

BANKERS LIFE AND CASUALTY COMPANY

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Tax Qualified Long-Term Care Insurance Policy

This is a Long-Term Care Insurance Policy that covers care provided by a Nursing Home, Assisted Living Facility, Home Health Care Agency, Hospice or Adult Day Care Facility. The benefits provided are supplemental and are not intended to cover all medical expenses.

This Policy is a legal contract between You and Us. We agree that, subject to all the terms and conditions set forth in the Policy, We will provide coverage to You against loss based on the application and in return for Premium payments.

RENEWAL CONDITIONS - GUARANTEED RENEWABLE: We cannot cancel this Policy. As long as You pay the required Premium, You have the right to continue this Policy for as long as You live or until all benefits have been provided under this Policy. You must pay the Premium on or before its due date.

PRE-EXISTING CONDITION LIMITATION:

Pre-Existing Conditions means medical conditions for which treatment was given or recommended by a Licensed Health Care Practitioner within six (6) months before the Effective Date of coverage.

Any loss due to a Pre-Existing Condition is not covered unless the loss begins more than six (6) months after the Effective Date of coverage.

RIGHT TO CHANGE PREMIUM: We may change the Premium rates for this Policy only if We change it for all policies like Yours based on the state in which Your Policy was issued on a Class basis. We will provide You with written notice of any change in the Premium at least sixty (60) days prior to any change.

THIRTY DAY RIGHT TO REVIEW AND RETURN: If for any reason You are not satisfied with this Policy, You can send the Policy to Our Home Office or Our agent within thirty (30) days after You receive it, We will then void this Policy and refund any Premium paid. We will refund any Premium paid within 30 days of the return, directly to payer.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION: Caution: The issuance of this Policy is based upon Your responses to the questions on Your application. A copy of Your application is attached to this Policy. If Your answers are incorrect or untrue, the Company has the right to deny benefits or rescind Your Policy. The best time to clear up any questions is now, before a claim arises. If, for any reason, any of Your answers are incorrect, contact the Company at the Home Office address.

NOTICE TO BUYER: The Policy may not cover all of the costs associated with Long-Term Care incurred by You during the period of coverage. You are advised to review all Policy limitations.

Signed by Our Secretary and President on the Policy's Effective Date.

[Secretary

Rachel J. Speller

President

James C. Dugay

]

This Policy is intended to be a Tax-Qualified Long-Term Care Insurance Policy under Section 7702B(b) of the Internal Revenue Code as enacted by The Health Insurance Portability and Accountability Act of 1996.

This is a non-participating Policy.

POLICY GUIDE

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DEFINITIONS

Activities of Daily Living means Bathing, Continence, Dressing, Eating, Toileting, and Transferring, which are defined below as part of the definition of Functional Incapacity/Functionally Incapacitated.

Adult Day Care Facility means an organization that provides a program of adult day health care and: (a) if licensing or certification is required, maintains all appropriate licensing or certification under the laws where it is located to provide such care; or (b) if licensing or certification is not required, meets ALL of the following requirements:

1. Operates at least five (5) days a week for a minimum of 6 hours a day and is not an overnight facility; and
2. Maintains a written record for each client that includes a Plan of Care and a record of all services provided; and
3. Has established procedures for obtaining appropriate aid in the event of a medical emergency; and
4. Has formal arrangements for providing the services of: a dietician; a licensed physical therapist; a licensed speech therapist and a licensed occupational therapist; and
5. Its staff includes a full-time director and one or more nurses in attendance during operating hours for at least four (4) hours a day; and
6. Is not owned or operated by a member of the Immediate Family.

Assisted Living Facility means a place providing care (room, board and Maintenance and Personal Care Services) to persons in need of assistance because of a Functional Incapacity or Severe Cognitive Impairment but given at a level of care less intense than that which would be received in a Nursing Home. An Assisted Living Facility must: (a) if licensing or certification is required, maintain all appropriate licensing or certification under the laws where it is located to provide such care; or (b) if licensing or certification is not required, meets ALL of the following requirements:

1. Provide twenty-four (24) hour a day care and services to at least ten (10) inpatients in one location; and
2. Have a trained and ready-to-respond employee on duty at all times to provide care; and
3. Provide three (3) meals a day and accommodate special dietary needs; and
4. Have formal arrangements for the services of a Physician or nurse to furnish emergency medical care; and
5. Have appropriate methods and procedures for handling and administering drugs and biologicals.

