LifeSecure Insurance Company
10559 Citation Drive, Suite 300
Brighton, Michigan
48116
1-866-582-7701

LONG TERM CARE INSURANCE - OUTLINE OF COVERAGE

For Policy Form Series LS-0002 NC 07/07

Name of Applicant: _____ Date of Application: _____

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for people with Medicare, which is available from LifeSecure Insurance Company.

NOTICE TO 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.

CAUTION: The issuance of this long term care insurance policy is based upon your responses to the questions on your Application. A copy of your Application will be attached to your policy if one is issued to you. If your answers are incorrect or untrue, we 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 the address shown above.

1. POLICY DESIGNATION

This is an individual policy of insurance.

2. PURPOSE OF THE 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 policies available to you. This is not an insurance contract, but only a summary of coverage. Only the policy contains governing contractual provisions. This means that the policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY CAREFULLY!**

3. 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 and as amended.

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

Renewability – THIS POLICY IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of the policy, to continue the policy as long as premiums for your coverage are paid on time. LifeSecure Insurance Company cannot change any of the terms of your policy on its own, except that, in the future, WE MAY INCREASE THE PREMIUM YOU PAY.

Waiver of Premium – We will waive the payment of premium beginning on the first day you begin receiving benefits. As long as you continue to receive benefits, additional premiums will not be required. Premium payments will again be required after 30 days of not receiving benefits. We will credit or refund, on a pro rata basis, any premiums paid for periods in which Waiver of Premium is in effect. Any such refund will be made as described in the Refund of Premiums in Certain Cases paragraph of Section 6 below:

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS

You cannot be singled out for a rate increase due to a change in your age or health status. We can, however, change premiums, but only if we change premiums for all similar policies issued in the same state and on the same form as your policy. Any premium changes will be effective on the next premium due date following our notice to you. If we ever increase your premium, you will have the option to reduce coverage in order to preserve the premium amount you had previously been paying.

6. TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED

30-Day Free Look – You may cancel your policy for any reason within 30 days after you receive it. Simply return the policy to us. We will treat the policy as though it had never been issued. We will refund the full amount of any premium paid.

Partial Refund of Premium Upon Death (additional premium required) – This policy contains an optional benefit called the **Money-Back Promise Option** for the refund of premium in the event of death. The Money-Back Promise Option provides for reimbursement of a portion of your premiums paid, less any benefits paid, to a Beneficiary upon your death. If we receive a death certificate as proof of your death while your policy was in force for five or more years, and continues in force until death, we will refund the amount shown in the table below:

Years Since Policy Effective Date	**Percentage of Premium Reimbursable (less any benefits paid)**
Less than 5	0%
5 – 9	25%
10 – 14	50%
15 or more	75%

Refund of Premiums in Certain Cases – If you die while covered under the policy or choose to cancel your policy, we will refund the pro rata part of any premiums paid for periods beyond your death or cancellation. In addition, if you become eligible for Waiver of Premium, We will refund any outstanding credit with respect to the Waiver of Premium as described above in Section 4. In the event of death, any refund will be made within 30 days of our receipt of your death certificate and will be paid to your Beneficiary. If there is no named or living Beneficiary on the date of your death, any refund will be paid to your estate. In the event of your cancellation of the policy, any refund will be paid to you. In the event of an outstanding credit applicable to Waiver of Premium, any such refund will be paid upon the earlier of your death or your cancellation of the policy and will be paid to your Beneficiary, your estate or to you in the manner described above. The aggregate amount of all refunds paid upon your death or cancellation of the policy cannot exceed the total premiums you paid for your policy.

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from us. Neither LifeSecure Insurance Company nor its agents represent Medicare, the federal government, or any state government.

8. 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. This policy reimburses you incurred Covered Expenses for Qualified Long Term Care Services. In addition, the policy includes a Flexible Benefit that is not restricted by the definitions of Covered Expenses and Qualified Long Term Care Services.

9. BENEFITS PROVIDED BY THIS POLICY / BENEFIT ELIGIBILITY

Benefit Descriptions and Coverage Amounts

Benefit Bank – Your Benefit Bank represents the lifetime dollar benefit amount available to you under the policy. Your Benefit Bank balance is reduced by all benefit amounts paid to you, whether based on reimbursement for Covered Expenses for Qualified Long Term Care Services or payments related to the Flexible Benefit.

