



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.

This is a Pre-certified Long Term-Care Insurance Policy that provides Medicaid Asset Protection under



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 approval by the Connecticut Insurance Department. 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, or call the toll-free number 1-888-565-3761.

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 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 Henrickson
President and Chief Operating Officer

COORDINATION WITH OTHER BENEFITS NOTICE: As long as this policy remains precertified for Medicaid Asset Protection, Benefits provided under this policy may be reduced to the extent that similar benefits are payable under any other plans or programs to which You are entitled (including Medicare). Please refer to the "Coordination With Other Benefits" provision of this policy for a full explanation. This provision will NOT reduce the Total Lifetime Benefit under this policy.

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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Specimen
Policy

SCHEDULE OF BENEFITS

INSURED

[John Doe]

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

Original Coverage Effective Date	[April 1, 2005]
Original Issue Age	[64]
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

PRIMARY SERVICES

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

ADDITIONAL SERVICES

Care Advisory Services
Transition Expense Allowance
Informal Caregiver Training
Specialized Transportation

BENEFIT AMOUNTS

MAXIMUM DAILY BENEFIT AMOUNT[†]

[\$160]/day*
[\$80]/ day*
[\$160]/day **or**
[\$ 80]/day
[\$ 80]/ day*

MAXIMUM BENEFIT AMOUNT[†]

[\$500]/Policy Year
2,400]/lifetime
[\$ 800]/lifetime
[\$80]/month

[†]The benefit amounts will increase in accordance with the 5% Automatic Compound Inflation Protection included with this policy.

*There is no daily limit for these Benefits. Instead, there is a monthly limit, referred to as a Monthly Benefit Amount.^{1,2}

¹This Monthly Benefit Amount will be pro-rated for any month in which: (1) You complete any required Elimination Period; and (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**.

²During 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: [Spousal Discount**, Marital Discount, Residential Discount, Multi-Life Discount, None]
[[Spousal or Residential] Discount applies as long as associated policies do not lapse.]

** If Your spouse or **Domestic Partner** purchased a policy, the Spousal Discount will remain in effect as long as both policies stay inforce. However, if Your spouse or **Domestic Partner** dies or exhausts his/her Total Lifetime Benefit, the discount will continue. If the Marital Discount is in effect even though Your spouse or **Domestic Partner** did not purchase a policy, the discount will remain in effect as long as Your policy stays inforce.

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]
5% Automatic Compound Inflation Protection	Included
[Nonforfeiture Coverage Rider]	[\$XXX.XX]
[Paid-Up Survivorship Rider]	[\$XXX.XX]
[Restoration of Benefits Rider]	[\$XXX.XX]
[Return of Premium Rider]	[\$XXX.XX]
[Shared Care Rider]	[\$XXX.XX]
[Calendar Day Rider]	[\$XXX.XX]
[Home Care Elimination Period Waiver]	[\$XXX.XX]
[Ten Year Premium Payment Rider]	[\$XXX.XX]
[Paid-up Premiums Rider]	[\$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 Reduced Pay at 65 Rider]

[[Monthly, Quarterly, Semi-annual, Annual] Premium Amount*:]	
[Before Policy Anniversary at age 65]	[\$XXX.XX]
[On and after Policy Anniversary at age 65]	[\$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 charges.]