Assisted Living Facilities may also include Alzheimer facilities, adult foster homes or other residential health care facilities.

Assisted Living Facility does not include:

1. Congregate housing;
2. Individual residences or independent living units;
3. A Hospital;
4. A Nursing Home;
5. A place that primarily treats mental illness, drug addiction or alcoholism;
6. A home for the aged, or a rest home;
7. A place that primarily provides domiciliary, residency or retirement care; or
8. A place owned or operated by a member of the Immediate Family.

Authorized Designee means the person You have designated to receive a notification of lapse of this Policy due to the nonpayment of Premium. You may change this designation at any time by sending us written notification. We will notify You of Your right to change Your designation no less often than once every two (2) years.

Beneficiary(ies) means the person(s) You designate in writing to Us on the application to receive any benefits which may be payable in the event of Your death. If You designate more than one person, then, unless otherwise indicated, any benefit payment shall be in equal shares to the beneficiaries who survive You.

Calendar Year means the period beginning January 1st and ending December 31st.

Chronically Ill means You have been certified by a Licensed Health Care Practitioner within the preceding 12 month period as:

1. being Functionally Incapacitated for a period expected to last at least 90 days; or
2. having a Severe Cognitive Impairment.

Class means a class of covered persons who have the same policy form number as this Policy and who have certain factors in common. These factors may include, but are not limited to, one or more of the following: age on the Effective Date, coverage type, coverage plan, level of benefits, State of Issue, distribution channel as of the Effective Date, underwriting class, and payment method.

Covered Expenses means specified charges incurred for care or supplies received while this Policy is in force and while all eligibility requirements are met and for which benefits may be payable under the Facility Care or Home and Community Based Care benefit provisions of this Policy. The Facility Care Covered Expenses and Home and Community Based Care Covered Expenses for which benefits may be payable are specified in the Benefit provisions. The term Covered Expenses does not include charges for comfort or convenience items such as television, radio or telephone.

Day(s) means calendar day(s).

Elimination Period means the number of Days You must incur Covered Expenses that would otherwise be payable before benefits are payable. There is not an Elimination Period for Hospice Care. The Elimination Period is shown in the Policy Schedule. Any days for which Medicare pays benefits for Qualified Long-Term Care Services You received while the Policy is in force and prior to the expiration of the Elimination Period can be used to satisfy the Elimination Period even though those expenses are not covered under the terms of this Policy.

Effective Date means the date shown on the Policy Schedule for the described coverage. Coverage becomes effective on the later of: (1) the Effective Date as shown on the Policy Schedule for the described coverage; or (2) the date the first Premium for the described coverage is accepted by Us. For any rider added to the Policy, the Effective Date for the described rider coverage is the date shown on the Policy Schedule for the described rider coverage. Coverage under a rider, if any, becomes effective on the later of: (1) the Effective Date as shown on the Policy Schedule for the described rider coverage; or (2) the date the first rider Premium is accepted by Us for the rider.

Functional Incapacity/Functionally Incapacitated means the inability to perform two (2) or more of the Activities of Daily Living defined below without Hands-on Assistance or Standby Assistance of another person. Activities of Daily Living are:

1. **Bathing** means washing oneself by sponge bath; or in either a tub or shower, including getting into or out of the tub or shower.
2. **Continence** means 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 a catheter or colostomy bag).
3. **Dressing** means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
4. **Eating** means feeding oneself by getting food into the body from a table, a plate, cup or other receptacle or by a feeding tube or intravenously.
5. **Toileting** means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
6. **Transferring** means moving into or out of a bed, chair or wheelchair.

Medication management is not an Activity of Daily Living.

Hands-on Assistance means physical assistance without which the individual would be unable to perform an Activity of Daily Living.

Home means Your primary place of residence.

