

Metropolitan Life Insurance Company

A Stock Company Incorporated in New York State

LONG-TERM CARE INSURANCE POLICY

Metropolitan Life Insurance Company (MetLife) will pay the Benefits of this policy according to its provisions. The Insured named on the Schedule of Benefits has the Coverage described in this policy as of the Original Effective Date shown on the Schedule of Benefits. In this policy, "you" and "your" mean the Insured and "we", "us" and "our" mean MetLife. Please see the Definitions section for additional defined terms. Terms defined in the Definitions section appear throughout this policy with initial capitalization.

- **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 this 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 unless the change is required by law, except that we may change premium rates on a class basis, subject to approval by the Connecticut Insurance Department. Any such change in premium rates will apply to all policies in the same class as yours.
- 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 or call the toll-free number 1-800-565-3761.

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 DOES NOT QUALIFY FOR MEDICAID ASSET PROTECTION.

NOTE: The Connecticut Insurance Department does not in any way warrant that the policy meets the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

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 this 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
Senior Vice-President and Secretary



C. Robert Henrikson
Chairman of the Board, President and Chief Executive 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 agent or producer from whom you bought it within 30 days from the date you receive it. If you return it within the 30 day period, this policy will be void from the beginning. We will refund any premium paid within 30 days after we receive the returned policy.

SPECIMEN

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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]
[Address]	[123 ABC Street Anytown, USA]
[Date of Birth]	[XX/XX/19XX]
Policy Number	[211000000 LTC]
[Plan Number]	[XXXX]
Original Effective Date ¹	[January 1, 2007]
Effective Date of this Schedule of Benefits ²	[January 1, 2007]
Original Issue Age	[61]
Elimination Period for Covered Services	[100] calendar days
[Elimination Period for the International Benefit** ** does not apply if your policy includes the Cash Benefit Rider]	[[100] calendar days]
Monthly Benefit Amount (MBA)	[\$3,000]
Total Benefit Amount ³	[\$100,000]
[Transferred Total Benefit Amount – Shared Care Rider]	[\$XXXXX]
Covered Services	Maximum Coverage Amount
Nursing Home ⁴	The actual charge incurred, up to the Monthly Benefit Amount per Calendar Month.
Hospice Facility ⁴	
Assisted Living Facility ⁴	
Home Care Services ⁴	
Adult Day Care ⁴	
Bed Reservation ⁴	The actual charge incurred, up to 50 days per Calendar Year.
Needs Assessment	Benefit limited to 1 visit per lifetime. If provided by a Care Management Organization selected by you, the actual charge incurred, up to \$275 per lifetime.
International Benefit	50% of the Monthly Benefit Amount per Calendar Month. See the International Benefit section of this policy for information on the Total Benefit Amount for this Benefit.

¹ This policy will not take effect unless and until we receive payment of the full first modal premium amount.

² Increases in Coverage will not take effect unless we receive payment of the full first modal premium for the increase when due. This Schedule of Benefits replaces any previous Schedule of Benefits for this policy.

³ The Total Benefit Amount shown does not reflect any Benefits paid or payable. Note, however, that increases to your Total Benefit Amount under any applicable Benefit increase rider will be calculated based on your remaining Total Benefit Amount. See the following for more information: definition of Total Benefit Amount; and, the Impact of Payment of Claims on Your Total Benefit Amount provision of the Claims section of this policy.

⁴ If you receive more than one of these Covered Services in a Calendar Month, the most we will pay for all such Covered Services for that Calendar Month is the Monthly Benefit Amount.

Discounts: [spousal discount, marital discount, residential discount, multi-life discount, none]

Initial Health Rating: [preferred] [standard] [rated] -- If you make a Coverage change that requires proof of your good health after your Original Effective Date, your initial Health Rating may not apply to that Coverage change.

PREMIUM SCHEDULE

COVERAGE	ANNUAL PREMIUM ⁵ (Includes Health Rating and any applicable discounts)
Base Coverage	[\$XXX.XX]
[Cash Benefit Rider]	[\$XXX.XX]
[Future Purchase Rider] [Guaranteed Purchase Option Rider]	[\$XXX.XX]
[Automatic Benefit Increase Rider:] 5% Automatic Compound Inflation Protection Rider 3% Automatic Compound Inflation Protection Rider Urban CPI Compound Inflation Protection Rider]	
[Nonforfeiture Coverage Rider]	[\$XXX.XX]
[Shared Care Rider]	[\$XXX.XX]
[Total annual premium with discounts and Health Rating applied] [monthly, quarterly, semi-annual, annual] modal premium amount ⁵	[\$XXX.XX] [\$XXX.XX]

⁵ There is an additional cost if you pay premiums more frequently than annually.

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DEFINITIONS

Terms defined in this section appear throughout this policy with initial capitalization.

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.
- Contenance: 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 of Qualified Long-Term Care Services furnished at an Adult Day Care Center.

Adult Day Care Center means:

- a facility operated and licensed or certified as an Adult Day Care Center under the laws where it is located that only provides services for a portion of the day; or
- if licensing or certification is not required, a facility that meets ALL of the following requirements:
 - provides a program of Adult Day Care;
 - only provides services for a portion of the day;
 - keeps a Written record of services performed for each client;
 - has established procedures to obtain emergency medical care;
 - has a full-time director; and 1 or more Nurses present at least 4 hours a day during operating hours; and
 - operates at least 5 days a week for a minimum of 6 hours a day.

The term Adult Day Care Center does not include any facility which chiefly provides services for recreation or social activities.

Assisted Living Facility means a facility that meets ALL of the following requirements:

- if licensing or certification is required, maintains all appropriate licensing or certification under the laws where it is located to provide Maintenance or Personal Care;
- provides 24 hour 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;
- has at least 5 clients;
- uses aides trained or certified to provide Maintenance or Personal Care in accordance with any laws which apply to the provision of such care;
- provides 24 hour supervision of clients by a trained and awake staff;
- has established procedures to obtain emergency medical care;
- keeps a Written record of services performed for each client;
- makes available at least 3 meals a day and accommodates special dietary needs; and
- has appropriate methods and procedures to assist in administering prescribed drugs where allowed by law.