The Benefit Bank amounts available to you range from: $75,000 to $1,000,000.

Monthly Benefit Access Limit – Your Monthly Benefit Access Limit represents the dollar benefit amount available to you on a monthly basis during a claim period. The original dollar amount is calculated as a percentage of your Benefit Bank.

The Monthly Benefit Access Limit percentages available to you are: 1%, 2% or 3% of the Benefit Bank. (*Note*: The 3% choice is not available for Benefit Bank amounts greater than $500,000.)

Example Illustration – Monthly Benefit Access Limit (MBAL) Calculation

Benefit Bank		MBAL (%)		MBAL ($)
$300,000	X	1%	=	$3,000

Benefit Payout Structure – When you are eligible for benefits, we will reimburse you for Covered Expenses for Qualified Long Term Care Services, up to your Monthly Benefit Access Limit each calendar month. If you are eligible for benefits and you have not incurred Covered Expenses for Qualified Long Term Care Services up to the full Monthly Benefit Access Limit for a given calendar month, 50% of your unused Monthly Benefit Access Limit will be available to you as a Flexible Benefit. All benefits, both Covered Expenses and Flexible Benefits, payable to you under the policy must be pursuant to a written Plan of Care.

Example Illustration – Benefit Payout Structure

In this example, assume a claimant has a Monthly Benefit Access Limit of $3,000. This claimant uses $2,000 for qualified home health care during a one-month period. The unused monthly benefit = $1,000. Claimant may receive a Flexible Benefit of up to $500.

Home Health Cost	Flexible Benefit	
$2,000	$500	⇨ ***Remaining Amount Stays in Benefit Bank***

Flexible Benefit – The Flexible Benefit is not restricted by the definition of Covered Expenses. It is designed to provide you greater flexibility in the types of care or services you receive under the policy, such as: care provided by an informal caregiver or family member; installation of a wheelchair access ramp to your home; or rental of durable medical equipment for your home. This benefit is calculated as defined in the previous paragraph.

Benefit Wait Period – You must satisfy a Benefit Wait Period of 90 days before benefits are payable. The Benefit Wait Period is the total number of days that you remain Chronically Ill before benefits are payable. It begins on the first day that we verify that you are Chronically Ill. The Benefit Wait Period need be met only once during your lifetime. You do not need to be receiving Qualified Long Term Care Services in order to satisfy the Benefit Wait Period. Any day on which we verify that you are Chronically Ill will count toward the Benefit Wait Period.

LifeSecure Care Advisor Services – LifeSecure Care Advisor Services are provided through our LifeSecure Care Advisors. You may use the LifeSecure Care Advisor Services anytime while your policy is in force. The services are optional and provided at no cost to you. A LifeSecure Care Advisor is available to: assist in identifying your specific personal care needs and the long term care services in your area which may appropriately meet those needs; assist in developing a Plan of Care that meets your needs; and help you arrange for care or services.

Guaranteed Future Purchase Offers – *This is a standard feature unless you elect one of the optional inflation protection benefits: Automatic 3% Compound Inflation Protection Benefit or Automatic 5% Compound Inflation Protection Benefit, as described in Section 11 below.*

Under the Guaranteed Future Purchase Offers, you will be offered the opportunity to increase your Monthly Benefit Access Limit and Benefit Bank every three years, subject to the conditions listed below.

Each offer to increase will be for 15% of the dollar amount of your current Monthly Benefit Access Limit and the remaining dollar amount of your Benefit Bank. This offer will be made beginning on the third anniversary of your policy effective date and every three years thereafter. You may elect to increase your coverage by the amount offered under this feature without submitting evidence of insurability. The premium for the amount of increased coverage will be based on your attained age, your original rate class, and our premium rate schedule as of the date the benefit increase offer is made to you.

We will notify you by mail or e-mail of the offer at least 60 days prior to the anniversary of the policy effective date. You may accept or decline the offer within 60 days after we send the notification. If we do not receive your acceptance of our offer within 60 days, we will deem this to be a declination of the offer. You may accept or decline ongoing offers to increase coverage each time an offer is made.

