READ YOUR POLICY CAREFULLY. This is a legal contract between you, the Owner, and us, Pacific Life Insurance Company, a stock insurance company. We agree to pay the benefits of this policy ("Policy") according to its provisions. The consideration for this policy is the Application for it, a copy of which is attached, and payment of the initial premium.

The method for determining the Death Benefit is described in the Death Benefit section of this policy. The amount of the Death Benefit may decrease as a result of withdrawals or paid policy or rider benefits.

Benefits as specified under this policy will be reduced upon receipt of an accelerated death benefit. We recommend you contact a qualified tax advisor about the tax status of an accelerated death benefit payment.

Premiums are flexible, subject to minimums required to keep the policy In Force. It is possible that, due to loans or withdrawals, the policy may lapse before any Death Benefit or accelerated benefits are payable.

Signed for Pacific Life Insurance Company,

Chairman and Chief Executive Officer     Secretary

FLEXIBLE PREMIUM ADJUSTABLE LIFE INSURANCE
- Death Benefit Payable On The Death Of The Insured
- Net Cash Surrender Value Payable Upon Surrender
- Adjustable Face Amount
- Non-Participating
- Terminal Illness Benefit (Accelerated Death Benefit)

Insured: [Jane Doe]  
Owner: [Leland Stanford]  
Policy Number: [LTC6999990]  
Policy Date: [February 1, 2013]  

Free Look Right – The Owner has 30 days from the day the policy and any riders are received to examine and return them to us if the Owner decides not to keep them. The Owner does not have to tell us the reason for returning the policy and riders. The policy and riders can be returned to us at our Administrative Office or to the Producer through whom they were bought. We will refund, directly to the payer, the full amount of any premium paid within 30 days of such a return and the policy and any riders will be void from the start.
### POLICY SPECIFICATIONS

#### Summary of Coverages Effective on the Policy Date

<table>
<thead>
<tr>
<th>Code</th>
<th>Coverage Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>P12PPC</td>
<td>Flexible Premium Adjustable Life Insurance (Life Coverage)</td>
</tr>
<tr>
<td>R12ABR</td>
<td>Accelerated Benefit Rider (&quot;ABR&quot;) for Long-Term Care</td>
</tr>
<tr>
<td>[R12EBR]</td>
<td>Extended Benefit Rider (&quot;EBR&quot;) for Long-Term Care</td>
</tr>
</tbody>
</table>

- **Life Policy:** Flexible Premium Adjustable Life Insurance
- **Insured:** [Jane Doe]
- **Owner:** [Leland Stanford]
- **Policy Date:** [February 1, 2013]
- **Sex And Age:** [Female 35]
- **Risk Class:** [Nonsmoker] [with Couples Discount]

**Death Benefit Qualification Test:** Cash Value Accumulation Test  
**Net Amount at Risk Factor:** [1.0028709]  
**[This Policy Is a Modified Endowment Contract]**  
**[7 Pay Premium]:** $737.80  
**Guaranteed Annual Interest Rate:** [3.50%]  
**Maximum Premium Load Rate:** [4.00%]  
**Minimum Face Amount:** [$25,000.00]  
**Monthly Deduction End Date:** Policy Anniversary When the Insured Attains Age 95

**Surrender Charge**  
**Initial Amount:** [$378.50]  
**Level Period:** [5] Years  
**Reduction Factor:** [$75.70]  
**Surrender Charge Period:** [10] Years

**Maximum Monthly Coverage Charge**  
**Years 1 -10:** [$9.25]  
**Year 11 +:** [$0.00]
### Summary of Values Effective on the Policy Date

**Death Proceeds (Before Minimum Death Benefit)**

<table>
<thead>
<tr>
<th>Face Amount (Life Coverage):</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>[$25,000.00]</td>
<td></td>
</tr>
<tr>
<td>Death Proceeds:</td>
<td>[$25,000.00]</td>
</tr>
</tbody>
</table>

**Coverage Type**

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Premium Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Coverage:</td>
<td>[$6,707.00]</td>
</tr>
<tr>
<td>Accelerated Benefit Rider (ABR):</td>
<td>[$3,007.75]</td>
</tr>
<tr>
<td>[Extended Benefit Rider (EBR):]</td>
<td></td>
</tr>
<tr>
<td>Total Premium:</td>
<td>[$11,713.75]</td>
</tr>
</tbody>
</table>

Return of Premium Benefit: [$11,713.75]

**Long-Term Care Benefit Limits**

<table>
<thead>
<tr>
<th>Benefit Limit</th>
<th>Benefit Duration</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum ABR Benefit Limit:</td>
<td>[2 Years]</td>
<td>[$25,000.00]</td>
</tr>
<tr>
<td>[Maximum EBR Benefit Limit:]</td>
<td>[4 Years]</td>
<td>[$50,000.00]</td>
</tr>
<tr>
<td>[Inflation Benefit Option:]</td>
<td></td>
<td>[$5,625.00]</td>
</tr>
<tr>
<td>Total Long-Term Care Benefit:</td>
<td>[6 Years]</td>
<td>[$80,625.00]</td>
</tr>
</tbody>
</table>

Monthly Maximum ABR [and EBR] Benefit Amount: [$1,041.67]

Inflation Benefit Option for ABR [and EBR]: [Rejected] [3% Simple]

**Long-Term Care Benefits**

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Elimination Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternative Care Benefit:</td>
<td>[0] Days</td>
</tr>
<tr>
<td>Assisted Living Facility Benefit:</td>
<td>[90] Days</td>
</tr>
<tr>
<td>Care Coordination Benefit:</td>
<td>[0] Days</td>
</tr>
<tr>
<td>Caregiver Training Benefit:</td>
<td>[0] Days</td>
</tr>
<tr>
<td>Home and Community Care Benefit:</td>
<td>[0] Days</td>
</tr>
<tr>
<td>International Benefit:</td>
<td>[90] Days</td>
</tr>
<tr>
<td>Non-Continual Alternative Care Benefit:</td>
<td>[0] Days</td>
</tr>
<tr>
<td>Nursing Home Benefit:</td>
<td>[90] Days</td>
</tr>
</tbody>
</table>

**Non-Continual Alternative Care Benefit Lifetime Maximum** – Lesser of $[5,000] or Monthly Maximum ABR Benefit Amount at time of policy issue while covered under ABR [and EBR].

**Caregiver Training Benefit Lifetime Maximum** – $[1,000] for the Caregiver Training Benefit while covered under ABR [and EBR].

For questions about your policy or to discuss policy and rider benefits, you may contact us at our Administrative Office at (800) 347-7787 or at www.PacificLife.com.
TABLE OF COST OF INSURANCE RATES
FOR LIFE COVERAGE

INSURED: [JANE DOE]

MAXIMUM MONTHLY COST OF INSURANCE RATES PER $1000.00 OF NET AMOUNT AT RISK APPLICABLE TO THIS COVERAGE.

<table>
<thead>
<tr>
<th>POLICY YEAR</th>
<th>MONTHLY RATE</th>
<th>POLICY YEAR</th>
<th>MONTHLY RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>[1]</td>
<td>0.07670</td>
<td>45</td>
<td>3.43850</td>
</tr>
<tr>
<td>2</td>
<td>0.08250</td>
<td>46</td>
<td>3.82530</td>
</tr>
<tr>
<td>3</td>
<td>0.08750</td>
<td>47</td>
<td>4.30290</td>
</tr>
<tr>
<td>4</td>
<td>0.09170</td>
<td>48</td>
<td>4.81110</td>
</tr>
<tr>
<td>5</td>
<td>0.09670</td>
<td>49</td>
<td>5.34790</td>
</tr>
<tr>
<td>6</td>
<td>0.10260</td>
<td>50</td>
<td>5.95010</td>
</tr>
<tr>
<td>7</td>
<td>0.10920</td>
<td>51</td>
<td>6.56440</td>
</tr>
<tr>
<td>8</td>
<td>0.11670</td>
<td>52</td>
<td>7.29570</td>
</tr>
<tr>
<td>9</td>
<td>0.12590</td>
<td>53</td>
<td>8.20720</td>
</tr>
<tr>
<td>10</td>
<td>0.13680</td>
<td>54</td>
<td>9.17860</td>
</tr>
<tr>
<td>11</td>
<td>0.14930</td>
<td>55</td>
<td>10.15600</td>
</tr>
<tr>
<td>12</td>
<td>0.16430</td>
<td>56</td>
<td>10.88250</td>
</tr>
<tr>
<td>13</td>
<td>0.18180</td>
<td>57</td>
<td>11.58260</td>
</tr>
<tr>
<td>14</td>
<td>0.20110</td>
<td>58</td>
<td>12.75540</td>
</tr>
<tr>
<td>15</td>
<td>0.22280</td>
<td>59</td>
<td>14.36970</td>
</tr>
<tr>
<td>16</td>
<td>0.24700</td>
<td>60</td>
<td>16.42160</td>
</tr>
<tr>
<td>17</td>
<td>0.27460</td>
<td>61+</td>
<td>0.00000</td>
</tr>
<tr>
<td>18</td>
<td>0.30550</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>0.33810</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>0.37240</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>0.41180</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>0.45450</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>0.49970</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>0.54660</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>0.59440</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>0.64480</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>0.70020</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>0.75900</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>0.82120</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>0.88930</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>0.96510</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>1.04770</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>1.13960</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>1.24180</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>1.35340</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>1.47950</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>1.62360</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>1.78150</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>1.95420</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>2.14600</td>
<td></td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>2.35700</td>
<td></td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>2.58910</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>2.84660</td>
<td></td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>3.12830</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DEFINITIONS

In this section, we define certain terms used throughout this policy. Other terms may be defined in other parts of the policy. Defined terms are usually capitalized to provide emphasis.

Accumulated Value – is the sum of Net Premiums and credited interest less withdrawals, monthly deductions, and any reductions due to the Terminal Illness Benefit Payment or benefit payments under a rider. See the Accumulated Value and Policy Loan sections for details.

Administrative Office – is the office that administers your policy. The mailing address of the Administrative Office at the time you applied for this policy is shown in the heading of the Application. If the address changes, we will send you written notice of the new address.

Age – means the age as of the Insured's birthday prior to the Policy Date, increased by the number of complete policy years elapsed.

Application – consists of the application for this policy, including any Statement of Good Health and Insurability, amendments, endorsements, and any application for reinstatement.

Class – is used in determining Policy Charges and interest credited, and depends on a number of factors, including (but not limited to) the Death Benefit, Face Amount, Policy Date, policy duration, the Insured’s Age and Risk Class and the presence of optional riders and benefits.


Evidence of Insurability – is information, including medical information, that is used to determine insurability and the Insured’s Risk Class, subject to our approval.

Face Amount – is the Face Amount of Life Coverage as shown in the Policy Specifications.

Insured – is the person insured under this policy, as shown in the Policy Specifications.

In Force – means a policy is in effect and provides a Death Benefit or Residual Death Benefit on the Insured.

Life Coverage – is insurance coverage on the Insured provided by this policy as shown in the Policy Specifications, rather than coverage provided by rider.

Monthly Deduction End Date – is shown in the Policy Specifications and is the date when Monthly Deductions end.

Monthly Payment Date – is the same day in each month as the Policy Date and is the date on which certain Policy Charges are deducted from the Accumulated Value. The first Monthly Payment Date is the Policy Date.

Net Accumulated Value – is the Accumulated Value less any Policy Debt.

Net Amount at Risk – is the difference between the Death Benefit and the Accumulated Value.

Net Premium – is the premium we receive for Life Coverage reduced by any Premium Load.

Owner, you, or your – refers to the Owner of this policy.

Policy Date – is shown in the Policy Specifications and means the date the policy and associated riders become effective. Policy and rider months, quarters, years and anniversaries are measured from this date.
**Policy Debt** – is the sum of the Loan Account and accrued Loan Interest charged, as described in the Policy Loans section.

**Policy Specifications** – is a section of the policy that shows information specific to your policy.

**Risk Class** – is used in determining Policy Charges and is determined by us during the underwriting process. Risk Class depends on the Insured’s gender, health, tobacco use, and other factors. The Risk Class of the Insured is shown in the Policy Specifications. Risk Class may also be referred to as Risk Classification.

**We, our, ours, and us** – refers to Pacific Life Insurance Company.

**Written Request** – is your signed request in writing, or on a form we provide, and received by us at our Administrative Office, containing information we need to act on the request.

### DEATH BENEFIT

**When the Policy is In Force** – This policy is In Force as of the Policy Date, subject to your acceptance of the delivered policy and payment of the initial premium. The policy remains In Force until the earliest of the following:

- Surrender, as described in the Surrender and Withdrawal of Values section;
- Lapse, as described in the Policy Lapse and Reinstatement section; or
- The death of the Insured.

Coverage under this policy will be reduced by any decreases in Face Amount, as described in later sections of this policy or riders attached to this policy.

**Death Benefit** – This policy provides a Death Benefit on the death of the Insured while this policy is In Force. This section describes how the Death Benefit is calculated. The Death Benefit is the larger of:

- The Face Amount reflecting any reductions as a result of withdrawals, any Terminal Illness Benefit Payment, or any rider benefits paid; or
- The Minimum Death Benefit according to the Cash Value Accumulation Test.

The Death Benefit as calculated above is subject to any increase required by the minimum death benefit provisions set out in General Provisions to satisfy certain federal tax qualification requirements.

**Death Benefit Qualification Test** – In order for your policy to qualify as a life insurance contract under the Code, it must at all relevant times satisfy the Cash Value Accumulation Test. The policy provides a Minimum Death Benefit amount, as needed, for the policy to qualify under the Cash Value Accumulation Test.

**Minimum Death Benefit** – The Minimum Death Benefit at any time will be the minimum amount required for this policy to qualify as a life insurance contract under the Code, but not less than 101% of the greater of the Accumulated Value or the Life Return of Premium Benefit.

**Death Proceeds** – The Death Proceeds ("Proceeds") amount is the actual amount payable to the beneficiary if the Insured dies while this policy is In Force. The Proceeds amount is equal to the greater of the Death Benefit or the Residual Death Benefit, as of the date of death:

- Less any Policy Debt; and
- Less any Monthly Deductions that may be due and unpaid if death occurs during a Grace Period.

Proceeds paid are subject to the conditions and adjustments defined in other policy provisions, such as General Provisions, withdrawals, Policy Loans, and Timing of Payments. We will pay interest on the Proceeds from the date of death at a rate not less than the rate payable for funds left on deposit (see the
Income Benefits section). If payment of Proceeds is delayed more than 31 calendar days after we receive the following requirements needed to pay the claim, we will pay additional interest at a rate of 10% annually beginning with the 31st calendar day referenced above. Proceeds are paid as a lump sum unless you choose to have the Proceeds paid under an income benefit plan available on the date of election, subject to our requirements.

We will pay the Proceeds to the beneficiary after we receive, at our Administrative Office:

- Due proof of the Insured’s death, consisting of a certified copy of the death certificate for the Insured or other lawful evidence providing equivalent information;
- Proof of the claimant’s legal interest in the Proceeds; and
- Sufficient evidence that any legal impediments to payment of Proceeds that depend on parties other than us have been resolved. Legal impediments to payment include, but are not limited to (a) the establishment of guardianships and conservatorships; (b) the appointment and qualification of trustees, executors and administrators; (c) submission of information required to satisfy state and federal reporting requirements; and (d) conflicting claims.

**Residual Death Benefit** – This policy provides a Residual Death Benefit if greater than the Death Benefit, in an amount equal to the lesser of 5% of the initial Face Amount, as shown on the Policy Specifications, or $5,000.00. Any withdrawals and any Terminal Illness Benefit Payment will reduce the Residual Death Benefit in the same proportion that they reduce the Face Amount.

**Face Amount Changes** – A requested increase or decrease in Face Amount is not allowed.

**Face Amount Decreases** – A decrease in Face Amount will occur as a result of:

- Withdrawals of policy Accumulated Value; or
- Rider benefits or Terminal Illness Benefit exercised while the policy is In Force.

The effective date of the decreased Face Amount will be the date we have processed the withdrawal, rider benefit, or Terminal Illness Benefit. Upon processing any decrease, we will send you written notification reflecting the decrease.

**Change in Benefits** – Under the Cash Value Accumulation Test, any change in policy or rider benefits or certain other factors may require an adjustment to the policy’s tax qualification limits.