The term Assisted Living Facility includes any facility that meets all of the above requirements that specializes in the care of persons with Alzheimer's disease and other dementias.

The term Assisted Living Facility does not include:

- any facility used primarily to provide residential services and not Maintenance or Personal Care (retirement homes, independent living units of continuing care retirement communities, senior housing and other facilities primarily intended to provide residential services but not Maintenance or Personal Care do not qualify as an Assisted Living Facility);
- any facility that provides services primarily for detoxification of or rehabilitation for alcoholism or drug addiction (chemical dependency); or
- any facility where a majority of the residents are related to the owner or manager.

If a facility has more than one license, certification or purpose, only that section of the facility specifically meeting the definition of Assisted Living Facility will qualify as an Assisted Living Facility.

Automatic Benefit Increase Rider means the rider, if any, identified as an Automatic Benefit Increase Rider on your Schedule of Benefits.

Bed Reservation means payment to hold your space in a Facility to enable you to return to the Facility.

Benefit or Benefits means the amount or amounts we will pay under the terms of this policy.

Calendar Month means a month of the Calendar Year, such as January, February or March.

Calendar Year means a 12 month period which begins on any January 1 and ends on December 31.

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;
- identifying the long-term care providers to meet those needs;
- requisitioning and coordinating long-term care services;
- implementing the long-term care service plan; and
- monitoring and reassessing long-term care needs as required from time to time.

Care Management Organization means:

- an organization operated and licensed or certified as a care management organization under the laws where it is located; or
- if licensing or certification is not required, an organization that meets ALL of the following requirements:
 - provides Care Advisory Services;
 - has a full-time administrator;
 - keeps a Written record of services performed for each client; and
 - has a staff which includes at least one Nurse and one Social Worker.

Chronically Ill means:

- you are unable to perform, without Substantial Assistance from another individual, at least 2 Activities of Daily Living for an expected period of at least 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.

Coverage means the long-term care insurance that is in effect for you and which is described in this policy.

Covered Services means Qualified Long-Term Care Services which are part of your Plan of Care for which Coverage is provided under this policy.

Designated Beneficiary means, for purposes of the Payments on Death provision of the General Provisions section of this policy, the beneficiary you have designated on the form we provide for such designation.

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 or filing is available; or
- 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 Effective Date of this policy during which you must be eligible for Benefits before Benefits, other than Benefits for the Needs Assessment, become payable. These days need not be consecutive. The Elimination Period for Covered Services and the Elimination Period for the International Benefit are shown on your Schedule of Benefits.

Facility means a Nursing Home, Hospice Facility or Assisted Living Facility.

Health Rating means your risk classification based on our underwriting criteria in effect at the time that we process your application for initial Coverage or a Coverage change.

Home means any private residence in which you are living or staying. **The term Home does not include** any: hospital or other acute care facility; nursing home; hospice facility; assisted living facility; or other residential long-term care facility.

Home Care Agency or Homemaker-Home Health Aide Agency means an organization or agency that:

- is certified as a Home Health Care Agency by Medicare; or
- if licensing or certification is required, maintains all appropriate licensing and/or certification under the laws where it is located, or under a public health law or similar law, to provide Home Care Services; or
- if licensing or certification is not required, meets ALL of the following requirements:
 - uses Home Care Aides, trained or certified in accordance with any laws which apply to such care, to provide Maintenance or Personal Care;
 - has at least 5 clients;
 - provides on-site supervision of Home Care Aides and Homemakers by a qualified person who has special training to provide such supervision;
 - provides on-call availability of a supervisor of the organization or agency during the hours that the Home Care Aide or Homemaker is in the client's Home;
 - requires, at a minimum, a background check and employment eligibility verification for all Home Care Aides and Homemakers;
 - Home Care Aides and Homemakers are employees of the organization or agency and are not independent contractors;
 - has a Written treatment plan in place for each client;
 - maintains a Written record of services performed for each client; and
 - a majority of the organization's or agency's clients are not related to the organization's or agency's owner

or manager.

Home Care Aide means a person whose main function is to provide Maintenance or Personal Care and whose services are arranged and supervised through a Home Care Agency or a Homemaker-Home Health Aide Agency. 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 Care Services means the following medical and non-medical services provided to Chronically Ill persons at Home: Nursing Care; Home Care Aide services; Homemaker Services; Hospice Care, Independent Caregiver services, Care Advisory Services; Therapy Services and services provided by a Social Worker.

Homemaker means a skilled or unskilled person whose services are arranged and supervised through a Home Care Agency or a Homemaker-Home Health Aide Agency.

Homemaker Services means Maintenance or Personal Care services provided by a Homemaker that are necessary for or consistent with a 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 persons who are Terminally Ill.

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

Hospice Facility means a facility or unit of a facility that meets the definition of Hospice.

Hospital means a facility that is licensed as a hospital, and provides:

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

Household Member means another person who resides at the same address and shares the same living quarters as you. This definition only applies to the Discounts section of this policy.

Immediate Family means your spouse, Domestic Partner, child (natural, step or adopted), parent, sibling, grandchild, or in-law. It also includes anyone who normally lives in your Home.

Independent Caregiver means a person who is appropriately trained or credentialed to provide Maintenance or Personal Care:

- whose services are not arranged and supervised by a Home Care Agency;
- who is paid directly by you and you or someone acting on your behalf are responsible for the supervision and adequacy of the care provided;
- whose services are a cost-effective alternative to Covered Services provided by a Home Care Agency;
- whose services effectively meet your needs;
- who is not a member of your Immediate Family; and
- whose services are part of your Written Plan of Care and have been approved by us.

Initial Annual Premium means your annual premium on the Original Effective Date as shown on your Schedule of Benefits. In determining the Initial Annual Premium and any changes to it, 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.

Insured means the person so named on the Schedule of Benefits for whom Coverage is in effect under this policy.

International Benefit means a Benefit paid to you if: you are outside the United States for at least 15 consecutive days during a Calendar Month regardless of the actual charges that you incur for Qualified Long-Term Care Services; and you meet the requirements of the International Benefit section of this policy.