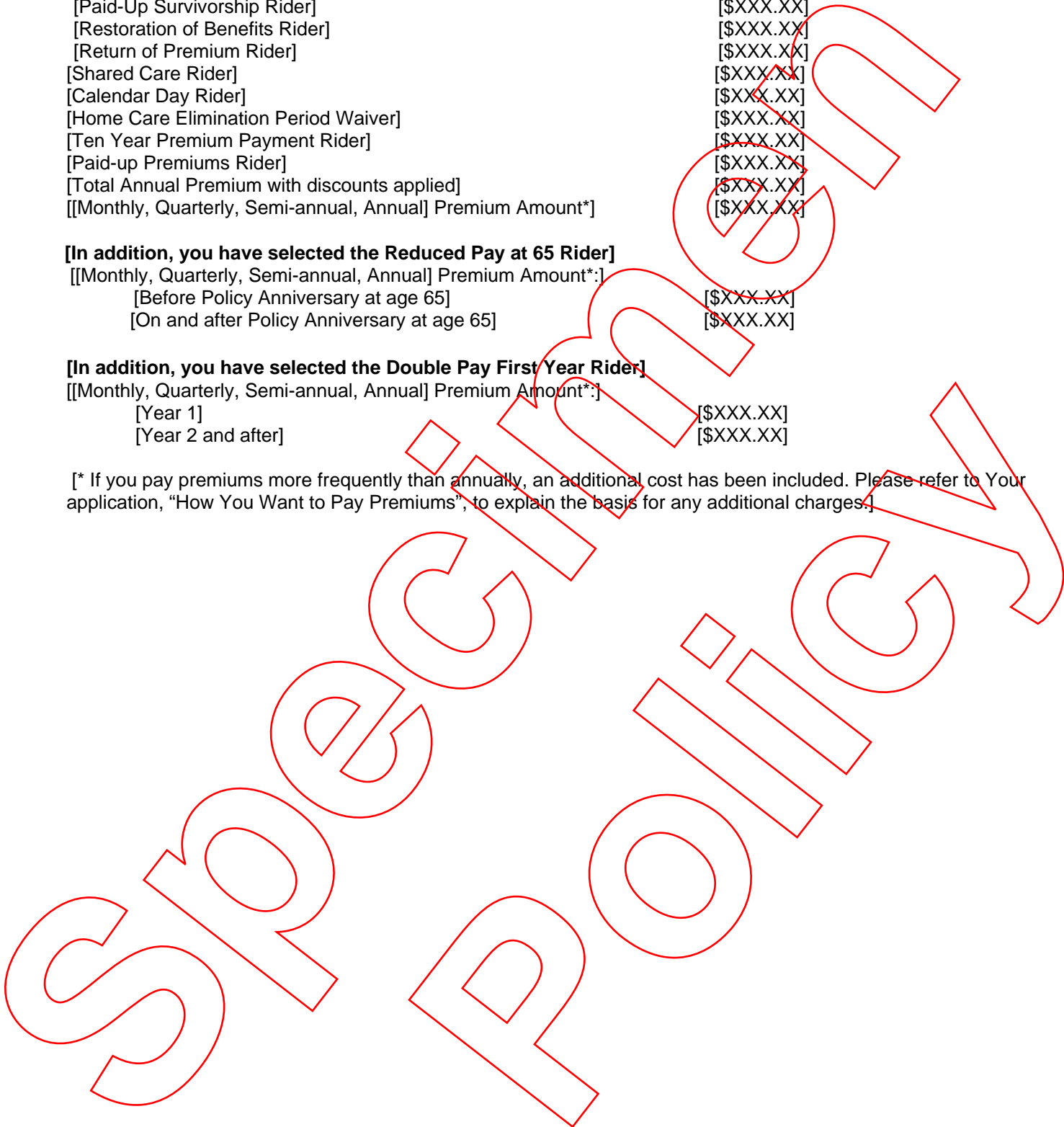


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Definitions of Policy Terms

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.

“Access Agency” means an organization that provides case management services, including assessments and reassessments, care plan development, and coordination and monitoring of home and community-based services, and has been approved as an Access Agency by the State of Connecticut as meeting the requirements for such agency as defined in Connecticut State Regulation Section 17b-342.

“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 of **Qualified Long-Term Care Services** furnished at an **Adult Day Care Center**.

“Adult Day Care Center” means a facility operated and licensed and/or certified as an **Adult Day Care Center** under the laws where it is located if licensing or certification is required; or, if licensing or certification is not required, 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
- * has a full-time director; and 1 or more **Nurses** present at least four (4) hours a day during operating hours; and
- * operates at least five (5) days a week for a minimum of six (6) hours a day.

Definitions of Policy Terms (Continued)

“Asset Protection” means the right extended by Sections 17b-252 and 17b-253 of the Connecticut General Statutes to persons who purchase a Partnership-approved long-term care insurance policy to retain amounts of assets equal to the sum of qualifying insurance payments made on their behalf in determining eligibility for the **Medicaid** Program. (Refer to the Medicaid Asset Protection section for more information).

“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
- * 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
- * makes available three (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.

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 **Licensed Health Care Practitioner** who is employed by an **Access Agency**.