**PREMIUMS**

**Premiums** – The initial premium is payable either at our Administrative Office or to our authorized representative before we can place your policy In Force. At your request, we will give you a premium receipt signed by one of our officers. Additional premiums are optional and are payable at any time at our Administrative Office. We will consider any premium paid after the initial premium, whether delivered to an independent producer or otherwise, to be “received” when it is actually delivered to our Administrative Office. Except for the initial premium, we bear no responsibility for any premium unless we have received the premium. We reserve the right to reject premium payments less than $50 unless such premium is required to keep the policy In Force. Premiums may be paid at any time before the Monthly Deduction End Date, subject to the premium limits below. Any payment we receive from you while you have a loan will be first considered a loan repayment, unless you tell us by Written Request it is a premium payment.

**Premium Load** – The Premium Load is equal to the premium paid for Life Coverage multiplied by the Premium Load Rate. The Maximum Premium Load Rate is shown in the Policy Specifications.

**Premium Processing** – When a premium is received by us, the Premium Load will first be deducted. Then the resulting Net Premium will be credited to the Accumulated Value.
**Premium Limitation** – We reserve the right to require Evidence of Insurability satisfactory to us for any premium payment that would result in an increase in the Net Amount at Risk and, if such Evidence of Insurability is not satisfactory, to limit or refuse the premium payment, unless it is necessary to keep the policy In Force.

**Modified Endowment Contract Premium Limit** – The provisions of this subsection will not apply if your policy is classified as a Modified Endowment Contract under Section 7702A of the Code as of the Policy Date. Otherwise, in order that this policy not be classified as a Modified Endowment Contract under Section 7702A of the Code, the sum of premiums paid less a portion of any withdrawals may not exceed the 7-Pay limit as defined in the Code. The 7-Pay limit is the cumulative sum of the 7-Pay Premiums during the applicable 7-Pay testing period. In the event that a premium payment would cause the 7-Pay limit to be exceeded, we will refund the excess payment to you, unless you have provided a Written Request in which you accept your policy being classified as a Modified Endowment Contract and indicate that we may accept such payments and apply them to the policy, in accordance with the Modified Endowment Contract Tax Status subsection of this policy.

The 7-Pay Premium may change whenever there is a change in the Face Amount of insurance or in other policy benefits or factors. The 7-Pay Premiums are determined according to the rules applicable to this policy set forth in the Code. The 7-Pay Premium will be adjusted to conform to any changes in the Code. To the extent that a premium payment would cause such limits to be exceeded, we will refund the excess payment to you, in accordance with the Modified Endowment Contract Tax Status section of this policy. Further, as indicated in that section, we will increase the Death Benefit to the extent we deem necessary to continue to classify this policy as a non-Modified Endowment Contract under the Code.

**TERMINAL ILLNESS BENEFIT**

**Terminal Illness Benefit** – If the Insured has been diagnosed with a terminal illness, you have the option to receive a portion of the Face Amount while the Insured is still living. This is called a Terminal Illness Benefit. A "terminal illness" means an illness causing the Insured to have a life expectancy of 12 months or less.

**Eligible Coverage** – is the portion of the Face Amount that will qualify for determining the Terminal Illness Benefit at the time the benefit is exercised. Eligible Coverage is the policy Face Amount less any reductions as a result of withdrawals or paid rider benefits on the policy.

**Requested Portion** – is the amount of the Face Amount you request in a Written Request on a form provided by us. The Requested Portion cannot exceed the lesser of 75% of the Eligible Coverage or $500,000.

**Requested Percentage** – is the Requested Portion divided by the Eligible Coverage.

**Terminal Illness Benefit Payment** – is the actual dollar amount of benefit you will receive as a Terminal Illness Benefit. The Terminal Illness Benefit Payment will be determined as of the date we approve your Written Request for a Terminal Illness Benefit. Your Terminal Illness Benefit Payment will equal your Requested Portion less the following adjustments:

- A reduction rate will be applied to the Requested Portion, and reflects the early payment of the Requested Portion of your policy. The reduction rate will be based on the 12 month life expectancy of the Insured at an annual interest rate declared by us. The reduction rate shall be no greater than the greater of the following rates in effect on the date of your written request for a Terminal Illness Benefit:
  - the yield on 90-day treasury bills; or
  - the maximum statutory adjustable policy loan interest rate.
b) If there is a Policy Loan on your policy as of the date we approve your Written Request, we will reduce the Requested Portion in order to repay a portion of the Policy Loan equal to the Requested Percentage times the outstanding Policy Debt.

c) A processing charge deducted from the Terminal Illness Benefit, not to exceed $150.

We will refund the amounts discussed in a) and c) above should the death of the Insured occur within 30 days of the Terminal Illness Benefit Payment.

The Terminal Illness Benefit Payment will be paid as a lump sum. The minimum Terminal Illness Benefit Payment amount is $500. We place no restrictions on how you use any Terminal Illness Benefit that may be paid under this provision.

This Terminal Illness Benefit is not meant to cause involuntary access to proceeds payable to the beneficiary on the death of the Insured. Therefore, this benefit is not available if either you or the Insured:

a) is required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or

b) is required by a government agency to use this benefit in order to apply for, obtain or keep a government benefit or entitlement.

To Whom We Will Pay Benefits – All benefits will be payable to the Owner or the Owner’s estate while the Insured is still living, unless otherwise designated by the Owner, subject to any required acknowledgment of concurrence for payout. We will be discharged to the extent of any such payment made in good faith.

Effect of Terminal Illness Benefit Payment on Policy and Riders – After a Terminal Illness Benefit Payment is made, the policy and riders will remain In Force subject to the following adjustments. The Face Amount, Coverage Charge, and any Accumulated Value will be reduced by the Requested Percentage. The Return of Premium Benefit will be reduced by the Requested Portion corresponding to the Terminal Illness Benefit Payment amount paid. Any outstanding Policy Debt balance will be reduced by the amount repaid as specified in the Terminal Illness Benefit Payment Section. Cost of Insurance Charges will be adjusted to reflect the reduction in the Death Benefit. A statement demonstrating how the Terminal Illness Benefit impacts your policy values will be sent with the Terminal Illness Benefit Payment.

Eligibility – The following conditions must be met before any Terminal Illness Benefit Payment is made:

- The policy must be In Force on the date the Terminal Illness Benefit Payment is approved;
- We must receive written proof that the life expectancy of the Insured is 12 months or less from the date of the Written Request. Proof will include the certification by a licensed physician. Such person may not be you or a member of your family. Such proof should include clinical, radiological or laboratory evidence of the condition. We reserve the right to obtain a second medical opinion from a physician of our choice at our expense. In the case of conflicting opinions, eligibility for benefits shall be determined by a third medical opinion, at our expense, that is provided by a physician that is acceptable to you and to us.
- The Owner or legal guardian must make the Written Request.

The Terminal Illness Benefit Payment will be paid immediately upon receipt of the due written proof of eligibility.

Terminal Illness Benefit Payment Notice – Prior to or concurrent with the election to effect the Terminal Illness Benefit Payment, we will send the Owner, a statement demonstrating the effect of the Terminal
Illness Benefit Payment on the Accumulated Value, Death Benefit, Premium, Cost of Insurance Charges, and Policy Loans (including loans to pay premiums).

Expiration Date – Your right to exercise the Terminal Illness Benefit will end when the policy is no longer In Force, when the Accumulated Value is zero, or when a Terminal Illness Benefit is paid.

Disclosure – The following should be taken into consideration before you exercise your option to receive the Terminal Illness Benefit:

- Policy Death Benefits, Coverage Charge, Accumulated Value, and Cash Surrender Value will be reduced if a Terminal Illness Benefit is paid;
- This Terminal Illness Benefit is NOT health, nursing home or long-term care insurance, and it is not intended or designed to eliminate the need for such coverage;
- Receipt of the Terminal Illness Benefit Payment may affect Medicaid, Medicare, and/or Supplemental Security Income (SSI) eligibility. Exercising the option to accelerate and receive benefits before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility.

ACCUMULATED VALUE

Accumulated Value – The Accumulated Value equals the sum of:

- Fixed Accumulated Value; and
- Loan Account Value, as described in the Policy Loans section.

Fixed Accumulated Value – On the Policy Date, the Fixed Accumulated Value equals the Net Premium received less the first Monthly Deduction. On each other day, the Fixed Accumulated Value equals:

- The Fixed Accumulated Value as of the prior day;
- Plus interest earned on such amount since the prior day;
- Plus the amount of any Net Premiums received since the prior day;
- Less the amount of any withdrawal since the prior day;
- Less the amount of any Policy Loan, including any Policy Loan to pay Policy Loan interest, taken since the prior day;
- Less reduction for benefits paid since the prior day as described in the riders attached to this policy;
- Less reduction for the Requested Portion for any Terminal Illness Benefit Payment since the prior day as described in the Terminal Illness Benefit section;
- Plus the amount of any loan repayment made since the prior day; and
- Less, on a Monthly Payment Date, the Monthly Deduction.

We credit interest to the Fixed Accumulated Value on a daily basis at the end of each day, using a 365-day year, at a rate not less than the Guaranteed Annual Interest Rate shown in the Policy Specifications. At our discretion, we may credit additional interest. Any such additional interest may be adjusted to reflect expenses, taxes, profit, or sources of earnings other than investment earnings and will be applied uniformly to all members of the same Class. Once credited, the additional interest is nonforfeitable except indirectly due to the Surrender Charge.

POLICY CHARGES

Monthly Deduction – The Monthly Deduction provides coverage for the policy month following the Monthly Payment Date and is deducted from the Accumulated Value on each such date before the Monthly Deduction End Date. It is equal to the sum of the following items:

- The Cost of Insurance Charge;
• The Coverage Charge; and
• Rider charges, if any.

The maximum for each such charge is described below or in the rider forms. We may charge less than such maximum charge. Any lesser charge will apply uniformly to all members of the same Class.

Coverage Charge – This charge is based on the Face Amount of the policy and will not exceed the Maximum Monthly Coverage Charge shown in the Policy Specifications. The Coverage Charge will decrease proportionately to the Face Amount Decrease as a result of a withdrawal or payment of a Terminal Illness or rider benefit.

Rider Charges – Any rider charges are described in the rider.

Cost of Insurance Charge – The Cost of Insurance Charge is equal to (1) multiplied by (2), where: (1) is the Monthly Cost of Insurance Rate divided by 1000 as shown in the Policy Specifications; and (2) is the Death Benefit divided by the Net Amount at Risk Factor shown in the Policy Specifications, reduced by the Accumulated Value as of the beginning of the policy month before the Monthly Deduction is assessed.

Cost of Insurance Rates – The Maximum Monthly Cost of Insurance Rates for the Life Coverage are shown in the Policy Specifications.

POLICY LAPSE AND REINSTATEMENT

Grace Period – If the Accumulated Value less Policy Debt on a Monthly Payment Date is sufficient to cover the Monthly Deduction due, the policy will continue In Force. If the Accumulated Value less Policy Debt on a Monthly Payment Date is not sufficient to cover the Monthly Deduction due, a Grace Period of 61 days will be allowed for the payment of sufficient loan repayment or premium to keep your policy In Force. The Grace Period begins on the Monthly Payment Date on which the insufficiency occurred and ends 61 days thereafter. At the start of the Grace Period, we will provide a Grace Notice to you, any assignee of record, and any additional person designated to receive notice of lapse or termination. There is no penalty for paying a premium during the Grace Period. Your policy will remain In Force during the Grace Period.

Notification of Termination for Non-Payment – Thirty days after the Monthly Payment Date on which the insufficiency occurred, we will provide a notification of termination for non-payment to you, any assignee of record, and any additional person designated to receive notice of lapse or termination. The notice will be provided to each person at their last known addresses by first class United States mail, postage prepaid and will state the due date and the amount of loan repayment or premium required for your policy to remain In Force. A minimum of the monthly charges not deducted plus three times the monthly deduction due when the insufficiency occurred must be paid.

Lapse – If sufficient loan repayment or premium is not paid by the end of the Grace Period, a lapse will occur. If the Insured dies during the Grace Period, the Death Proceeds will be equal to the Death Proceeds as of the beginning of the Grace Period reduced by any overdue charges. Upon lapse, the policy will terminate with no value.

Reinstatement – If it has not been surrendered, this policy may be reinstated within five years after the end of the Grace Period. To reinstate this policy you must provide us with the following:

• A written application;
• Full repayment of Policy Debt, if a loan was outstanding at the time of lapse;
• Evidence of Insurability satisfactory to us; and
• Sufficient premium, after reduction by Premium Load, to cover all Monthly Deductions and Loan Interest Charges due and unpaid during the Grace Period.
The effective date of the policy reinstatement will be the Monthly Payment Date on or next following the date we approve your reinstatement application. Upon reinstatement:

- The Accumulated Value will equal the amount it was at the beginning of the Grace Period, plus the reinstatement Net Premium, less Monthly Deductions as indicated below (including those due and unpaid during the Grace Period);
- The Surrender Charges, Life Return of Premium Benefit and Policy Charges (other than Cost of Insurance Charges) for Life Coverage under this policy will resume on their schedule as of the Monthly Payment Date when lapse occurred;
- Cost of Insurance Charges will be calculated using Cost of Insurance Rates that resume their original schedule as if lapse had never occurred, reflecting the Insured’s Age at reinstatement and policy duration measured from the original Policy Date; and
- The periods during which we may exclude death by suicide and contest coverage due to a material misstatement in the reinstatement application will begin from the reinstatement date.

After the reinstatement premium has been applied, regular policy processing of Monthly Deductions will occur for the period of time when coverage was provided during the Grace Period. There will be no Monthly Deductions between the time of lapse and reinstatement.

**SURRENDER AND WITHDRAWAL OF VALUES**

**Surrender** – Upon Written Request while the policy is In Force, you may surrender this policy for its Net Cash Surrender Value. If surrendered within 30 days following a policy anniversary, the value available shall not be less than the anniversary value, less any withdrawal, Policy Loan, Terminal Illness Benefit Payment, or rider benefit paid since the policy anniversary. If surrendered at any time other than on a policy anniversary, the value available shall be calculated with allowance for lapse of time from the last preceding policy anniversary. The policy will terminate on the date the Written Request is received at our Administrative Office. The policy cannot be surrendered during the Grace Period.

**Net Cash Surrender Value** – The Net Cash Surrender Value is the Cash Surrender Value less any Policy Debt plus any Return of Premium Benefits under any attached riders.

**Life Return of Premium Benefit** – The Life Return of Premium Benefit is equal to the Life Coverage Premium Amount at issue, as shown in the Policy Specifications.

**Return of Premium Benefit** – The Return of Premium Benefit is not available if your policy was issued upon the exercise of a conversion option from another policy. Otherwise, the Return of Premium Benefit, if greater than the Accumulation Value less any Surrender Charge, is available upon surrender of the policy. The Return of Premium Benefit is equal to the sum of the Life Return of Premium Benefit and any Return of Premium Benefit under riders attached to the policy. There are no increases to the Return of Premium Benefit after issue, even if additional premiums are paid.

After issue, the Return of Premium Benefit is reduced by the following events:

- Any withdrawals;
- The Requested Portion corresponding to a Terminal Illness Benefit Payment made under the policy; and
- Any benefit payments made under the riders.

These events will reduce the Life Return of Premium Benefit first (but not below zero), and then any Return of Premium Benefit under riders attached to the policy.

**Cash Surrender Value** – The Cash Surrender Value is equal to the greater of:

- Life Return of Premium Benefits; or
- The Accumulated Value:
• Less any Surrender Charge; and
• Less any Return of Premium Benefits under any riders attached to this Policy.

**Surrender Charge** – If you surrender this policy, there may be a Surrender Charge deducted from the Accumulated Value. During the Level Period, the Surrender Charge is equal to the Initial Amount. After the Level Period, the Surrender Charge decreases by the Reduction Factor for the remaining Surrender Charge Period. The Initial Amount, Level Period, Reduction Factor and Surrender Charge Period are shown in the Policy Specifications.

**Withdrawals** – Upon Written Request on or after the first policy anniversary, you may withdraw a portion of the Net Cash Surrender Value of this policy. Such withdrawal will be deducted from the Accumulated Value. There is no Surrender Charge imposed for a withdrawal, even if the Face Amount is reduced as a result of the withdrawal. Withdrawals may be restricted or prohibited by certain riders attached to the policy. Withdrawals will be subject to the following conditions:

• The amount of each withdrawal must be at least $200;
• The Net Accumulated Value less any Surrender Charge remaining after a withdrawal must be at least $500; and
• The Face Amount remaining after the withdrawal must be at least the Minimum Face Amount as shown in the Policy Specifications.

A withdrawal will reduce the Face Amount in proportion to the amount of the withdrawal divided by the Accumulation Value before the withdrawal. If such a reduction in Face Amount would cause the policy to become a Modified Endowment Contract, we will not process your withdrawal request unless and until we receive your Written Request to have your policy classified as a Modified Endowment Contract. Refer to the Premiums section for details.

