



**METROPOLITAN LIFE INSURANCE COMPANY ("METLIFE")**

**P.O. Box 937, Westport, CT 06881-0937**

**1-888-565-3761**

**LONG-TERM CARE INSURANCE  
INSURANCE OUTLINE OF COVERAGE  
POLICY FORM LTC2007-CT**

**CAUTION:** The issuance of this long-term care insurance policy will be based upon your responses to the questions on your application. If you are accepted for coverage, a copy of your application will be attached to the policy. If your answers are incorrect or untrue, we may have the right to deny benefits or rescind the policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at this address: Metropolitan Life Insurance Company, P.O. Box 937, Westport, Connecticut 06881-0937.

**NOTICE TO THE BUYER:** The 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.

**FEDERAL TAX CONSEQUENCES.**

The policy is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

**THIS CONTRACT DOES NOT QUALIFY FOR MEDICAID ASSET PROTECTION.**

- 1. THE POLICY IS AN INDIVIDUAL POLICY OF INSURANCE WHICH WAS ISSUED IN CONNECTICUT.**
- 2. PURPOSE OF OUTLINE OF COVERAGE.** This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other long-term insurance coverage available to you. This is not an insurance contract, but only a summary of coverage. Only the individual policy contains the governing contractual provisions. This means that the policy sets forth in detail the rights and obligations of both you and MetLife (referred to as "we/us/our"). Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY CAREFULLY!**
- 3. TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED.**
  - a. Return of Policy ("Free Look")**

If you are not satisfied with the policy, you may return it to us, or to the sales agent or producer from whom you bought it, within 30 days from the date you receive it. If so returned, the policy will be void from the beginning. We will refund any premium you have paid within 30 days of our receipt of the policy.
  - b. Return of Earned Premiums**

The policy contains a Return of Earned Premium on Death provision. If you die on or before your 70<sup>th</sup> birthday, we will pay an amount equal to all premiums due and paid to us up to your 70<sup>th</sup> birthday, less any benefits that were paid to you or on your behalf. We will not return any

premiums under this provision if your coverage was in paid-up status under the Contingent Benefit Upon Lapse provision of the policy or under the Nonforfeiture Coverage Rider, if included in the policy.

**c. Refund of Unearned Premiums**

We will refund any unearned premium due at your death or on cancellation of the policy.

**4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.**

If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide ("Guide to Health Insurance for People with Medicare") available from MetLife. Neither MetLife nor its sales agents or producers represent Medicare, the federal government or any state government.

**5. LONG-TERM CARE COVERAGE.**

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

The policy provides coverage in the form of a reimbursement benefit for covered long-term care expenses, subject to requirements for eligibility for benefits, the elimination period and other policy requirements and limitations.

**6. BENEFITS PROVIDED BY THE POLICY.**

**a. Coverage Amounts and Elimination Period**

Applicant A (name): \_\_\_\_\_ Applicant B (name): \_\_\_\_\_

monthly benefit amount: \$ \_\_\_\_\_ monthly benefit amount: \$ \_\_\_\_\_

total benefit amount: \$ \_\_\_\_\_ total benefit amount: \$ \_\_\_\_\_

elimination period for covered services:  
100 calendar days                      elimination period for covered services:  
100 calendar days

elimination period for the international benefit:  
100 calendar days                      elimination period for the international benefit:  
100 calendar days

"Monthly benefit amount" is the most we will pay in a calendar month for covered services, not including benefits for the needs assessment.

"Total benefit amount" is the most we will pay under the policy during your lifetime, not including benefits for the needs assessment.

"Elimination period" is the number of days, after the effective date of the policy, during which you must be eligible for benefits before benefits, other than the benefit for needs assessment, become payable. These days need not be consecutive. No elimination period is required to receive the benefit for needs assessment. Note that there is an elimination period for covered services (when you are in the United States) and an elimination period for the international benefit (when you are outside the United States).

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.

**b. Covered Services**

We will pay benefits for the services listed below if they are included in your plan of care, you are eligible for benefits, you have satisfied the elimination period for covered services (there is no elimination period for the needs assessment) and you have not exhausted your total benefit amount. Payment of benefits will be subject to all policy maximums, limitations, exclusions, requirements and provisions.