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

- * assessing long-term care service needs (including reports and/ or tests);

Definitions of Policy Terms (Continued)

- * developing and approving a written long-term **Plan of Care**;
- * requisitioning and coordinating long-term care services;
- * implementing the long-term **Plan of Care**; and
- * monitoring and reassessing long-term care services as needed from time to time; and
- * modifying the written long-term **Plan of Care**.

“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 Partner” means Your spouse or **Domestic Partner** whom You have named as Your **Covered Partner** in Your application.

“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. Days when **Covered Services-Primary Services** are covered in full or in part by Medicare, or other health care coverage, will count towards satisfying the **Elimination Period**.

"Folstein Mini-Mental State Examination" means a method for clinicians to grade a person's cognitive status.

"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**, except as described in the Limitations and Exclusions section.

"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 **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** or a **Homemaker-Home Health Aide 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" or **"Homemaker- Home Health Aide Agency"** means a **Hospital** or other organization that:

- * if licensing or certification is required, is licensed or certified as a **Home Health Care Agency** or **Homemaker-Home Health Aide 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

Definitions of Policy Terms (Continued)

* meets ALL of the following:

1. is licensed or certified where it is located to provide **Home Health Care Services**; and
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 **Chronically Ill** 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** or a **Homemaker-Home Health Aide 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, when required, 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:

* 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. It also includes anyone who normally lives in Your **Home**.

Definitions of Policy Terms (Continued)

“**Informal Caregiver**” means a person who provides **Maintenance or Personal Care**, not as a **Formal Caregiver**. Members of the **Insured's Immediate Family** do NOT 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.

“**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.

“**Mental Status Questionnaire**” (**MSQ**) means the Short Portable Questionnaire, comprised of ten (10) questions, for clinicians to grade a person's cognitive status.

“**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.

“**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 **Nursing Home** under the laws where it is located that provides skilled, intermediate or **Custodial Care** and 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

Definitions of Policy Terms (Continued)

- * 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.

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(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**. For **Home Care and Community Care Benefits**, the **Plan of Care** which must be approved by a **Licensed Health Care Practitioner** employed by an **Access Agency**, must specify: the type and frequency of all services required to maintain the **Insured** in his/her **Home** or in the community; the service providers; and the cost of services, regardless of whether or not there is an actual charge for the service.

“**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 29th, 30th or 31st 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.

“**Respite Care**” means **Covered Services** from a **Formal Caregiver** that temporarily relieves the primary 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**.

“**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.

Definitions of Policy Terms (Continued)

“**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 services rendered by a **Therapist**.

“**Total Lifetime Benefit**” means the most We will pay under this policy during Your lifetime. 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.

Specimen Policy

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** (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**).

“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.

The presence of **“Severe Cognitive Impairment”** must be established in one of the following ways:

1. You have been assessed using the Mental Status Questionnaire and have seven (7) or more incorrect responses on the test (or its current equivalent accepted by the State of Connecticut); or

Eligibility for the Payment of Benefits (Continued)

2. You exhibit behavior problems requiring daily supervision, including, but not limited to, wandering, abusive or assaultive behavior, poor judgment or uncooperativeness which poses a danger to self or others, and extreme or bizarre personal hygiene; and You have been assessed using either:
 - * the Mental Status Questionnaire and have four (4) or more incorrect answers (or its current equivalent accepted by the State of Connecticut); or
 - * the Folstein Mini-Mental State Examination and have a score of twenty-three (23) or lower (or its current equivalent accepted by the State of Connecticut).

“Substantial Supervision”, with reference to **Severe Cognitive Impairment**, 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**. Days when **Covered Services-Primary Services** are covered in full or in part by **Medicare**, or other health care coverage, will count towards satisfying the **Elimination Period**.

No **Elimination Period** is required in order to receive **Benefits** for **Hospice Care, Respite Care, Care Advisory Services** 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.

SPECIALTY POLICY

Covered Services

Conditions for Benefit Payments

We will pay for **Covered Services** (subject to the Coordination with Other Benefits provisions of this policy) 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**.

In no event will We pay less than the minimum daily benefit level established by the Connecticut Partnership for Long-Term Care, except in the cases where the charges You incur are less than the minimum daily benefit levels.

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

Covered Services-Primary Services (Continued)

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.