If the Insured dies after the request for a withdrawal is received by us and prior to the withdrawal being processed, the withdrawal, if allowed under this provision, will be processed and paid to the Owner, or to the Owner’s estate, before the Death Proceeds are determined and paid to the beneficiary.

**INCOME BENEFITS**

**Income Benefits** – All or part of any policy proceeds may, instead of being paid in a lump sum, be left with us under any one, or a combination of the income benefit plans available, subject to our minimum amount requirements on the date of election. If the payee is not a natural person, the choice of a payment option will be subject to our approval. We guarantee that the income benefit will not be less than the income that would be provided by the single premium immediate annuity purchase rates we offer at the time. We guarantee that we will have at least the following income benefit plans available.

**Fixed Income** – Equal payments of the amount chosen with interest of not less than 2% per year until the funds left on deposit are exhausted.

**Life Income** – Monthly income will automatically be guaranteed to continue for at least ten years. If the payee dies before the end of the ten-year period, payments will continue to the end of the ten-year period to a person designated in writing by that payee. The purchase rates for the monthly income for a male or female income recipient bought by each $1,000 of benefits are shown below.

<table>
<thead>
<tr>
<th>Age</th>
<th>Monthly Income</th>
<th>Age</th>
<th>Monthly Income</th>
<th>Age</th>
<th>Monthly Income</th>
<th>Age</th>
<th>Monthly Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-30</td>
<td>2.38</td>
<td>40</td>
<td>2.63</td>
<td>50</td>
<td>3.00</td>
<td>60</td>
<td>3.60</td>
</tr>
<tr>
<td>32</td>
<td>2.42</td>
<td>42</td>
<td>2.69</td>
<td>52</td>
<td>3.10</td>
<td>62</td>
<td>3.76</td>
</tr>
<tr>
<td>34</td>
<td>2.47</td>
<td>44</td>
<td>2.76</td>
<td>54</td>
<td>3.20</td>
<td>64</td>
<td>3.94</td>
</tr>
<tr>
<td>36</td>
<td>2.52</td>
<td>46</td>
<td>2.83</td>
<td>56</td>
<td>3.32</td>
<td>66</td>
<td>4.14</td>
</tr>
<tr>
<td>38</td>
<td>2.57</td>
<td>48</td>
<td>2.91</td>
<td>58</td>
<td>3.45</td>
<td>68</td>
<td>4.37</td>
</tr>
</tbody>
</table>
Monthly income amounts for ages not shown are halfway between the two amounts for the nearest two ages that are shown. Amounts shown are based on an annual interest rate of 2% and the Annuity 2000 female mortality table with five-year age setback. We may require evidence of survival for incomes that last more than ten years.

POLICY LOANS

Policy Loans – You may obtain Policy Loans by Written Request after the Free Look Period, on the sole security of the Loan Account of this policy. We recommend you consult a qualified tax advisor before requesting a Policy Loan.

Loan Amount Available – The amount of the loan must be at least $200. The maximum amount available for a loan on any date is equal to the Accumulated Value less:

- Three times the most recent Monthly Deduction;
- Any Surrender Charge; and
- Any existing Policy Debt.

Loan Account – The amount of any Policy Loan will be added to the Loan Account.

Loan Repayment – You may make loan repayments at any time prior to lapse of this policy. Any payment we receive from you while you have a loan will be treated as a loan repayment, unless you tell us by Written Request that it is a premium payment.

Loan Interest Charge – Interest will accrue daily based on the balance in the Loan Account and will be due on each policy anniversary. Such interest is calculated using the simple interest method and is based on the balance in the Loan Account, using an annual interest rate of 5.50%. The corresponding daily interest rate is equal to the annual rate divided by 365. If the policy terminates before a policy anniversary, the Loan Interest Charge will be due at such time.

Policy Debt – The Policy Debt is the amount necessary to repay the Policy Loan in full and is equal to the Loan Account plus any Loan Interest Charge. The Policy Debt reduces any amount otherwise payable under the policy.

Loan Account Value – The Loan Account Value is a portion of the Accumulated Value set aside to secure the Policy Debt. The Loan Account Value is equal to the Loan Account plus Loan Interest. Such interest is based on the balance in the Loan Account, and accrues daily on a simple interest basis, using the Loan Account Interest rate, which is an annual interest rate not less than the Guaranteed Annual Interest Rate shown in the Policy Specifications. The corresponding daily interest rate is equal to the annual rate divided by 365.

Loan Processing on Policy Anniversary – On each policy anniversary we will adjust the values of the Policy Debt, Loan Account and Loan Account Value so that they are equal to each other. To do this, we calculate the difference between the Policy Debt and the Loan Account Value. If the Policy Debt is greater than the Loan Account Value, which is generally the case when the policy loan interest has not been paid, a new loan will be taken for the excess and will be added to the Loan Account. If the Loan Account Value is greater than the Policy Debt, which is generally the case when the policy loan interest has been paid, the excess will be transferred into the Fixed Accumulated Value.

OWNER AND BENEFICIARY

Owner – The Owner of this policy is as shown in the Policy Specifications or as later changed by Written Request. If you change the Owner, the change is effective on the date the Written Request is signed, unless otherwise specified by the Owner, subject to our receipt of it and subject to any action taken or payment made by us prior to its receipt. If there are two or more Owners, they will own this contract as
joint tenants with right of survivorship, unless otherwise provided by Written Request. We recommend you consult a qualified tax advisor before requesting a change of Owner.

**Assignment** – Pursuant to Section 7702B of the Code, a policy providing qualified long-term care insurance benefits may not provide for a cash surrender value or other money that can be paid, assigned, or pledged as collateral for a loan. Accordingly, this Policy may not be assigned.

**Beneficiary** – The beneficiary is named by you in the Application to receive the Death Proceeds. You may name one or more beneficiaries. If you name more than one beneficiary, they will share the Death Proceeds equally or as you may otherwise specify by Written Request. If you have named a contingent beneficiary, that person becomes the beneficiary if the beneficiary dies before the Insured. A beneficiary may not, on or after the Insured's death, assign, transfer or encumber any benefit payable. To the extent allowed by law, policy benefits will not be subject to the claims of any creditor of any beneficiary.

You may make a change of beneficiary by Written Request on a form provided by us while the policy is In Force. The change will take place as of the date the request is signed, unless otherwise specified by the Owner. Any rights created by the change will be subject to any payments made or actions taken by us before we have received the Written Request.

The interest of a beneficiary who does not outlive the Insured will be divided pro rata among the surviving beneficiaries. If no beneficiaries survive to receive payment, the death proceeds will pass to the Owner, or the Owner’s estate if the Owner does not survive the Insured. In the event of a simultaneous death of the Insured and a beneficiary such that it cannot be determined who died first, it will be assumed, unless proof to the contrary is provided, that the beneficiary died last.

**GENERAL PROVISIONS**

**Entire Contract** – This policy is a contract between you and us. This policy, the attached copy of the initial Application, including any amendments and endorsements to the Application, any applications for reinstatement, any endorsements, benefits, or riders, and all additional policy information sections added to this policy are the entire contract. Only our president, chief executive officer or secretary is authorized to change this contract or extend the time for paying premiums. Any such change must be in writing.

All statements in the Application shall, in the absence of fraud, be deemed representations and not warranties. We will not use any statement to contest this policy or defend a claim on grounds of misrepresentation unless the statement is in an Application.

**Incontestability** – We will not contest this policy unless there was a material misrepresentation in the Application. We will rescind the policy if:

- The policy has been In Force for less than six months and we determine that the Application contains a misrepresentation that is material to acceptance for coverage; and
- The policy has been In Force for at least six months but less than two years and we determine that the Application contains a misrepresentation that is material to acceptance for coverage and which pertains to a claim made under this policy or the riders attached to this policy.

If we rescind the policy, we will return to you the premiums paid less any Policy Loans, any withdrawals taken, and any benefits paid under this policy or the riders attached to this policy. No Death Benefit will be paid. This policy cannot be contested, except as provided below, after it has been In Force for two years during the Insured’s lifetime.

If this policy lapses and is later reinstated, we will rescind the policy as of the reinstatement date if:

- Less than six months after the reinstatement date, we determine that the Application required for reinstatement contains a misrepresentation that is material to acceptance for coverage; and
- After six months from the reinstatement date but less than two years from the reinstatement date, we determine that the Application required for reinstatement contains a misrepresentation that is material
to acceptance for coverage and which pertains to a claim made under this policy or the riders attached to this policy.

If we rescind the policy following reinstatement, we will return to you the premiums paid after the reinstatement date less any Policy Loans and any withdrawals taken after the reinstatement date. No Death Benefit will be paid. We will not contest the reinstated policy after it has been In Force for two years following such reinstatement during the Insured’s lifetime.

If there has been a change to the policy for which we required the Insured to submit Evidence of Insurability, we will rescind the policy change and all Policy Charges made after the change will be reversed and corrected charges applied so that the policy’s Accumulated Value will be unaffected by the change if:

- Less than six months after the change, we determine that the Application required for the change contains a misrepresentation that is material to acceptance for coverage; and
- After six months from the change but less than two years from the change, we determine that the Application required for the change contains a misrepresentation that is material to acceptance for coverage and which pertains to a claim made under this policy or the riders attached to this policy.

Any Death Benefits or other benefits that become payable will be determined as though the policy change had never been requested. We will not contest any such change after two years following the effective date of the change during the Insured’s lifetime.

**Non-Participating** – This policy will not share in any of our surplus earnings.

**Suicide Exclusion** – If the Insured dies by suicide, while sane or insane, within two years of the Policy Date, the Death Proceeds will be limited to an amount equal to the sum of the premiums paid, less the sum of any Policy Loans, withdrawals taken, and any benefits paid under this policy or the riders attached to this policy. If this policy has been reinstated and the Insured dies by suicide, while sane or insane, within two years of the latest reinstatement date, the Death Proceeds will be limited to an amount equal to the sum of the premiums paid less the sum of any Policy Loans, withdrawals taken, and any benefits paid under this policy or the riders attached to this policy since such date.

**Misstatement** – If the Insured’s sex or birth date is misstated in the Application and it is discovered on or after the death of the Insured, the Death Benefit shall be the minimum Death Benefit for the correct sex and birth date, or if greater, a Death Benefit based on a Net Amount at Risk adjusted by the ratio of the incorrect Cost of Insurance Rate to the correct Cost of Insurance Rate. The adjusted Net Amount at Risk will result in an adjusted Death Benefit, since the Death Benefit depends on the Net Amount at Risk.

If the Insured’s sex or birth date is misstated in the Application and it is discovered before the death of the Insured, we will not recalculate the Accumulated Value, but we will use the correct sex and birth date of the Insured in calculating future Monthly Deductions.

**Maturity** – This policy does not mature, but will continue In Force so long as the Insured is alive and the policy has not been surrendered and lapse has not occurred.

**After the Monthly Deduction End Date** – Provided the policy is still In Force, coverage will continue on and after the Monthly Deduction End Date, subject to all policy provisions, with these exceptions and clarifications:

- Monthly Deductions will cease;
- Premiums will not be accepted, except amounts required to keep the policy in force;
- Loans will be allowed;
- Loan repayments will be permitted;
- Loan interest will continue to accrue; and
- Withdrawals will not be allowed.
Timing of Payments – We may defer payments of any Net Cash Surrender Value, withdrawal or loan (except for loans to pay a premium on any policy issued by us) for up to six months after we receive your request. If we defer any such payment for more than 30 days after we receive your request, we will pay interest at the rate required by the state in which this policy is delivered, and such rate will be at least equal to the Guaranteed Annual Interest Rate shown in the Policy Specifications.

Annual Report – A report will be mailed to your last known address no less frequently than annually. This report will show:

- The beginning and end dates of the reporting period;
- The Accumulated Value at the beginning and end of the reporting period;
- Amounts that have been credited or debited to the Accumulated Value during the reporting period, identified by type;
- The Death Benefit at the end of the reporting period;
- The Net Cash Surrender Value at the end of the reporting period;
- A notice if the Net Cash Surrender Value will not be sufficient to keep the policy in Force until the end of the next reporting period, unless further premium payments are made;
- Any Policy Debt outstanding at the end of the reporting period; and
- Any other information required by law.

Additional Report – Each year, you may request, without charge, an additional report showing the same information as the Annual Report.

Basis of Values – All nonforfeiture values for this policy will be at least equal to the minimums required by the state in which this policy was delivered. Cash Values and nonforfeiture benefits available under this policy are not less than the minimum values and benefits required by or pursuant to the law of the state where the policy was delivered. To calculate the minimum required nonforfeiture values, we use the Guaranteed Annual Interest Rate shown in the Policy Specifications and mortality rates from the 2001 CSO mortality tables using age last birthday. The rates we use are both smoker and sex distinct.

Tax Qualification as Life Insurance – This policy is intended to qualify as a life insurance contract for federal tax purposes, and the Death Benefit under this policy is intended to qualify for federal income tax exclusion. The provisions of this policy, including any rider or endorsement that does not specifically override this tax qualification provision, shall be interpreted to ensure and maintain such tax qualification, despite any other provision to the contrary. At no time shall the amount of Death Benefit under this policy ever be less than the minimum amount needed to ensure or maintain such tax qualification. If need be, the Death Benefit shall be increased retroactively and prospectively to the minimum extent necessary to accomplish that purpose. In addition, the Accumulated Value will be reduced to reflect the increased Monthly Deductions that result from such Death Benefit increase(s), starting on the date that each increase is effective. We reserve the right to amend this Policy from time to time to reflect any clarifications that may be needed or are appropriate to maintain such tax qualification or to conform the Policy provisions to any applicable changes in such tax qualification requirements, as provided in the Code or any published IRS guidance relating thereto, without consent (where allowed by law). We will send you a copy of such amendment. As of the effective date of the filing of this policy in the state in which it was delivered, the Internal Revenue Service has not published final guidance on all aspects of the tax treatment of life insurance policies that continue coverage beyond Age 100. You should consult a qualified tax advisor, as there may be tax consequences.

If you request a withdrawal that causes a decrease in policy or rider benefits, it may cause a reduction in any applicable tax limits on premiums or Accumulated Value for the policy to maintain such tax qualification. Such a reduction in these limits may require us to make a distribution from the policy equal to the greatest amount by which the premiums paid or Accumulated Value for the policy exceed any such reduced limits, as determined under federal tax law, in order to maintain the policy’s tax qualification. If such a distribution is made, the distribution will be paid to you and the Accumulated Value will be reduced by the amount of the distribution. However, no request for a withdrawal that causes a decrease in policy or rider benefits will be allowed to the extent that we determine that the resulting reduction in such tax limits would require us to distribute more than the Net Cash Surrender Value for the policy.
Modified Endowment Contract Tax Status – The provisions of this subsection will not apply if your policy is classified as a Modified Endowment Contract (“MEC”) as of the Policy Date. If, at the time your policy is issued, we have classified it as a MEC, this will be indicated on the Policy Specifications. Otherwise, unless and until you have given us a Written Request to accept a MEC classification for your policy, the provisions of this Modified Endowment Contract Tax Status subsection apply to your policy.

Under federal tax law, if the funding of a life insurance contract occurs too rapidly, it becomes a MEC and fails to qualify for certain favorable tax treatment as a result. This policy is intended to qualify as a life insurance contract that is not a MEC for federal tax purposes. To achieve these purposes, the provisions of this policy (including any rider or endorsement that does not specifically override this tax qualification provision) shall be interpreted to prevent this policy from being subject to such MEC treatment, despite any other provision to the contrary. If and while the provisions of this subsection apply to your policy, the amount of Death Benefit under this policy shall never be less than the minimum amount needed to avoid such MEC treatment. We reserve the right to amend this Policy from time to time to reflect any clarifications that may be needed or are appropriate to maintain such tax qualification for non-MEC treatment or to conform the Policy provisions to any applicable changes in such tax qualification requirements, as provided in the Code or any published IRS guidance relating thereto, without consent (where allowed by law). We will send you a copy of such amendment.

We will not accept a payment as premium or otherwise which would cause the policy to become a MEC. The 7-Pay Premium, shown on Page 3.0, is used solely to determine the policy’s premium limits to avoid MEC treatment. Payment of one or more 7-Pay Premium amounts does not guarantee that the policy will never lapse, and additional premiums may be necessary to prevent the policy from lapsing in the future.

If at any time the amounts paid under the policy exceed the limit for avoiding such MEC treatment, this excess amount, including any interest as determined under federal tax law, shall be removed from the policy as of the date of its payment, and any appropriate adjustment in the Death Benefit and/or Accumulated Value shall be made as of such date. This excess amount, including any interest, shall be refunded no later than 60 days after the end of the applicable contract year, as determined under federal tax law.