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

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 United States Secretary of the Treasury. You may select any Licensed Health Care Practitioner; however, a Licensed Health Care Practitioner may not be a member of your Immediate Family.

Maintenance or Personal Care means any care with the primary purpose of providing needed personal 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 needed assistance with Activities of Daily Living and services provided on an extended basis to a person who is Chronically Ill, which are aimed at maintaining a person's health and/or functional status.

Maximum Coverage Amount means the most we will pay for a particular Covered Service as shown on your Schedule of Benefits.

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 the most we will pay for Covered Services (other than Needs Assessment) in a Calendar Month as shown on your Schedule of Benefits.

Needs Assessment means the services provided by a Care Advisor to: (1) assess your long-term care service needs; (2) identify options for your long-term care; and (3) discuss the long-term care options with you or your Representative.

Nonforfeiture Feature means the Contingent Benefit Upon Lapse provision of this policy, or if listed on your Schedule of Benefits, the Nonforfeiture Coverage Rider.

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 to improve or maintain your health that require the professional skills of a Nurse and are performed by a Nurse under the orders of a Physician.

Nursing Home means a facility that provides skilled, intermediate or custodial care that meets ALL of the following requirements:

- if licensing or certification is required, maintains all appropriate licensing or certification under the laws where it is located as a skilled or intermediate nursing facility;
- has 24 hour a day Nursing Care;
- has 24 hour a day Maintenance or Personal Care performed by an awake, and trained or certified staff supervised by a Nurse;
- keeps a Written record of services performed for each client;
- has established procedures to obtain emergency medical care; and
- services are not limited to provision of food, shelter, and other residential services such as laundry.

The term Nursing Home includes any facility that meets the above requirements that specializes in the care of persons with Alzheimer's disease and other dementias. **The term Nursing Home does not include:**

- a Hospital (except a designated separate unit licensed as a Nursing Home or Hospice Facility);
- a facility that provides services primarily for detoxification of or rehabilitation for alcoholism or drug addiction (chemical dependency);

- a facility where a majority of the residents are related to the owner or manager; or
- an Assisted Living Facility.

Original Effective Date means the date that your Coverage initially becomes effective as shown on your Schedule of Benefits.

Original Issue Age means the age we use to calculate your premium for the Coverage in effect on your Original Effective Date. Your Original Issue Age is your age 30 days, or, for months with 31 days, 31 days prior to the date you signed your application for Coverage. Your Original Issue Age is shown on your Schedule of Benefits.

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 that:

- has been developed, prescribed and approved by a Licensed Health Care Practitioner at the time you are Chronically Ill as a result of an assessment of your functional and cognitive status and incorporates any information provided by your personal Physician;
- fairly, accurately and appropriately identifies ways of meeting your Qualified Long-Term Care Service needs;
- is appropriate and consistent with generally accepted standards of care for a similarly situated Chronically Ill person; and
- specifies the type, cost, frequency, expected duration and providers of all the services needed to meet your Qualified Long-Term Care Service needs.

No more than one Plan of Care may be in effect for you at a time.

Policy Anniversaries, Policy Years and Policy Months mean dates measured from the Original Effective Date of this policy. For example, if the Original Effective Date of this policy is May 5, 2007, the first Policy Anniversary is May 5, 2008; the first Policy Year ends May 4, 2008; and Policy Months start on the fifth day of each month, e.g., June 5, 2007. If your Original Effective Date falls on the 29th, 30th or 31st day of a month, and a particular Policy Month does not have that date, then that Policy Month will begin on the first day of the following 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 appropriately authorized by you or by a court of law to represent you.

Schedule of Benefits means the customized listing of your Coverage selections.

Severe Cognitive Impairment means a deterioration or loss in intellectual capacity that is: (a) comparable to (and includes) Alzheimer's Disease and similar forms of irreversible dementia; 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.

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.

State means any of the states of the United States of America, the District of Columbia, the Commonwealth of Puerto Rico, Guam and the Virgin Islands.

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 (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).

Substantial Premium Increase means an increase or series of increases in your premium that cumulatively increase your Initial Annual Premium by a percentage equal to or greater than the Percentage Increase shown in the table below for your Original Issue Age. **The term Substantial Premium Increase does not include** an increase in premium due to: an increase in your Benefits; a change in your Coverage that you request; a change in your payment arrangements; or the end or reduction of a discount.

Original Issue Age	Percentage Increase	Original Issue Age	Percentage Increase
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%

Substantial Supervision means 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, for instance, while wandering.

Terminal Illness means an illness or injury which a Physician certifies is likely to result in a person's death within 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. **The term Therapist includes** a registered dietician in the case of nutritional therapy.

Therapy Services means physical, respiratory, speech, occupational or nutritional therapy services rendered by a Therapist.

Total Benefit Amount means the most we will pay under this policy during your lifetime, not including Benefits for Needs Assessment. Your Total Benefit Amount will be reduced by the amount of any Benefits that are paid, other than the Benefit for the Needs Assessment. This reduction to your Total Benefit Amount will be effective as of the date that Covered Services were received. For purposes of the International Benefit, this reduction will be effective as of the date that the Benefit was payable. Any references to your remaining Total Benefit Amount in this policy, including riders, refers to the Total Benefit Amount as reduced by any Benefits paid. If your policy is converted to paid-up status under a Nonforfeiture Feature, your Total Benefit Amount will be adjusted in accordance with the provisions of such feature.

United States means the United States of America, its territories and possessions.

Written or **Writing** means a record which is on or transmitted by paper or electronic media which is acceptable to us and consistent with applicable law.

REQUIREMENTS FOR PAYMENT OF BENEFITS

We will pay for long-term care services you receive only if:

- they are Qualified Long-Term Care Services that are consistent with your needs and approved in your Plan of Care;
- they are received after the Original Effective Date of this policy;
- you are eligible for Benefits;
- they are received after you have satisfied the Elimination Period for Covered Services shown on your Schedule of Benefits -- the Elimination Period does not apply to the Needs Assessment;
- they are Covered Services; and
- you have not exhausted your Total Benefit Amount.