**Covered Service**

**Maximum Coverage Amount**

nursing home/hospice facility/assisted living facility (room and board and the following services received by you and provided by the facility: nursing care, maintenance or personal care, therapy services and hospice care)

We will pay the actual charge incurred, up to 100% of the monthly benefit amount per calendar month.

home care services\*\*/  
adult day care

We will pay the actual charge incurred, the monthly benefit amount per calendar month.

bed reservation  
(to hold your bed in a nursing home, hospice facility or assisted living facility if you have to leave the facility)

We will pay the actual charge incurred, up to 50 days per calendar year.

needs assessment by a care advisor  
(to: assess your long- term care services needs; identify options for your long-term care; and discuss the options with you or your representative)

Benefit limited to 1 visit per lifetime. If provided by a care management organization selected by you, we will pay the actual charge incurred, up to \$275 in your lifetime

\*\*\*"Home care services" means the following services provided at home: nursing care, home care aide services; homemaker services; hospice care; independent caregiver services; care advisory services, therapy services and social worker services. "Home" means any private residence in which you are living or staying. It does not include any: hospital or other acute care facility; nursing home; hospice facility; assisted living facility; or other residential long-term care facility.

**Alternate Services**

We may agree to pay benefits for qualified long-term care services that are not specifically defined in the policy as covered services. These are referred to as "alternate services". If we agree to pay benefits for alternate services, the benefits we will pay will be the lesser of: the actual charges you incur for the services received; or the benefits we would pay for the covered service we determine to be most closely related to the alternate services received.

**c. 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 (described below) and the bed reservation benefit will reduce the monthly benefit amount available.

**d. International Benefit**

We will pay the international benefit if you are outside the United States and you:

- are eligible for benefits;
- have satisfied the elimination period for the international benefit; 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. We will pay 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. Payment of the international benefit will be 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 under the policy will never exceed your total benefit amount.

**Tax Note:** Since benefits under this provision will be paid without regard to actual charges you incur, part of the benefits could be considered taxable income if they exceed the limitations prescribed by the Internal Revenue Code of 1986, as amended. You should consult with your independent tax advisor.

**e. Optional Riders**

The following optional riders are available for an additional premium.

**Shared Care Rider.** Allows your covered partner to receive benefits under the policy as described below:

- your covered partner (spouse or domestic partner) can receive benefits under your coverage after the total benefit amount under his/her coverage has been exhausted; and
- if your covered partner dies, the remaining total benefit amount, if any, from his/her coverage will be added to your total benefit amount. You must provide us with written proof, satisfactory to us, of the death of your covered partner.

In order for your covered partner to receive benefits under the Shared Care Rider, you and your covered partner must each apply and be approved for identical coverage that includes the Shared Care Rider and must maintain such identical coverage. Identical coverage means policies issued in the same state that are identical with respect to: form number; monthly benefit amount and total benefit amount; and any riders purchased.

**Tax Note:** Since benefits under a policy with this rider will be paid without regard to actual charges you incur, part of the benefits could be considered taxable income if they exceed the limitations prescribed by the Internal Revenue Code of 1986, as amended. You should consult with your independent tax advisor.

**Nonforfeiture Coverage Rider. (Note:** this rider is only available at initial application).

Provides that the policy will be converted to paid-up status, as described below, if this rider: has been in effect for at least 3 policy years; and is in effect when the policy ends due to nonpayment of premiums or your written request to cancel the policy. If the policy is converted to paid-up status under this rider, we will pay the same benefits that were in effect under the policy immediately prior to the date the policy was converted to paid-up states, except that:

- the total benefit amount will be adjusted to equal the greater of: the sum of all paid and waived premiums for the policy during the time this rider is in effect; or the monthly benefit amount in effect immediately prior to the date the policy was converted to paid-up status; and
- benefits cannot be changed and will not change after the policy is converted to paid-up status.