If this excess amount is not refunded by the end of such 60-day period, the Death Benefit shall be increased retroactively and prospectively to the minimum extent necessary (e.g., to the end of any MEC 7-year test period) so that at no time is the Death Benefit ever less than the minimum amount necessary to avoid Modified Endowment Contract classification. In addition, the Accumulated Value will be reduced to reflect any increased Monthly Deductions resulting from such Death Benefit increase, starting on the date that the increase is effective.

Any request that would change the Death Benefit or any other benefit or rider under the policy will not be processed if the change would cause the policy to be classified as a Modified Endowment Contract. Requested changes that could cause the policy to be classified as a Modified Endowment Contract include, but are not limited to a withdrawal that would cause a reduction in the Face Amount.

Other Distributions of Accumulated Value – If the Net Amount at Risk ever exceeds three times the original Face Amount, we reserve the right to make a distribution of Accumulated Value to make the Net Amount at Risk equal three times the original Face Amount. In such case, the distribution will be treated as a premium refund. Note that while such a distribution will be treated as a premium refund for certain contract purposes, normal tax rules will apply in determining the amount of such a distribution, if any, which is taxable.

Additional Services – While this policy is In Force, we may, either directly or through a third party service provider, provide you with access to independent living-related resources and discounted independent living-related goods and services.
INDEX

Accumulated Value 5, 10
Additional Report 17
Additional Services 18
Administrative Office 5
After the Monthly Deduction End Date 16
Age 5
Annual Report 17
Application 5
Assignment 14
Basis of Values 17
Beneficiary 15
Cash Surrender Value 12
Change in Benefits 7
Class 5
Code 5
Cost of Insurance Charge 11
Cost of Insurance Rates 11
Coverage Charge 11
Death Benefit 6
Death Benefit Qualification Test 6
Death Proceeds 6
Definitions 5
Disclosure 10
Effect of Terminal Illness Benefit Payment on Policy and Riders 9
Eligibility 9
Eligible Coverage 8
Entire Contract 15
Evidence of Insurability 5
Expiration Date 9
Face Amount 5
Face Amount Changes 7
Face Amount Decreases 7
Fixed Accumulated Value 10
Fixed Income 13
General Provisions 15
Grace Period 11
In Force 5
Income Benefits 13
Incontestability 15
Insured 5
Lapse 11
Life Coverage 5
Life Income 13
Life Return of Premium Benefit 12
Loan Account 14
Loan Account Value 14
Loan Amount Available 14
Loan Interest Charge 14
Loan Processing on Policy Anniversary 14
Loan Repayment 14
Maturity 16
FLEXIBLE PREMIUM ADJUSTABLE LIFE INSURANCE

- Death Proceeds Payable On The Death Of The Insured
- Net Cash Surrender Value Payable Upon Surrender
- Adjustable Face Amount
- Non-Participating
- Terminal Illness Benefit (Accelerated Death Benefit)
ACCELERATED BENEFIT RIDER (“ABR”) FOR LONG-TERM CARE

This rider (“Rider”) becomes a part of the policy to which it is attached (“Policy”) as of the Policy Date and covers only the person named as the Insured in the Policy Specifications. The Application and premium put this Rider In Force as of the Policy Date. A copy of the Application is attached. If the provisions of this Rider and those of the Policy do not agree, the provisions of this Rider will apply. Please read it carefully.

This Rider accelerates the Policy’s benefits by reimbursing the Owner shown on the Policy Specifications for Covered Expenses the Insured incurs for Qualified Long-Term Care Services.

Renewability – This Rider is Non-Cancellable. This Rider will continue as long as the Insured lives or until this Rider is terminated in accordance with the When Insurance Under This Rider Ends provision.

This is a long-term care insurance Rider that provides benefits for Covered Expenses incurred for adult day care, assisted living care, home health care services, hospice care, and nursing home care.

Caution – The issuance of this Rider is based upon the responses to questions on the Application for the Policy and this Rider. A copy of that Application is attached. If any answers are incorrect or untrue, we have the right to deny benefits or rescind this Rider. The best time to clear up any questions is now, before a claim arises. If, for any reason, any answers are incorrect, contact us at our Administrative Office.

Notice to Buyer – This Rider may not cover all of the costs associated with long-term care that may be incurred by the Insured during the period of coverage. The Owner is advised to review carefully all Policy and Rider limitations.

This Rider is not qualified under any state long-term care insurance partnership program. For more information on partnership qualified products, contact the state department of insurance.

This Rider is not Medicare Supplement Coverage – If the Insured is eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from us. Neither Pacific Life Insurance Company nor its producers represent Medicare, the federal government or any state government.

This is intended to be a Tax Qualified Rider – This Rider is intended to provide federally tax qualified long-term care insurance under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. You are advised to consult with a qualified tax advisor.

30-Day Right to Examine – The Owner has 30 days from the day the Policy and this Rider are received to examine and return both of them to us if the Owner decides not to keep them. The Owner does not have to tell us the reason for returning the Policy and this Rider, but both must be returned together. The Policy and Rider can be returned to us at our Administrative Office or to the Producer through whom it was bought. We will refund, directly to the payer, the full amount of any premium paid for both the Policy and this Rider within 30 days of such a Policy and Rider return and the Policy and Rider will be void from the start.

[STATE] Department of Insurance: [(XXX) XXX-XXXX]

Signed for Pacific Life Insurance Company,

[Signature]
Chairman and Chief Executive Officer

[Signature]
Secretary

DEFINITIONS

In this section, we define certain terms used throughout this Rider. Other terms may be defined in other parts of the Policy. Defined terms are usually capitalized to show emphasis. All terms used to define providers of services are defined in relation to the services and facilities required to be available and the licensure, certification, registration or degree status of those providing or supervising the services in the state where the policy was issued. When the definition requires that the provider be appropriately licensed, certified or registered, it also states what requirements a provider shall meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of such services to be licensed, certified or registered, or if the state licenses, certifies or registers the provider of services under another name.

**ABR Benefit Duration** – The period of coverage under this Rider. The ABR Benefit Duration was elected on the Application for the Rider, and is shown on the Policy Specifications. The ABR Benefit Duration may increase or decrease depending on how the Policy and Rider benefits are used.

**Activities of Daily Living** – means the following self-care functions:

- **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.
- **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.)
- **Dressing** – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- **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.
- **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.

**Adult Day Care** – means a state licensed or certified program for a specified number of individuals providing social or health-related or both types of services during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

**Adult Day Care Center** – means a facility that is licensed 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 or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

- Provides Adult Day Care services in a protective setting and under appropriate supervision, including personal, social, and related supportive services that are designed to meet the needs of functionally or cognitively impaired adults through an individualized service plan;
- Operates on less than a 24-hour basis;
- Keeps written record of services for each person; and
- Has established procedures for obtaining appropriate aid in the event of a medical emergency.

**Assessment** – means an evaluation done by a Licensed Health Care Practitioner to determine or verify that the Insured is a Chronically Ill Individual. The Assessment uses generally accepted tests and instruments that use objective measures and produce verifiable results.

**Assisted Living Care** – means personal/custodial monitoring and assistance with Activities of Daily Living provided in a residential setting in a state licensed or certified facility.

**Assisted Living Facility** – means a facility that is appropriately licensed or certified or complies with the state’s facility licensing requirements to engage primarily in providing ongoing Assisted Living Care and
related services. If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

- Provides Assisted Living Care on a continuous 24-hour basis sufficient to support the needs resulting from the inability to perform Activities of Daily Living or from a Severe Cognitive Impairment;
- Has trained and ready-to-respond personnel actively on duty in the facility at all times to provide the services and care;
- Makes and keeps records of all care and services provided to each resident;
- Provides at least three meals a day and accommodates special dietary needs;
- Provides residential services and Maintenance or Personal Care Services for at least six inpatients in one location;
- Has formal arrangements with a Physician or Nurse to furnish medical care in case of an emergency; and
- Has appropriate procedures to provide onsite assistance with prescription medications.

An Assisted Living Facility is not: a hospital; clinic; a place that operates primarily for the treatment of alcoholism, drug addiction or Mental or Nervous Disorders; a Nursing Home Facility; a Hospice Care Facility; an individual residence; an independent living unit; or a group living situation that fails to meet the above requirements.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as an Assisted Living Facility only if it is engaged primarily in providing care and services that meet all of the above criteria.

**Care Coordination** – means identifying a person’s functional, cognitive, personal, and social needs for care and services and can help link the person to a full range of appropriate services. It may include but is not limited to the following:

- Performance of comprehensive individualized Assessments, including reassessments as needed;
- Development of Plans of Care, including an initial Plan of Care and subsequent Plans of Care as needed for changes in the Insured’s condition, by a Care Coordinator; and
- Coordination of appropriate services and ongoing monitoring of the delivery of such services, when desired by the Insured or Representative and determined necessary by the Care Coordinator.

**Care Coordination Provider** – means an agency, entity or person that provides Care Coordination and meets certain standards that pertain to staffing requirements, quality assurance, agency functions, reporting and records maintenance requirements.

**Care Coordinator** – means a Licensed Health Care Practitioner employed by or under contract to a Care Coordination Provider who is qualified by training and experience to assess and coordinate the overall care needs of a person who is a Chronically Ill Individual.

**Chronically Ill Individual** – means the Insured has been certified by a Licensed Health Care Practitioner as:

- Being unable to perform (without Substantial Assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
- Requiring Substantial Supervision to protect the individual from threats to health and safety due to Severe Cognitive Impairment.

A Chronically Ill Individual shall not include an Insured who otherwise meets these requirements unless within the preceding twelve-month period a Licensed Health Care Practitioner has certified that the Insured meets these requirements.

**Confinement or Confined** – means the Insured is a resident in a Nursing Home Facility, an Assisted Living Facility or a Hospice Care Facility for a period for which a room and board charge is made.
Covered Expenses – means costs incurred by the Insured for Qualified Long-Term Care Services and for which a benefit is payable under this Rider. Each benefit section defines its own Covered Expenses.

Durable Medical Equipment – means equipment included in the Plan of Care which:

- Can enhance the Insured’s abilities to perform Activities of Daily Living;
- Is functionally necessary and not just for the Insured’s convenience;
- Is designed for repeated and prolonged use; and
- Is suited for use in the Home.

Infusion pumps, special hospital-style beds, walkers or wheelchairs are examples of types of equipment that may be considered Durable Medical Equipment. Durable Medical Equipment does not include any drug, medicine or equipment implanted in the Insured’s body, temporarily or permanently. Also not included is any Home Modification, motorized scooter, or sporting, protective, athletic or exercise equipment.

Elimination Period – means the total number of days that the Insured is a Chronically Ill Individual before benefits are payable. Each occurrence of days counted towards satisfying the Elimination Period begins on the first day that the Insured is a Chronically Ill Individual and incurs Covered Expenses. The Insured is not required to continue to incur Covered Expenses during that occurrence to satisfy the Elimination Period. The days do not have to be consecutive; days over separate occurrences may accumulate towards satisfying the Elimination Period. An occurrence ends when the Insured is no longer a Chronically Ill Individual.

The Elimination Period need only be met once during the Insured’s lifetime. The Elimination Period is shown on the Policy Specifications.

Any days for which benefits have been paid by Medicare or other insurance for covered Qualified Long-Term Care Services otherwise covered by this Rider will count towards the applicable Elimination Period.

Days may be accumulated before the filing of a claim if we can establish that the Insured met these requirements before the filing of a claim. However, in no case will the Elimination Period start date be more than:

- 90 days prior to the date the Owner or Insured contacts us for a loss related to the Insured’s inability to perform Activities of Daily Living; or
- 365 days prior to the date the Owner or Insured contacts us for a loss due to Severe Cognitive Impairment.

Hands-On Assistance – means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform an Activity of Daily Living.

Home – means the Insured’s domicile. Home does not include:

- A Nursing Home Facility, Assisted Living Facility or Hospice Care Facility;
- A hospital; or
- Any other institutional setting.

Home and Community Care – means services for which benefits are payable under the Home and Community Care Benefit.

Home Health Care Agency – means an entity that is licensed or certified to provide Home Health Care Services or Maintenance or Personal Care Services for compensation by the state in which it operates, where required, and employs staff who are qualified by training or experience to provide such care. If the state does not license or certify such entities, then it must be operated pursuant to law and meet all of the following standards:
• Be supervised by a qualified professional such as a Registered Nurse, a licensed social worker, or a Physician;
• Keep clinical records, which include daily records of care provided to its clients, and care plans on all patients; and
• Provide ongoing supervision and training to its employees appropriate to the services to be provided.

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

**Home Modification** – means the labor, equipment, and supplies used to make changes in the Insured’s Home. These changes must be designed to:

• Enhance the Insured’s ability to perform Activities of Daily Living; and
• Allow the Insured to live safely and independently in his or her Home.

Examples include installation of a ramp in the Home or grab bars in the bathroom. It cannot include home repair, remodeling, or installation of a hot tub, swimming pool, or Jacuzzi or other similar items or services.

**Homemaker Services** – means assistance with activities necessary to or consistent with the Insured’s ability to live safely and independently in his or her Home.

**Hospice Care** – means services designed to provide palliative care and alleviate the Insured’s physical, emotional and social discomforts if he or she is Terminally Ill and in the last phases of life.

**Hospice Care Facility** – means a facility that is appropriately licensed or certified to provide Hospice Care in the state in which it operates. If the state does not license or certify such entities, then it must be operated pursuant to law and provide a formal Hospice Care program directed by a Physician on an inpatient basis. Hospice Care Facility does not mean a hospital or clinic, a community living center or a place that provides residential care only.

**Immediate Family** – means the Insured’s Spouse and the parents, brothers, sisters and children of either the Insured or the Insured’s Spouse by blood, adoption or marriage.

**Independent Provider** – means an individual who is not employed by a Home Health Care Agency but is properly licensed or certified, in states where required, or trained to provide Home Health Care Services or Maintenance or Personal Care Services.

**Informal Caregiver** – means the person who has responsibility for providing nonprofessional care on an unpaid basis for the Insured in the Insured’s Home. A person who is paid to care for the Insured cannot be an Informal Caregiver.

**In Force** – means that this Rider is in effect.

**Licensed Health Care Practitioner** – means a physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States. A Licensed Health Care Practitioner does not include anyone who is an Immediate Family member.

**Maintenance or Personal Care Services** – means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the Insured is a Chronically Ill Individual. This includes protection from threats to health and safety due to Severe Cognitive Impairment.

**Maximum ABR Benefit Limit** – is the total amount of lifetime benefits payable under this Rider as shown on the Policy Specifications. The Maximum ABR Benefit Limit will increase in accordance with the terms
of the Inflation Benefit Option the Owner elected, if any, described in this Rider and shown on the Policy Specifications. The Maximum ABR Benefit Limit will be reduced when:

- A payment of benefit is made in accordance with the terms of this Rider;
- A withdrawal is made on the Policy; or
- A payment of benefit under the Terminal Illness Benefit is made on the Policy.

**Medicare** – means Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof.

**Mental or Nervous Disorder** – means neurosis, psychoneurosis, psychopathology, psychosis, or mental or emotional disease or disorder, as classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. If the DSM is discontinued or replaced, the diagnostic manual in use by the American Psychiatric Association as of the date of the Insured’s illness will be used.

**Monthly Maximum ABR Benefit Amount** – is the total amount of monthly benefits payable under this Rider for the Care Coordination Benefit, Nursing Home Benefit, Assisted Living Facility Benefit, Home and Community Care Benefit, International Benefit and Alternative Care Benefit. The initial Monthly Maximum ABR Benefit Amount is shown on the Policy Specifications. The Monthly Maximum ABR Benefit Amount will increase in accordance with the terms of the Inflation Benefit Option the Owner elected, if any, described in this Rider and shown on the Policy Specifications. The Monthly Maximum ABR Benefit Amount will be reduced when:

- A withdrawal is made on the Policy; or
- A payment of benefit under the Terminal Illness Benefit is made on the Policy.

**Nurse** – means someone who is licensed as a Registered Nurse, Licensed Practical Nurse, or Licensed Vocational Nurse and is operating within the scope of that license.

**Nursing Home Care** – means nursing care and related services provided on an in-patient basis by a state licensed or certified facility, other than a hospital (except for an area of a hospital or unit that is licensed or certified as a nursing care facility and that is not providing acute care).

**Nursing Home Facility** – means 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 Home Care to inpatients under a planned program supervised by a Physician. If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

- Provides Nursing Home Care to inpatients under a planned program supervised by a Physician;
- Provides 24 hour-a-day nursing care by a Nurse under the supervision of a Registered Nurse or a Physician;
- Has formal arrangements with a Physician to furnish medical care in case of an emergency;
- Maintains a daily medical record of each inpatient; and
- Provides nursing care at skilled, intermediate, or custodial levels.