Payment of Benefits is also subject to the maximums and limitations shown on your Schedule of Benefits and all exclusions, limitations, requirements and conditions set forth in this policy.

Please refer to the International Benefit section of this policy for information on payment of Benefits when you are outside of the United States.

ELIGIBILITY FOR BENEFITS (CONDITIONS AND LIMITATIONS)

You will be eligible for Benefits only if:

- Coverage is in effect for you;
- we are given proof, satisfactory to us, that you are Chronically Ill;
- a Licensed Health Care Practitioner has certified in Writing to us within the last 12 months, that you are Chronically Ill; and
- a Written Plan of Care, acceptable to us, that includes the Qualified Long-Term Care Services you need is in place for you and we are provided with a copy of the Plan of Care.

If You Need Benefits

You or someone acting for you may write to us or call our toll-free number shown on your Schedule of Benefits to request that we determine whether you are eligible for Benefits.

To determine if you are eligible for Benefits we may:

- contact you, your Representative, your Physician, a Licensed Health Care Practitioner, or other persons familiar with your condition;
- access your medical records to get information about your condition (we cannot determine that you are eligible for Benefits if we are not given access to your medical records); and
- request to have you examined, at our expense, by a licensed health care professional and/or to conduct an on-site assessment (we may not be able to determine that you are eligible for Benefits if you do not agree to be examined or if you do not agree to an on-site assessment).

Notice and Review of Benefit Eligibility Decision

We will send you Written notice of our decision on whether you are eligible for Benefits no later than 10 business days after we have received all the information we need. If we determine that you are eligible for Benefits, our notice will: state the date as of which you are eligible for Benefits; and include claim forms.

If we determine that you are not eligible for Benefits, our notice will provide the reason(s) for the denial. You or your Representative may request an appeal of a denial in accordance with the Appeals of Eligibility for Benefits or Claims Decisions section.

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 12 months, but no more frequently than every 30 days.

Your Written Plan of Care must be updated and provided to us as your condition and needs change.

ELIMINATION PERIOD

Elimination Period is the number of calendar days after the Original Effective Date of this policy during which you must be eligible for Benefits before Benefits, other than Benefits for Needs Assessment, become payable. These days need not be consecutive. There is an Elimination Period for Covered Services and an Elimination Period for the International Benefit, as shown on your Schedule of Benefits.

A day of the Elimination Period for Covered Services and a day of the Elimination Period for International Benefits will be satisfied each day that you are eligible for Benefits.

Benefits will not be paid for Covered Services, other than Benefits for the Needs Assessment, that you receive during the Elimination Period for Covered Services. No Elimination Period is required in order to receive Benefits for the Needs Assessment. Please refer to the International Benefit section for additional information on the Elimination Period for the International Benefit.

Once you have satisfied a day of the Elimination Period, that day is satisfied for the life of this policy.

COVERED SERVICES

We will pay Benefits for the following Covered Services if you meet all requirements for payment of Benefits set forth in this policy: Nursing Home, Hospice Facility, Assisted Living Facility, Bed Reservation, Home Care Services, Adult Day Care and Needs Assessment. Your Schedule of Benefits shows the maximum Benefits we will pay for Covered Services. Payment of Benefits for Covered Services, other than the Needs Assessment, will reduce your Total Benefit Amount.

Nursing Home, Hospice Facility, Assisted Living Facility

For each day you are in a Nursing Home, Hospice Facility or Assisted Living Facility, we will pay Benefits for:

- room and board; and
- the following services received by you in the Facility and provided by the Facility: Nursing Care, Maintenance or Personal Care, Therapy Services and Hospice Care.

Bed Reservation

If you are in a Facility and you leave the Facility, we will pay Benefits for the actual charges you incur to hold your space in the Facility to enable you to return to it. We will not pay more than the Benefit we would pay if you have been in the Facility on those days you were absent from the facility.

Bed Reservations are limited to 50 days per Calendar Year. Once the 50 day limit for a particular Calendar Year is exhausted, Benefits for Bed Reservation are no longer available until the following Calendar Year.

Home Care Services

We will pay for Benefits for the following Home Care Services:

- Nursing Care;
- Services provided by a Home Care Aide;
- Homemaker Services;
- Hospice Care;
- Care Advisory Services;
- Therapy Services;

- services provided by an Independent Caregiver; and
- services provided by a Social Worker.

Adult Day Care

We will pay Benefits for Adult Day Care.

Needs Assessment

After you become eligible for Benefits, you can receive one Needs Assessment from a Care Management Organization. You can receive the Needs Assessment from a Care Management Organization that we select and to whom we make direct payment. You may instead select a Care Management Organization to conduct the Needs Assessment and we will pay Benefits for the actual charge you incur for that service up to the Maximum Coverage Amount for Needs Assessment shown on your Schedule of Benefits. You do not have to satisfy the Elimination Period for this Benefit to be payable. Payment of this Benefit will not reduce your Total Benefit Amount or the Monthly Benefit Amount available for other Covered Services.

Alternate Services

Alternate services are Qualified Long-Term Care Services which are not specifically defined in this policy as Covered Services. Alternate services for which we pay Benefits under this provision will be considered Covered Services.

We will consider paying Benefits for actual charges you incur for alternate services as stated below. We will pay for alternate services only if you are eligible for Benefits, have satisfied the Elimination Period for Covered Services, and we determine that the alternate services meet ALL of the following requirements:

- the services fall within our guidelines;
- they are part of a Written Plan of Care, acceptable to us;
- they effectively meet your long-term care service needs;
- they are a cost-effective alternative to Covered Services that are specifically defined in this policy for which Benefits would be payable;
- they are not provided by a member of your Immediate Family;
- they are not excluded under the Exclusions provision of the Limitations and Exclusions section of this policy; and
- the alternate services and Benefits we will pay must be mutually agreed to, in Writing, by you, your Licensed Health Care Practitioner, and us, through an alternate services agreement.