If the policy is converted to paid-up status under this rider, all riders under the policy end. The total benefits that we will pay under this rider will not be more than the remaining total benefit amount in effect immediately prior to the date the policy was converted to paid-up status. The policy includes a Contingent Benefit Upon Lapse provision (described in section 14). We will not pay benefits under both this rider and the Contingent Benefit Upon Lapse provision. If you meet the requirements for conversion to paid-up status under both this rider and the Contingent Benefit Upon Lapse provision, we will automatically apply the feature that will provide the higher adjusted total benefit amount.

**Benefit Increase Riders.** See section 14 of this outline of coverage for details on the benefit increase riders available. You may only select one of these riders. You are not required to select any of them.

**f. Eligibility for Benefits**

You will be eligible for benefits 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.

“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 a feeding tube or intravenously.

“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.

“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.

“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.

## 7. LIMITATIONS AND EXCLUSIONS.

### a. Exclusions

The policy does not pay benefits for any of the following:

- confinement for the treatment of alcoholism or drug addiction, unless the drug 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 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 the United States, except as described in section 6(d), titled International Benefit;
- 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); 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.

### b. 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.

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

**8. RELATIONSHIP OF COST OF CARE AND BENEFITS.**

Because the cost of long-term care services is likely to increase over time, you should consider whether and how the benefits of the policy may be adjusted.

**a. Benefit Increase Riders**

You may select one of the optional benefit increase riders described in section 16 below. Benefits are not guaranteed to increase over time unless you select a rider that is marked with a double asterisk (\*\*).

**b. Increases in Monthly Benefit Amount and/or Total Benefit Amount**

You may ask for an increase in your monthly benefit amount and/or total benefit amount in writing. We will approve a request for such an increase 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 the policy. The extra premium for the increase will be based on: your age on the effective date of the increase; premium rates, discounts, if any, and your health rating, in effect on the 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 will be the policy anniversary that next follows the date of our approval of your request.

**c. Decreases in Monthly Benefit Amount and/or Total Benefit Amount**

You may ask for a decrease in your monthly benefit amount and/or total benefit amount in writing. You may only make such a decrease to those amounts and in those combinations that are available for the policy. The amount of the premium reduction for the decrease will be computed assuming that the levels of benefits purchased last are discontinued first. The effective date of any decrease requested and approved will be the first day of the policy month on or next following the date that we approve the decrease.

**d. Other Coverage Changes**

You may be eligible to make other changes to your coverage. Such changes may require proof of your good health and may affect your premium.

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

**a. RENEWABILITY: THE POLICY IS GUARANTEED RENEWABLE.** This means you have the right, subject to the terms of the policy, to continue the policy as long as you pay your premiums on time. We cannot change any of the terms of the policy on our own, except that, in the future, WE MAY INCREASE THE PREMIUM YOU PAY. All changes are subject to approval by the Connecticut Insurance Department.

**b. Waiver of Premium**

We will waive your premium if:

- you are eligible for benefits;
- you have satisfied the required elimination period; and

- you are receiving payment of benefits.

If you are in the United States, waiver of premium will end when you are no longer eligible for benefits or are no longer submitting proof of your receipt of covered services, whichever is earlier. If you are outside the United States, waiver of premium will end when you are no longer eligible for benefits or when the international benefit is no longer payable, whichever is earlier.

**c. Terms Under Which MetLife May Change Premiums**

We reserve the right to change premiums rates on a class basis, subject to approval by the Connecticut Insurance Department. Accordingly, your premium may change on a class basis. Your premium will not increase because you get older or your health changes. We will notify you in writing 45 days prior to any increase in your premium on a class basis.

**10. ALZHEIMER’S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.**

If your application is approved and a policy is issued, the policy provides coverage if you are clinically diagnosed as having Alzheimer’s disease or related degenerative and dementing illnesses, subject to all policy requirements and provisions, including, but not limited to requirements for eligibility for benefits and for payment of benefits.