No further offers will be made if your policy is terminated, or if coverage is continuing in effect under: the Extension of Benefits; the Shortened Non-Foreiture Benefit Period Option, if any; or the Contingent Non-Forfeiture Benefit, if any. No further offers will be made: once you have attained age 80; during the Benefit Wait Period; or if you meet the Eligibility Requirements for benefits.

Contingent Non-Forfeiture Benefit – *This is a standard feature unless you elect the Shortened Non-Forfeiture Benefit Period Option as described below under Optional Benefits and Features.*

This benefit provides protection in the event of a substantial rate increase. If there is an increase in premium rates so that the cumulative amount of all premium rate increases is considered to be substantial, as determined by the schedule below, we will do all of the following:

- We will offer to reduce your current level of coverage without evidence of insurability so that the required premium for your coverage is not increased.
- We will offer to convert your coverage to a paid-up status with a lesser Benefit Bank. This option may be elected at any time during the 120-day period following the date of the premium rate increase. Under this conversion option, the amount of your revised Benefit Bank will be equal to the greater of: (a) one hundred percent (100%) of the sum of all premiums paid, excluding any waived premiums; or (b) one times your Monthly Benefit Access Limit in effect at the time of conversion. Your Monthly Benefit Access Limit will remain at the dollar amount in effect at the time of conversion, restricted only by the size of your revised Benefit Bank. This conversion option may be elected at any time during the 120-day period following the effective date of the premium rate increase.
- We will notify you that a premium lapse at any time during the 120-day period following the effective date of the premium increase will be deemed to be the election of the preceding offer to convert your coverage to a paid-up status. A premium lapse is your failure to pay the required premiums within the 31-day grace period.

Please refer to the schedule below to determine whether or not a change in premiums constitutes a Substantial Premium Increase. Cumulative premium increases over original premium that will allow the Contingent Non-Forfeiture Benefit to be initiated appear in the chart. (Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Triggers for a Substantial Premium Increase

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

Special Guidelines for Limited-Pay Premium Modes

If we increase the annual premium equal to or exceeding the percentage of your initial annual premium as indicated in the chart below based on your Issue Age and your premium is not paid, the Policy will lapse within 120 days of the due date of the increased premium. You will be notified at least 45 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase (for Limited-Pay Premium Modes)

Issue Age	% Increase over Initial Premium
Under Age 65	50%
65-80	30%
Over 80	10%

On or before the effective date of the premium increase We will offer to:

1. Reduce the benefits provided by the current coverage without the requirement of additional underwriting so the premium payments are not increased;

2. Convert the coverage to paid-up status where the amount payable for each benefit is 90% of the amount payable in effect immediately prior to lapse times the ratio of number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period.

   We will notify You that a default or lapse at any time during the 120-day period shall be deemed to be the election of the offer to convert if the ratio is 40% or more.

Optional Benefits and Features

The following benefits and features are available to you as options under this policy.

Money-Back Promise Option – (defined previously in Section 6 above.)

Shortened Non-Forfeiture Benefit Period Option – If you elect the optional Shortened Non-Forfeiture Benefit Period Option, it will provide a continuation of your policy up to a specified dollar amount. If you elect it and your coverage terminates due to non-payment of premium on or after the third anniversary of this option and before your Benefit Bank has been exhausted, the Shortened Non-Forfeiture Benefit Period Option provides a paid-up continuation of your coverage with a lesser Benefit Bank. The amount of your revised Benefit Bank will be equal to the greater of: (a) one hundred percent (100%) of the sum of all premiums paid, excluding any waived premiums; or (b) one times your Monthly Benefit Access Limit in effect at the time of lapse. The revised Benefit Bank is reduced by the sum of all benefits previously paid to you. Your Monthly Benefit Access Limit will remain at the dollar amount in effect at the time of lapse, restricted only by the size of your revised Benefit Bank. Your coverage under this option ends when the revised Benefit Bank has been exhausted.

Automatic Inflation Protection Choices – You have *two* optional automatic inflation protection benefit choices: Automatic 3% Compound Inflation Protection Benefit and Automatic 5% Compound Inflation Protection Benefit. These two benefits are described in Section 11 below.

Optional Premium Payment Modes

You may elect any one of the following limited-pay options to pay the premiums for your policy. (*Note*: Limited-pay options can only be elected with plan designs that include either the Automatic 3% Compound Inflation Protection Benefit or the Automatic 5% Compound Inflation Protection Benefit.)

