



## Metropolitan Life Insurance Company

A Stock Company Incorporated in New York State

Metropolitan Life Insurance Company (MetLife) will pay the benefits of this policy according to its provisions.

### Long-Term Care Insurance Policy

- \* **RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE FOR LIFE. PREMIUM RATES ARE SUBJECT TO CHANGE.** This means You have the right, subject to the terms of the policy, to continue this policy as long as You pay Your premiums on time. We cannot change any of the terms of this policy without Your consent, except that We may change the premium rates, subject to applicable state Insurance Department approval. Any such change in premium rates will apply to all policies in the same class as Yours in the state where this policy was issued.
- \* The SCHEDULE OF BENEFITS provided by this policy is shown on page 3.
- \* This policy is not eligible for dividends.

**CAUTION:** We issued this policy on the basis of Your responses to the questions on Your application. A copy of Your application is attached. If Your answers are incorrect or untrue, We may have the right to deny benefits or rescind Your policy. The best time to clear up any questions is now, before a claim arises. If, for any reason, any of Your answers are incorrect, contact Us at this address: Metropolitan Life Insurance Company, P.O. Box 937, Westport, CT 06881-0937.

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

**This policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. If in the future, it is determined that this policy does not meet the requirements of the Internal Revenue Code, We will make every reasonable effort to amend the policy if We are required to do so in order to gain favorable federal income tax treatment. We will offer You an opportunity to receive these amendments, with any appropriate adjustments, as determined by MetLife, to premium rates and/or benefits.**

Gwenn L. Carr  
Vice-President and Secretary

C. Robert Henrikson  
President and Chief Operating Officer

**30-Day Right to Examine Policy.** Please read this policy carefully. It is a legal contract between You and MetLife. If You are not satisfied for any reason, You may return this policy to Us or to the sales representative from whom You bought it within thirty (30) days from the date You receive it. If You return it within the thirty (30) day period, this policy will be void from the beginning. We will refund any premium paid within thirty (30) days after We receive the returned policy.

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Proof

Metropolitan Life Insurance Company  
P. O. Box 937  
Westport, CT 06881-0937  
Toll-Free Number: 1-888-565-3761

**SCHEDULE OF BENEFITS**

**INSURED**  
[John Doe]

**CURRENT COVERAGE: EFFECTIVE DATE [July 1, 2005]  
(REPLACES ANY PREVIOUS SCHEDULE OF BENEFITS)**

Original Coverage Effective Date	[January 1, 2005]
Original Issue Age	[61]
Policy Number	[211100000 LTC]
Plan Number	[XXXXX]
Elimination Period	[45 days]
Benefit Period	[UNLIMITED]
TOTAL LIFETIME BENEFIT (does not reflect claims paid or payable)	[UNLIMITED]

**COVERED SERVICES**

**BENEFIT AMOUNTS**

**PRIMARY SERVICES**

**MAXIMUM DAILY BENEFIT AMOUNT**

Nursing Home/Hospice Facility	[\$100]/day*
Assisted Living Facility	[\$100]/ day*
Respite Care - [21] days/Policy Year	
- In a facility or	[\$100]/day or
- At Home	[\$75]/day
Home Care And Community Care	[\$75]/ day*

**ADDITIONAL SERVICES**

**MAXIMUM BENEFIT AMOUNT**

Needs Assessment	[\$275]/lifetime
Transition Expense Allowance	[\$1,500]/lifetime
Informal Caregiver Training	[\$500]/lifetime
Supportive Services and Specialized Transportation	[\$75]/month

\*There is no daily limit for these Benefits. Instead, there is a monthly limit, referred to as a Monthly Benefit Amount.<sup>1,2</sup>

<sup>1</sup>This **Monthly Benefit Amount** will be pro-rated for any month in which (1) You complete any required **Elimination Period**; (2) You are no longer eligible for **Benefits**; or (3) Your **Total Lifetime Benefit** is reduced to zero. Payment of **Benefits** for **Respite Care** will reduce Your **Monthly Benefit Amount**.

<sup>2</sup>During any **Calendar Month**, You may receive one or more **Primary Services** for which **Benefits** are payable on a monthly basis. The most We will pay for any combination of **Primary Services** You receive during any **Calendar Month** (for which **Benefits** are payable on a monthly basis) is the highest **Monthly Benefit Amount** for one of those **Primary Services**. However, the most we will pay for each **Primary Service** that You receive is the **Monthly Benefit Amount** for that **Primary Service**. Payment of **Benefits** for **Primary Services** will reduce Your **Total Lifetime Benefit**.

**Health Rating:** [Preferred, Standard, Rated]  
**Discounts:** [Marital Discount, None]

**PREMIUM SCHEDULE**

Gross Annual Premium (includes Riders and Health Rating; does not include Discounts, if any): [\$XXXX.XX]

**COVERAGE**

**ANNUAL PREMIUM \***

(includes Health Rating and Discounts)

Base Coverage

[\$XXX.XX]

[Future Purchase Rider]

[\$XXX.XX]

[5% Automatic Compound Inflation Protection Rider] [5% Automatic Simple Inflation Protection Rider]

[\$XXX.XX]

[Nonforfeiture Coverage Rider]

[\$XXX.XX]

[Paid-Up Survivorship Rider]

[\$XXX.XX]

[Restoration of Benefits Rider]

[\$XXX.XX]

[Shared Care Rider]

[\$XXX.XX]

[Calendar Day Rider]

[\$XXX.XX]

[Home Care Elimination Period Waiver]

[\$XXX.XX]

[Total Annual Premium with discounts applied]

[\$XXX.XX]

[[Monthly, Quarterly, Semi-annual, Annual] Premium Amount\*]

[\$XXX.XX]

**[[In addition, you have selected the Double Pay First Year Rider]**

**[[Monthly, Quarterly, Semi-annual, Annual] Premium Amount\*:]**

[Year 1]

[\$XXX.XX]

[Year 2 and after]

[\$XXX.XX]

[\* If you pay premiums more frequently than annually, an additional cost has been included. Please refer to Your application, "How You Want to Pay Premiums", to explain the basis for any additional charge.]

PROOF

## Table of Contents

The page numbers listed identify the first page of each section.