Home does not include:

1. A Nursing Home;
2. A Hospital;
3. An Assisted Living Facility;
4. An Alzheimer's facility;
5. A place that operates primarily for the treatment of alcoholism, drug addiction, or mental or nervous disorders;
6. Any other institutional setting where You are dependent on others for assistance with Activities of Daily Living; or
7. The residence of the person who provides Homemaker Services or home health care.

Home Health Care Agency means an agency or organization that is state licensed or certified to provide such care, if the state in which it is located requires licensure or certification for such care, or is certified as a Home Health Care Agency under Title XVIII of the Social Security Act of 1965, as amended, and:

1. Specializes in giving Nursing Care or therapeutic services in the Home;
2. Is operating within the scope of its license or certification; and
3. Maintains a complete medical record and Plan of Care for each patient.

Homemaker Services Incidental to Maintenance or Personal Care Services means only the following services when received in conjunction with Maintenance or Personal Care Services performed by an eligible Home Health Care Agency or Qualified Home Health Care Provider:

1. Domestic or cleaning services;
2. Laundry services;
3. Food shopping and errands;
4. Meal preparation and cleanup;
5. Assistance to and from medical appointments; and
6. Formal Home delivered meals.

Homemaker services does not mean any type of pet care, lawn or yard care, snow removal, transportation expenses, or vehicle maintenance. Also, homemaker services do not include construction, renovation, or upkeep to Your Home, such as painting.

Hospice means an agency that is licensed to provide hospice care to Terminally Ill patients in the state where the services are given. If such state has no licensing requirements, the agency must:

1. Be primarily engaged in providing pain relief, symptom management and support service to dying persons and their families; and
2. Provide nursing care under the supervision of a registered nurse.

Hospital means a medical facility which:

1. Is licensed and operated as a Hospital, pursuant to law;
2. Provides care of injured and sick people on an inpatient basis for which a charge is made;
3. Is supervised by one or more Physicians;
4. Provides twenty-four (24) hour a day nursing services supervised by or under a registered graduate nurse (RN); and
5. Provides on-site or prearranged use of x-ray equipment, laboratory and surgical facilities.

A Hospital is not a bed, unit, or facility that functions as a/an:

1. Skilled nursing facility;
2. Nursing home;
3. Extended care facility;
4. Convalescent home;
5. rest home, or a home for the aged;
6. sanatorium;
7. rehabilitation facility;
8. Place primarily providing care for alcoholics or drug addicts; or
9. Facility for the care and treatment of mental disease or mental disorders.

Immediate Family means anyone related to You in the following manner: mother; father; stepmother; stepfather; mother-in-law and father-in-law; spouse including common law marriage, domestic partner or civil union partner, if legally recognized; children and stepchildren; brothers; stepbrothers and brothers-in-law; sisters; stepsisters and sisters-in-law; grandchildren; or grandparents.

Licensed Health Care Practitioner means any licensed Physician, registered professional nurse or licensed social worker or other individuals who meet requirements prescribed by the Secretary of the Treasury. It does not include a member of Your Immediate Family.

Maintenance or Personal Care Services means any care by eligible providers the primary purpose of which is to assist You with the Activities of Daily Living while You are Chronically Ill, including protecting you from threats to health and safety due to Severe Cognitive Impairment.

Maximum Benefit means the maximum amount We will pay You for the combined total of all Covered Expenses. This amount is equal to the Maximum Daily Benefit amount times the Maximum Benefit Multiplier. The Maximum Benefit is shown in the Policy Schedule.

Maximum Benefit Multiplier means the number used to multiply the Maximum Daily Benefit by in order to equal the Maximum Benefit amount payable. The Maximum Benefit Multiplier is shown in the Policy Schedule.

Maximum Daily Benefit means the maximum amount We will pay per Day for You, after any applicable Elimination Period, for Facility Care. The Maximum Daily Benefit is shown in the Policy Schedule. See Facility Care Covered Expenses under the Benefit Provisions section of this Policy.

Maximum Monthly Benefit means the maximum amount We will pay per calendar month for You, after any applicable Elimination Period, for Home and Community Based Care. The Maximum Monthly Benefit is shown in the Policy Schedule. See Home and Community Based Care Covered Expenses under the Benefit Provisions section of this Policy.