Nursing Home Facility also means a facility that is licensed as a specialized Alzheimer’s Unit or Memory Care Unit in all states where such licensure exists.

A Nursing Home Facility is not:

- A hospital or clinic;
- A place which operates primarily for the treatment of alcoholism, drug addiction, or Mental or Nervous Disorders;
• An Assisted Living Facility;
• A Hospice Care Facility;
• An adult residential care home;
• A domiciliary care facility;
• The Insured’s primary place of residence in an area used principally for independent residential living; or
• A similar establishment.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as a Nursing Home Facility only if it:

• Meets all of the above criteria;
• Is authorized to provide nursing care to inpatients; and
• Is engaged principally in providing such nursing care in accordance with that license.

Physician – (as defined in Section 1861(r)(1) of the Social Security Act) – means 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 – means a written individualized plan of services, which we verify as appropriate and consistent with generally accepted standards, prescribed by a Licensed Health Care Practitioner. It specifies the Insured’s 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:

• The Insured’s functional or cognitive abilities;
• The Insured’s social situation; and
• The Insured’s care service needs.

Policy – means the life insurance policy to which this Rider is attached.

Policy Date – means the date the Policy and this Rider become effective.

Qualified Long-Term Care Services – means services that meet the requirements of Section 7702B(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventative, 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.

Representative – means a person or entity legally empowered to represent the Insured.

Respite Care – means supervision and care the Insured receives while the family or other individuals who normally provide substantial amounts of care on a daily basis take short-term leave or rest that provides them with temporary relief from the responsibilities of providing care.

Severe Cognitive Impairment – means a deficiency in an individual’s short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

Spouse – means the person to whom the Insured is legally married or the Insured’s partner in a civil union or domestic partnership.

Standby Assistance – means the presence of another person, within arm’s reach of the Insured, which is necessary to prevent, by physical intervention, the Insured’s injury while the Insured is performing an Activity of Daily Living.
Substantial Assistance – means either Hands-on Assistance or Standby Assistance.

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

Terminally Ill – means the Insured has a life expectancy of 12 months or less, as certified by a Physician.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

Eligibility for the Payment of Benefits – Subject to all the terms and provisions of this Rider, benefits are payable as described in this Rider when we verify that the Insured meets all of the following conditions:

- The Insured is a Chronically Ill Individual;
- A Licensed Health Care Practitioner certifies the Insured as being a Chronically Ill Individual;
- The cost is a Covered Expense under this Rider and is provided pursuant to a written Plan of Care for the Insured that is appropriate and consistent with generally accepted standards of care for persons who are Chronically Ill Individuals;
- Coverage under this Rider is In Force on the date(s) the care is received;
- The applicable Elimination Period has been satisfied;
- The Insured has not exhausted the applicable limits on the specific benefits claimed, or the Maximum ABR Benefit Limit for this Rider; and
- The Insured meets the additional requirements for the specific benefits claimed.

The Owner must elect to accelerate benefits under the Policy by making a claim for benefits under this Rider.

Chronically Ill Individual – means the Insured has been certified by a Licensed Health Care Practitioner as:

- Being unable to perform (without Substantial Assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
- Requiring Substantial Supervision to protect the individual from threats to health and safety due to Severe Cognitive Impairment.

A Chronically Ill Individual shall not include an Insured who otherwise meets these requirements unless within the preceding twelve-month period a Licensed Health Care Practitioner has certified that the Insured meets these requirements.

Activities of Daily Living – means the following self-care functions:

- **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.
- **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.)
- **Dressing** – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- **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.
- **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.
Severe Cognitive Impairment – means a deficiency in an individual’s short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

Elimination Period – The applicable Elimination Period must be completed before benefits are payable. The Policy Specifications show the number of days for the Elimination Period.

Benefits Paid Reduce the Amount Available Under this Rider – Any benefit paid under this Rider reduces the amount available under this Rider’s applicable benefit-specific maximums and the Maximum ABR Benefit Limit. Benefits for Caregiver Training and the Non-Continual Alternative Care Benefit do not reduce the Monthly Maximum ABR Benefit Amount.

Certain Exclusions Apply – There are certain conditions under which benefits will not be paid under this Rider even if the Eligibility for the Payment of Benefits requirements are otherwise met. These exclusions are stated in the Exclusions and Limitations section.

Multiple Benefits Per Day – Although the benefits of this Rider are expressed in terms of monthly units, Covered Expenses are typically incurred on a daily basis. If the Insured is eligible for more than one of the following benefits, benefits are payable for only one of the following, which would provide the greatest benefit on a single day:

- Care Coordination Benefit;
- Nursing Home Benefit;
- Assisted Living Facility Benefit;
- Home and Community Care Benefit;
- Alternative Care Benefit; and
- International Benefit.

CARE COORDINATION

Care Coordination – Care Coordination helps the Insured identify his specific care needs and the long-term care services and programs in his area that can best meet those needs. The Insured may use a Care Coordinator to help him make the most informed decision regarding his care.

About Care Coordination – Care Coordination provides the Insured with the knowledge and training of a Care Coordinator who will review his unique situation and develop Plans of Care to meet his needs. The Care Coordinator, a Licensed Health Care Practitioner, will:

- Assess the Insured’s functional, cognitive and personal needs for care and services on an ongoing basis;
- Work with the Insured to determine the specific services required;
- Develop and suggest initial and subsequent Plans of Care to assist the Insured in meeting the needs of the Insured;
- Coordinate and monitor the Insured’s care needs on an ongoing basis to help the Insured receive appropriate care; and
- Help the Insured arrange for care, if desired.

Care Coordination is Voluntary – Care Coordination is advisory only. The Insured is not required to use Care Coordination to arrange for care providers or to use the specific care providers identified in the Plan of Care. However, all the Insured’s Rider benefits must be provided in accordance with an approved Plan of Care.
Limited Availability Outside United States – Care Coordination other than performing an Assessment or developing a Plan of Care is not available for care received outside the United States.

Transition Planning – If the Insured desires, the Care Coordination Provider will recommend a transition plan that specifies how the Insured’s care needs may be met once:

- The Insured has exhausted the benefits under his Rider; or
- The Insured is no longer a Chronically Ill Individual but needs some continued level of assistance.

Care Coordination Provided by Us – Care Coordination provided by us does not require a claim for benefits under this Rider. Any Care Coordination provided by us will not reduce the Maximum ABR Benefit Limit or the Monthly Maximum ABR Benefit Amount.

CARE COORDINATION BENEFIT

Care Coordination Benefit – Benefits are payable for Covered Expenses for Care Coordination that is not performed by us. The Covered Expenses and the amount of the benefit we pay are described below.

Covered Expenses – Covered Expenses for Care Coordination means expenses the Insured incurs, while the Insured is a Chronically Ill Individual, for Care Coordination that is not performed by us.

How Much We Will Pay – Benefits are payable for the Covered Expenses the Insured incurs for Care Coordination during the Policy month up to the Monthly Maximum ABR Benefit Amount.

NURSING HOME BENEFIT

Nursing Home Benefit – Benefits are payable for Covered Expenses during the Insured’s Confinement in a Nursing Home Facility. The Covered Expenses and the amount of the benefit we will pay are described below.

Covered Expenses – Covered Expenses for a Nursing Home Facility means expenses the Insured incurs during his Confinement in a Nursing Home Facility for:

- Room and board, provided the Insured is receiving Qualified Long-Term Care Services from employees of the Nursing Home Facility;
- Ancillary services such as therapy services;
- Patient supplies provided by the Nursing Home Facility for care of its residents;
- Hospice Care and Respite Care; and
- Bed reservation to keep the Insured’s bed in the Nursing Home Facility while the Insured is absent for any reason (except discharge), for up to 30 days per Policy year.

Covered Expenses also include fees charged for Hospice Care provided by a Hospice Care Facility.

Covered Expenses do not include the cost of drugs. We will not pay for any charges for comfort and convenience items such as televisions, telephones, beauty care and entertainment, or for expenses or charges incurred by or for individuals other than the Insured (e.g., guest meals or Spouse charges).

How Much We Will Pay – Benefits are payable for the Covered Expenses the Insured incurs in a Nursing Home Facility during the Policy month up to the Monthly Maximum ABR Benefit Amount. However, if the Insured is not a Chronically Ill Individual and incurring Covered Expenses for this benefit each day of the Policy month, the benefit for the month will be pro-rated. It will consist of the Insured’s Covered Expenses incurred during the month for each day the Insured was a Chronically Ill Individual and incurring Covered Expenses, subject to a maximum of 1/30 of the Monthly Maximum ABR Benefit Amount times the number of days the Insured is a Chronically Ill Individual and incurring Covered Expenses during the month.
ASSISTED LIVING FACILITY BENEFIT

Assisted Living Facility Benefit – Benefits are payable for Covered Expenses during the Insured’s Confinement in an Assisted Living Facility. The Covered Expenses and the amount of the benefit we will pay are described below.

Covered Expenses – Covered Expenses for an Assisted Living Facility means expenses the Insured incurs during his Confinement in an Assisted Living Facility for:

- Room and board, provided the Insured is receiving Qualified Long-Term Care Services from employees of the Assisted Living Facility;
- Ancillary services such as therapy services;
- Patient supplies provided by the Assisted Living Facility for care of its residents;
- Hospice Care and Respite Care; and
- Bed reservation to keep the Insured’s bed in the Assisted Living Facility while the Insured is absent for any reason (except discharge), for up to 30 days per Policy year.

Covered Expenses do not include the cost of drugs. We will not pay for any charges for comfort and convenience items such as televisions, telephones, beauty care and entertainment, or for expenses or charges incurred by or for individuals other than the Insured (e.g., guest meals or Spouse charges).

How Much We Will Pay – Benefits are payable for the Covered Expenses the Insured incurs in an Assisted Living Facility during the Policy month up to the Monthly Maximum ABR Benefit Amount. However, if the Insured is not a Chronically Ill Individual and incurring Covered Expenses for this benefit each day of the Policy month, the benefit for the month will be pro-rated. It will consist of the Insured’s Covered Expenses incurred during the month for each day the Insured was a Chronically Ill Individual and incurring Covered Expenses, subject to a maximum of 1/30 of the Monthly Maximum ABR Benefit Amount times the number of days the Insured was a Chronically Ill Individual and incurring Covered Expenses during the month.

HOME AND COMMUNITY CARE BENEFIT

Home and Community Care Benefit – Benefits are payable for Covered Expenses the Insured incurs for Home and Community Care. The Covered Expenses and the amount of the benefit we will pay are described below.

Covered Expenses – Covered Expenses for Home and Community Care means fees charged for the following services when provided to the Insured by a Home Health Care Agency:

- Home Health Care Services;
- Maintenance or Personal Care Services; and
- Hospice Care and Respite Care.

Covered Expenses also includes fees charged for Adult Day Care provided by an Adult Day Care Center.

Criteria for Receiving Care from an Independent Provider – The Independent Provider must be licensed or certified in the state where the care will be provided, if licensing or certification is required for the services provided. An Independent Provider must present written proof of completion of an established training course or written proof of licensure or certification. The education must include training in safely assisting persons with all Activities of Daily Living. We will accept as proper credentials the Independent Provider’s inclusion in a government-sponsored nurse aide registry. If the state in which the Insured lives does not require or accept licensure or certification for Independent Providers, then we may approve benefits for an Independent Provider if we can determine that the individual is qualified by...
training and experience to provide Home Health Care Services and Maintenance or Personal Care Services.

**How Much We Will Pay** – Benefits are payable for the Covered Expenses the Insured incurs for Home and Community Care during the policy month up to the Monthly Maximum ABR Benefit Amount. However, if the Insured is not a Chronically Ill Individual and incurring Covered Expenses for this benefit each day of the policy month, the benefit for the month will be pro-rated. It will consist of the Insured’s Covered Expenses incurred during the month for each day the Insured was a Chronically Ill Individual, subject to a maximum of 1/30 of the Monthly Maximum ABR Benefit Amount times the number of days the Insured is a Chronically Ill Individual and incurring Covered Expenses during the month.

**INTERNATIONAL BENEFIT**

**International Benefit** – The Insured is eligible to receive cash benefits when Confined in a Nursing Home Facility outside the United States. The conditions under which we will pay this International Benefit and the amount of benefit payable are described below.

**Conditions for International Benefits** – This cash benefit will be available beginning on the day the Insured first satisfies the Eligibility for the Payment of Benefits requirements and is Confined in a Nursing Home Facility outside the United States. This benefit is in lieu of all other benefits under this Rider.

The Insured must provide written proof, in English, that the Insured is a Chronically Ill Individual and Confined in a Nursing Home Facility outside the United States. Certification that the Insured is a Chronically Ill Individual shall be performed by a Licensed Health Care Practitioner. For proof that the Insured is Confined in a Nursing Home Facility outside the United States, we will accept a bill from the Nursing Home Facility, and such proof shall be provided monthly. Proof that the Insured is a Chronically Ill Individual must be provided every 90 days. The cost for providing any of the proof required for this benefit is the responsibility of the Owner.

The Insured must notify us in advance to receive benefits under this provision. The notice must be made in writing and in English. If we are not notified prior to the date of admission to the Nursing Home Facility, then the first date the Insured is eligible for this benefit is the date we receive satisfactory written notice of an eligible Nursing Home Facility stay.

The International Benefit will end at the earliest of the date on which the Insured:

- Has received the Maximum ABR Benefit Limit;
- Is no longer a Chronically Ill Individual;
- Is no longer Confined in a Nursing Home Facility; or
- Returns to the United States.

No other benefit under this Rider is payable during a Policy month for which the Insured receives the International Benefit.

If the Insured is currently in claim in the United States, the Insured cannot leave the United States and be eligible for the International Benefit.

**How Much We Will Pay** – Benefits are payable for each month that the Insured meets the Conditions for International Benefits. We will pay the Monthly Maximum Benefit ABR Benefit Amount. However, if the Insured is not a Chronically Ill Individual and Confined in a Nursing Home Facility each day of the Policy month, the benefit for the month will be pro-rated. It will consist of 1/30 of the Insured’s Monthly Maximum Benefit ABR Benefit Amount times the number of days the Insured is a Chronically Ill Individual during the month.

All benefit payments will be made in U.S. dollars.
ALTERNATIVE CARE BENEFIT

Alternative Care Benefit – (For expenses not otherwise covered, but authorized by us) – We reserve the right to authorize benefits for Covered Expenses relating to providers, treatments, or services not otherwise specified in this Rider.

Covered Expenses – Benefits and services can be authorized if we determine that they:

- Are cost-effective;
- Are appropriate to the Insured’s needs;
- Are consistent with general standards of care;
- Provide the Insured with an equal or greater quality of care; and
- Are for and constitute Qualified Long-Term Care Services.

Any benefits, treatments, or services we authorize must also be agreed to by the Owner, the Insured or his Representative and, if appropriate, the Insured’s Physician.

We reserve the right to decline to authorize benefits and services.

Benefits are not payable for any expenses incurred either: prior to the date of mutual agreement; or once the Insured has exhausted the benefits under this Rider. Agreement to participate in Alternative Care Benefits will not waive any of the rights the Insured or we have under this Rider.

Alternative Care Benefits that we have previously authorized may be discontinued by us at any time without affecting the Insured’s right to the benefits otherwise available under this Rider.

How Much We Will Pay – Benefits are payable for the Covered Expenses the Insured incurs for the Alternative Care Benefit during the Policy month up to the Monthly Maximum ABR Benefit Amount.

NON-CONTINUAL ALTERNATIVE CARE BENEFIT

Non-Continual Alternative Care Benefit – Benefits are payable for Covered Expenses the Insured incurs for Non-Continual Alternative Care Benefits. The amount of the benefit we will pay and the conditions under which we will pay this benefit are described below.

Covered Expenses – Covered Expenses for the Non-Continual Alternative Care Benefit means expenses the Insured incurs for the following, as described below:

- Home Modification; and
- Durable Medical Equipment.

Home Modification – The Non-Continual Alternative Care Benefit is payable if Home Modification is recommended by a Care Coordinator in a Plan of Care and is mutually agreeable to the Owner, the Insured, and us as a cost-effective alternative to benefits otherwise provided by this Rider. Our determination of whether the Home Modification is a cost-effective alternative will occur within a reasonable period of time. Benefits are not payable for any expenses incurred prior to the date of agreement between the Owner, the Insured, and us. Agreement to participate in Home Modification under the Non-Continual Alternative Care Benefit will not waive any of the rights the Owner has or we have under this Rider. This benefit may not be used solely to increase the value of the Home. We determine what shall be considered Home Modification under this Rider.
Covered Home Modification Expenses – Covered Expenses for Home Modification means the cost of Home Modification if the Insured’s Care Coordinator finds that modification to the Insured’s Home is a cost-effective alternative method of care and recommends the modification. We will pay the actual charges incurred for labor, equipment, and supplies for modifications to the Insured’s Home that will enhance his ability to perform the Activities of Daily Living and allow the Insured to remain in his or her Home safely.

