(2) Your Spouse/Partner qualifies for and receives the Waiver of Premium Benefit under the same policy form series.

To keep Your Policy in force when Your Joint Waiver of Premium Rider ends or when We are no longer waiving the premium, premiums must be paid as they become due. Any unearned premiums paid which apply to the period that premiums are being waived will be refunded to You following the Policy monthly anniversary on which the Waiver of Premium began.

This Joint Waiver of Premium Rider ends when:
(1) the Policy Maximum Amount has been exhausted under either Your Policy or Your Spouse/Partner's policy;
(2) Your Policy or Your Spouse/Partner's Policy is continued under any nonforfeiture or contingent nonforfeiture benefit; or
(3) Your Policy or Your Spouse/Partner's Policy ends.

Rider Effective Date: _____

Jay Orlandi
Secretary

Blake Bostwick
President

TRANSAMERICA®
LIFE INSURANCE COMPANY

HOME OFFICE: CEDAR RAPIDS, IOWA
Long Term Care Administrative Office
P.O. Box 869090
Plano, TX 75086-9090
1-(800) 227-3740

NONFORFEITURE BENEFIT – SHORTENED BENEFIT PERIOD RIDER

This Rider is made a part of Your Policy. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy which do not conflict with this Rider. In case of conflict between the Policy and this Rider, the provisions of this Rider will control.

The additional premium amount for this Rider is shown on the Schedule. The effective date of this Rider is the Policy's Effective Date shown on the Schedule.

BENEFIT

This Rider provides for Your coverage to continue on a limited basis if it would have otherwise Lapsed because You stopped paying premiums. Your Policy must have been in effect for at least 3 full years before this Rider will pay benefits.

The daily benefit amounts available will be the same amounts in effect at the time the coverage would have Lapsed. The total benefit amount in force under this Rider will be equal to all of the premium paid for all coverage combined, including this Rider. It does not include any waived premiums.

The minimum Policy Maximum Amount under this Rider will be equal to 30 times the Long Term Care Facility Maximum Daily Benefit at the time the coverage would have Lapsed. Combined benefits under Your Policy and this Rider will not be more than the maximum amount payable for each benefit. Nor will they be more than the total benefits that would have been payable under Your Policy if You had continued to pay the premiums. All of the eligibility requirements and any elimination period that applied in order for You to be eligible for the payment of benefits at the time Your coverage would have Lapsed will continue to apply. To the extent that any of the eligibility requirements or the elimination period was satisfied under Your Policy at the time it would have Lapsed, it will also be satisfied under this Rider.

All optional coverage, including any other riders, will end when Your coverage is continued under this Rider. In addition, no inflation adjustment will be made while the Policy is in effect under this benefit.

At the time Your coverage would have Lapsed, if You have a benefit in force that allows coverage to become paid-up or premium to be waived for life at some future date, this Rider will only apply if: (1) Your coverage would have Lapsed before the date when coverage would otherwise have become paid-up; or (2) Your coverage would have Lapsed before the date when the waiver of premium for life under a survivorship rider, if applicable, would have applied. This Rider will end on the date coverage becomes paid-up or premium is waived for life under any such provision.

At the time Your coverage would have Lapsed, if You had a return of premium benefit that was in force: (1) the return of premium benefit will end; and (2) no return of premium benefit will be paid.

Jay Orlandi
Secretary

Blake Bostwick
President

AUTHORIZATION FOR THE RELEASE OF INFORMATION TO FAMILY MEMBERS & OTHER INDIVIDUALS

A copy of this authorization will be considered as valid as the original

I hereby authorize the use or disclosure of information about me as described below:

1) Transamerica Life Insurance Company has my permission to disclose my personal information to the following people who are involved in my care or the handling of my affairs:

Name of Person:	Description of Relationship:
1)	
2)	
3)	

(List the full name of up to three relatives, friends or other individuals involved in your care to whom you want personal information disclosed.)