Medicaid means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as Then Constituted or Later Amended.

Medicare means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as Then Constituted or Later Amended.

Mental Illness means a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind. It does not mean a demonstrable organic brain disease, such as Parkinson's Disease, Alzheimer's Disease or senile dementia.

Nursing Care means skilled care required because You are Functionally Incapacitated or Severely Cognitively Impaired and included in Your Plan of Care provided by one or more of the following health care professionals: registered nurse, licensed vocational nurse, licensed practical nurse, physical therapist, occupational therapist, speech therapist, respiratory therapist, medical social worker or registered dietitian.

Nursing Home means a place providing care (room, board and Maintenance or Personal Care Services) to persons in need of assistance because of a Functional Incapacity or Severe Cognitive Impairment, which is licensed or certified as a Nursing Home in the state in which is located to provide Nursing Care (skilled or intermediate) for persons at their own expense. If the state in which it is located does not require licensure or certification, the Nursing Home must meet ALL of the following requirements:

1. Has services performed by or under the continual, direct and immediate supervision of a registered nurse, licensed practical nurse or licensed vocational nurse, on-site twenty-four (24) hours per day; and
2. Has beds for patients who need care; and
3. Has a doctor available to furnish emergency service.

Nursing Home also means a wing, area or floor of a Hospital specifically operating as a Centers for Medicare and Medicaid Services approved Swing Bed, or duly licensed as a Nursing Home.

Nursing Home does not mean:

1. A Hospital;
2. A place that primarily treats mental illness, drug addiction or alcoholism;
3. A home for the aged, or a rest home;
4. A place that primarily provides domiciliary, residency or retirement care;
5. Individual residences or independent living units; or
6. A place owned or operated by a member of the Immediate Family.

Physician means a person other than You or a member of Your Immediate Family who:

1. Is licensed by the state to practice medicine and surgery as defined in Section 1861 (r)(1) of the Social Security Act; and
2. Performs services which are allowed by that license.

Plan of Care means a written individualized plan of services developed, approved in writing and supervised by a Licensed Health Care Practitioner. A Plan of Care may consist of the Licensed Health Care Practitioner's written notes of treatment or orders found in Your medical records. We may require a copy of the initial Plan of Care and any changes later made to it.

Policy means this individual Tax Qualified Long-Term Care Insurance Policy issued by Us to the Policyowner

Policyowner means the person named as the Policyowner in the Policy Schedule.

Pre-Existing Condition means medical conditions for which treatment was given or recommended by a Licensed Health Care Practitioner within six (6) months before the Effective Date of coverage.

Premium means the amount of money You are required to pay Us in return for the coverage provided by this Policy and any attached rider(s).

Qualified Home Health Care Provider means an individual or organization licensed or certified to provide home health care services. The Qualified Home Health Care Provider must be included in the Plan of Care as the provider of home health care services.

Qualified Long-Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services and Maintenance or Personal Care Services which are:

1. needed by You because You are Chronically Ill; and
2. provided under a Plan of Care prescribed by a Licensed Health Care Practitioner.

Severe Cognitive Impairment/Severely Cognitively Impaired means there is a deterioration or loss in intellectual capacity which requires a person to receive Substantial Supervision to protect one's self from threats to health and safety. Severe Cognitive Impairment is measured by clinical evidence or standardized tests which reliably measure impairment in one's:

1. Short or long-term memory;
2. Orientation as to people, place, and time;
3. Deductive or abstract reasoning Or;
4. Judgement as it relates to safety awareness

Such loss of intellectual capacity can result from the following covered conditions: Alzheimer's disease, Parkinson's disease, senile dementia or other nervous or mental disorders.

Standby Assistance means the presence of another person within arm's reach of You that is necessary to prevent, by physical intervention, injury to You while You are performing an Activity of Daily Living, (such as being ready to catch You if You fall while getting into or out of the bathtub or shower as part of Bathing).

State of Issue means the state in which Your Policy was issued. The State of Issue is shown on the Policy Schedule page.

Swing Bed means a Hospital participating in Medicare that has Centers for Medicare and Medicaid Services approval to provide post-hospital skilled nursing facility care as a Swing Bed.