Durable Medical Equipment – The Non-Continual Alternative Care Benefit is payable if the use of Durable Medical Equipment is specified in the Insured’s Plan of Care and is mutually agreeable to the Owner, the Insured, and us as a cost-effective alternative to benefits otherwise provided by this Rider. Benefits are not payable for any expenses incurred prior to the date of mutual agreement. Agreement to participate in Durable Medical Equipment under the Non-Continual Alternative Care Benefit will not waive any of the rights the Owner has or we have under this Rider. The Durable Medical Equipment must be located in the Insured’s Home.

Covered Durable Medical Equipment Expenses – Covered Expenses for Durable Medical Equipment are the rental charges for Durable Medical Equipment that is normally rented on a daily or weekly basis or the purchase price of such equipment if it is more cost-effective to purchase such equipment and it is specified in the Insured’s Plan of Care. We will decide whether a rental or purchase of the Durable Medical Equipment is more appropriate.

How Much We Will Pay – Benefits are payable for Covered Expenses the Insured incurs for Home Modification and Durable Medical Equipment. This benefit is subject to the Non-Continual Alternative Care Benefit Lifetime Maximum shown on the Policy Specifications.

CAREGIVER TRAINING BENEFIT

Caregiver Training Benefit – Benefits are payable for Covered Expenses the Insured incurs for training a person (family or friend) to be an Informal Caregiver to provide care for the Insured in his or her Home.

Covered Expenses – Covered Expenses for Caregiver Training means expenses the Insured incurs for Caregiver Training in the proper use and care of a therapeutic device or an appropriate caregiving procedure. We will not pay for training provided to someone who will be paid to care for the Insured. The training cannot be received when the Insured is Confined in a hospital, Assisted Living Facility, Hospice Care Facility, or Nursing Home Facility, unless it is reasonably expected that the training will make it possible for the Insured to return Home, where the Insured can be cared for by the person receiving the training.

How Much We Will Pay – Benefits are payable for Covered Expenses the Insured incurs for Caregiver Training. This benefit is subject to the Caregiver Training Benefit Lifetime Maximum shown on the Policy Specifications.

INFLATION BENEFIT OPTION

Inflation Benefit Option – Unless an inflation option was rejected, the Inflation Benefit Option increases the benefit amounts under this Rider. The Inflation Benefit Option and the inflation interest type and rate elected are shown in the Policy Specifications. The Inflation Benefit Option provides inflation protection benefit increases that shall continue without regard to the age of the Insured, claim status or claim history, or the length of time the Policy has been In Force.

Simple Inflation Benefit Options – If one of these Options is in effect, the Monthly Maximum ABR Benefit Amount and the Maximum ABR Benefit Limit will be increased on each Policy anniversary. The new Monthly Maximum ABR Benefit Amount is calculated as A plus (B times C), where:

A. Is the existing Monthly Maximum ABR Benefit Amount;
B. Is the Monthly Maximum ABR Benefit Amount applicable on the Policy Date, adjusted for withdrawals and for benefits paid under the Terminal Illness Benefit; and
C. Is the inflation interest rate.

The Maximum ABR Benefit Limit is calculated as A times (B divided by C), where:

A. Is the existing Maximum ABR Benefit Limit;
B. Is the new Monthly Maximum ABR Benefit Amount as calculated above; and
C. Is the previous Monthly Maximum ABR Benefit Amount.

**Compound Inflation Benefit Option** – If this Option is in effect, the Monthly Maximum ABR Benefit Amount and the Maximum ABR Benefit Limit will be increased on each Policy anniversary. The new Monthly Maximum ABR Benefit Amount is calculated as A times the result of (B plus C), where:

A. Is the existing Monthly Maximum ABR Benefit Amount;
B. Is 1; and
C. Is the inflation interest rate.

The Maximum ABR Benefit Limit is calculated as A times the result of (B plus C), where:

A. Is the existing Maximum ABR Benefit Limit;
B. Is 1; and
C. Is the inflation interest rate.

**Termination** – Increases will cease on the first to occur of:
- The date of the Insured’s death;
- The date this Rider and the Policy are cancelled pursuant to the Owner’s request; or
- The date the Maximum ABR Benefit Limit has been paid.

**ABR RETURN OF PREMIUM BENEFIT**

**ABR Return of Premium Benefit** – This Rider offers a Return of Premium Benefit, which is payable to the Owner if the Policy is surrendered or lapsed. At issue, the ABR Return of Premium Benefit is equal to the ABR Premium, as shown on the Policy Specifications. After issue, the ABR Return of Premium Benefit may be reduced (but not below zero) as described in the Policy, after the reduction of the Life Return of Premium Benefit.

**EFFECT OF RIDER ON POLICY**

**Effect of Benefit Payment Under This Rider on Death Proceeds** – We reserve the right to withhold any portion of the Death Proceeds that would otherwise be payable for a reasonable period of time under the facts and circumstances to allow verification that we have received all remaining claims for Covered Expenses incurred before the date of death of the Insured.

**Effect of Benefit Payment Under This Rider on Policy Withdrawals** – Once a claim for benefit payment under this Rider has been received by us, no withdrawals may be made under the Policy.

**Effect of Benefit Payment Under This Rider on Policy’s Face Amount** – Benefit payment under this Rider will reduce the Policy’s Face Amount. The reduction in the Policy’s Face Amount after payment of the benefit is calculated as A times the result of (B divided by C) where:

A. Is the Policy’s Face Amount prior to payment of the benefit;
B. Is the benefit payment; and
C. Is the Maximum ABR Benefit Limit before the benefit payment.
Effect of Benefit Payment Under This Rider on Policy’s Accumulated Value – Benefit payment under this Rider will reduce the Policy’s Accumulated Value. The Policy’s Accumulated Value after payment of the benefit will be calculated as A times the result of (B divided by C) where:

A. Is the Policy’s Accumulated Value prior to payment of the benefit;
B. Is the Policy’s Face Amount after the benefit payment; and
C. Is the Policy’s Face Amount before the benefit payment.

Effect of Benefit Payment Under This Rider on Policy Debt – If there is a loan outstanding under the Policy at the time a benefit under this Rider is payable, a portion of the benefit will be applied towards repayment of the loan. The amount of the benefit that will be allocated as a loan repayment will be calculated as A times the result of (one minus (B divided by C)) where:

A. Is Policy Debt prior to payment of the benefit;
B. Is the Policy’s Face Amount after the benefit payment; and
C. Is the Policy’s Face Amount before the benefit payment.

The Policy Debt after payment of the benefit will be calculated as A times the result of (B divided by C) where:

A. Is Policy Debt prior to payment of the benefit;
B. Is the Policy’s Face Amount after the benefit payment; and
C. Is the Policy’s Face Amount before the benefit payment.

Effect of Benefit Payment Under This Rider on Policy’s Coverage Charge – Benefit payment under this Rider will reduce the Policy’s Coverage Charge. The Coverage Charge after payment of the benefit will be calculated as A times the result of (B divided by C) where:

A. Is the Coverage Charge prior to payment of the benefit;
B. Is the Policy’s Face Amount after the benefit payment; and
C. Is the Policy’s Face Amount before the benefit payment.

Effect of Withdrawals on This Rider – Any withdrawal made under the Policy will reduce the Monthly Maximum ABR Benefit Amount and the Maximum ABR Benefit Limit. The new Monthly Maximum ABR Benefit Amount after the withdrawal will be calculated as A times the result of (B divided by C) where:

A. Is the Monthly Maximum ABR Benefit Amount before the withdrawal;
B. Is the Policy’s Face Amount after the withdrawal; and
C. Is the Policy’s Face Amount before the withdrawal.

The new Maximum ABR Benefit Limit after the withdrawal will be calculated as A times the result of (B divided by C) where:

A. Is the Maximum ABR Benefit Limit before the withdrawal;
B. Is the Policy’s Face Amount after the withdrawal; and
C. Is the Policy’s Face Amount before the withdrawal.

Effect of Terminal Illness Benefit Payment on this Rider – Any amount paid under the Terminal Illness Benefit will reduce the Monthly Maximum ABR Benefit Amount and the Maximum ABR Benefit Limit. The new Monthly Maximum ABR Benefit Amount after the Terminal Illness Benefit Payment will be calculated as A times the result of (B divided by C) where:

A. Is the Monthly Maximum ABR Benefit Amount before the Terminal Illness Benefit Payment;
B. Is the Policy’s Face Amount after the Terminal Illness Benefit Payment; and
C. Is the Policy’s Face Amount before the Terminal Illness Benefit Payment.

The new Maximum ABR Benefit Limit after the Terminal Illness Benefit Payment will be calculated as A times the result of (B divided by C) where:

A. Is the Maximum ABR Benefit Limit before the Terminal Illness Benefit Payment;
B. Is the Policy’s Face Amount after the Terminal Illness Benefit Payment; and
C. Is the Policy’s Face Amount before the Terminal Illness Benefit Payment.

EXCLUSIONS AND LIMITATIONS

Benefits under this Rider will not be limited or excluded by type of illness, treatment, medical condition or accident, except as provided in this section. In this section, we state the conditions under which payment will be limited or not made at all, even if the Insured otherwise qualifies for benefits. These conditions apply to all benefits provided by this Rider.

Exclusions – This Rider will not pay benefits for any room and board, care, treatment, services, equipment, or other items for:

- Care or services provided by the Insured’s Immediate Family 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;
- Care or services for which no charge is made in the absence of insurance;
- Care or services provided outside the United States of America, except as provided for under the International Benefit;
- Care or services that result from an attempt at suicide (while sane or insane) or an intentionally self-inflicted injury;
- Treatment provided in a government facility (unless otherwise required by law);
- Services for which benefits are available under Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount) or other governmental program (except Medicaid), any state or federal workers’ compensation, employer’s liability or occupational disease law, or any motor vehicle no-fault law; or
- Services received while this Rider is not In Force, except as provided in the Extension of Benefits provision.

No Pre-Existing Conditions Exclusion – We will not reduce or deny any claim under this Rider because of a sickness or physical or medical condition disclosed on the Application.

Non-Duplication With Other Plans – We will not pay benefits for any amount that would be reimbursable under Medicare or any other plan or program but for the application of a deductible or coinsurance amount. We will pay the difference between the actual expense and the benefits payable by Medicaid or private insurance, but our payment will not exceed the amount we would have paid in the absence of such other insurance. However, if the Insured’s Medicaid or private insurance denies payment for a service that we cover, we will pay the benefit as outlined in this Rider. The Care Coordinator can assist in identifying other insurance benefits to which the Insured is entitled that can be applied to meet actual expenses.

CLAIMS PROVISIONS

In this section, we describe when we must be notified of a claim; what to send us; how we evaluate and pay claims; and other rights and responsibilities under the Rider.
The Insured’s Role in the Claims Process – Early awareness by us will facilitate a timely claim review. It is important that the Owner or Insured notify us immediately when the Owner or Insured thinks the Insured is eligible for benefits under this Rider. To file a claim, the Owner or Insured may call us, notify us in writing or submit a completed claim form we provide.

Notify Us as Soon As Possible – We can handle the claim request more efficiently if we are notified within 30 days after the Insured is eligible for benefits or as soon as reasonably possible. We prefer to be notified as soon as the Insured first becomes disabled to the extent that the Insured may soon need care covered by this Rider. Notify us even if the Owner or Insured is unsure, and we can help determine whether the Insured is eligible for benefits.

How Claims Are Evaluated – When notice of claim is received, we will collect the information we need to verify whether the Eligibility for the Payment of Benefits requirements have been met. We may need to contact the Insured’s Physician or other care provider and to review the Insured’s medical records. Based on our evaluation of this information, we will verify the Insured’s eligibility for benefits. We will not pay benefits until we verify eligibility for benefits. If we determine that the Insured is eligible for benefits, we will arrange for a Plan of Care to be developed by a Licensed Health Care Practitioner or Care Coordinator.

Cross Border Rules – Benefits will be paid for similar services obtained in a state other than the Policy state of issue if benefits for those services would have been paid in the Policy state of issue, irrespective of any facility licensing, certification or registration requirement (or similar requirements) differences between the states.

Claim Forms – We will provide claim forms for the filing of proofs of loss when we receive the notice of claim. If the Owner, Insured or Insured’s Representative does not get the necessary claim forms within 15 days, Proofs of Loss can be filed without them by sending us a letter which describes the occurrence, the character and the extent of the loss for which the claim is made. That letter must be sent to us at our Administrative Office within the time noted below under Proof of Loss.

Proof of Loss – In the case of a claim for continuing loss for which this Rider provides any periodic benefits, written proof of loss must be given to us within 90 days after the end of each 30-day period for which Covered Expenses are incurred. In the case of a claim for any other loss, written proof must be given to us within 90 days after the date of such loss. However, a claim will still be considered if it was not possible to furnish proof within this time and the proof was furnished as soon as reasonably possible. Except in the absence of legal capacity, in no event will an expense be considered as a Covered Expense if proof for that expense is furnished more than one year after the date the proof is otherwise required.

Written Notification – The Owner will be notified in writing whether or not the Insured is eligible for benefits. We will provide notification within ten days of receiving all the required information. If the Owner wants to receive information related to a denial of benefits, that information will be sent to the Owner within 60 days of receipt of his or her written request, or as required by the applicable laws and regulations where the policy is delivered or issued for delivery.

When Benefit Payments Will Be Made – Once the applicable Elimination Period has been completed, benefit payments will be made upon our receipt of the required written claims and evidence of the Insured’s continued eligibility. Benefit payments will be made as long as the loss and our liability continue. When a claim is paid, the Owner will receive an Explanation of Benefits from our Administrative Office.

To Whom We Will Pay Benefits – All benefits will be payable to the Owner unless otherwise provided as a Direct Payment of Benefits to a Care Provider. Any benefits to which the Owner is entitled that are unpaid at the Insured’s death will be payable to the Owner. If benefits are payable to an estate, we may pay a portion of those benefits, up to $5,000, directly to the Owner’s spouse or someone related to the Owner by blood or marriage who is deemed by us to be justly entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.
Physical Examination – At our expense, we have the right to require an examination of the Insured’s functional or cognitive status when a claim is made and at reasonable intervals while benefits are being claimed.

How the Owner or Insured Can Appeal a Claim Decision – If the Owner or Insured disagrees with our decision regarding a claim, the Owner may request in writing within 60 days of that decision that we reconsider the claim. Any internal review of claim decisions will be consistent with the applicable laws and regulations where the policy is delivered or issued for delivery. The Owner or Insured should submit any additional information that the Owner or Insured feels we need to review our decision. The Owner or Insured should include the names, addresses, and phone numbers of any care providers we should contact to learn more about the loss. The Owner is responsible for the expense of securing additional information, if applicable, for each instance of reconsideration. We will reconsider our decision and send written notification of the results to the Owner. If we deny the appeal request and the Owner wants to receive written information related to such denial, that information will be sent within 60 days of receipt of the written appeal request. This Rider will comply with any requirements regarding external review of claim decisions, consistent with the applicable laws and regulations where the policy is delivered or issued for delivery.

Legal Actions – No action may be brought to recover under this Rider until 60 days after proof of loss has been given. No action can be brought more than three years from the date written proof of loss was required to be given. Any legal cause of action shall conform to the laws of the state in which the policy was delivered or issued for delivery.

Direct Payment of Benefits to Care Provider – The Owner may instruct us to pay benefits due under this coverage directly to a Nursing Home Facility, Assisted Living Facility, Hospice Care Facility, Adult Day Care Center or Home Health Care Agency providing the care for which we are reimbursing Covered Expenses. The care provider must also agree to the direction of the payment of benefits. The Owner must notify us by Written Request, which will be effective only when recorded at our Administrative Office. When received, the instruction will take effect as of the date the Written Request was signed, unless otherwise specified by the Owner. Any rights created by the direct payment of benefits will be subject to any payments made or actions taken by us before the change is recorded. We will not be responsible for the validity of the instructions provided to us.

PREMIUMS, LAPSE AND REINSTATEMENT PROVISIONS

In this section, we describe such things as the premium for this Rider and the reinstatement provisions.

Non-Cancellable – This Rider will continue as long as the Insured lives or until this Rider is terminated in accordance with the When Insurance Under This Rider Ends provision. The premiums under this Rider are paid by a one-time premium on or before the Policy Date and cannot be increased.