We will only pay for alternate services received on or after the date all parties have signed the 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 Benefits we would pay for the Covered Service we determine to be most closely related to the alternate services received.

Maximum We Will Pay For Covered Services

If in a Calendar Month, you receive more than one Covered Service, other than the Needs Assessment, the most we will pay for all of those Covered Services is the Monthly Benefit Amount. Payment of the International Benefit and the Bed Reservation Benefit will reduce the Monthly Benefit Amount available.

When the Monthly Benefit Amount Will Be Pro-Rated

The Monthly Benefit Amount will be pro-rated accordingly, if after the first day but before the end of a Calendar Month, you:

- satisfy the Elimination Period for Covered Services;
- become eligible for Benefits; or
- cease to be eligible for Benefits.

Services/Items that are Not Covered

Benefits are only payable for the Covered Services listed above. We will not pay for any service or item that is not a Covered Service including, but not limited to, the following services or items. We will not pay for any charges for:

- Physician, Hospital or laboratory services;
- prescription or non-prescription medication;
- medical supplies or durable medical equipment;
- transportation;
- services for convenience, companionship, entertainment or personal beautification;
- independent living quarters in a continuing care retirement community or similar entity;
- residential upkeep (such as painting, plumbing, yard care, snow removal), construction or renovation; and
- care or services which are not included in, or that are inconsistent with, your Plan of Care.

INTERNATIONAL BENEFIT

We will pay the International Benefit described below if you are outside the United States and meet ALL of the following requirements:

- you are eligible for Benefits;
- you have satisfied the Elimination Period for the International Benefit shown on your Schedule of Benefits; and
- you are outside the United States for at least 15 consecutive days during a Calendar Month.

For each Calendar Month that you meet the above requirements, we will pay the International Benefit, regardless of the actual charges you incur for Qualified Long-Term Care Services. The International Benefit is equal to 50% of your Monthly Benefit Amount per Calendar Month. When you are outside the United States, we do not pay Benefits for any services or supplies that you receive, we instead pay the International Benefit.

We will pay you the International Benefit up to the lesser of: (1) your Total Benefit Amount less any Benefits paid while you are in the United States; or (2) 50% of your Total Benefit Amount. If you are receiving Covered Services in the United States for part of a Calendar Month and you qualify for payment of the International Benefit for part of that month, payment of the International Benefit will reduce the Monthly Benefit Amount available for the Covered Services received in the United States.

This policy will continue to be in force after the International Benefit is exhausted if there are any remaining Benefits available to pay for Covered Services received in the United States.

Payment of the International Benefit is subject to all applicable policy exclusions, requirements and provisions.

Regardless of whether you are inside or outside of the United States, the sum of all Benefits we will pay will never exceed your Total Benefit Amount.

We will pay you the International Benefit in United States currency. You may not assign the International Benefit.

Changes to the Limitations and Exclusions Section of This Policy

The Non-Duplication of Benefits and Coordination With Other MetLife Coverages provisions of the Limitations and Exclusions section do not apply to the International Benefit. The following exclusions under the What is Not Covered Under This Policy provision of the Limitations and Exclusion section of this policy are the only exclusions listed in that section that apply to payment of the International Benefit:

No payment will be made for any of the following:

- any injury or sickness which is caused by declared or undeclared war or any act thereof; or
- any intentionally self-inflicted injury.

Tax Note: Because the International Benefit is paid without regard to the actual charges you incur, part of the International Benefit could be considered taxable income if it exceeds the limitations prescribed by the Internal Revenue Code of 1986, as amended. You should consult with your independent tax advisor.

Note: Benefits payable under this International Benefit section are intended to help cover the costs of long-term care. They are not related to earnings and they do not replace income.

CHANGING BENEFIT AMOUNTS AND OTHER COVERAGE CHANGES

While you are insured, you may request changes to your Coverage as described below as long as your policy is not in paid-up status under a Nonforfeiture Feature. A change in your Coverage may change the amount of premium for your Coverage.

You may request information about making increases or decreases to your Monthly Benefit Amount and/or Total Benefit Amount or about making other changes to your Coverage by calling our toll-free number listed on your Schedule of Benefits.

All requests for changes in Coverage under this section must be provided to us in Writing. We reserve the right to require your Written acceptance before any change in Coverage under this section takes effect.

Anytime your Monthly Benefit Amount changes under this section, all Maximum Coverage Amounts listed on your Schedule of Benefits that are determined based on your Monthly Benefit Amount will change accordingly.

For any change in Coverage that we approve under this section, we will send you a new Schedule of Benefits that reflects your updated Coverage and premium.

Increases in Monthly Benefit Amount and/or Total Benefit Amount

We will approve your request for an increase in your Monthly Benefit Amount and/or Total Benefit Amount under this provision only if you provide at your expense, proof of your good health, satisfactory to us.

You may increase your Monthly Benefit Amount and/or Total Benefit Amount to those amounts and in those combinations that are available for this policy.

You cannot increase Benefits for the Needs Assessment under this provision. If your premium is being waived under the Waiver of Premium section, you cannot increase your Monthly Benefit Amount and/or your Total Benefit Amount under this provision.

The extra premium for an increase in Benefits under this provision will be based on:

- your age on the effective date of the increase;
- the premium rates, discounts, if any, and your Health Rating, in effect on the effective date of the increase; and
- your Coverage and your premium in effect prior to the increase.

The effective date of any increase requested and approved under this provision will be the Policy Anniversary that next follows the date of our approval of your request. We will send you a Written notice of the increase in Benefits, the effective date of the increase and the amount of premium due.

Decreases in Monthly Benefit Amount and/or Total Benefit Amount

You may decrease your Monthly Benefit Amount and/or Total Benefit Amount to those amounts and in those combinations that are available for this policy.

You cannot decrease Benefits for the Needs Assessment under this provision.

The effective date of a decrease in your Monthly Benefit Amount and/or Total Benefit Amount requested and approved under this provision will be the day we approve your request, if it is the first day of a Policy Month. In all other cases, the decrease will take effect on the first day of the Policy Month following the month in which your request is approved. The amount of the premium reduction for the decrease will be computed assuming that the levels of benefits purchased last are discontinued first.