10-Year Premium Payment Option – This option provides that your policy premiums may be paid over a ten-year period, after which no additional premiums will be due. Prior to the end of your tenth policy year, we have the right to change your premiums in accordance with the terms described in Section 5 above. In the event of a future benefit increase, a separate 10-year premium payment period will be applied for the increased benefit portion only, beginning on the effective date of the benefit increase.

To-Age-65 Premium Payment Option (*allowed only for issue ages 55 and under*) – This option provides that your policy premiums may be paid as due until the anniversary of the policy effective date following your 65th birthday, after which no additional premiums will be due. Prior to the policy anniversary date following your 65th birthday, we have the right to change your premiums in accordance with the terms described in Section 5 above. In the event of a future benefit increase, a separate 10-year premium payment period will be applied for the increased benefit portion only, beginning on the effective date of the benefit increase.

Eligibility Requirements For The Payment of Benefits

We will pay benefits under the policy when we verify that you meet all of the following conditions:

- You are Chronically Ill (refer to full definition in Section 16 below);
- You receive any service covered under the policy and provided pursuant to a written Plan of Care;
- Coverage under the policy is in force on the date(s) the care is received;
- You have satisfied the applicable Benefit Wait Period;
- You have not exhausted your Benefit Bank or your applicable Monthly Benefit Access Limit; and
- You meet the additional policy requirements for the specific policy benefits you claim.

DEFINITIONS

Activities of Daily Living: Each of the following functions is an Activity of Daily Living:

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 necessary braces, fasteners or artificial limbs.

Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring: Moving into or out of a bed, chair or wheelchair.

Continence: The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for 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.

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

Adult Day Care Center: A facility that is licensed, registered or certified to provide a planned program of Adult Day Care services by the state in which it operates. If the state does not license such facilities, then it must be operated pursuant to law and meet certain standards.

Application: The written or electronic application form provided by us and completed by you when you apply for coverage.

Assisted Living Facility: A facility that is engaged primarily in providing ongoing care and related services that: (a) has the appropriate state licensure or certification as an Assisted Living Facility where required; and (b) meets certain requirements.

Beneficiary: The person designated by you to receive benefits, if any are payable, under the policy after your death, or to receive a refund of premiums paid beyond your death, if applicable.

Benefit Bank: The overall maximum benefit amount payable under the policy. This amount decreases for benefits paid and increases for applicable optional inflation protection benefits (if elected by you), Guaranteed Future Purchase Offers that are accepted, and underwritten coverage amount increases.

Benefit Wait Period: The total number of days that you remain Chronically Ill before benefits are payable. The Benefit Wait Period begins on the first day that we verify you are Chronically Ill. Days in excess of 180 days prior to the date you submit your initial claim request will not count towards meeting the Benefit Wait Period, even if it can be established that you were Chronically Ill at that time. The Benefit Wait Period need only be met once during your lifetime. You do not have to be receiving Qualified Long Term Care Services in order to satisfy the Benefit Wait Period. Any day on which we verify that you are Chronically Ill will count toward the Benefit Wait Period.

Chronically Ill: You are Chronically Ill when you have been certified by a Licensed Health Care Practitioner as: a) being unable to perform, without Substantial Assistance from another person, at least two Activities of Daily Living for a period that is expected to last at least 90 consecutive days due to a loss of functional capacity; or b) requiring Substantial Supervision to protect yourself from threats to health and safety due to a Severe Cognitive Impairment. You will not meet the definition of Chronically Ill unless within the preceding 12-month period a Licensed Health Care Practitioner has certified that you meet such requirements.

Substantial Assistance means either Hands-on Assistance or Standby Assistance.

Hands-on Assistance means the physical assistance of another person without which you would be unable to perform the Activity of Daily Living. **Standby Assistance** means the presence of another person, within your arm's reach, that is necessary to prevent, by physical intervention, your injury while you are performing the Activity of Daily Living.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect you from threats to your health or safety (including, but not limited to, such threats as may result from wandering.)

Confinement or Confined: A period of time you are a resident in a Nursing Home or an Assisted Living Facility during which a room and board charge is made, or when you are in Hospice Care provided in a facility or provided in the home or community.