Paying Premiums, One-Time Premium – In order for this Rider to be In Force, a one-time premium covering the entire cost of the Rider must have been paid to us on or before the Policy Date. No portion of the Rider’s premium shall be added to the Accumulated Value or other values of the Policy.

Protection Against Unintentional Lapse – In order to protect the Policy and Rider against unintentional lapse, at least one person in addition to the Owner must be designated to receive notice of lapse or termination or the Owner must sign a waiver electing not to designate an additional person to receive notice. The Owner may change this designation at any time. To do so, notify us in writing. We will remind the Owner in writing every two years of this opportunity.

Grace Period – The Grace Period provision in the Policy applies to this Rider.

Notification of Non-Payment – The Notification of Non-Payment provision in the Policy applies to this Rider.
Lapse – The Lapse provision in the Policy applies to this Rider. Upon lapse, we will refund any ABR Return of Premium Benefit.

Reinstatement – If the Policy is reinstated under its Reinstatement provision, this Rider is also eligible to be reinstated provided that such reinstatement occurs within six months from the end of the Grace Period. After the six-month period, this Rider will not be reinstated, even if the Policy is reinstated.

Added Protection Against Lapse – If coverage terminates due to lapse, we will provide a reinstatement of coverage as specified below, if certain conditions are met. To be eligible for this reinstatement, the Insured must provide us proof that the Insured was a Chronically Ill Individual, beginning on or before the date of termination.

The proof must be in the form of a certification and Assessment from a Licensed Health Care Practitioner that demonstrates that the Insured was a Chronically Ill Individual. The proof must be provided to us within five months of the termination date. The Owner must pay all past due premiums and outstanding Policy Debt prior to the date of lapse. In that event, the Policy and this Rider will be reinstated as of the date of that termination without interruption of insurance for that period.

Requirements for Reinstatement – If this Rider is eligible to be reinstated, in order for us to evaluate your request for reinstatement, you must satisfy the requirements for reinstatement of the Policy and this Rider.

Reinstatement of the Policy and this Rider is effective upon our approval of your reinstatement application. If we issue a temporary insurance agreement in connection with the premium tendered for reinstatement, and we do not act to approve the application, the reinstatement is effective on the 45th day following the date of the temporary insurance agreement unless we have given notice to the Owner of our disapproval of the application prior to the expiration of the 45 day time limit.

If approved, the Policy and this Rider will be reinstated retroactive to the date of termination of coverage. In all other respects, including benefits for Covered Expenses, the Owner will have the same rights under this Rider as prior to the termination. Any amount refunded due to lapse in connection with the ABR Return of Premium Benefit must be repaid to us prior to coverage being reinstated.

EFFECTIVE DATE AND TERMINATION OF INSURANCE PROVISIONS

In this section, we describe when this Rider becomes effective and when coverage ends.

Evidence Of Insurability – The Insured is required to provide evidence of insurability in a form and manner specified by us.

Rider Effective Date – The Insured will become covered under this Rider on the Policy Date shown on the Policy Specifications, provided the required premium has been received.

The Owner’s Right to Cancel Coverage at Any Time – The Owner may cancel coverage at any time by sending us written notice. The Policy and this Rider both must remain In Force or be cancelled at the same time. We must receive a request to cancel 30 days prior to the requested cancellation date. Termination of coverage will be effective within 30 days of the date we receive the request, unless the requested termination date is later. The cancellation will not prejudice any claim for care received before the effective date of the cancellation.

When Insurance Under This Rider Ends – This Rider terminates on the first to occur of:

- The date of the Insured’s death;
- The date this Rider and the Policy are cancelled pursuant to the Owner’s request;
- The date the Maximum ABR Benefit Limit has been paid; or
- The date the Policy is terminated.
Extension of Benefits – If the Policy and this Rider terminate due to lapse, we will recognize the basis for a claim under this Rider for the Insured’s Confinement in a Nursing Home Facility, Hospice Care Facility, or an Assisted Living Facility before the date of termination in the same manner as if the insurance was In Force. Extension of Benefits stops on the earliest of:

- The date when the Insured no longer meets the Eligibility for the Payment of Benefits requirements;
- The date the Insured is no longer Confined in a Nursing Home Facility, Hospice Care Facility, or an Assisted Living Facility; or
- The date when the Policy’s Face Amount remaining after monthly benefit payment is zero.

If benefits are continued under this Extension of Benefits provision, we will calculate the Policy’s Face Amount remaining as if the Policy had remained In Force, but no Death Benefit will be payable to the beneficiary under the Policy.

This Extension of Benefits will be subject to all of the provisions of this Rider, including but not limited to the Elimination Period and Eligibility for Payment of Benefits.

This provision is subject to the applicable coverage maximums shown on the Policy Specifications and all other applicable provisions of the Policy and Rider.

If the Insured’s benefits are continued under this provision, no Death Benefit will be payable.

QUALIFIED LONG-TERM CARE SERVICES

Benefit for Qualified Long-Term Care Services – This Rider provides benefits for Qualified Long-Term Care Services received by a Chronically Ill Individual provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner. Benefits for Qualified Long-Term Care Services are conditioned on a determination that the Insured is a Chronically Ill Individual.

Certification by A Licensed Health Care Practitioner – Certification that the Insured is a Chronically Ill Individual shall be performed by a Licensed Health Care Practitioner. Such certifications may be performed by a Licensed Health Care Practitioner at our direction as is reasonably necessary with respect to a specific claim, except that when a Licensed Health Care Practitioner has certified that the Insured is a Chronically Ill Individual and the Owner or Insured has made a claim for benefits under this Rider, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the 90-day period starting on the date of certification.

GENERAL PROVISIONS

In this section, we describe the generally applicable provisions; the importance of completing the application truthfully and correctly; and other basic rights, obligations and features applicable to this Rider.

Incontestability – In issuing this Rider, we have relied upon the information presented by the Owner and the Insured in the Application. We may rescind this Rider or deny a claim due to a misrepresentation that is material to acceptance for coverage if this Rider has been In Force for less than six months. The Policy Date is shown on the Policy Specifications.

If coverage has been In Force for at least six months but less than two years, we may rescind this Rider or deny a claim due to a showing of misrepresentation in the Application that is both material to the Insured’s acceptance for coverage and which pertains to the conditions for which benefits are sought.

After coverage has been In Force for two years, we may rescind this Rider and deny a claim for benefits that began after the two-year period if relevant facts were knowingly and intentionally misrepresented by the Owner or the Insured in the Application relating to the health of the Insured.
Misstatement – If the Insured’s sex or birth date is misstated in the Application, we will adjust the benefits payable to what the premium paid would have purchased at the Insured’s correct sex or birth date as of the Policy Date.

Fraud/Recovery – If we determine that benefits have been paid under the Policy or this Rider as a result of fraudulent actions, we have the right to recover those benefit amounts. We may recover those benefit amounts directly from the Owner or by reducing any subsequent benefit payments under the Policy or this Rider. We will determine the manner in which we seek recovery of benefit payments made under fraudulent conditions.

Tax Qualification – This Rider is intended to provide tax-qualified long-term care insurance under Section 7702B(b) of the Internal Revenue Code of 1986, as amended (the “Code”), and be treated for such tax purposes as a separate contract from the Policy to which this Rider is attached, pursuant to Code Section 7702B(e). To achieve these purposes, the provisions of this Rider and the Policy (including any other rider or endorsement that does not specifically override these tax qualification provisions) shall be interpreted to ensure and maintain such separate tax qualification of this Rider (and of the Policy), despite any other provision to the contrary. Accordingly, even though the Policy may have cash value that can be borrowed, neither this Rider nor any long-term care insurance (or benefit) provided by it shall be deemed to provide any cash value or other money that can be borrowed (or paid, assigned or pledged as collateral for a loan) within the scope of the prohibitions described in Code Section 7702B(b)(1)(D). Nor shall such a prohibition be deemed to preclude any right of the Owner to direct payment of benefits provided by this Rider, absent any final regulation or other final guidance to the contrary that is published by the Internal Revenue Service (“IRS”). We reserve the right to amend this Rider or the Policy from time to time to reflect any clarifications that may be needed or are appropriate to maintain any such separate tax qualification or to conform the Rider or Policy provisions to any applicable changes in such tax qualification or to conform the Rider or Policy provisions to any applicable changes in such tax qualification requirements, as provided in the Code or any published IRS guidance relating thereto, without consent (where allowed by law). We will send you a copy of any such amendment. If you reject any such amendment, it must be by giving us written notice, and your rejection may result in adverse tax consequences. Before any such rejection, you are advised to consult a qualified tax advisor.
Index

About Care Coordination................................................................. 9
ABR Benefit Duration .................................................................. 2
ABR Return of Premium Benefit .................................................. 15
Activities of Daily Living.............................................................. 15
Added Protection Against Lapse .................................................. 19
Adult Day Care ........................................................................... 2
Adult Day Care Center ................................................................. 2
Alternative Care Benefit .............................................................. 12
Assessment .................................................................................. 2
Assisted Living Care .................................................................... 2
Assisted Living Facility ............................................................... 3
Assisted Living Facility Benefit .................................................. 11
Benefit for Qualified Long-Term Care Services ......................... 21
Benefits Covered Reduce the Amount Available Under this Rider ......................................................... 9
Care Coordination ..................................................................... 10
Care Coordination Benefit ......................................................... 10
Care Coordination is Voluntary .................................................. 9
Care Coordination Provided by Us ............................................. 10
Care Coordination Provider ....................................................... 3
Care Coordinator ....................................................................... 3
Caregiver Training Benefit ......................................................... 14
Certain Exclusions Apply ........................................................... 9
Certification by A Licensed Health Care Practitioner .................. 21
Chronically Ill Individual ............................................................. 3, 8
Claim Forms ............................................................................... 18
Claims Provisions ....................................................................... 17
Compound Inflation Benefit Option ........................................... 15
Conditions for International Benefits ....................................... 12
Confinement or Confined ............................................................ 3
Conformity With Internal Revenue Code .................................. 21
Covered Durable Medical Equipment Expenses ...................... 14
Covered Expenses ..................................................................... 4, 10, 11, 13, 14
Covered Home Modification Expenses ..................................... 14
Criteria for Receiving Care from an Independent Provider ....... 11
Cross Border Rules ..................................................................... 18
Definitions ................................................................................. 2
Direct Payment of Benefits to Care Provider (Assignment of Benefits) ......................................................... 19
Durable Medical Equipment ....................................................... 4, 13
Effect of Benefit Payment Under This Rider on Death Proceeds ........................................................................... 15
Effect of Benefit Payment Under This Rider on Policy Debt ............................................................................ 15
Effect of Benefit Payment Under This Rider on Policy Withdrawals ...................................................................... 15
Effect of Benefit Payment Under This Rider on Policy’s Accumulated Value .................................................. 15
Effect of Benefit Payment Under This Rider on Policy’s Coverage Charge ................................................... 16
Effect of Benefit Payment Under This Rider on Policy’s Face Amount .................................................................. 15
Effect of Policy on Rider .............................................................. 16
Effect of Rider on Policy ............................................................... 15
Effect of Terminal Illness Benefit Payment on this Rider ............. 16
Effect of Withdrawals on This Rider ........................................... 16
Effective Date and Termination of Insurance Provisions ............. 20
Eligibility for the Payment of Benefits ....................................... 8
Elimination Period ..................................................................... 4, 9
Evidence Of Insurability ............................................................. 20
Exclusions ................................................................................. 17
EXTENDED BENEFIT RIDER ("EBR") FOR LONG-TERM CARE

This rider ("Rider") becomes a part of the policy to which it is attached ("Policy") as of the Policy Date and covers only the person named as the Insured in the Policy Specifications. The Application and premium put this Rider In Force as of the Policy Date. A copy of the Application is attached. If the provisions of this Rider and those of the Policy do not agree, the provisions of this Rider will apply. Please read it carefully.

This Rider extends the benefits provided by the Accelerated Benefit Rider ("ABR") for Long-Term Care. The benefits of this Rider become effective after payments for Covered Expenses under the ABR have reached the Maximum ABR Benefit Limit. This Rider reimburses the Owner shown on the Policy Specifications for Covered Expenses the Insured incurs for Qualified Long-Term Care Services.

Renewability – This Rider is Non-Cancellable. This Rider will continue as long as the Insured lives or until this Rider is terminated in accordance with the When Insurance Under This Rider Ends provision.

This is a long-term care insurance Rider that provides benefits for Covered Expenses incurred for adult day care, assisted living care, home health care services, hospice care, and nursing home care.

Caution – The issuance of this Rider is based upon the responses to questions on the Application for the Policy, the ABR and this Rider. A copy of that Application is attached. If any answers are incorrect or untrue, we have the right to deny benefits or rescind this Rider. The best time to clear up any questions is now, before a claim arises. If, for any reason, any answers are incorrect, contact us at our Administrative Office.

Notice to Buyer – This Rider may not cover all of the costs associated with long-term care that may be incurred by the Insured during the period of coverage. The Owner is advised to review carefully all Policy and Rider limitations.

This Rider is not qualified under any state long-term care insurance partnership program. For more information on partnership qualified products, contact the state department of insurance.

This Rider is not Medicare Supplement Coverage – If the Insured is eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from us. Neither Pacific Life Insurance Company nor its producers represent Medicare, the federal government or any state government.

This is intended to be a Tax Qualified Rider – This Rider is intended to provide federally tax qualified long-term care insurance under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. You are advised to consult with a qualified tax advisor.

30-Day Right to Examine – The Owner has 30 days from the day the Policy, ABR, and this Rider are received to examine and return all of them to us if the Owner decides not to keep them. The Owner does not have to tell us the reason for returning the Policy, ABR, and this Rider, but all must be returned together. The Policy, ABR, and this Rider can be returned to us at our Administrative Office or to the Producer through whom it was bought. We will refund, directly to the payer, the full amount of any premium paid for the Policy, ABR, and this Rider within 30 days of such a return and the Policy, ABR, and this Rider will be void from the start.

[STATE] Department of Insurance: [((XX) XXX-XXXX)]

Signed for Pacific Life Insurance Company,

[Handwritten Signature]

Chairman and Chief Executive Officer

[Handwritten Signature]

Secretary

[www.PacificLife.com] [((800) 347-7787)]
DEFINITIONS

In this section, we define certain terms used throughout this Rider. Other terms may be defined in other parts of the Policy or the ABR. Terms used in this Rider, the Policy and the ABR will have the same definition unless stated otherwise in this Rider. Defined terms are usually capitalized to show emphasis.

EBR Benefit Duration – The period of coverage under this Rider. The EBR Benefit Duration was elected on the Application for the Rider, and is shown on the Policy Specifications. The EBR Benefit Duration may increase or decrease depending on how the Policy and Rider benefits are used.

In Force – means that this Rider is in effect.

Maximum EBR Benefit Limit – is the total amount of lifetime benefits payable under this Rider as shown on the Policy Specifications. The Maximum EBR Benefit Limit will increase in accordance with the terms of the Inflation Benefit Option the Owner elected, if any, described in this Rider and shown on the Policy Specifications. The Maximum EBR Benefit Limit will be reduced when a payment of benefit is made in accordance with the terms of this Rider.

Monthly Maximum EBR Benefit Amount – is the total amount of monthly benefits payable under this Rider for the Care Coordination Benefit, Nursing Home Benefit, Assisted Living Facility Benefit, Home and Community Care Benefit and Alternative Care Benefit. The initial Monthly Maximum EBR Benefit Amount is shown on the Policy Specifications. The Monthly Maximum EBR Benefit Amount will increase in accordance with the terms of the Inflation Benefit Option the Owner elected, if any, described in this Rider and shown on the Policy Specifications.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

Eligibility for the Payment of Benefits – Subject to all the terms and provisions of this Rider, benefits are payable as described in this Rider when we verify that the Insured meets all of the following conditions:

- The Insured is a Chronically Ill Individual;
- A Licensed Health Care Practitioner certifies the Insured as being a Chronically Ill Individual;
- The cost is a Covered Expense under this Rider and is provided pursuant to a written Plan of Care for the Insured that is appropriate and consistent with generally accepted standards of care for persons who are Chronically Ill Individuals;
- Coverage under this Rider is In Force on the date(s) the care is received;
- The Insured has not exhausted the applicable limits on the specific benefits claimed, or the Maximum EBR Benefit Limit for this Rider;
- The Insured meets the additional requirements for the specific benefits claimed.

Chronically Ill Individual – means the Insured has been certified by a Licensed Health Care Practitioner as:

- Being unable to perform (without Substantial Assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
- Requiring Substantial Supervision to protect the individual from threats to health and safety due to Severe Cognitive Impairment.