Other Coverage Changes

You may be eligible to make other changes to your policy. Such changes may require proof of your good health, satisfactory to us and may affect your premium. Contact us for details by calling our toll-free number listed on your Schedule of Benefits.

LIMITATIONS AND EXCLUSIONS

What is Not Covered Under this Policy

No payment will be made for any of the following:

- confinement for the treatment of alcoholism or drug addiction, unless the addiction was due to drug(s) taken on the advice of a Physician;
- any care received while in a Hospital, except in a unit specifically designated and licensed as a Nursing Home or Hospice Facility;
- any injury or sickness which is caused by declared or undeclared war or any act thereof;
- any intentionally self-inflicted injury;
- services performed at Home by a member of your Immediate Family, unless: (a) he or she is a regular employee of a Home Care Agency or a Homemaker-Home Health Aide Agency which is providing services to you; (b) the Home Care Agency or Homemaker-Home Health Aide Agency receives payment for the services; and (c) he or she receives no compensation other than the normal compensation for employees of that Home Care Agency or Homemaker-Home Health Aide Agency;
- any care or services received outside of the United States, except as described in the International Benefit section;
- any service or item 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;
- treatment received in a government facility (unless otherwise required by law); or 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.

Non-Duplication of Benefits

To the extent permitted by applicable law, we will reduce the Benefits that we will pay for Covered Services to the extent that the combination of Benefits paid under this policy and amounts paid or payable for those services by any of the following exceed 100% of the actual charge for the Covered Services:

- any state or federal workers' compensation law or similar law;
- any employer's liability or occupational disease law; or
- any motor vehicle no-fault law.

This provision does not apply to policies or certificates which pay benefits without regard to actual charges you incur.

CLAIMS

Please contact us as soon as possible if you believe you may need long-term care or services.

Notice of Claim

You must provide us with notice of claim within 20 days after the beginning of any loss which may be covered by this policy, or as soon as reasonably possible. Your notice of claim must include your name, policy number, the type of care you are receiving or expect to receive, and an address to which the claim form(s) should be sent.

Claim Forms

When we receive your notice of claim, we will provide you with claim form(s). If we do not provide you with claim forms within 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 Loss

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. On a bill or invoice or other proof of service, we require the following information:

- the name of the provider;
- if you are using a licensed or certified provider, the provider's license or certification number and tax identification number;
- if you are using a non-licensed or non-certified provider that is a Facility or Home Care Agency, tax identification number and information satisfactory to us that the provider meets requirements for payment of Benefits;
- if you are using an non-licensed or non-certified independent provider:
 - the social security number or information that we determine to be an acceptable equivalent to a social security number; and
 - information satisfactory to us the provider meets the requirements for payment of Benefits;
- the dates and duration of service;
- description and confirmation of the services provided; and
- the fees charged for service.

You must submit Written proof of loss to us, at the address stated on the claim form we provide you, no later than 90 days after the date on which you incurred charges for which you are submitting a claim. Failure to submit proof of loss within this time limit will result in a claim denial unless it is shown that:

- it was not reasonably possible to provide proof of loss within the time period; and
- proof of loss 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 was otherwise required.

To help us determine whether you have incurred charges for Covered Services:

- we or a person we name may contact you, your Representative, your Physician, your Licensed Health Care Practitioner, any of your care providers, or other persons familiar with your condition or with the services you received;
- we may require that you provide us, or a person we name, with access to your medical records and your care provider's records, including daily notes of care, to obtain information about your condition or the services you received. We may not be able to approve a claim for Benefits if we do not have access to these records; and

- 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 services.

Claims for International Benefits

If you are making a claim for Benefits under the International Benefit section of this policy, any reference above to charges you incur for Covered Services does not apply.

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 a claim as soon as reasonably possible. In no event will we send this notice later than 10 working days after we have received all the information we need to assess your claim. If we deny your claim, our notice will include our specific reasons.

Payment of Claims

If we approve your claim, we will immediately pay the Benefits under the terms of this policy; ongoing claims that are submitted on a periodic basis will be paid on a monthly basis. We will pay Benefits based upon the Monthly Benefit Amount in effect:

- as of the date that Covered Services were received; or
- for the International Benefit, the date that the Benefit was payable.

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 Payments on Death provision of the General Provisions section of this policy.

Impact of Payment of Claims on Your Total Benefit Amount

Your Total Benefit Amount will be reduced by the amount of any Benefits that are paid, other than the Benefit for the Needs Assessment. This reduction to your Total Benefit Amount will be effective as of the date that Covered Services were received. For purposes of the International Benefit, this reduction will be effective as of the date that Benefit was payable.

Note: If after you receive an increase to your Total Benefit Amount under a rider that increases Benefits, we receive and approve a claim for:

- Covered Services received before the effective date of the increase; or
- for International Benefits payable before the effective date of the increase,

we will:

- reduce your Total Benefit Amount, as of the date the Covered Services were received or the International Benefit was payable, by the amount of Benefits paid for such claim; and
- recalculate the amount of such increase based on this reduction of the Total Benefit Amount.

APPEALS OF ELIGIBILITY FOR BENEFITS OR CLAIMS DECISIONS

We will reconsider our decision to deny your eligibility for Benefits or your claim for Benefits if you or your Representative:

- request in Writing that we review our decision; and
- send this request to us within 60 business days after you receive our denial.

Within 60 business 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.

PREMIUMS

Premium Payment

Your first premium is due and payable on the Original Effective Date of this policy. Subsequent premium is due and payable on the premium due date that we establish for this policy. The premium must be paid in United States currency.

You may change your premium payment mode (frequency) with our approval.

The amount of the premium for your initial coverage is based on your Original Issue Age, initial Health Rating and any applicable discounts.

When Your Premium May Change

Your premium will not increase because you get older or your health changes.

We reserve the right to change premium rates on a class basis, subject to approval by the Connecticut Insurance Department. We will notify you in Writing at least 45 days prior to any increase in your premiums on a class basis.