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** or in an **Adult Day Care Center**:

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

Asset Protection for Home Care and Community Care Benefits

In order to qualify for **Asset Protection, Home Care and Community Care Benefits** must be included in Your **Plan of Care**, which must be approved by a **Licensed Health Care Practitioner** employed by an **Access Agency**. We will not pay for **Home Care and Community Care, Respite Care, Alternate Service Benefits or Transition Expense Allowance** unless these **Benefits**, if they are **Home** or community based, are included in a **Plan of Care** approved by a **Licensed Health Care Practitioner** employed by an **Access Agency**.

Respite Care Benefits

“**Respite Care**” means **Covered Services** from a **Formal Caregiver** that temporarily relieves the primary 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**.

Covered Services-Primary Services (Continued)

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**.

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**. If the **Alternate Service** is a **Home Care and Community Care** service, it must be included in Your **Plan of Care**, which must be approved by a **Licensed Health Care Practitioner** employed by an **Access Agency**.

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.

Covered Services-Primary Services (Continued)

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.

Care Advisory Services

We will pay up to the **Maximum Benefit Amount** for **Care Advisory Services** shown on page 3 for charges You incur for **Care Advisory Services**, as described below.

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

- * assessing Your long-term care service needs (including reports and/or tests);
- * developing and approving a written long-term **Plan of Care**;
- * requisitioning and coordinating long-term care services;
- * implementing the long-term **Plan of Care**;
- * monitoring and reassessing long-term care services as needed from time to time; and
- * modifying the written long-term **Plan of Care**.

Benefits for Care Advisory Services may be received on the same day as **Covered Services-Primary Services**. There is no maximum **Daily Benefit Amount** for **Care Advisory Services**. The **Maximum Benefit Amount** for **Care Advisory Services** will increase each year in accordance with the 5% Automatic Compound Inflation Protection feature included with this policy. Any **Benefits for Care Advisory Services** not used in the previous **Policy Year** cannot be carried over into the next **Policy Year**. You do not need to complete the **Elimination Period** in order to receive **Care Advisory Services**. Receipt of this service will not count toward satisfying the **Elimination Period**. Payment of this **Benefit** will reduce Your **Total Lifetime Benefit**.

Benefits for Care Advisory Services must be provided by a **Care Advisor** employed by an **Access Agency**.

Covered Services-Additional Services (Continued)

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. For purposes of this **Informal Caregiver Training Benefit**, members of Your **Immediate Family** do qualify as an **Informal Caregiver**.

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 may have the sole effect of increasing 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**.

Specialized Transportation Benefits

We will pay up to the **Maximum Benefit Amount** shown on page 3 for **Specialized Transportation**, for actual charges You incur for **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**.

Medicaid Asset Protection

When Benefits will Earn Medicaid Asset Protection

Benefits paid to You, or a provider of long-term care services on Your behalf, under this policy can count towards **Medicaid Asset Protection** for purposes of eligibility for Connecticut's **Medicaid** program or any other state's **Medicaid** program that has a reciprocal agreement with Connecticut's **Medicaid** program. In order for **Benefit** payments to count towards **Medicaid Asset Protection**, the following three conditions must be met:

1. You are eligible for **Benefits** having met one of the following insured events:
 - * You have a documented need for Substantial Assistance or supervision (from another person) with two or more of the following **Activities of Daily Living: Dressing, Bathing, Eating, Toileting, Transferring, and Continence**; or
 - * You have been assessed using the **Mental Status Questionnaire** and have failed to answer correctly at least 7 of the 10 questions on the test (or its current equivalent accepted by the State of Connecticut); or
 - * You exhibit specific behavioral problems requiring daily supervision, including but not limited to, wandering, abusive or assaultive behavior, poor judgment or uncooperativeness which poses a danger to You or others, and extreme or bizarre personal hygiene habits; and You have taken either the **Mental Status Questionnaire** test and failed to answer correctly at least 4 questions on the test (or its current equivalent accepted by the State of Connecticut), or You have taken the **Folstein Mini-Mental State Examination** and achieved a score of 23 or lower (or its current equivalent accepted by the State of Connecticut).
2. The Benefits are paid under this Partnership approved policy; and
3. The Benefits that are paid for **Home Care and Community Covered Services** (including the **Alternate Service Benefits** and **Transition Expense Allowance**, if they are **Home** and community based or **Informal Caregiver Training**) are provided in accordance with a written **Plan of Care** approved by a **Licensed Health Care Practitioner** employed by an **Access Agency** (approved by the Connecticut Partnership for Long-Term Care).