Covered Expenses: Costs for Qualified Long Term Care Services received in a Nursing Home, Assisted Living Facility, Adult Day Care Center, Hospice Care facility, or through a Home Care Agency, or by an Independent Provider or at-home Hospice Care provider.

Covered Expenses for Nursing Home care, Assisted Living Facility care or facility-based Hospice Care include expenses you incur for Qualified Long Term Care Services during your Confinement in a Nursing Home, Assisted Living Facility or Hospice Care facility for:

- Room and board (including charges to reserve your bed when you are absent for any reason except discharge);
- Ancillary services;
- Patient supplies provided by the Nursing Home, Assisted Living Facility or Hospice Care facility for care of its residents; and
- Hospice Care services.

Covered Expenses for Home Care Agency or Independent Provider care or at-home Hospice care include expenses you incur for Qualified Long Term Care Services provided to you by a Home Care Agency, an Independent Provider or at-home Hospice Care provider:

- Home Care Services;
- Maintenance or Personal Care Services; and
- Hospice Care services.

Covered Expenses for any type of provider do not include the cost of drugs.

Domestic Partnership: Individuals who have a committed personal relationship with each other that is mutually independent and intended to be lifelong.

Flexible Benefit: The benefit available to you if you meet the Eligibility for the Payment of Benefits requirements and have not depleted the full amount of your Monthly Benefit Access Limit for Covered Expenses for Qualified Long Term Care Services incurred in a given calendar month. This benefit is designed to address various forms of care, services and/or products which are recognized to effectively support or serve special needs of a Chronically Ill individual, but which are not formally defined within the policy under the term Covered Expenses.

Home Care Agency: An entity that is regularly engaged in providing Home Care Services, or Maintenance or Personal Care Services for compensation and employs staff who are qualified by training or experience to provide such care. The entity must: be supervised by a qualified professional such as a Registered Nurse (RN), a licensed social worker, or a Physician; keep clinical records or care plans on all patients; provide ongoing supervision and training to its employees appropriate to

the services to be provided; and have the appropriate state licensure, accreditation or certification, where required.

Home Care Services: The following services provided in your home: part-time or intermittent skilled services provided by licensed nursing personnel; home health aide or personal care attendant services, including assistance with or performance of personal hygiene, Activities of Daily Living, medication management or other related supportive services; and homemaker services, such as meal preparation, laundry, housekeeping, transportation and shopping *when provided in conjunction with any other Home Care Services specified above*.

Hospice Care: Services designed to provide palliative care to someone diagnosed with a Terminal Illness in order to help alleviate that person's physical, emotional and/or spiritual discomforts during the last phases of life. Hospice Care can be provided in your home, or in a separate facility. The provider of Hospice Care services must be licensed or certified to provide Hospice Care by the state in which it is located.

> **Terminal Illness** means an illness or injury which a Physician certifies is likely to result in a person's death within six months.

Independent Provider: A home health aide, certified nursing assistant, Nurse, or physical, occupational, respiratory or speech therapist who is working independently and is not affiliated with a Home Care Agency. Such person must be licensed, registered or certified to provide Home Care Services and Maintenance or Personal Care Services by the state in which he or she is providing the services.

Licensed Health Care Practitioner: Any of the following who is not a family member: a Physician (as defined in Section 1861(r)(1) of the Social Security Act); a registered professional nurse; a licensed social worker; or any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States.

LifeSecure Care Advisor: A Licensed Health Care Practitioner designated by us who is qualified by training and experience to assist in identifying and coordinating the overall care needs of a person who is Chronically Ill.

Maintenance or Personal Care Services: Any care the primary purpose of which is the provision of needed assistance with helping you conduct your Activities of Daily Living while you are Chronically Ill. This includes protection from threats to health and safety due to Severe Cognitive Impairment.

Medicare: Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

Nursing Home: A facility or distinctly separate part of a hospital or other institution that is appropriately licensed or certified, or complies with the state's facility licensing requirements to engage primarily in providing nursing care to inpatients under a planned program supervised by a Physician. A Nursing Home provides 24-hour-a-day nursing care at skilled, intermediate, and/or custodial levels.

Physician: A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action.