SCHEDULE OF BENEFITS .....	3
DEFINITIONS OF POLICY TERMS .....	5
ELIGIBILITY FOR THE PAYMENT OF BENEFITS .....	12
Eligibility for Benefits .....	12
If You Need Benefits .....	12
Continuing Eligibility for Benefits .....	12
ELIMINATION PERIOD .....	13
COVERED SERVICES .....	14
Conditions for Benefit Payments .....	14
COVERED SERVICES-PRIMARY SERVICES .....	14
Primary Services .....	14
Nursing Home, Hospice Facility and Assisted Living Facility Benefits, including Bed Reservation Benefits .....	14
Home Care and Community Care Benefits .....	15
Ongoing Care Advisory Services .....	15
Respite Care Benefits .....	15
Alternate Services Benefits .....	16
COVERED SERVICES-ADDITIONAL SERVICES .....	17
Additional Services .....	17
Needs Assessment Benefits .....	17
Informal Caregiver Training Benefits .....	17
Transition Expense Allowance .....	17
Supportive Services and Specialized Transportation Benefits .....	18
CONTINGENT BENEFITS UPON LAPSE .....	19
Contingent Benefits Upon Lapse .....	19
Definitions .....	19
Eligibility for Contingent Benefits Upon Lapse .....	20
Contingent Nonforfeiture Coverage .....	20
When Contingent Nonforfeiture Coverage Begins .....	20
Limitations .....	20
INTERNATIONAL COVERAGE .....	21
CHANGING BENEFIT AMOUNTS .....	22
Benefit Increase With Proof of Good Health .....	22
Benefit Decreases .....	22
EXTENSION OF BENEFITS .....	23
LIMITATIONS AND EXCLUSIONS .....	24
What is Not Covered Under This Policy .....	24
PREMIUMS .....	25
Premium Payment .....	25
Grace Period .....	25
Waiver of Premiums .....	25
Reinstatement .....	26
Reinstatement for Cognitive Impairment or Loss of Functional Capacity .....	27
CLAIMS .....	28
Notice of Claim .....	28
Claim Forms .....	28
Proof of Claim .....	28
Physical Examination .....	29
Notice of Approval or Denial .....	29
Appeals of Denials .....	29
Time of Payment of Claims .....	29
Payment of Claims .....	29
GENERAL PROVISIONS .....	30
The Contract .....	30
Assignment; No Cash Value; Premium Refunds .....	30
Refund to Us for Overpayment of Benefits .....	30
Facility of Payment .....	30
Limitation on Representative's or Other Person's Authority .....	30
Incontestability .....	30
Misstatement of Age .....	31
Legal Actions .....	31
Termination of Policy .....	31
Conformity With State Statutes .....	31
Notice .....	32

## Definitions of Policy Terms

This section defines most of the words and phrases used in Your policy which have specific meaning. All terms with a defined meaning are capitalized and, except for *Our*, *Us*, *We*, *You* and *Your*, are **bolded** for easy identification throughout the policy.

**“Activities of Daily Living”** means any of the following:

- \* **Bathing:** Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- \* **Dressing:** Putting on and taking off all items of clothing and any required braces, fasteners, or artificial limbs.
- \* **Transferring:** Moving into or out of a bed, chair or wheelchair.
- \* **Toileting:** Getting to and from the toilet, getting on and off the toilet, and performing related personal hygiene.
- \* **Continence:** Ability to maintain control of bowel and bladder function; or, when not able to maintain control of bowel or bladder function, the ability to perform related personal hygiene (including caring for catheter or colostomy bag).
- \* **Eating:** Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously.

**“Adult Day Care”** means a program, for six (6) or more clients, of **Qualified Long-Term Care Services** furnished at an **Adult Day Care Center** for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the **Home**.

**“Adult Day Care Center”** means:

1. A facility operated and licensed and/or certified as an **Adult Day Care Center** under the laws where it is located; or
2. Any other organization that meets ALL of the following:
  - \* Provides a program of **Adult Day Care**; and
  - \* Keeps a written record of services furnished to each client; and
  - \* Has established procedures to obtain emergency medical care; and
  - \* Is not a place which chiefly provides services for recreation or social activities; and
  - \* Maintains a client-to-staff ratio of eight (8) (or less) to one, which staff includes: a full-time director; one or more **Nurses** present at least four (4) hours a day during operating hours; and at least two (2) staff members present whenever clients are present.

**“Assisted Living Facility”** means a facility that meets ALL of the following:

- \* Maintains all appropriate licensing under the laws where it is located to provide **Maintenance or Personal Care**; and

## Definitions of Policy Terms (Continued)

- \* Provides twenty-four (24) hours a day **Maintenance or Personal Care** services sufficient to assist clients with needs which result from the inability to perform **Activities of Daily Living** or from **Severe Cognitive Impairment**; and
- \* Has at least three (3) clients; and
- \* Uses aides trained or certified to provide **Maintenance or Personal Care** in accordance with any laws which apply to the provision of such care; and
- \* Provides twenty-four (24) hour supervision of clients by a trained and awake staff; and
- \* Has formal arrangements for emergency medical care; and
- \* Maintains written records of services furnished to each client; and
- \* Serves clients three (3) meals a day; and
- \* Has appropriate methods and procedures to assist in administering prescribed drugs where allowed by law.

An **Assisted Living Facility** is not, other than incidentally, a hotel, motel, a place for rest or a place for the treatment or rehabilitation of drug addiction or alcoholism. Retirement homes, congregate living, senior housing, or other facilities chiefly intended to provide residential services but not **Maintenance or Personal Care** do not typically qualify as an **Assisted Living Facility**. If an institution has more than one license or purpose, only that section of the institution specifically meeting the definition of **Assisted Living Facility** will qualify as an **Assisted Living Facility**.

**"Benefits"** means the amounts We will pay subject to the provisions of the policy.

**"Calendar Month"** means the period which begins on the first day of each calendar month.

**"Care Advisor"** means a health care professional from a **Care Management Organization**.

**"Care Advisory Services"** means any of the following services provided by a **Care Advisor**:

- \* Assessing long-term care service needs;
- \* Developing a long-term care service plan;
- \* Requisitioning and coordinating long-term care services;
- \* Implementing the long-term care service plan; and
- \* Monitoring and reassessing long-term care services as needed from time to time.

## Definitions of Policy Terms (Continued)

**“Care Management Organization”** means:

1. An organization operated and licensed as a **Care Management Organization** under the laws where it is located; or
2. Any other organization that meets ALL of the following:
  - \* Provides **Care Advisory Services**; and
  - \* Has a full-time administrator; and
  - \* Maintains written records of services performed for each client; and
  - \* Has a staff which includes at least one **Nurse** and one **Social Worker**.

**“Certified Private Aide”** means a health care worker who has received formal training for the delivery of **Maintenance or Personal Care** services in the **Home**, who is primarily employed to provide **Home Health Care Services**, but whose services are not necessarily arranged and supervised by a **Home Health Care Agency**. The person must be licensed or certified as a CNA (Certified Nurse’s Aide) or HHA ( **Home Health Aide**) under the laws where the service is provided. The term does not include members of Your **Immediate Family**.

**“Chronically III”**: Refer to the Eligibility for the Payment of Benefits section.

**“Community Care”** means care furnished outside of a **Nursing Home, Hospice facility or Assisted Living Facility** and includes **Home Health Care Services** and **Adult Day Care**.

**“Covered Services”** means **Qualified Long-Term Care Services** that are specifically provided subject to the terms of this policy.

**“Custodial Care”** means services provided on an extended basis to a person who is **Chronically III**, which are aimed at maintaining a person's health and/or functional status. **Custodial Care** does not include any transportation or other service which is chiefly for personal convenience or companionship.

**“Domestic Partner”** means each of two people:

- \* who have registered or filed as domestic partners or members of a civil union with a government agency or office where such registration is available; or

## Definitions of Policy Terms (Continued)

- \* Who meet the following requirements:
  - \* each person is 18 years of age or older
  - \* neither person is married;
  - \* they share the same residence;
  - \* they are not related by blood in a manner that would bar their marriage in the jurisdiction in which they reside; and
  - \* they have an exclusive mutual commitment to share the responsibility for each other's welfare and financial obligations and such commitment is expected to last indefinitely.

**"Elimination Period"** is the number of days after the **Original Coverage Effective Date** of this policy during which You must be: (1) **Chronically Ill**; and (2) receiving **Primary Services**, (other than **Hospice Care** and **Respite Care Services**) before certain **Benefits** become payable. These days need not be consecutive.