Medicaid Asset Protection (Continued)

Impact on Medicaid Asset Protection When a Policy or Rider Covers Both You and Your Covered Partner

The following applies only if You and Your Covered Partner select the optional Shared Care Rider.

The amount of assets You can protect under a Partnership-approved policy is equal to the amount of benefits paid for Your care. Please note that **Medicaid Asset Protection** is only available to the individual actually receiving the benefits. This means that if You receive benefits under this policy or under Your **Covered Partner's** policy pursuant to the terms of the Shared Care Rider the specific dollar amount of assets You can protect is dependent upon (limited to) the amount of coverage You, as an individual, use for Your long-term care services.

If one **Covered Partner** is accessing benefits under this policy, the other **Covered Partner** will NOT receive **Medicaid Asset Protection** for that care. **Medicaid Asset Protection** is NOT transferable between **Covered Partners**. In addition, continued access by Your **Covered Partner** to the benefits under this policy pursuant to the terms of the Shared Care Rider could lead to the exhaustion of the **Total Lifetime Benefit** under this policy. In such an event this rider and both policies will terminate and no additional **Medicaid Asset Protection** can be earned by either **Covered Partner**.

How to Stay Qualified for Medicaid Asset Protection Under the Partnership

In order to stay qualified for **Medicaid Asset Protection** under the Partnership, the following conditions must be met:

1. Each year Your **Nursing Home Maximum Daily Benefit Amount** must equal or exceed the minimum inflation-adjusted daily benefit specified by the Connecticut Insurance Department. The inflation-adjusted increase in the **Nursing Home Maximum Daily Benefit Amount** provided to You each year under the 5% Automatic Compound Inflation Protection feature will allow You to keep pace with the Insurance Department's minimum requirements.
2. You were a resident of Connecticut when You applied for and subsequently were issued this Partnership-approved long-term care insurance policy.
3. **Benefits** paid for **Home** and Community-based long-term care services covered under this policy, count toward **Medicaid Asset Protection** only when an **Access Agency** (the **Access Agency** must be approved by the Connecticut Partnership for Long-Term Care) developed and approved the written **Plan of Care**. Facility Care need not be approved by an **Access Agency** to count towards **Medicaid Asset Protection**. Services may be provided in Connecticut or elsewhere.

Medicaid Asset Protection (Continued)

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

Specimen Policy

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.

5% Automatic Compound Inflation Protection

Automatic Compound Inflation Benefit

Your benefit amounts will automatically increase each year with no corresponding increase in premium. The amounts of the increases are equal to five percent (5%) of the benefit amounts in effect at the end of the prior **Policy Year**.

If You have received any **Benefits** under this policy, then with regard to the **Total Lifetime Benefit** and the **Transition Expense Allowance**, the five percent (5%) increase will be applied to the remaining amounts.

The benefit amount increases will occur on each **Policy Anniversary** for the lifetime of Your policy, even when You are receiving **Benefits**. These increases will be made without regard to Your age, claim status, claim history, health, or the length of time You have been covered under the policy.

Your premium is not expected to increase as a result of these benefit amount increases. However, We reserve the right to adjust premiums on a class basis.

No increases will be made if **Nonforfeiture Coverage** is in effect under this policy.

SPECIAL POLICY

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.

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. However, in order to maintain the Partnership-approved status of this policy, We will not allow You to lower any **Maximum Daily Benefit Amount** to an amount that is lower than the minimum daily benefit amounts then required by the Connecticut Insurance Department for a Partnership-approved long-term care insurance policy. 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. See also, the Reduced Benefit Option provision of this policy.

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 date We receive a 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 are confined. 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 confined in a **Nursing Home, Hospice** facility or **Assisted Living Facility**; or
3. the **Total Lifetime Benefit** has been paid.

Specimen
POLICY

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 which is caused by declared or undeclared war or any act thereof.
4. Any intentionally self-inflicted injury.
5. Services performed by a member of Your **Immediate Family**, unless: (a) he or she is a regular employee of an organization which is providing services; (b) the organization receives payment for the services; and (c) he or she receives no compensation other than the normal compensation for employees in his or her job category.
6. Any care or services received outside of the United States and its territories.
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 a charge is made which You are required to pay).