Your premium may change if there is a change in Coverage under the Changing Benefit Amounts And Other Coverage Changes section of this policy or as a result of an increase in Benefits provided under the terms of this policy including any rider other than an Automatic Benefit Increase Rider. Please refer to the Changing Benefit Amounts and Other Coverage Changes section of this policy for more information. In addition, your premium may change if you change your premium payment mode or an applicable discount ends.

DISCOUNTS

You may be eligible for the spousal discount, marital discount or residential discount described below. You can only receive one of these discounts. If you qualify for both the spousal and residential discount, we will automatically apply the spousal discount.

We reserve the right to require proof satisfactory to us that you are eligible for a discount.

Spousal Discount

Premiums for your Coverage will be subject to a spousal discount if your spouse or Domestic Partner is insured under an individual long-term care insurance policy issued by MetLife. This discount will only apply to premiums due and payable on or after the latest of:

- your Original Effective Date;
- the date your spouse's or Domestic Partner's coverage initially becomes effective; or
- the date we are notified that you are eligible for the discount.

This discount will end if your spouse's or Domestic Partner's coverage ends for any reason other than his/her death or exhaustion of the total benefit amount under his/her policy.

Marital Discount

Premiums for your Coverage will be subject to a marital discount if you are married or have a Domestic Partner and you do not qualify for the spousal discount described above.

This discount will only apply to premiums due and payable on or after the latest of:

- your Original Effective Date; or
- the date we are notified that you are eligible for the discount.

Residential Discount

Premiums for your Coverage will be subject to a residential discount if a Household Member is insured under an individual long-term care insurance policy issued by MetLife.

This discount will only apply to premiums due and payable on or after the latest of:

- your Original Effective Date;
- the date the Household Member's coverage initially becomes effective; or
- the date we are notified that you are eligible for the discount.

This discount will end if the Household Member's coverage ends for any reason other than his/her death or exhaustion of the total benefit amount under his/her policy.

GRACE PERIOD

You have a grace period of 31 days to pay each premium due after the date it is due. If the premium is not paid by the end of the grace period, we will send a Written notice of Lapse of this policy to you and to any person named to receive such notice at the addresses given to us. You have 35 days after we mail this notice to pay the premium. This policy will stay in force during this time unless we receive a Written request from you to cancel this policy. If we do not receive the premium within 35 days of mailing the notice, this policy will then Lapse at the end of this 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 in addition to yourself 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 2 years.

WAIVER OF PREMIUMS

We will waive your premium if you:

- are eligible for benefits;
- have satisfied the applicable Elimination Period (if you are in the United States, you must satisfy the Elimination Period for Covered Services – if you are outside the United States, you must satisfy the Elimination Period for the International Benefit); and
- are receiving payment of Benefits.

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:

- if you are in the United States, when you are no longer eligible for Benefits or you are no longer submitting proof of your receipt of Covered Services, whichever is earlier; or
- if you are outside the United States, when you are no longer eligible for Benefits or when the International Benefit is no longer payable, whichever is earlier.

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. 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 premium payment mode once premiums are no longer waived.

RETURN OF EARNED PREMIUM ON DEATH

If you die on or before your 70th birthday, we will pay an amount equal to all premiums that were due and paid to us up to your 70th birthday less any Benefits that were paid to you or on your behalf.

Proof of your death satisfactory to us should be submitted to us within 90 days of your death. Payment under this provision will be made in accordance with the Payments on Death provision of the General Provisions section of this policy.

We will not return any premiums under this provision if:

- you die after your 70th birthday; or
- your Coverage was in paid-up status under a Nonforfeiture Feature on the date of your death.

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 end on the earliest of:

- the last day of the Policy Month in which we receive your Written request to cancel your policy**;
- the date your Total Benefit Amount is exhausted (reduced to zero);
- the date your policy Lapses**; or
- the date of your death.

** In this case, Coverage may be eligible for conversion to paid-up status under a Nonforfeiture Feature, if applicable.

REINSTATEMENT FOR SEVERE 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 6 months of the date of Lapse, you or someone acting for you:

- request reinstatement;
- submit proof, satisfactory to us, that you had a Severe Cognitive Impairment or loss of functional capacity on or after the 1st date that a premium was due and unpaid but before the date that this policy Lapsed for non-payment of that premium (the standard of proof we will use will be no more restrictive than that described in the Eligibility for Benefits section of this policy); and
- pay all past due premiums to us, if we approve your request for reinstatement.

If we reinstate your policy, your premium will be what it would have been if your policy had not Lapsed.

REINSTATEMENT

If your policy Lapses, you may apply for reinstatement by completing the reinstatement application form that we require. This policy will only be reinstated if:

- we receive the required completed reinstatement application form at the address stated on the application form no later than 12 months after the date your policy Lapsed;
- we receive any additional proof of your good health that we require;

- we do not send you a Written disapproval of such completed application by the 45th day after the date that we received the completed application; and
- we receive the full amount of all premiums due for your policy no later than the due date on the bill that we send you for the premiums required to reinstate your policy.

Please note that we will not accept any premium payment with your application for reinstatement. If your policy has Lapsed, we will only accept payment of premium after your application for reinstatement: has been approved by us; or has not been disapproved in Writing by us by the 45th day after the date that we received your completed reinstatement application.

If your policy is reinstated, it will be reinstated back to the date that the policy Lapsed.

EXTENSION OF BENEFITS

If as of the date your policy Lapses or as of the date we receive your Written request to cancel your policy, you are eligible for Benefits and are confined in a Nursing Home, Hospice Facility or Assisted Living Facility, we will extend the payment of Benefits for Covered Services received so long as, without interruption, you remain eligible for Benefits and confined. Benefits will be extended subject to Elimination Period requirements and other terms of this policy until the earliest of the following:

- the date you are no longer eligible for Benefits;
- the date you are no longer confined in a Nursing Home, Hospice Facility or Assisted Living Facility; or
- the date your Total Benefit Amount is exhausted.

CONTINGENT BENEFIT UPON LAPSE

Contingent Benefit Upon Lapse

Under this Contingent Benefit Upon Lapse provision, you have certain options in the event of a Substantial Premium Increase as described below.