**"Formal Caregiver"** means any of the following: a **Nurse, Care Advisor, Therapist, Social Worker, Home Health Aide, Homemaker** or **Certified Private Aide**. Members of Your **Immediate Family** cannot be **Formal Caregivers**.

**"Home"** means any residence in which You are living or staying. **Home does not include** any: hospital or other acute care facility. For purposes of the **Transition Expense Allowance**, the **Supportive Services and Specialized Transportation Benefit**, the **Home Care Elimination Period Waiver** rider, and the **Calendar Day Rider**, the term **Home** also **does not include** a nursing home, assisted living facility, or hospice facility.

**"Home Health Aide"** means a person whose services are arranged and supervised through a **Home Health Care Agency** and whose main function is to assist with **Activities of Daily Living**. If state or local licensing or certification is required, the person must be licensed or certified as a **Home Health Aide** under the laws where the service is performed.

**"Home Health Care Agency"** means a **Hospital** or other organization that:

- \* If licensing or certification is required, is licensed or certified as a **Home Health Care Agency** under the laws where it is located, or under a public health law or similar law, to provide **Home Health Care Services**; or
- \* Is recognized as a **Home Health Care Agency** by **Medicare**; or
- \* Meets ALL of the following:
  1. Is licensed or certified where it is located to provide **Home Health Care Services**; and

## Definitions of Policy Terms (Continued)

2. Has at least five (5) clients; and
3. Develops and reviews long-term care service plans at appropriate intervals; and
4. Uses **Home Health Aides**, trained or certified in accordance with any laws which apply to such care, to provide **Maintenance or Personal Care**; and
5. Provides on-site supervision of **Home Health Aides** by a **Nurse** or **Social Worker**; and
6. Has a **Nurse** or a **Physician** on call for a medical emergency during the hours that the **Home Health Aide** is in the client's **Home**; and
7. Maintains a written record of services performed for each client.

**"Home Health Care Services"** means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include **Homemaker Services**, assistance with **Activities of Daily Living** and **Respite Care**.

**"Homemaker"** means a skilled or unskilled person whose services are arranged and supervised through a **Home Health Care Agency** and who provides **Homemaker Services**.

**"Homemaker Services"** means **Maintenance or Personal Care** services that are necessary for or consistent with the **Chronically Ill** person's ability to stay in his or her **Home**. Such **Qualified Long-Term Care Services** may include light housekeeping, meal preparation and shopping for necessary items.

**"Hospice"** means a facility, unit of a facility, public or private agency or unit of a public or private agency that meets federal certification requirements as a **Hospice**, or is comparably licensed under the laws where it is located, to provide care or management of the **Terminally Ill**.

**"Hospice Care"** means services furnished by a **Hospice** for the care or management of a **Terminal Illness**.

**"Hospital"** means a facility that is licensed as a **Hospital**, and provides on its premises or in facilities available to the **Hospital** on a prearranged basis:

- \* A broad range of medical and surgical services for sick and injured persons twenty-four (24) hours a day by, or under the supervision of, a staff of **Physicians**; and
- \* **Nursing Care** twenty-four (24) hours a day.

**"Immediate Family"** means Your spouse, child (natural, step or adopted), parent, sibling, grandchild, or in-law.

**"Informal Caregiver"** means a person who provides **Maintenance or Personal Care**, not as a **Formal Caregiver**. Members of the **Insured's Immediate Family** qualify as **Informal Caregivers**.

**"Insured"** means the person so named on page 3.

**"Lapse"** means termination of this policy because of failure to pay premiums.

## Definitions of Policy Terms (Continued)

**“Licensed Health Care Practitioner”** means a **Physician**; any registered professional **Nurse**; a licensed **Social Worker**; or other individual who meets such requirements as may be prescribed by the U.S. Secretary of the Treasury.

**“Maintenance or Personal Care”** means any care with the primary purpose of providing needed assistance when You are **Chronically Ill** (including protection from threats to health and safety due to **Severe Cognitive Impairment**). **Maintenance or Personal Care** services may include **Custodial Care** and needed assistance with **Activities of Daily Living** (“ADL”).

**“Maximum Benefit Amount”** means the most We will pay for **Covered Services-Additional Services** as shown on page 3, subject to the terms of the policy, for the time period specified.

**“Medicaid”** means any state medical assistance program under Title XIX of the Social Security Act, as amended.

**“Medicare”** means the Health Insurance for the Aged and Disabled provisions of Title XVIII of the Social Security Act, as amended.

**“Monthly Benefit Amount”** means an amount equal to the number of days in a **Calendar Month** multiplied by the **Maximum Daily Benefit Amount for Nursing Home, Assisted Living Facility or Home Care and Community Care** shown on page 3, as applicable.

**“Needs Assessment”** means the services provided by a **Care Advisor** to: (1) assess Your needs for long-term care services; (2) develop or work with others to develop options for Your long-term care; and (3) discuss the long-term care options with You or Your **Representative**.

**“Nonforfeiture Coverage”** means coverage provided under the Contingent Benefits Upon Lapse provision of this policy, or under the Nonforfeiture Coverage Rider if the Rider is shown on page 3 of this policy.

**“Nurse”** means a registered professional **Nurse** (R.N.), licensed practical **Nurse** (L.P.N.) or licensed vocational **Nurse** (L.V.N.) who is licensed under the laws where the services are performed.

**“Nursing Care”** means services: requiring the professional skills of a **Nurse**; performed by a **Nurse**; under the orders of a **Physician**; and to improve or maintain Your health.

**“Nursing Home”** means a facility licensed as a skilled or intermediate nursing facility under the laws where it is located that meets ALL of the following:

- \* Has twenty-four (24) hours a day **Nursing Care**; and
- \* Has twenty-four (24) hours a day **Maintenance or Personal Care** performed by a trained/certified and awake staff supervised by a **Nurse**; and
- \* Keeps a written record of services performed for each client; and
- \* Has formal arrangements for emergency medical care; and
- \* Services are not limited to provision of food, shelter, and other residential services such as laundry.

## Definitions of Policy Terms (Continued)

A **Nursing Home** is not, other than incidentally, a **Hospital** (except a distinct part of a **Hospital** which is a nursing facility), residential facility, hotel, motel, place for rest, home for the aged, sheltered living accommodation, facility for the treatment of mental illness, continuing care retirement community or similar entity, or place for the treatment or rehabilitation of drug addiction or alcoholism.

“**Physician**” means a **Physician** as defined in section 1861(r)(1) of the Social Security Act, as amended.

“**Plan of Care**” means a written plan prescribed by a **Licensed Health Care Practitioner** that identifies ways of meeting the **Qualified Long-Term Care Service** needs of a person who is **Chronically Ill**.

“**Policy Anniversaries**,” “**Policy Years**” and “**Policy Months**” mean dates measured from the **Original Coverage Effective Date** of the policy. For example, if the **Original Coverage Effective Date** of the policy is May 5, 2005, the first **Policy Anniversary** is May 5, 2006; the first **Policy Year** ends May 4, 2006; and **Policy Months** start on the fifth day of each month, e.g., June 5, 2005. If the **Original Coverage Effective Date** is the 29<sup>th</sup>, 30<sup>th</sup> or 31<sup>st</sup> day of a **Calendar Month**, and a **Calendar Month** does not have that date, then that **Policy Month** shall begin on the first of the following **Calendar Month**. For purposes of this definition, a date will begin at 12:01 A.M. in the time zone in which You reside.