Plan of Care: A written individualized plan of services prescribed by a LifeSecure Care Advisor or another Licensed Health Care Practitioner. The Plan of Care specifies your long term care needs and the type, frequency, and providers of the services appropriate to meet those needs and the costs, if any, of those services. The Plan of Care will be modified as required to reflect changes in: your functional or cognitive abilities, your social situation, and your care service needs.

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

Severe Cognitive Impairment: A loss or deterioration in intellectual capacity that is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia and is measured by clinical evidence and standardized tests that reliably measure impairment in your: short-term or long term memory; orientation as to people, places or time; deductive or abstract reasoning; and judgment as it relates to safety awareness.

Usual and Customary Charges: amounts customarily charged in a given geographic region for similar forms of care, services and/or products which are recognized to effectively support the long term care needs of a Chronically Ill individual, as recommended by a Licensed Health Care Practitioner.

10. LIMITATIONS AND EXCLUSIONS

No benefits, including the Flexible Benefit, will be payable under the policy for:

- a loss that occurs while the policy is not in force; or
- an illness, treatment or medical condition that is due to war or act of war (which is not an act of terrorism) whether declared or not; or
- an illness, treatment or medical condition that results from an attempt at suicide (while sane or insane) or an intentionally self-inflicted injury; or
- any loss sustained or contracted in consequence of you being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician; or
- expenses for services or items to the extent that such expenses are reimbursable under Title XVIII of the Social Security Act (Medicare), or would be so reimbursable but for the application of a deductible or coinsurance amount; or
- care or services, unless otherwise required by law, for which benefits are duplicated or provided under a governmental program (except Medicaid), Services or supplies for the treatment of an occupational injury or sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act; or
- care or services provided outside the United States of America, its territories or possessions, or Canada.

Charges for the following types of care or services are excluded under the reimbursable Covered Expenses for Qualified Long Term Care Services portion of the policy; however, the following types of care or services may be covered under the Flexible Benefit portion of the policy:

- care or services provided by a Family Member unless:
  - ✓ he or she is a regular employee of an organization which is providing the treatment, service or care; and
  - ✓ the organization receives the payment for the treatment, service or care; and
  - ✓ he or she receives no compensation other than the normal compensation for employees in his or her job category; or
- care or services for which no charge is made in the absence of insurance.

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

11. RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the costs of long term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. You may elect one of the automatic inflation protection options to increase your coverage. If you do not elect one of the automatic inflation protection options, your coverage will include Guaranteed Future Purchase Offers by default. Only increases taken in accordance with one of the options listed below do not require evidence of insurability. Increases taken in accordance with one of the inflation protection features listed below do not require future evidence of insurability.

Benefit Adjustment Provisions

Automatic 3% Compound Inflation Protection Benefit – If you elect the optional Automatic 3% Compound Inflation Protection Benefit, we will increase your Monthly Benefit Access Limit and the amount remaining in your Benefit Bank. The dollar amount of your current Monthly Benefit Access Limit will be increased each year by 3%. The remaining dollar amount of your Benefit Bank will be increased each year by 3%. The increase will be effective on each anniversary of the Policy Effective Date, even if you are receiving benefits. Premiums do not increase as a result of these annual benefit increases. Annual compound inflation protection increases will terminate if your coverage is continuing in effect under: the Extension of Benefits; the Shortened Non-Forfeiture Benefit Period Option, if any; or the Contingent Non-Forfeiture Benefit, if any.

Automatic 5% Compound Inflation Protection Benefit – If you elect the optional Automatic 5% Compound Inflation Protection Benefit, we will increase your Monthly Benefit Access Limit and the amount remaining in your Benefit Bank. The dollar amount of your current Monthly Benefit Access Limit will be increased each year by 5%. The remaining dollar amount of your Benefit Bank will be increased each year by 5%. The increase will be effective on each anniversary of the Policy Effective Date, even if you are receiving benefits. Premiums do not increase as a result of these annual benefit increases. Annual compound inflation protection increases will terminate if your coverage is continuing in effect under: the Extension of Benefits; the Shortened Non-Forfeiture Benefit Period Option, if any; or the Contingent Non-Forfeiture Benefit, if any.