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

Coordination with Other Benefits

The **Benefits** of this policy are designed to supplement NOT duplicate other benefits. If You have any health insurance plan or non-Partnership long-term care plan and You are entitled to benefits under those plans that would also be **Covered Services** under this policy, You are required to obtain payment for those benefits first, prior to using **Benefits** under this policy. Examples of Health Insurance plans include, but are not limited to, basic hospital, health maintenance organization (HMO), medical/surgical, major medical plan, **Medicare**, **Medicare** managed care plan, and **Medicare** supplemental programs.

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

Any **Benefit** amounts that You are entitled to receive under this policy will be reduced by any benefits payable by those other plans. This provision will NOT reduce the **Total Lifetime Benefit** payable under this policy.

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, subject to approval by the Connecticut Insurance Department. 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.

Reduced Benefit Option

In the event Your policy is about to **Lapse**, We will offer You the option to reduce Your current **Total Lifetime Benefit** and reduce Your premium. You will have no less than thirty-five (35) days to consider the offer. Notice will be sent thirty-one (31) days after the premium is due. The premium for the new **Total Lifetime Benefit** will be based upon Your Original Issue Age and no underwriting will be required. It will be Your responsibility to continue to promptly pay this new reduced premium when it is due.

Premiums (Continued)

The reduced **Total Lifetime Benefit** will take into account any increases in coverage that have accumulated due to the 5% Automatic Compound Inflation Protection feature. For example, if your initial **Total Lifetime Benefit** grew from \$100,000 to \$200,00 because there were fourteen (14) years of 5% Automatic Compound Inflation increases, the reduced **Total Lifetime Benefit** would also include fourteen (14) years of 5% Compound Inflation Increases.

The **Maximum Daily Benefit Amount** and Maximum Monthly Benefit amounts will NOT be reduced and will continue to reflect any increases in accordance with the 5% Automatic Compound Inflation Protection feature. For example, if your Maximum Daily Benefit grew from \$200 to \$400, then after any reduction under this provision the **Maximum Daily Benefit Amount** would still be \$400 and will continue to increase annually. All other provisions in Your policy will remain the same.

We will make such an offer whenever Your policy is about to **Lapse** during the first year it is in force, and at least once after the policy has been in force for one year. We will NOT make a **Reduced Benefit Option** offer to You if the balance of Your **Total Lifetime Benefit** (after any claims have been paid) would provide for the equivalent for one year of coverage or less.

We will send notice of this Reduced Benefit Option offer to You and to any person You have named to receive notice of **Lapse**. We must receive Your written acceptance of this offer within thirty-five (35) days after We mail the offer to You.

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**.

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
2. submit proof of good health, acceptable to Us, at Your expense; and

Premiums (Continued)

3. 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 coverage had not **Lapsed**.

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**.

SPECIAL POLICY

Claims

How to Submit a Claim You should notify Us as soon as You think You might need **Covered Services** under this policy. You may call Us at the toll-free number shown on page 3 or You may notify Us at the address provided on page 3.

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**, subject to the Coordination with Other Benefits provision of this policy. If We approve Your request for **Home Care and Community Care Benefits**, We will arrange, at Our expense, for a **Licensed Health Care Practitioner** employed by an **Access Agency** to conduct an initial assessment and develop a written **Plan of Care**. (In order for **Benefits** paid for **Home Care and Community Care** to qualify for **Medicaid Asset Protection**, the **Home Care and Community Care** must be included in a **Plan of Care** approved by a **Licensed Health Care Practitioner** employed by an **Access Agency**).

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 the calendar year in which 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

Claims (Continued)

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**.

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 as soon as reasonably possible. 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.

Payment of Claims

If We approve Your claim, We will immediately pay the **Benefits** under the terms of this policy. 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

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 the policy.

Assignment; No Cash Value; Premium Refunds

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

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

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 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 applicable 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, We have the right to recover the excess amount from that person or entity.

However, We may not recover any **Benefit** payments paid to You or on Your behalf in the event that We rescind the policy.

Facility of Payment

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.

Limitation on Representative's or Other Person's Authority

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 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 the policy.

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, it shall be incontestable, except for nonpayment of premiums.

Misstatement of Age

If Your date of birth is not correct as shown on Your application, an adjustment in premium and/or amounts of coverage may be made, at Our option, based on the correct information.

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.

General Provisions (Continued)

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.

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

SPECIAL POLICY