“**Qualified Long-Term Care Services**” means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and **Maintenance or Personal Care** services which: (a) are required by a **Chronically Ill** individual; and (b) are provided pursuant to a **Plan of Care** prescribed by a **Licensed Health Care Practitioner**.

“**Representative**” means the person named by You or by a court of law to represent You.

“**Severe Cognitive Impairment**”: Refer to the Eligibility for the Payment of Benefits section.

“**Social Worker**” means a licensed **Social Worker**, including any **Social Worker** who has a license, certificate or similar permit to act as a **Social Worker** from a state or a body authorized by a state to issue such permits, or a person with a Masters degree in Social Work from an accredited university.

“**Terminal Illness**” means an illness or injury which a **Physician** certifies is likely to result in a person's death within six (6) months. “**Terminally Ill**” means an individual diagnosed with a **Terminal Illness**.

“**Therapist**” means a person who has a license or appropriate professional certificate to provide **Therapy Services** under the laws where the services are being provided.

“**Therapy Services**” means physical, respiratory, speech or occupational **Therapy Services** rendered by a **Therapist**.

“**Total Lifetime Benefit**” means the most We will pay under this policy during Your lifetime, not including **Benefits for Needs Assessment**. This amount is shown on page 3 and will change if Your benefit amounts are changed.

“**We**,” “**Us**” and “**Our**” mean Metropolitan Life Insurance Company (MetLife).

“**You**” and “**Your**” mean the **Insured** named on page 3.

## Eligibility for the Payment of Benefits

**Eligibility for Benefits** You will be eligible for **Benefits** only if:

1. We are given proof, satisfactory to Us, that You are **Chronically III**; and
2. A **Licensed Health Care Practitioner** has certified in writing to Us, in the last twelve (12) months, that You are **Chronically III**; and
3. A **Plan of Care** including the **Qualified Long-Term Care Services** You need is in place for You.

In order for certain **Benefits** to be payable, You must also satisfy an **Elimination Period** as described in this policy.

**“Chronically III”** means You are unable to perform, without **Substantial Assistance** from another individual, at least two (2) **Activities of Daily Living (“ADL”)** for an expected period of at least ninety (90) days due to a loss of functional capacity; or You require **Substantial Supervision** to protect You from threats to health and safety due to **Severe Cognitive Impairment**.

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

**“Severe Cognitive Impairment”** means a deterioration or loss in intellectual capacity that: (a) places You in jeopardy of harming Yourself or others and, therefore, You require **Substantial Supervision** by another individual; and (b) is measured by clinical evidence and standardized tests which reliably measure impairment in: (1) short or long-term memory; (2) orientation to people, places or time; and (3) deductive or abstract reasoning.

**“Substantial Supervision”** means that You require continual supervision (which may include cueing by verbal prompting, gesture or other demonstrations) by another person that is necessary to protect You from threats to Your health and safety (such as may result from wandering).

**If You Need Benefits** You or someone acting for You may write to Us or call the toll-free number shown on page 3 to request that We determine whether You are eligible for **Benefits**.

Please refer to the Claims section of this policy for further information.

**Continuing Eligibility for Benefits** We will reassess Your continuing eligibility for **Benefits**, based upon the criteria used to determine Your Eligibility for Benefits, at least once every twelve (12) months, but no more frequently than every thirty (30) days.

## Elimination Period

### Elimination Period

**“Elimination Period”** is the number of days after the **Original Coverage Effective Date** of this policy during which You must be: (1) **Chronically Ill**; and (2) receiving **Primary Services** (other than **Hospice Care** and **Respite Care**), before certain **Benefits** become payable. These days need not be consecutive. The **Elimination Period** for this policy is shown on page 3. Except as stated below, **Benefits** will not be paid for **Covered Services** You receive during the **Elimination Period**.

No **Elimination Period** is required in order to receive **Benefits** for **Hospice Care, Respite Care, Needs Assessment** or **Informal Caregiver Training**. Receipt of these services will not count toward satisfying the **Elimination Period**.

Once You complete the **Elimination Period**, You will be eligible to receive the **Transition Expense Allowance** for expenses for **Qualified Long-Term Care Services** received during or after the **Elimination Period**.

You only have to satisfy the **Elimination Period** once. Once You have satisfied a day of the **Elimination Period**, that day is satisfied for the life of the policy.

PROOF

## Covered Services

### Conditions for Benefit Payments

We will pay for **Covered Services** only if:

1. They are **Qualified Long-Term Care Services**; and
2. They are received after the **Original Coverage Effective Date** of this policy; and
3. They are received after satisfying any required **Elimination Period**; and
4. You are eligible for **Benefits**; and
5. The **Total Lifetime Benefit** has not been paid.

However, **Covered Services** do not include any service or supply which is primarily for personal convenience or companionship.

There are two types of **Covered Services** under this policy: **Primary Services** and **Additional Services**.

### Covered Services-Primary Services

#### Primary Services

During any **Calendar Month**, You may receive one or more **Primary Services** for which **Benefits** are payable on a monthly basis. The most We will pay for any combination of **Primary Services** You receive during any **Calendar Month** (for which **Benefits** are payable on a monthly basis) is the highest **Monthly Benefit Amount** for one of those **Primary Services**. However, the most We will pay for each **Primary Service** that You receive is the **Monthly Benefit Amount** for that **Primary Service**. Payment of **Benefits** for **Primary Services** will reduce Your **Total Lifetime Benefit**.

#### Nursing Home, Hospice Facility and Assisted Living Facility Benefits, including Bed Reservation Benefits

We will pay up to the **Nursing Home Monthly Benefit Amount** for the actual charges You incur in a **Calendar Month** for the following **Covered Services** received in and provided by a **Nursing Home, Hospice facility or Assisted Living Facility**:

1. Room and board; and
2. **Nursing Care, Maintenance or Personal Care, Therapy Services and Hospice Care**, from a **Formal Caregiver**; and
3. **Bed Reservation Benefits** up to fifty (50) days per **Policy Year**. "**Bed Reservation Benefits**" means the **Benefits** We will pay for actual charges You incur to hold a space in a **Nursing Home, Hospice facility or Assisted Living Facility**, to enable You to return to the facility. The amount We will pay for **Bed Reservation Benefits** will not be more than the **Benefits** We would pay if You had been confined in the **Nursing Home, Hospice facility or Assisted Living Facility** on those days.

## Covered Services-Primary Services (Continued)

### Home Care and Community Care Benefits

We will pay up to the **Home Care and Community Care Monthly Benefit Amount** for the actual charges You incur in a **Calendar Month** for the following **Covered Services** You receive while at **Home**:

1. **Home Health Care Services** performed by a **Nurse, Therapist or Certified Private Aide**; and
2. **Home Health Care Services** performed by a **Home Health Aide** from a **Home Health Care Agency**; and
3. **Homemaker Services** performed by a **Homemaker** from a **Home Health Care Agency**; and
4. Ongoing **Care Advisory Services** performed by a **Care Advisor**; and
5. At-home **Hospice Care**; and
6. **Adult Day Care**.