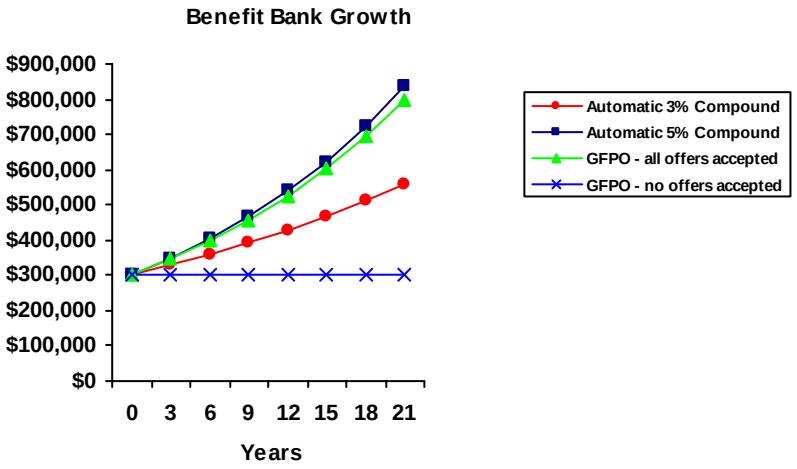
Guaranteed Future Purchase Offers – If you do not elect one of the optional automatic inflation protection benefits described above, your coverage will include the Guaranteed Future Purchase Offers feature, as described in Section 9 above.

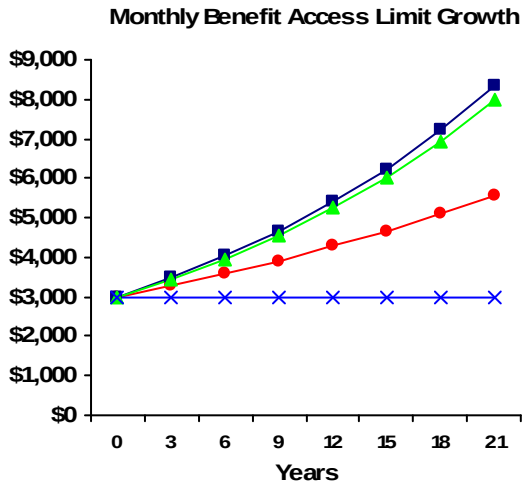
Inflation Protection – Graphic Comparisons

The charts below compare and contrast the growth of an initial Benefit Bank amount of $300,000 and a 1% Monthly Benefit Access Limit ($3,000 initially) over a 21-year period, considering four variations:

1) a plan with the Automatic 3% Compound Inflation Protection Benefit;
2) a plan with the Automatic 5% Compound Inflation Protection Benefit;
3) a plan with Guaranteed Future Purchase Offers where *all* such offers are accepted; and
4) a plan with Guaranteed Future Purchase Offers where *no* such offers are accepted.

Example

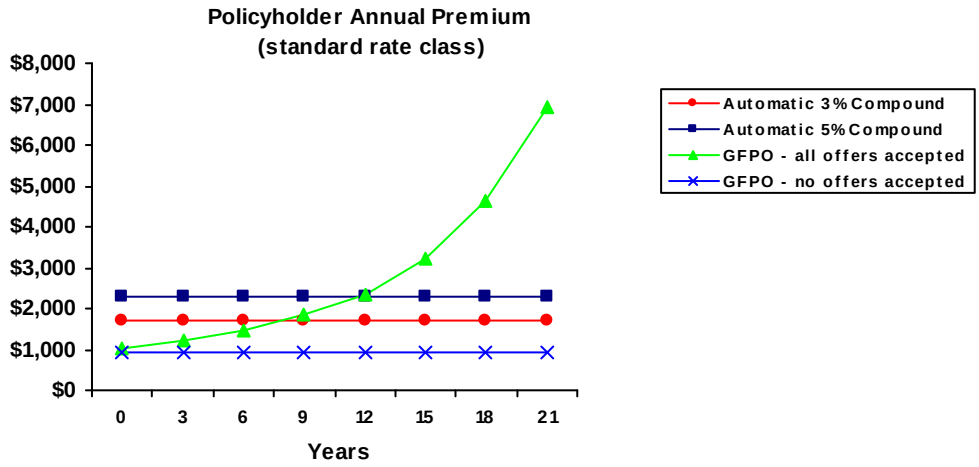




The chart below compares and contrasts the annual premium applicable to a person who purchases a policy at 55 years of age with an initial Benefit Bank amount of $300,000 and a 1% Monthly Benefit Access Limit over a 21-year period, considering four variations:

1) a plan with the Automatic 3% Compound Inflation Protection Benefit;
2) a plan with the Automatic 5% Compound Inflation Protection Benefit;
3) a plan with Guaranteed Future Purchase Offers where *all* such offers are accepted; and
4) a plan with Guaranteed Future Purchase Offers where *no* such offers are accepted.