2) **Description of the information that may be used or disclosed:**
This authorization includes the release of any information regarding the coverage under my long term care insurance policy, any personal information related to my care or benefits, and any other information contained in the Company's records about me or my coverage.

3) **The information will be used for the following purpose:**
The information will be disclosed to the individuals named above in Section I. This form will not provide the above-named individuals with the authority to change or modify my policy, or to make any decision related to my care.

STATEMENTS OF UNDERSTANDING:

- I understand that I may refuse to sign this authorization, and my refusal will not affect my eligibility for benefits or the continuation of my coverage.
- I understand that if any person that receives the above information is not a health care provider covered by state or federal privacy regulations, the information described above may be redisclosed by such person and will likely no longer be protected by state or federal privacy regulations.
- I understand that I may revoke the authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization, by sending a written revocation to Transamerica Life Insurance Company, P.O. Box 869090, Plano, TX 75086-9090.
- I understand that this authorization is not a Power of Attorney and does not give the above-named individuals the authority to act on my behalf.
- Unless revoked in writing, this authorization will remain valid for as long as my policy remains in force. My submission of a subsequent version of this authorization will serve to add the named individuals to the original submission. It will not serve as a written revocation.

Name of Policyholder (includes applicant, policyholder, or other insured)	Policy/Certificate Number
Signature of Policyholder	Date

If Personal Representative, please provide explanation and documentation of authority (e.g., power of attorney, court-appointed administrator)

AUTHORIZATION FOR THE RELEASE OF INFORMATION TO FAMILY MEMBERS & OTHER INDIVIDUALS

A copy of this authorization will be considered as valid as the original

I hereby authorize the use or disclosure of information about me as described below:

1) Transamerica Life Insurance Company has my permission to disclose my personal information to the following people who are involved in my care or the handling of my affairs:

Name of Person:	Description of Relationship:
1)	
2)	
3)	

(List the full name of up to three relatives, friends or other individuals involved in your care to whom you want personal information disclosed.)

2) **Description of the information that may be used or disclosed:**

This authorization includes the release of any information regarding the coverage under my long term care insurance policy, any personal information related to my care or benefits, and any other information contained in the Company's records about me or my coverage.

3) **The information will be used for the following purpose:**

The information will be disclosed to the individuals named above in Section I. This form will not provide the above-named individuals with the authority to change or modify my policy, or to make any decision related to my care.

STATEMENTS OF UNDERSTANDING:

- I understand that I may refuse to sign this authorization, and my refusal will not affect my eligibility for benefits or the continuation of my coverage.
- I understand that if any person that receives the above information is not a health care provider covered by state or federal privacy regulations, the information described above may be redisclosed by such person and will likely no longer be protected by state or federal privacy regulations.
- I understand that I may revoke the authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization, by sending a written revocation to Transamerica Life Insurance Company, P.O. Box 869090, Plano, TX 75086-9090.
- I understand that this authorization is not a Power of Attorney and does not give the above-named individuals the authority to act on my behalf.
- Unless revoked in writing, this authorization will remain valid for as long as my policy remains in force. My submission of a subsequent version of this authorization will serve to add the named individuals to the original submission. It will not serve as a written revocation.

Name of Policyholder (includes applicant, policyholder, or other insured)	Policy/Certificate Number
Signature of Policyholder	Date

If Personal Representative, please provide explanation and documentation of authority (e.g., power of attorney, court-appointed administrator)

TRANSAMERICA®
LIFE INSURANCE COMPANY

HOME OFFICE: CEDAR RAPIDS, IOWA
Long Term Care Administrative Office
P.O. Box 869090
Plano, TX 75086-9090
1-(800) 227-3740

Certificate of Mailing Receipt

Insured: JOHN DOE
Policy/Certificate Number: 211063428

Printed Name: _____

Signature: _____

Date Policy was Mailed _____