### Ongoing Care Advisory Services

Ongoing **Care Advisory Services** are considered a **Home Care and Community Care Benefit** under this policy.

### Respite Care Benefits

**"Respite Care"** means **Covered Services** from a **Formal Caregiver** that temporarily relieves the **Informal Caregiver**. These **Covered Services** may be received in a **Nursing Home, Hospice facility, Assisted Living Facility, at Home** or in an **Adult Day Care Center**.

We will pay up to the **Maximum Daily Benefit Amount** for **Respite Care** shown on page 3, for a maximum of twenty-one (21) days per **Policy Year**, for actual charges You incur, based on the type of service received.

If You receive more than one type of **Respite Care** service on the same day, the most We will pay is the highest **Respite Care Maximum Daily Benefit Amount** that relates to the services used.

You do not need to satisfy the **Elimination Period** for **Respite Care Benefits** to be payable. Receipt of **Respite Care** will not count toward satisfying the **Elimination Period**.

Payment of these **Benefits** will reduce the **Monthly Benefit Amounts** available for other **Primary Services**.

## Covered Services-Primary Services (Continued)

**Alternate Services Benefits** “Alternate Services” means **Qualified Long-Term Care Services** which are furnished by a facility or person not defined in this policy.

We will consider paying for actual charges You incur for covered **Alternate Services** as stated below. We will pay for **Alternate Services** only if We determine that the **Alternate Services** meet ALL of the following:

1. The service falls within guidelines We establish as approved **Alternate Services**; and
2. It is a type of service described in Your **Plan of Care**; and
3. It effectively meets Your long-term care service needs; and
4. It is, for You, a cost-effective alternative to **Primary Services** which would have been covered under this policy; and
5. It is not provided by a member of Your **Immediate Family**; and
6. The **Alternate Services** and benefit amounts must be mutually agreed to, in writing, by You, Your **Licensed Health Care Practitioner**, and Us, through an **Alternate Services Agreement**.

The **Benefits** We will pay for **Alternate Services** will be the lesser of:

1. The actual charges You incur for the services received; or
2. The maximum benefit amount for the **Covered Services** We determine to be most closely related to the **Alternate Services** received.

We will not pay for any **Alternate Services** received prior to the date all parties have signed the **Alternate Services Agreement**.

An Agreement to receive **Alternate Services Benefits** will not waive any of Our rights or any of Your rights under this policy.

Receipt of **Alternate Services** as specified in the **Alternate Services Agreement** will count toward satisfying the **Elimination Period**.

## Covered Services-Additional Services

### Additional Services

**Additional Services** may be received on the same day as **Primary Services**, without affecting the benefit amounts for **Primary Services**. The **Maximum Benefit Amounts** We will pay for **Additional Services** are shown on page 3.

### Needs Assessment Benefits

After You become eligible for **Benefits**, You can receive, at no extra charge to You, one **Needs Assessment** from a **Care Management Organization**, selected by Us and to whom We make direct payment. Or, You may select a **Care Management Organization** to conduct one **Needs Assessment** and We will pay as a **Covered Service** the actual charges You incur up to the **Maximum Benefit Amount** for **Needs Assessment** shown on page 3.

You do not need to satisfy the **Elimination Period** for this **Benefit** to be payable. Receipt of this service will not count toward satisfying the **Elimination Period**. Payment of this **Benefit** will not reduce Your **Total Lifetime Benefit**.

### Informal Caregiver Training Benefits

We will pay up to the **Maximum Benefit Amount** for **Informal Caregiver Training** shown on page 3, for the actual charges You incur to train an **Informal Caregiver** to perform **Maintenance or Personal Care** services for You in Your **Home**. This training can take place while You are at **Home**, or in a **Hospital, Nursing Home, Hospice facility or Assisted Living Facility**, to make it possible for You to return **Home** and be cared for by the person who received the training. We will not pay for training someone who will be paid, under the terms of this policy, to care for You.

You do not need to satisfy the **Elimination Period** for this **Benefit** to be payable. Receipt of this service will not count toward satisfying the **Elimination Period**. Payment of this **Benefit** will reduce Your **Total Lifetime Benefit**.

### Transition Expense Allowance

After You have satisfied the **Elimination Period**, We will pay up to the **Maximum Benefit Amount** for **Transition Expense Allowance** shown on page 3. We will pay for actual charges You incur for **Qualified Long-Term Care Services** during or after the **Elimination Period**, if the expense was incurred on a day You were eligible for **Benefits** and not paid under any other provisions of this policy.

**Transition Expense Allowance** may include items required pursuant to a **Plan of Care**, such as personal emergency response systems, durable medical equipment or **Home** modifications, required by a **Chronically Ill** person in order to continue to live at **Home**. We will not pay for modifications that would increase the value of Your **Home**. Receipt of this **Benefit** will not count toward satisfying the **Elimination Period**. Payment of this **Benefit** will reduce Your **Total Lifetime Benefit**.

## Covered Services-Additional Services (Continued)

### **Supportive Services and Specialized Transportation Benefits**

We will pay up to the **Maximum Benefit Amount** shown on page 3 for **Supportive Services and Specialized Transportation**, for actual charges You incur for the following **Qualified Long-Term Care Services** required to promote Your health and safety while **Chronically III**:

1. **Supportive Services**, which are services that enable You to remain safely at **Home**. Such **Supportive Services** may include:
  - a) Shopping for items You need;
  - b) Personal laundry services;
  - c) Meal preparation;
  - d) Meals on Wheels; and
  - e) Light housekeeping.

**Supportive Services** can be provided by an **Informal Caregiver**.

2. **Specialized Transportation**, which is hiring a vehicle, with ramps, lifts or other special equipment to assist You to get in and out of it, to enable You to receive **Qualified Long-Term Care Services**.

You must satisfy the **Elimination Period** for this **Benefit** to be payable. Receipt of these services will not count toward satisfying the **Elimination Period**. Payment of this **Benefit** will reduce Your **Total Lifetime Benefit**.

## Contingent Benefits Upon Lapse

### Contingent Benefits Upon Lapse

We will provide limited coverage if Your policy ends because of nonpayment of premiums or Your written request to cancel the policy, following a **Substantial Premium Increase**, as described below. Note, however, that if Your policy includes a Nonforfeiture Coverage Rider shown on page 3, We will not pay **Benefits** under both that Rider and this provision. We will automatically apply the feature that will provide You with the higher adjusted **Total Lifetime Benefit**.

### Definitions

**"Initial Annual Premium"** means the **Gross Annual Premium** on the **Original Coverage Effective Date** as shown on page 3 of the policy. In determining the **Initial Annual Premium** and any changes thereto, We will not take into account Any premium payment mode factors or any discounts (for example, spousal Discount).

Any premium increase which results from a change in **Benefits** as provided under the terms of Your policy, will be added to and become part of the **Initial Annual Premium**. If You decrease Your **Benefits**, the **Initial Annual Premium** will be reduced by the amount of the decrease in Your premium.

**"Substantial Premium Increase"** means a cumulative increase in Your **Initial Annual Premium** which equals or exceeds a given percentage increase over Your **Initial Annual Premium**, as shown in the following table. Any premium increase which results from a change in **Benefits** requested by You, as a result of an increase in benefit amounts as provided under the terms of Your policy, or due to a change in payment arrangements, is not an increase for the purpose of determining a **Substantial Premium Increase**.