We will send you Written notice of a Substantial Premium Increase at least 45 days before it takes effect. In this notice, we will:

- provide you with the option to decrease your Benefits so that your premium will not increase;
- offer you the option to stop paying premiums and convert your policy to paid-up status, as described below, at any time during the 120 day period following the first due date of the Substantial Premium Increase; and
- advise you that we will automatically convert your policy to paid-up status, as described below, if your policy Lapses or you cancel your policy at any time during the 120 day period following the first due date of the Substantial Premium Increase.

Paid-Up Status Under Contingent Benefit Upon Lapse

If your policy is converted to paid-up status under this provision, we will pay the same Benefits that were in effect under this policy immediately prior to the date your policy was converted to paid-up status, except that:

- your Total Benefit Amount will be adjusted to equal the greater of:
 - the sum of all paid and waived premiums for your policy; or
 - the Monthly Benefit Amount in effect immediately prior to the date your Coverage was converted to paid-up status; and
- Benefits cannot be changed and will not be changed under any provisions of the Changing Benefit Amounts and Other Coverage Changes section of this policy or any rider that increases Benefits.

The total Benefits that we will pay before and after your policy is converted to paid-up status will not exceed your remaining Total Benefit Amount in effect immediately prior to the date your policy was converted to paid-up status.

If your policy includes a Nonforfeiture Coverage Rider, your policy can only be converted to paid-up status under this Contingent Benefit Upon Lapse provision or the Nonforfeiture Coverage Rider, but not both. If you meet the requirements for conversion to paid-up status under both this provision and the Nonforfeiture Coverage Rider, we will automatically apply the provision that will provide you with the higher adjusted Total Benefit Amount.

Limitations

Once your policy is converted to paid-up status under this provision, all riders under your policy end, except the Cash Benefit Rider (if included in your policy).

GENERAL PROVISIONS

The Contract

This policy, with any riders, endorsements and Written application attached, make up the entire contract.

The provisions of this policy must be read as a whole. For example, the Limitations and Exclusions apply to all Benefits in this policy.

Assignment

The Benefits payable under this policy may only be assigned after a loss.

No Cash Value

This policy has no cash surrender value or other money that can be paid, assigned, borrowed, or pledged as collateral for a loan.

Unearned Premium Refund

Any refund of unearned premiums due on cancellation of this policy will be paid to you. Any refund of unearned premiums due at your death will be paid in accordance with the Payments on Death provision of this General Provisions section of this policy. Any other refund of unearned premiums shall be, at our option, applied against future premiums or applied to increase future Benefits.

Refund to Us for Overpayment of Benefits

If at any time we determine that the total Benefits paid to you was more than the total Benefits due, we have the right to recover the excess amount from you, to the extent permitted by law. Total Benefits includes any overpayment resulting from your subsequent recovery of other insurance proceeds or litigation damages for charges incurred for which we have already paid Benefits to you.

If at any time we determine that the total Benefits paid to any other person or entity was more than the total Benefits due, to the extent permitted by applicable law, we have the right to recover the excess amount from that person or entity. This includes the right to recover any Benefits paid in error or paid as a result of fraudulent claims. However, we may not recover any Benefit payments paid to you or on your behalf in the event that we rescind this policy.

Payments on Death

On your death, we will pay to your Designated Beneficiary, or, if there is no Designated Beneficiary, to your spouse or Domestic Partner, or if there is no spouse or Domestic Partner, to your estate*:

- all amounts due to you, if any, in accordance with the Return of Earned Premium section of this policy;
- any unassigned, unpaid Benefits due to you under the Payment of Claims provision of the Claims section of this policy; and
- any premiums due to you under the Unearned Premium Refund provision of this General Provisions section of this policy.

For purposes of this provision, Designated Beneficiary means the beneficiary you have designated on the form We provide for such designation.

*If amounts due at your death are to be paid to your estate as provided above, we may instead pay up to \$1,000 to an alternative payee. The alternative payee must be a person related to you by blood or marriage whom we

determine to be entitled to payment. We will not be liable as a result of any payment made in good faith to an alternative payee.

Change of Beneficiary

You have a right to change your Designated Beneficiary (as defined in the Payments on Death provision above) as stated in and in accordance with the provisions of the form that we provide for designation of a beneficiary.

Limitation on Sales Agent's or Producer's or Other Person's Authority

No sales agent, producer, 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 approved by the Connecticut Insurance Department, if such approval is required.

Statements Made By You Relating To Insurability

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 this policy.

If your policy has been in force for less than 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 6 months but less than 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 2 years or more, it shall be incontestable, except for non-payment of premium.

If you are approved for a Coverage change that requires proof of your good health, we may contest the Coverage change based on information provided by you in connection with your request for the Coverage change, in accordance with the rules and the time periods set forth above. The time periods for contesting a Coverage change will begin on the day the Coverage change becomes effective.

Misstatement of Age

If your date of birth is misstated on your application, we may adjust Benefits to those amounts that the premium that you paid would have purchased at your correct age.

Legal Actions

No legal action may be brought until 60 days after Written proof of loss has been given. No such action may be brought after 3 years from the time Written proof of loss is required to be given.

Right to Change Policy Provisions

We reserve the right to make changes to this policy to comply with federal or state laws or regulations applicable to this policy. We will give you Written notice of any such change as soon as reasonably possible.

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

If a change is required in order to maintain this policy as a qualified long-term care insurance policy under Section 7702B(b) of the Internal Revenue Code of 1986, as amended, we will offer you the option of rejecting the change.

Your Name, Address and Telephone Number

You are required to promptly inform us of any change in your name, address or telephone number. When you write to us, you must provide your name, current address and policy number. We will write to you at your last known address.

Address for MetLife

Written correspondence to us regarding this policy should be addressed to:

Metropolitan Life Insurance Company
P.O. Box 937
Westport, CT 06881-0937

Payments to MetLife

Checks, drafts or money orders may be drawn on a U.S. bank to the order of 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).

Attachments to Your Policy

A copy of your application is attached. Riders and endorsements, if any, follow.

SPECIMEN