**11. PREMIUM.**

**a. Annual Premium**

The initial annual premium amounts shown below reflect a standard health rating and:

for Applicant A - discounts: *circle applicable discount(s)* spousal marital residential multi-life  
 payment mode: *circle applicable mode* monthly quarterly semi-annual annual

for Applicant B - discounts: *circle applicable discount(s)* spousal marital residential multi-life  
 payment mode: *circle applicable mode* monthly quarterly semi-annual annual

<b>Applicant A Annual Premium</b>	<b>Initial Annual Premium</b>	<b>Applicant B</b>	<b>Initial</b>
LTC2007-CT Policy	\$ _____	LTC2007-CT Policy	\$ _____
_____	\$ _____	_____	\$ _____
Insert name of benefit increase rider, if any		Insert name of benefit increase rider, if any	
Nonforfeiture Coverage Rider	\$ _____	Nonforfeiture Coverage Rider	\$ _____
Shared Care Rider	\$ _____	Shared Care Rider	\$ _____
<b>Total Annual Premium</b>	<b>\$ _____</b>	<b>Total Annual Premium</b>	<b>\$ _____</b>

**b. Discounts**

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

**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 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.

**Multi-Life Discount.** A premium discount is available to employees of an employer or members of an association where the employer or association has entered into a "multi-life" arrangement with us. This discount may also be available to family members of the employee or member to whom the multi-life arrangement applies.

**12. ADDITIONAL FEATURES.**

**a. Medical Underwriting**

The approval of your application and issuance of a policy is subject to medical underwriting. We will only approve your application if we are provided with proof of your insurability that is satisfactory to us.

**b. Grace Period and Lapse**

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 the policy to you and to any person named by you to receive such notice at the addresses given to us. You have 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 35 days of mailing the notice, the policy will then lapse at the end of this 35 day period.

**c. Reinstatement For Severe Cognitive Impairment or Loss of Functional Capacity**

If the policy lapses, we will reinstate it 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 1<sup>st</sup> date that a premium was due and unpaid but before the date that the policy lapsed for non-payment of that premium (the standard of proof we will use will be no more restrictive than that described in section 9(f) of this outline of coverage under Eligibility for Benefits); and pay all past due premiums to us, if we approve your request for reinstatement. If we reinstate the policy, your premium will be what it would

have been if the policy had not lapsed.

**d. Reinstatement**

If the 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 45<sup>th</sup> 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 an application for reinstatement. If your policy lapses, 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 45<sup>th</sup> 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.

**e. Contingent Benefit Upon Lapse**

In the event of a substantial premium increase as defined in the policy, 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 premium and convert the policy to paid-up status, as described below, within the 120 day period following the first due date of such increase; and automatically convert the policy to paid-up status, as described below, if the policy lapses or you cancel the policy within the 120 day period following the first due date of such increase. If the policy is converted to paid-up status under this provision, we will pay the same benefits that were in effect under the policy immediately prior to the date the policy was converted to paid-up status, except that:

- the total benefit amount will be adjusted to equal the greater of: the sum of all paid and waived premiums for the policy; or the monthly benefit amount in effect immediately prior to the date the policy was converted to paid-up status; and
- benefits cannot be changed and will not change after the policy is converted to paid-up status.

Once your policy is converted to paid-up status under this provision, all riders under the policy end. The total benefits that we will pay under this provision will not be more than the remaining total benefit amount in effect immediately prior to the date the policy was converted to paid-up status.

**13. CONTACT THE CONNECTICUT SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM, CHOICES, AT 1-800-994-9422 IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY.**

**14. BENEFIT INCREASE RIDERS AVAILABLE.** You have the option to increase your benefits under one of the following benefit increase riders. You are not required to select one of these riders. Benefits are not guaranteed to increase over time unless you select a rider that is marked with a double asterisk (\*\*).

**5% Automatic Compound Inflation Protection Rider.\*\*** On each policy anniversary, provides an annual automatic increase in your monthly benefit amount and your remaining total benefit amount with no corresponding increase in premium. The amount of each increase will be equal to

5% of each of the monthly benefit amount and remaining total benefit amount in effect at the end of the preceding policy year. Your premium will not increase as a result of increases under this rider; however, we reserve the right to change premiums on a class basis. Increases under this rider will occur without regard to your age, claim status or history, health, or the length of time you have been covered under the policy. If you end this rider, your premium for the policy will be recalculated based upon your age on the rider effective date to account for increases in benefits that took effect under this rider.