**Substantial Premium Increase Table**

Original Issue Age*	Percent Increase Over Initial Annual Premium	Original Issue Age*	Percent 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%

\* **Original Issue Age** means Your age as shown on page 3 of the policy.

## Contingent Benefits Upon Lapse (Continued)

### Eligibility for Contingent Benefits Upon Lapse

We will provide You with written notice of a **Substantial Premium Increase** at least forty-five (45) days prior to the date on which such premium increase will take effect. In this notice, We will:

1. Offer to reduce Your **Benefits**, without Your providing proof of good health, so that Your premium will not increase; and
2. Offer You the ability to receive **Contingent Nonforfeiture Coverage** as described below; and
3. Advise You that a **Lapse** at any time during the 120-day period following the due date of the increased premium will be deemed to be an election to receive **Contingent Nonforfeiture Coverage**.

### Contingent Nonforfeiture Coverage

If **Contingent Nonforfeiture Coverage** takes effect, the same benefit amounts as those payable under the policy immediately prior to the **Contingent Nonforfeiture Date** will be payable under **Contingent Nonforfeiture Coverage**, except that the **Total Lifetime Benefit** will be the greater of: (a) the sum of all premiums paid or waived under the terms of the policy; or (b) thirty (30) times the **Nursing Home Maximum Daily Benefit Amount** (shown on page 3 of the policy) in effect immediately prior to the **Contingent Nonforfeiture Date**.

The total **Benefits** available under the policy after the **Contingent Nonforfeiture Date** will not be more than the remaining **Total Lifetime Benefit** (after taking into account any prior claims paid) when Your policy ended.

### When Contingent Nonforfeiture Coverage Begins

**Contingent Nonforfeiture Coverage** takes effect on the **Contingent Nonforfeiture Date**. "**Contingent Nonforfeiture Date**" means: (a) the date on which Your policy Lapses; or (b) the last day of the **Policy Month** in which We receive Your written request to cancel Your policy, if it is received within 120 days after the first premium due date following a **Substantial Premium Increase**.

### Limitations

Once **Contingent Nonforfeiture Coverage** becomes effective: (1) You cannot make any changes to Your policy; and (2) all Riders under Your policy end.

## International Coverage

We will pay **Benefits** for **International Coverage** if You qualify under the conditions defined in this section. **"International"** means any location outside of the United States and its territories.

### Eligibility for Payment of Benefits for International Coverage

In order to receive payment for **Benefits** for **International Coverage** under this policy, You must:

1. Be outside the United States and its territories; and
2. Provide proof, satisfactory to Us, that You are **Chronically III**; and
3. Be eligible for **Benefits** under this policy; and
4. Satisfy the **Elimination Period for International Coverage**; and
5. Provide a written **Plan of Care** that includes the **Qualified Long-Term Care Services** You need.

### Per Diem Benefit for International Coverage

The **Per Diem Benefit** We will pay for **International Coverage** is equal to fifty percent (50%) of the **Home Care and Community Care Maximum Daily Benefit Amount** shown on page 3.

**"Per Diem Benefit"** means a **Benefit** computed on a daily basis for each day You are outside the United States, regardless of actual charges You incur. You do not need to receive **Covered Services** in order to receive the **Per Diem Benefit**.

If You are receiving the **Per Diem Benefit** for **International Coverage**, You cannot receive any other **Benefits** under this policy for the same period of time. Coverage for **Additional Services** is not available outside the United States and its territories.

The **Per Diem Benefit** will be paid to You in United States dollars. You may not assign the **Per Diem Benefit**.

### Elimination Period for International Coverage

The **Elimination Period for International Coverage** is two (2) times the **Elimination Period** shown on page 3. Each day on which You are eligible for **Benefits** under this policy while You are outside of the United States and its territories will count toward satisfying the **Elimination Period for International Coverage**. You do not need to receive **Covered Services** in order to satisfy the **Elimination Period for International Coverage**.

### Total Lifetime Benefit for International Coverage Benefits

We will pay You **Benefits** for **International Coverage** up to the lesser of: (1) Your **Total Lifetime Benefit** less any **Benefits** paid while You are in the United States and its territories; or (2) the **Per Diem Benefit for International Coverage** times 3,650.

The sum of all **Benefits** We will pay while You are in the United States and its territories and outside the United States and its territories will never exceed the **Total Lifetime Benefit** shown on page 3.

### Tax Note

Since **Benefits** for **International Coverage** are paid without regard to the actual charges You incur, part of the **Benefits** could be considered taxable income if they exceed the daily benefit amount limit prescribed by U.S. tax law (referred to as a "Per Diem" limit). This "Per Diem" limit is indexed for inflation. You should consult with Your tax advisor.

## Changing Benefit Amounts

While You are insured, You may change benefit amounts so long as **Nonforfeiture Coverage** is not in effect for You. As stated in the Premiums section of this policy, a change in benefit amounts may change the amount of premium for the policy.

We will send You a written notice of any change in benefit amounts and the date it takes effect.

### **Benefit Increase With Proof of Good Health**

You may, at any time, ask for an increase in Your benefit amounts in writing. We will approve the request only if You provide Us, at Your expense, proof satisfactory to Us of Your good health. Increases in amounts are subject to Our underwriting rules and limits in effect at the time of Your request. If You have received any **Benefits** under this policy, then with regard to the **Total Lifetime Benefit**, and the **Transition Expense Allowance** and **Informal Caregiver Training Maximum Benefit Amounts**, the percentage increase in Your **Nursing Home Maximum Daily Benefit Amount** will be applied to the remaining amounts. There will be no increase in the **Needs Assessment Maximum Benefit Amount**.

The extra premium for this benefit increase will be based on Your age, the premium rates and Your **Health Rating**, at the time the increase takes effect.

The increase will take effect on the first day of the **Policy Month** which starts on or next follows the date We approve Your request. We will send You a written notice of the increase in benefit amounts, the effective date of the increase and the amount of premium due. We will require Your written acceptance before the change You requested takes effect.

### **Benefit Decreases**

You may, at any time, request a decrease in Your benefit amounts in writing. Decreases in amounts are subject to Our rules and limits in effect at the time of the request. If You have received any **Benefits** under this policy, then with regard to the **Total Lifetime Benefit**, and the **Transition Expense Allowance** and **Informal Caregiver Training Maximum Benefit Amounts**, the percentage decrease in Your **Nursing Home Maximum Daily Benefit Amount** will be applied to the remaining amounts. There will be no decrease in the **Needs Assessment Maximum Benefit Amount**.

The decrease will take effect on the first day of the **Policy Month** which starts on or next follows the date We approve Your request. The premium will decrease as of the effective date of any decrease You requested in Your benefit amounts.

The amount of the premium reduction will be computed assuming that the benefit amounts purchased last are discontinued first. We will send You a written notice of the decrease in benefit amounts, the effective date of the decrease and the amount of premium due or to be applied to future premiums. We will require Your written acceptance before the change You requested takes effect.

## Extension of Benefits

### Extension of Benefits

If as of the date Your policy **Lapses** or as of the last day of the **Policy Month** in which We receive a written request to cancel Your policy, You are eligible for **Benefits** and are receiving **Benefits for Covered Services**, We will extend the payment of **Benefits for Covered Services** received so long as, without interruption, You remain eligible for **Benefits** and are receiving **Benefits for Covered Services**. Subject to the **Elimination Period** and the terms of this policy, **Benefits** will be extended only until the earliest of the date:

1. You are no longer eligible for **Benefits**; or
2. You are no longer receiving **Benefits for Covered Services**; or
3. The **Total Lifetime Benefit** has been paid.