Example



12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

Once your Application for coverage under the policy is approved, the policy provides coverage for treatment of Alzheimer's disease, Parkinson's disease, senile dementia, and other forms of organic brain disease.

13. PREMIUM

Refer to the table below to find the premium applicable to the coverage amounts and policy design of your choice.

PREMIUM	**Benefit Bank**: $ _____ **Monthly Benefit Access Limit**: ____ %	
Premium Payment Mode • Annual • Semi-Annual • Quarterly • Monthly EFT • Monthly Credit Card • Bi-Weekly • Other Payroll Cycle • Direct Bill* **Premium Payment Time Period** • Lifetime • 10-years • To-Age-65	Base Policy Coverage Premium:	$ _____
	Money-Back Promise Option:	$ _____
	Shortened Non-Forfeiture Benefit Period Option:	$ _____
	Automatic 3% Compound Inflation Protection Benefit:	$ _____
	Automatic 5% Compound Inflation Protection Benefit:	$ _____
	Total Annual Premium:	$ _____
	Modal Premium (based on Mode & Time Period elected):	$ _____
	* Monthly Direct Bill includes a $2.00 monthly administrative fee.	

14. ADDITIONAL FEATURES

Underwriting – Medical underwriting is required. We will underwrite your Application by reviewing one or more of the following: the information submitted on your Application; an attending Physician's report; copies of your medical records; a medical evaluation; a telephone interview; and an in-person interview.

Extension of Benefits – If your policy terminates due to failure to pay premium, we will recognize your basis for a claim for your Confinement in a Nursing Home, Hospice Care or an Assisted Living Facility before the date your policy ended in the same manner as if your policy was in force. Extension of Benefits stops on the earlier of the date when you no longer meet the Eligibility for the Payment of Benefits requirements; the date you are no longer Confined in a Nursing Home or an Assisted Living Facility; or the date your Benefit Bank is exhausted.

Reinstatement Provision – If Your coverage is terminated due to non-payment of premiums, You may apply for Reinstatement by notifying Us. You will be asked to complete an Application and We have the right to require evidence of insurability. A completed Application must be received by Us within one year after the end of the Grace Period. You will be given a conditional receipt for any premiums paid with the Application. You will be required to pay the cost of any records that may be necessary to provide this evidence. If We approve the Application, the Policy will be reinstated as of the approval date. The Policy will be reinstated on the 45th day after the date of the conditional receipt, unless We notify You of Our disapproval sooner. In all other respects, upon Reinstatement You will have the same rights under the Policy as You had prior to the Premium Due Date of the defaulted premium. Any premiums that We accept for Reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than 60 days prior to the date of Reinstatement.

Added Protection Against Lapse – If Your coverage is terminated due to non-payment of premiums because You were Chronically Ill before the Grace Period expired, We will provide a Reinstatement of coverage based on the conditions specified below. To be eligible for this Reinstatement, You must provide Us proof that You were Chronically Ill before the Grace Period expired.

The proof must be in the form of a certification and Assessment from a Licensed Health Care Practitioner which demonstrates that You were Chronically Ill. The proof must be provided to Us within five months of the termination date. You must pay all past due premiums for the coverage that was in

force immediately prior to the date of termination. In that event, Your insurance will be reinstated as of the date of that termination without interruption of insurance for that period.

15. CONTACT THE NORTH CAROLINA SENIORS HEALTH INSURANCE INFORMATION PROGRAM (SHIIP) IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT LIFESECURE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE POLICY.

NC Seniors Health Insurance Information Program
Department of Insurance
11 S. Boylan Ave.
Raleigh, NC 27603
http://www.ncdoi.com/Consumer/Shiip/Shiip.asp
800-443-9354