**3% Automatic Compound Inflation Protection Rider.\*\*** On each policy anniversary, provides an automatic increase in your monthly benefit amount and your remaining total benefit amount with no corresponding increase in premium. The amount of each increase will be equal to 3% of each of the monthly benefit amount and remaining total benefit amount in effect at the end of the preceding policy year. Your premium will not increase as a result of increases under this rider; however, we reserve the right to change premiums on a class basis. Increases under this rider will occur without regard to your age, claim status or history, health, or the length of time you have been covered under the policy. If you end this rider, your premium for the policy will be recalculated based upon your age on the rider effective date to account for increases in benefits that took effect under this rider.

**Future Purchase Rider.** On each policy anniversary, provides an annual automatic increase in your monthly benefit amount and your remaining total benefit amount, unless you give us written notice of rejection of the increase before it takes effect. However, you cannot receive an increase if you are eligible for benefits on the date the increase is to take effect. The amount of each increase will be equal to 5% of each of the monthly benefit amount and remaining total benefit amount in effect at the end of the preceding policy year. There will be an additional premium for each such increase based on: your age on the effective date of the increase; and the following, in effect on the effective date of the increase: premium rates, discounts, if any, and your health rating. If you reject an increase 2 times in a row, you will no longer receive these increases. Increases under this rider will occur without regard to your age, claim status, claim history, health or the length of time you have been covered under the policy.

**Guaranteed Purchase Option Rider.** (Note: this rider is only available at initial application). This Rider has two features: the Guaranteed Purchase Option and the Future Purchase Benefit.

- Under the Guaranteed Purchase Option, every 3 years, on the policy anniversary, up to and including the policy anniversary on or next following your 64<sup>th</sup> birthday, we will provide you with the opportunity to increase your monthly benefit amount and total benefit amount. Each increase: must be equal to at least and be in multiples of 25% of each of the monthly benefit amount and total benefit amount in effect on the policy's original effective date; and must be the same percentage for both the monthly benefit and the total benefit amount. The sum of all increases under this rider cannot exceed 100% of each of the monthly benefit amount and the total benefit amount in effect on the policy's original effective date. The Guaranteed Purchase Option will end: (1) if you become eligible for benefits; (2) if you fail to accept a Guaranteed Purchase Option offer two times in a row; (3) when you reach age 65 or are no longer eligible to receive offers under the Guaranteed Purchase Option; or (4) if we approve an increase or decrease to your monthly benefit amount and/or total benefit amount under the Changing Benefit Amounts and Other Coverage Changes section of your policy.
- If the Guaranteed Purchase Option ends, you will be eligible to receive increases under the Future Purchase Benefit. The Future Purchase Benefit only applies once the Guaranteed Purchase Option has ended.
- Under the Future Purchase Benefit, on each policy anniversary, your monthly benefit amount and total benefit amount will automatically increase, unless you give us written notice of your

rejection of the increase. The amount of each increase will be equal to 5% of each of the monthly benefit amount and your remaining total benefit amount in effect at the end of the preceding policy year. Increases under this Future Purchase Benefit will occur without regard to your age, claim status, claim history, health or the length of time you have been covered under the policy. If you reject a Future Purchase Benefit increase 2 times in a row, you will no longer receive these increases and the rider will end.

- There will be an additional premium for each increase in benefits under either the Guaranteed Purchase Option or the Future Purchase Benefit. The additional premium will be based on: your age on the effective date of the increase; the premium rates and discounts, if any, in effect on the effective date of the increase; and, for increases under the Guaranteed Purchase Option, your health rating on your original effective date, and, for increases under the Future Purchase Benefit, your health rating on the effective date of the increase.

**Graphic Comparison.** The following graph assumes a policy issued to an individual whose original issue age is 55 with: a \$3,000 monthly benefit amount; a \$75,000 total benefit amount; a standard health rating; and no applicable discounts. The graph compares the benefits and premiums for such a policy issued with no inflation protection to the same policy issued with: the 5% Automatic Compound Inflation Protection Rider; or the 3% Automatic Compound Inflation Protection Rider; or the Future Purchase Rider (assuming all increases are accepted).