PROOF

## Limitations and Exclusions

### What is Not Covered Under This Policy

No payment will be made for any of the following:

1. Treatment of alcoholism or drug addiction, unless the addiction was due to drug(s) taken on the advice of a **Physician**.
2. Any care received while in a **Hospital**, except in a unit specifically designated as a **Nursing Home** or **Hospice** facility.
3. Any injury or sickness that results from:
  - a. Any war, or act of war (whether declared or undeclared); or
  - b. Participation in a felony, riot or insurrection.
4. Any intentionally self-inflicted injury.
5. Services, other than **Supportive Services**, performed by a member of Your **Immediate Family**.
6. Any care or services received outside of the United States and its territories, except as described in the **International Coverage** section.
7. Any service or supply to the extent the expense for it is reimbursable under **Medicare**, or would be reimbursable but for the application of a deductible, coinsurance or co-payment amount. This exclusion will not apply where **Medicare** is secondary payer under applicable law.
8. Treatment received in a government facility (unless otherwise required by law); services for which benefits are available under a government program (except **Medicaid**); or services for which no charge is normally made in the absence of insurance.

**There are no limitations or exclusions for pre-existing conditions, or mental and nervous disorders, including Alzheimer's Disease.**

## Premiums

### Premium Payment

The premium is due and payable on the **Original Coverage Effective Date** of the policy and thereafter in accordance with the Premium Schedule that is in effect for the policy as shown on page 3. The premium must be paid in U.S. currency.

You may change the premium payment mode with Our approval.

The amount of the premium for Your initial coverage is based on Your **Original Issue Age, Health Rating and Discounts**, as of the **Original Coverage Effective Date** as shown on page 3.

We reserve the right to change premium rates on a class basis. The premium will not increase because You get older or Your health changes. Your premiums will change if We change Your benefit amounts as a result of Your request or as a result of an increase as provided under the terms of this policy.

### Grace Period

You have a **Grace Period** of thirty-one (31) days to pay each premium due after the first premium. If the premium is not paid by the end of the **Grace Period**, We will send a written notice of **Lapse** of the policy to You and to any person named to receive such notice at the addresses given to Us. You have thirty-five (35) days after We mail this notice to pay the premium. The policy will stay in force during this time unless We receive a written request from You to cancel the policy. If We do not receive the premium within thirty-five (35) days of mailing the notice, the policy will then **Lapse** at the end of this thirty-five (35) day period.

If a claim is payable for services incurred prior to **Lapse**, any unpaid premiums due will be deducted from the claim payment.

You have the right to name a person to receive notice of **Lapse** at the same time We send such notice to You. The person named will not be responsible for payment of the premium. You are responsible to inform Us of any change relating to the person named. We will inform You of Your right to change the person named at least once every two (2) years.

### Waiver of Premiums

We will waive Your premium if You are receiving payment of **Benefits** for Primary Services. If this requirement is initially met on the first day of a **Calendar Month**, waiver of premium will begin on that date. If this requirement is initially met on a date other than the first day of a **Calendar Month**, waiver of premium will begin on the first day of the next **Calendar Month**.

Waiver of premium will end when You are no longer receiving **Covered Services**. If waiver of premium ends on the first day of a **Calendar Month**, payment of premium must resume on that date. If waiver of premium ends on a day other than the first day of a **Calendar Month**, payment of premium must resume the first day of the next **Calendar Month**.

## Premiums (Continued)

If You selected a premium payment mode other than monthly, You will be considered to be on a monthly premium payment mode while premiums are waived. You may change Your payment mode once premiums are no longer waived.

### Reinstatement

If Your policy **Lapses**, We will reinstate Your policy back to the date it **Lapsed**, if within twelve (12) months of that date You or someone acting for You:

1. request reinstatement and submit an application ("Reinstatement Health Questionnaire"); an application for reinstatement is always required; and
2. submit evidence of Your insurability, acceptable to Us, at Your expense; and
3. Pay all past due premiums to Us, if We approve Your request for reinstatement. We will notify You of the amount of premium owed.

The policy will be reinstated upon approval of Your application ("Reinstatement Health Questionnaire") and payment in full of all past due premiums. If We reinstate Your policy, Your premium will be what it would have been had Your coverage not been interrupted.

If We accept premium at any time without requiring an application ("Reinstatement Health Questionnaire"), Your policy will be reinstated. All past due premiums must be paid at that time.

If We accept a premium prior to reinstatement and You complete the application ("Reinstatement Health Questionnaire") as required, We will issue a Conditional Receipt for the premium tendered. We also require evidence of Your insurability acceptable to Us. No sales representative or other person may waive or change any of these requirements.

We will notify You in writing of Our decision on or before the forty-fifth (45) day after: (1) We receive Your request for reinstatement; or (2) the date of the Conditional Receipt (if any), whichever is earlier. If We do not notify You within this forty-five (45) day period, Your policy will be reinstated at the end of this forty-five (45) day period. If your policy is reinstated, You must also pay all past due premiums to Us.

The reinstated policy will cover those **Benefits** which We would pay pursuant to the terms of the policy if You become eligible for **Benefits** after the date of reinstatement. In all other respects, Your rights and Ours will be the same as they were just prior to the date of **Lapse**.

## Premiums (Continued)

### Reinstatement for Cognitive Impairment or Loss of Functional Capacity

If Your policy **Lapses**, We will reinstate Your policy back to the date it **Lapsed**, without proof of Your good health, if within six (6) months of that date, You or someone acting for You:

1. Request reinstatement; and
2. Submit proof acceptable to Us, that You had a **Severe Cognitive Impairment** or loss of functional capacity before the policy **Lapsed**; and
3. Pay all past due premiums to Us, if We approve Your request for reinstatement.

The standard of proof We will use will be no more restrictive than that described in the Eligibility for the Payment of Benefits section.

If We reinstate Your policy, Your premium will be what it would have been if Your coverage had not **Lapsed**.

PROOF

## Claims

- Notice of Claim** You must provide Us with notice of claim within twenty (20) days after the beginning of any loss covered by the policy, or as soon as reasonably possible.
- Claim Forms** When We receive Your notice of claim, We will provide You with claim form(s). Your notice of claim must include Your name, the Policy Number, the type of care, and an address to which the claim form(s) should be sent. If We do not provide You with claim forms within fifteen (15) days after We receive Your notice of claim, Our claim form requirements will be satisfied if You provide Us with written proof of the date(s) and exact nature of the charges You have incurred for **Covered Services**.
- Proof of Claim** We will pay **Benefits** only if We determine that You are eligible for **Benefits**, have satisfied any required **Elimination Period** and We receive Your completed claim form(s) and written proof satisfactory to Us that You have incurred charges for **Covered Services**.
- For periodic payment for a continuing claim, You must submit written proof of claim to Us, at the address stated on the claim form We provide You, no later than ninety (90) days after the end of each period for which We are liable, or no later than ninety (90) days after the end of the calendar year in which You incurred charges, whichever is later. For payment of any other claim, You must submit written proof of claim no later than ninety (90) days after the day You incurred charges. Failure to submit proof of claim within this time limit will result in a claim denial unless it is shown that:
1. It was not reasonably possible to provide proof of claim within the time period; and
  2. Proof of claim was submitted as soon as reasonably possible and in no event, except in the absence of Your legal capacity, later than one year from the time proof is otherwise required.
- To help Us determine whether You are eligible for **Benefits** or You have incurred charges for **Covered Services**:
1. We or a person We name may contact You, Your **Representative**, Your **Physician** or other persons familiar with Your condition or with the services You received; and
  2. We may require that You provide Us, or a person We name, with access to Your medical records to obtain information about Your condition or the services You received. We may not be able to determine Your eligibility for **Benefits** or approve a claim for **Benefits** if We do not have access to these records; and
  3. We have the right to require You to submit to Us Your Explanation(s) of Benefits from **Medicare** or records from any other source from whom You may have received reimbursement for the same **Covered Services**.
- Claims for International Coverage** If You are making a claim for **Benefits** under the International Coverage section of this policy, any reference above to either charges You incur for **Covered Services** or to claim forms do not apply.