Substantial Supervision means providing continual (i.e., around the clock) supervision (which may include verbal prompting, gestures or other demonstrations) by another person that is necessary to protect a Severely Cognitively Impaired person from threats to his or her own health or safety (such as may result from wandering).

Terminally Ill means that a Physician certifies that You:

1. Have no reasonable prospect of cure;
2. Have a life expectancy of less than six (6) months;
3. Need Hospice services for palliation or management of the terminal illness and related conditions; and
4. Would have to be confined in a Hospital or Nursing Home if Hospice care services were not available.

We, Us, Our, Company means Bankers Life and Casualty Company.

You, Your, and Yours means the Policyowner named in the Policy Schedule.

BENEFIT PROVISIONS

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

Before benefits will be paid for Your Covered Expenses, subject to the terms of this Policy, including without limitation the Pre-Existing Condition limitation, and all other limitations and exclusions,

1. A Licensed Health Care Practitioner must certify that such Covered Expenses are needed because You are Chronically Ill;
2. The Covered Expense must be incurred for care or supplies received while You are covered by this Policy;
3. The Covered Expense must be incurred for care or supplies received after Your Effective Date of coverage;
4. The Covered Expense must not be excluded by the terms of this Policy; and
5. The Elimination Period, if any, must be satisfied.

We reserve the right, at Our expense and discretion, to independently assess Your benefit eligibility. This review will be performed only to the extent it is reasonably necessary and not more often than once every 90 days. This may include without limitation, a personal interview with, and an assessment of You, including examination or tests by a Licensed Health Care Practitioner of Our choice, and Our receipt of copies of any relevant medical records from any healthcare provider involved in Your care.

A Covered Expense is incurred on the Day the service or treatment is given or the supply is bought.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

We will not pay more per Day than the Maximum Daily Benefit amount shown in the Policy Schedule for the total of all Facility Care Covered Expenses described in the Section I below. We will not pay more per calendar month than the Maximum Monthly Benefit amount shown in the Policy Schedule for the total of all Home and Community Based Care Covered Expenses described in Section II below.

We will not pay more than the Maximum Benefit for the total of all Covered Expenses, whether they are Facility Care Covered Expenses described in Section I below, Home and Community-Based Care Covered Expenses as described in Section II below, or a combination of both.

If both Facility Care and Home and Community Based Care expenses are incurred on the same Day, only the earliest type of incurred expense for that Day will be covered.

The following are Covered Expenses, but only to the extent that they are Qualified Long-Term Care Services.

I. FACILITY CARE COVERED EXPENSES

The following benefits are limited to the Maximum Daily Benefit amount, per Day, for the total of all Facility Care Covered Expenses.

A. FACILITY CARE:

We will pay up to the Maximum Daily Benefit amount, per Day, for the total of all Facility Care Covered Expenses for the following care provided while confined in a Nursing Home or Assisted Living Facility:

1. Room and board;
2. Maintenance or Personal Care Services; and
3. Supplies provided by the facility related to Your care

B. BED RESERVATION:

We will pay up to the Maximum Daily Benefit, not to exceed twenty-one (21) Days each Calendar Year to reserve Your bed while You are absent from a Nursing Home or Assisted Living Facility. The Bed Reservation benefit will be paid if:

1. We are paying benefits for Facility Care; and
2. The Nursing Home or Assisted Living Facility continues to charge You to reserve the bed.

Any unused days cannot be carried forward into the next Calendar Year.

If both Facility Care and Bed Reservation expenses are incurred on the same Day, only the earliest type of incurred expense for that Day will be covered.

II. HOME AND COMMUNITY-BASED CARE COVERED EXPENSES

The following benefits are limited to the Maximum Monthly Benefit amount, per calendar month, for the total of all Home and Community-Based Care Covered Expenses.

A. HOME HEALTH CARE:

We will pay up to the Maximum Monthly Benefit amount, per calendar month, for the total of all Home and Community-Based Care Covered Expenses for the following services and supplies provided in Your Home by a Home Health Care Agency or a Qualified Home Health Care Provider under a Plan of Care:

1. Visits by: licensed nurse; licensed nutritional specialist; medical social worker; home health aide; legally qualified physical, occupational, speech or inhalation therapist;
2. Maintenance or Personal Care Services; and
3. Homemaker Services Incidental to Maintenance or Personal Care Services.