A Chronically Ill Individual shall not include an Insured who otherwise meets these requirements unless within the preceding twelve-month period a Licensed Health Care Practitioner has certified that the Insured meets these requirements.

Activities of Daily Living – means the following self-care functions:

- 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.
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.)

Dressing – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

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.

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.

Severe Cognitive Impairment – means a deficiency in an individual's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

Conditions – In addition to meeting the Eligibility for the Payment of Benefits criteria shown above, the following conditions must also be met in order for benefits to be paid under this Rider:

- The Owner must elect to claim benefits under this Rider; and
- The Covered Expense incurred for which benefits are claimed under this Rider must occur after the Maximum ABR Benefit Limit has been exhausted.

Benefits Paid Reduce the Amount Available Under this Rider – Any benefit paid under this Rider reduces the amount available under this Rider’s applicable benefit-specific maximums and the Maximum EBR Benefit Limit. Benefits for Caregiver Training and the Non-Continual Alternative Care Benefit do not reduce the Monthly Maximum EBR Benefit Amount.

Certain Exclusions Apply – There are certain conditions under which benefits will not be paid under this Rider even if the Eligibility for the Payment of Benefits requirements are otherwise met. These exclusions are stated in the Exclusions and Limitations Section.

Multiple Benefits Per Day – Although the benefits of this Rider are expressed in terms of monthly units, Covered Expenses are typically incurred on a daily basis. If the Insured is eligible for more than one of the following benefits, benefits are payable for only one of the following, which would provide the greatest benefit on a single day:

- Care Coordination Benefit;
- Nursing Home Benefit;
- Assisted Living Facility Benefit;
- Home and Community Care Benefit; and
- Alternative Care Benefit.

LONG-TERM CARE BENEFITS

Long-Term Care Benefits – This Rider extends the benefits provided under the ABR by providing a Maximum EBR Benefit Limit and a Monthly Maximum EBR Benefit Amount, which become effective when the Maximum ABR Benefit Limit under the ABR is exhausted.

Specific Benefits – The specific benefits in the ABR to which this extension applies are the following:

- Care Coordination;
- The Care Coordination Benefit;
- The Nursing Home Benefit;
- The Assisted Living Facility Benefit;
• The Home and Community Care Benefit;
• The Alternative Care Benefit;
• The Non-Continual Alternative Care Benefit; and
• The Caregiver Training Benefit.

**Differences from the ABR** – When benefits are payable under this Rider, the benefits shown above will be paid as described in the ABR except for the following:

- References in the ABR to the Maximum ABR Benefit Limit will be considered to be references to the Maximum EBR Benefit Limit shown on the Policy Specifications;
- References in the ABR to the Maximum Monthly ABR Benefit Amount will be considered to be references to the Monthly Maximum EBR Benefit Amount;
- This Rider does not provide an International Benefit; and
- The Elimination Period does not apply to this Rider.

If benefits that are subject to the Maximum Monthly ABR Benefit Amount become payable partly under both this Rider and the ABR (because the Maximum ABR Benefit Limit has been exhausted during the month), the maximum amount payable under all such benefits is limited to the greater of:

- The Monthly Maximum ABR Benefit Amount; and
- The Monthly Maximum EBR Benefit Amount.

Benefits payable under the Non-Continual Alternative Care Benefit and the Caregiver Training Benefit of this Rider will:

- Be reduced by the respective amounts for which payment is made under the ABR; and
- Not be provided if the respective lifetime maximum benefit has been exhausted under the ABR.

The terms, conditions and exclusions of the ABR apply to the payment of benefits under this Rider unless otherwise stated in this Rider.

**INFLATION BENEFIT OPTION**

**Inflation Benefit Option** – Unless an inflation option was rejected, the Inflation Benefit Option increases the benefit amounts under this Rider. The Inflation Benefit Option and the inflation interest type and rate elected are shown in the Policy Specifications. The Inflation Benefit Option provides inflation protection benefit increases that shall continue without regard to the age of the Insured, claim status or claim history, or the length of time the Policy has been In Force.

**Simple Inflation Benefit Options** – If one of these Options is in effect, the Monthly Maximum EBR Benefit Amount and the Maximum EBR Benefit Limit will be increased on each Policy anniversary. The new Monthly Maximum EBR Benefit Amount is calculated as A plus (B times C), where:

A. Is the existing Monthly Maximum EBR Benefit Amount;
B. Is the Monthly Maximum EBR Benefit Amount applicable on the Policy Date; and
C. Is the inflation interest rate.

The Maximum EBR Benefit Limit is calculated as A times (B divided by C), where:

- A. Is the existing Maximum EBR Benefit Limit;
- B. Is the new Monthly Maximum EBR Benefit Amount as calculated above; and
- C. Is the previous Monthly Maximum EBR Benefit Amount.

**Compound Inflation Benefit Option** – If this Option is in effect, the Monthly Maximum EBR Benefit Amount and the Maximum EBR Benefit Limit will be increased on each Policy anniversary. The new Monthly Maximum EBR Benefit Amount is calculated as A times the result of (B plus C), where:
A. Is the existing Monthly Maximum EBR Benefit Amount;
B. Is 1; and
C. Is the inflation interest rate.

The Maximum EBR Benefit Limit is calculated as A times the result of (B plus C), where:

A. Is the existing Maximum EBR Benefit Limit;
B. Is 1; and
C. Is the inflation interest rate.

Termination – Increases will cease on the first to occur of:

- The date of the Insured’s death;
- The date this Rider and the Policy and ABR are cancelled pursuant to the Owner’s request; or
- The date the Owner has received the Maximum EBR Benefit Limit allowed.

EBR RETURN OF PREMIUM BENEFIT

EBR Return of Premium Benefit – This Rider offers a Return of Premium Benefit, which is payable to the Owner if the Policy is surrendered or lapsed. At issue, the EBR Return of Premium Benefit is equal to the EBR Premium, as shown on the Policy Specifications. After issue, the EBR Return of Premium Benefit may be reduced as described in the Policy, after the reduction of the Life Return of Premium Benefit and the ABR Return of Premium Benefit.

NONFORFEITURE BENEFIT

Nonforfeiture Benefit – Upon lapse of this Rider, the Owner is eligible for one of the two options described below. The Owner can change the elected benefit at any time before lapse by sending us a Written Request. The options available are:

1. Return of Premium Benefit as described in this Rider. This option will be effective automatically unless the Owner requests otherwise in writing.
2. Shortened Benefit Period. Under this option, we will continue coverage of eligible claims until the earlier of:
   a. The death of the Insured; or
   b. The date the Nonforfeiture Benefit Limit has been reached.

Nonforfeiture Benefit Limit – is an amount equal to the greater of:

1. The Monthly Maximum EBR Benefit Amount; or
2. The EBR Premium, as shown in the Policy Specifications.

The Nonforfeiture Benefit Limit is reduced by the sum of all benefits previously paid under this Rider. The Nonforfeiture Benefit Limit will never be greater than the remaining amount payable had this Rider stayed In Force.

EXCLUSIONS AND LIMITATIONS

Exclusions and Limitations – This Rider will not pay benefits for any expenses incurred:

- Prior to the date the Maximum ABR Benefit Limit has been exhausted under the ABR; or
- That would have been excluded from payment under the ABR had it remained In Force (as stated in the Exclusions and Limitations provision of that rider).
CLAIMS PROVISIONS

The Claims Provisions in the ABR apply to the payment of benefits under this Rider.

PREMIUMS, LAPSE AND REINSTATEMENT PROVISIONS

The Premiums, Lapse and Reinstatement provisions of the ABR apply to this Rider, except as modified below.

Lapse – The Lapse provision in the Policy applies to this Rider. Upon lapse, we will refund any EBR Return of Premium Benefit.

Reinstatement – If the ABR is reinstated under its Reinstatement provision, this Rider will also be reinstated. Any amount refunded due to lapse in connection with the EBR Return of Premium Benefit must be repaid to us prior to coverage being reinstated.

EFFECTIVE DATE AND TERMINATION OF INSURANCE PROVISIONS

In this section, we describe when this Rider becomes effective and when coverage ends.

Evidence Of Insurability – The Insured is required to provide evidence of insurability in a form and manner specified by us.

Rider Effective Date – The Insured will become covered under this Rider on the Policy Date shown on the Policy Specifications, provided the required premium has been received.

The Owner’s Right to Cancel Coverage at Any Time – The Owner may cancel coverage at any time by sending us written notice. The Policy, the ABR and this Rider both must remain In Force or be cancelled at the same time. We must receive a request to cancel 30 days prior to the requested cancellation date. Termination of coverage will be effective within 30 days of the date we receive the request, unless the requested termination date is later. The cancellation will not prejudice any claim for care received before the effective date of the cancellation.

When Insurance Under This Rider Ends – This Rider terminates on the first to occur of:

- The date of the Insured’s death;
- The date this Rider, the ABR and the Policy are cancelled pursuant to the Owner’s request;
- The date the Owner has received the Maximum EBR Benefit Limit allowed under this Rider; or
- The date the Policy is terminated.

Extension of Benefits – If the Policy, the ABR and this Rider terminate due to lapse, we will recognize the basis for a claim under this Rider for the Insured’s Confinement in a Nursing Home Facility, a Hospice Care Facility or an Assisted Living Facility before the date the Policy, the ABR or this Rider ended in the same manner as if the insurance was In Force. Extension of Benefits stops on the earliest of:

- The date when the Insured no longer meets the Eligibility for the Payment of Benefits requirements;
- The date the Insured is no longer Confined in a Nursing Home Facility, a Hospice Care Facility or an Assisted Living Facility; or
- The date when the Policy’s Face Amount remaining after monthly benefit payment is zero.

If benefits are continued under this Extension of Benefits provision, we will calculate the Policy’s Face Amount remaining as if the insurance was In Force. Extension of Benefits will be subject to all of the provisions of this Rider, including but not limited to the Eligibility for Payment of Benefits.
This provision is subject to the applicable coverage maximums shown on the Policy Specifications and all other applicable provisions of the Policy, the ABR and this Rider.

If the Insured’s benefits are continued under this provision, no Death Benefit will be payable.

**GENERAL PROVISIONS**

In this section, we describe the generally applicable provisions; the importance of completing the application truthfully and correctly; and other basic rights, obligations and features applicable to this Rider.

**Incontestability** – In issuing this Rider, we have relied upon the information presented by the Owner and the Insured in the Application. We may rescind this Rider or deny a claim due to a misrepresentation that is material to acceptance for coverage if this Rider has been In Force for less than six months. The Policy Date is shown on the Policy Specifications.

If coverage has been In Force for at least six months but less than two years, we may rescind this Rider or deny a claim due to a showing of misrepresentation in the Application that is both material to the Insured’s acceptance for coverage and which pertains to the conditions for which benefits are sought.

After coverage has been In Force for two years, we may rescind this Rider and deny a claim for benefits that began after the two-year period if relevant facts were knowingly and intentionally misrepresented by the Owner or the Insured in the Application relating to the health of the Insured.

**Misstatement** – If the Insured’s sex or birth date is misstated in the Application, we will adjust the benefits payable to what the premium paid would have purchased at the Insured’s correct sex or birth date as of the Policy Date.

**Fraud/Recovery** – If we determine that benefits have been paid under the Policy, the ABR, or this Rider as a result of fraudulent actions, we have the right to recover those benefit amounts. We may recover those benefit amounts directly from the Owner or by reducing any subsequent benefit payments under the Policy, the ABR, or this Rider. We will determine the manner in which we seek recovery of benefit payments made under fraudulent conditions.

**Tax Qualification** – This Rider is intended to provide tax-qualified long-term care insurance under Section 7702B(b) of the Internal Revenue Code of 1986, as amended (the “Code”), and be treated for such tax purposes as a separate contract from the Policy to which this Rider is attached, pursuant to Code Section 7702B(e). To achieve these purposes, the provisions of this Rider and the Policy (including any other rider or endorsement that does not specifically override these tax qualification provisions) shall be interpreted to ensure and maintain such separate tax qualification of this Rider (and of the Policy), despite any other provision to the contrary. Accordingly, even though the Policy may have cash value that can be borrowed, neither this Rider nor any long-term care insurance (or benefit) provided by it shall be deemed to provide any cash value or other money that can be borrowed (or paid, assigned or pledged as collateral for a loan) within the scope of the prohibitions described in Code Section 7702B(b)(1)(D). Nor shall such a prohibition be deemed to preclude any right of the Owner to direct payment of benefits provided by this Rider, absent any final regulation or other final guidance to the contrary that is published by the Internal Revenue Service (“IRS”). We reserve the right to amend this Rider or the Policy from time to time to reflect any clarifications that may be needed or are appropriate to maintain any such separate tax qualification or to conform the Rider or Policy provisions to any applicable changes in such tax qualification or to conform the Rider or Policy to any applicable changes in such tax qualification requirements, as provided in the Code or any published IRS guidance relating thereto, without consent (where allowed by law). We will send you a copy of any such amendment. If you reject any such amendment, it must be by giving us written notice, and your rejection may result in adverse tax consequences. Before any such rejection, you are advised to consult a qualified tax advisor.
Index

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities of Daily Living</td>
<td>2</td>
</tr>
<tr>
<td>Benefits Paid Reduce the Amount Available Under this Rider</td>
<td>3</td>
</tr>
<tr>
<td>Certain Exclusions Apply</td>
<td>3</td>
</tr>
<tr>
<td>Chronically Ill Individual</td>
<td>2</td>
</tr>
<tr>
<td>Claims Provisions</td>
<td>6</td>
</tr>
<tr>
<td>Compound Inflation Benefit Option</td>
<td>5</td>
</tr>
<tr>
<td>Conditions</td>
<td>3</td>
</tr>
<tr>
<td>Definitions</td>
<td>2</td>
</tr>
<tr>
<td>Differences from the ABR</td>
<td>4</td>
</tr>
<tr>
<td>EBR Benefit Duration</td>
<td>2</td>
</tr>
<tr>
<td>EBR Return of Premium Benefit</td>
<td>5</td>
</tr>
<tr>
<td>Effective Date and Termination of Insurance Provisions</td>
<td>6</td>
</tr>
<tr>
<td>Eligibility for the Payment of Benefits</td>
<td>2</td>
</tr>
<tr>
<td>Evidence Of Insurability</td>
<td>6</td>
</tr>
<tr>
<td>Exclusions and Limitations</td>
<td>5</td>
</tr>
<tr>
<td>Extension of Benefits</td>
<td>6</td>
</tr>
<tr>
<td>Fraud/Recovery</td>
<td>7</td>
</tr>
<tr>
<td>General Provisions</td>
<td>7</td>
</tr>
<tr>
<td>In Force</td>
<td>2</td>
</tr>
<tr>
<td>Incontestability</td>
<td>7</td>
</tr>
<tr>
<td>Inflation Benefit Option</td>
<td>4</td>
</tr>
<tr>
<td>Lapse</td>
<td>6</td>
</tr>
<tr>
<td>Limitations or Conditions on Eligibility for Benefits</td>
<td>3</td>
</tr>
<tr>
<td>Long-Term Care Benefits</td>
<td>3</td>
</tr>
<tr>
<td>Maximum EBR Benefit Limit</td>
<td>2</td>
</tr>
<tr>
<td>Misstatement</td>
<td>7</td>
</tr>
<tr>
<td>Monthly Maximum EBR Benefit Amount</td>
<td>2</td>
</tr>
<tr>
<td>Multiple Benefits Per Day</td>
<td>3</td>
</tr>
<tr>
<td>Nonforfeiture Benefit</td>
<td>5</td>
</tr>
<tr>
<td>Nonforfeiture Benefit Limit</td>
<td>5</td>
</tr>
<tr>
<td>Premiums, Lapse and Reinstatement Provisions</td>
<td>6</td>
</tr>
<tr>
<td>Reinstatement</td>
<td>6</td>
</tr>
<tr>
<td>Rider Effective Date</td>
<td>6</td>
</tr>
<tr>
<td>Severe Cognitive Impairment</td>
<td>3</td>
</tr>
<tr>
<td>Simple Inflation Benefit Options</td>
<td>4</td>
</tr>
<tr>
<td>Specific Benefits</td>
<td>3</td>
</tr>
<tr>
<td>Tax Qualification</td>
<td>7</td>
</tr>
<tr>
<td>Termination</td>
<td>5</td>
</tr>
<tr>
<td>The Owner’s Right to Cancel Coverage at Any Time</td>
<td>6</td>
</tr>
<tr>
<td>When Insurance Under This Rider Ends</td>
<td>6</td>
</tr>
</tbody>
</table>