## Claims (Continued)

### Physical Examination

We have the right to have You examined by a healthcare professional at Our expense and to conduct an on-site assessment. We may not be able to determine Your eligibility for **Benefits** or to approve a claim for **Benefits** if You do not consent to an on-site assessment, if such assessment is needed.

### Notice of Approval or Denial

We will send You a written notice of Our decision to approve or deny Your eligibility for **Benefits** or a claim immediately or as soon as reasonably possible after We have received all the information We need to assess Your claim. In no event will We send this notice later than ten (10) working days after We have received all the information We need to assess Your eligibility for **Benefits** or claim. If You are not eligible for **Benefits** or We do not approve Your claim, Our notice will state the reasons for denial.

### Appeals of Denials

If We deny Your eligibility for **Benefits** or Your claim, in whole or in part, We will review Our decision if You or Your **Representative**:

- \* Request in writing that We review Our decision; and
- \* Send this request to Us within sixty (60) days after You receive Our denial.

Within sixty (60) days of the date We receive Your request, We will review the denial and make a final decision. Our final decision will be in writing, and if it is a denial, it will include Our specific reasons for the denial and make available all information directly relating to such denial.

### Time of Payment of Claims

If We approve Your claim, We will immediately pay the **Benefits** under the terms of this policy. Once our liability has ended, any balance remaining will be paid immediately once We receive proper written Proof of Claim.

### Payment of Claims

All **Benefits** will be paid to You, unless they are assigned by You. Unless assigned, any unpaid **Benefits** due to You at Your death will be paid in accordance with the Facility of Payment provision.

## General Provisions

<b>The Contract</b>	<p>This policy, with any Riders, endorsements and written application attached, make up the entire contract.</p> <p>The provisions of this policy must be read as a whole. For example, the Limitations and Exclusions apply to all <b>Benefits</b> in the policy.</p>
<b>Assignment; No Cash Value; Premium Refunds</b>	<p>The <b>Benefits</b> payable under the policy may only be assigned after a loss.</p> <p>The policy has no cash surrender value or other money that can be paid, Assigned, borrowed, or pledged as collateral for a loan.</p> <p>Any refund of unearned premiums due at Your death or on cancellation of this policy will be paid to You, or to Your estate at Your death. Any other refund of unearned premiums shall be, at Our option, applied against future premiums or applied to increase future <b>Benefits</b>.</p>
<b>Refund to Us for Overpayment of Benefits</b>	<p>If at any time We determine that the total <b>Benefits</b> paid to You was more than the total <b>Benefits</b> due, We have the right to recover the excess amount from You.</p> <p>If at any time We determine that the total <b>Benefits</b> paid to any other person or entity was more than the total <b>Benefits</b> due, We have the right to recover the excess amount from that person or entity.</p> <p>However, We may not recover any <b>Benefit</b> payments paid to You or on Your behalf in the event that We rescind the policy.</p>
<b>Facility of Payment</b>	<p>Any amounts due to You at Your death, as provided in the Payment of Claims provision or Premium Refunds provision, that is not more than \$1,000, may be made to anyone related to You by blood or marriage whom We find entitled to payment. Any payment made by Us in good faith will fully discharge Us to the extent of the payment.</p>
<b>Limitation on Representative's or Other Person's Authority</b>	<p>No sales representative, agent, broker or other person except Our President, Secretary or a Vice-President may: (a) make or change any contract of insurance; or (b) change or waive any of the terms of this policy. Any change or waiver must be in writing and signed by Our President, Secretary or a Vice-President and be endorsed or attached to the policy.</p>
<b>Incontestability</b>	<p>Any statement made by You in the application will be deemed a representation and not a warranty. No such statement made by You which relates to insurability can be used by Us to: (a) contest the validity of Your policy; or (b) deny an otherwise valid claim, unless the application was signed by You, and a copy of the application has been attached to the policy.</p>

## General Provisions (Continued)

If Your policy has been in force for less than six (6) months, We may contest the validity of Your policy or deny an otherwise valid claim upon a showing of misrepresentation by You that was material to the acceptance for coverage.

If Your policy has been in force for at least six (6) months but less than two (2) years, We may contest the validity of Your policy or deny an otherwise valid claim upon a showing of misrepresentation by You that is both material to the acceptance for coverage and which pertains to the condition for which **Benefits** are sought.

If Your policy has been in force for two (2) years or more, no misstatement, except a fraudulent misstatement, may be used to void the policy or deny a claim.

### **Misstatement of Age**

If Your date of birth is not correct as shown on Your application, an adjustment in amounts of coverage shall be made based on what the premium paid would have purchased at the correct age.

### **Legal Actions**

No legal action may be brought until sixty (60) days after written proof of claim has been given. No such action may be brought after six (6) years from the time written proof of claim is required to be given.

### **Termination of Policy**

Your policy will remain in force and will not terminate because of Your age or a deterioration in Your mental or physical health. Your policy will only terminate upon:

1. Our receipt of a written request to cancel the policy (the policy will terminate on the last day of the **Policy Month** in which such request was received, subject to any **Nonforfeiture Coverage**);
2. Payment of Your **Total Lifetime Benefit** under the policy;
3. **Policy Lapse** (subject to any **Nonforfeiture Coverage**); or
4. Your death.

### **Conformity With State Statutes**

Any provision in this policy which, on the **Original Coverage Effective Date** of the policy, conflicts with the laws of the state in which You reside on that date, is amended to meet the minimum requirements of such laws.

## General Provisions (Continued)

### Notice

When You write to Us, please give Us Your name, address and Policy Number. Please inform Us promptly of any changes. We will write to You at Your last known address.

Checks, drafts or money orders may be drawn on a U.S. bank to the order of Metropolitan Life Insurance Company (or "MetLife"). They are received subject to the condition that they may be handled for collection in accordance with the practice of the collecting bank or banks. If We do not receive the full amount of any check, draft or money order, it will not constitute payment. All payments are to be made in U.S. currency. We may refuse to accept any payments made in a manner that applicable law requires Us to refuse (such as any large cash payment made without information that We are required by law to obtain).

You may write to Us at: Metropolitan Life Insurance Company  
P.O. Box 937  
Westport, CT 06881-0937

Copy of application is attached. Riders and endorsements, if any, follow.

PROOF