B. HOSPICE CARE:

We will pay up to the Maximum Monthly Benefit amount, per calendar month, for the total of all Home and Community-Based Care Covered Expenses if You are Terminally Ill and receive services and supplies provided by a Hospice, to the extent not otherwise covered by another Policy benefit provision. This benefit does not include any charges for room and board. Benefits payable for Hospice Care are not subject to the Elimination Period nor will the Days for which Hospice benefits are payable count toward satisfying the Elimination Period.

C. ADULT DAY CARE:

We will pay up to the Maximum Monthly Benefit amount, per calendar month, for the total of all Home and Community-Based Care Covered Expenses for the following services provided at an Adult Day Care Facility:

1. Visits by a licensed nurse;
2. Occupational, physical or speech therapy;
3. Social, recreational and educational events designed to improve the patient's self-awareness and level of functioning;
4. Training and help with the regular and customary Activities of Daily Living;
5. Transportation to and from the Adult Day Care Facility; and
6. Meals provided by the Adult Day Care Facility.

CROSS BORDER SERVICES

We will pay benefits for similar services obtained in a state other than the State of Issue if benefits for those services would have been paid in the State of Issue, irrespective of any facility naming convention or facility licensing, certification or registration requirement (or similar requirements) differences between the states.

INTERNATIONAL COVERAGE

If You require Qualified Long-Term Care Services otherwise covered by this Policy while You are outside the United States or its territories, benefits will be payable according to the terms of this Policy, subject to a lifetime maximum equal to thirty (30) times the Maximum Daily Benefit payable for Facility Care described above. Providers of care must meet the certification or licensing requirements, if any, of the jurisdiction in which the care is received.

OPTIONAL BENEFIT INCREASE

If the following option applies, it will be shown on the Policy Schedule. The Policy Schedule also shows the percentage increase, if any.

ANNUAL COMPOUND INCREASES BENEFIT OPTION

If this option is shown as elected in the Policy Schedule and this Policy is then in force, We will increase all Policy maximum benefit amounts each Policy anniversary by the percentage shown in the Policy Schedule. We will apply the Policy's percentage increase to the then current amounts for each maximum benefit amount shown in the Policy Schedule. The increase amount will continue without regard to an Your age, claim status or claim history, or the length of time You have been insured under the Policy.

We will pay any increased benefit amount that becomes effective as of the next Policy anniversary. Only that portion of the Maximum Benefit which has not yet been paid toward Covered Expenses incurred before the anniversary date will increase. The increased amount that will be added to the Maximum Benefit is equal to the percentage increases in the Maximum Daily Benefit for Facility Care from the previous anniversary TIMES the unused portion of the Maximum Benefit.

If the resulting benefit amount is not a multiple of \$0.25, We will round the amount to the next highest multiple of \$0.25.

GUARANTEED PURCHASE OPTION

If You do not choose an Annual Compound Benefit Option, and Your Policy has been in force for three years, We will offer to increase Your Maximum Daily Benefits (Your Maximum Monthly Benefit and Maximum Benefit will also increase proportionally) by the amount shown on the Policy Schedule without providing evidence of insurability. The Premium for the additional benefits will be based on Your then current age. We will continue to offer to increase Your benefits every three years, up to the Maximum Guaranteed Purchase Option Age shown on the Policy Schedule, as long as You continue to accept the increase offers and you have not incurred any Covered Expenses as of the effective date of each offer. If You decline one of the offers, no future offers will be made.

If the resulting benefit amount is not a multiple of \$0.25, We will round the amount to the next highest multiple of \$0.25.

We'll pay any increased benefit amount that becomes effective as of the next Policy anniversary.

EXCLUSIONS AND LIMITATIONS

We will not pay for expenses incurred:

1. Due to war or act of war.
2. To the extent they are paid under Medicare or any other government insurance plan (except Medicaid), including a Veterans Administration plan. This includes expenses that would be reimbursable by Medicare but for the application of a deductible or coinsurance amount;
3. For services or supplies provided by a member of the Immediate Family.
4. For services and supplies not included in the Plan of Care.
5. For which no charge is customarily made in the absence of insurance.
6. Outside the United States or its territories except as specifically covered under the International Coverage provision.

Pre-Existing Condition Limitation: No benefits are payable for any loss due to a Pre-Existing Condition unless the loss begins more than six (6) months after the Effective Date of coverage. See the description for Pre-Existing Condition Limitation on page 1 of this Policy.

EXTENSION OF POLICY BENEFITS

If Your Policy terminates due to Your failure to pay Premium while You are receiving benefits for Covered Expenses under the Facility Care Covered Expenses as described in the Benefits section of this Policy, We will pay the benefits in the same manner as if Your Policy were still in force, subject to all of the terms of the Policy. Extension of benefits will end on the earliest of the date:

1. You no longer meet the Eligibility For Payment of Benefit provision requirements;
2. You are no longer confined in a Nursing Home or Assisted Living Facility; or
3. The Maximum Benefit has been exhausted.

RIGHT TO REDUCE COVERAGE

You have the right to lower the Premium for this Policy by reducing Policy benefit amounts. Any request is limited to the options available under this Policy and Your State of Issue's minimum requirements. Below is a listing of the possible options that are available:

You may choose to:

1. Reduce the Maximum Benefit;
2. Reduce the Maximum Daily Benefit; or
3. Increase the Elimination Period.

Premium will be based on the reduced amount of coverage chosen and Your age at the time the Policy was issued. No underwriting will be required. Any benefit decrease must be in a multiple of ten (\$10) dollars.

If You choose to exercise this right, You may contact Us at the Home Office to discuss reduction options.

We will also notify You of Your right to reduce coverage in the event this Policy is about to lapse or experience an increase in Premium.

If this Policy includes the Annual Compound Increases Benefit Option, the reduced coverage Policy Maximum Benefit amounts will continue to be adjusted in the same manner as prior to the reduction taking place.

PREMIUM CHANGE

We may change the Premium only after We give You the appropriate advance notice required by Your State of Issue. Before making any such change, We will get the necessary regulatory approval.

In the event We increase Premium, We will offer You the following options, as they apply to this Policy, at least sixty (60) days before a Premium increase becomes effective:

1. Pay the increased Premium and continue the Policy in force as is;
2. Reduce the Policy's benefits to a level such that Your Premium will not increase (subject to state law minimum standards);
3. Exercise the Non-Forfeiture Benefit Rider (if any such rider is attached to this Policy); or
4. Exercise the Contingent Benefit at Lapse, if applicable.

CONTINGENT BENEFIT AT LAPSE

This Contingent Benefit at Lapse provision is effective from the Effective Date and may only be exercised if this Policy lapses due to non-payment of Premium within 120 Days after the effective date of a Premium increase that meets or exceeds Your original Premium by the percentage shown in the table below. (*Note: additional Premium applied to increases in benefit amounts is not considered a Premium increase.*)

Under this provision, We will convert Your current coverage to paid-up insurance with no further Premiums being payable. The new Maximum Benefit under paid-up coverage will be equal to the greater of 100% of all Premiums You paid for the coverage or thirty (30) times Your Maximum Daily Benefit Amount for Facility Care. All other benefit amounts will remain at the level attained at the time the Policy lapses/converts to paid-up coverage. The Annual Compound Increases Benefit Option, if any, will not apply to the paid-up insurance.

Benefits paid while Your coverage is in paid-up status combined with benefits paid while this Policy was in force will not exceed the amount of benefits that would have been payable had the Policy remained in force.

In the event that Your Policy was issued at least twenty (20) years prior to the effective date of the increase, a value of zero percent (0%) shall be used in place of all values in the table below.

Cumulative Premium Increase over First Premium that will Allow the Contingent Benefit at Lapse to be exercised. (Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium Rate Schedule	Issue Age	Percent Increase Over Initial Premium Rate Schedule
29 and under	100%	72	36%
30-34	100%	73	34%
35-39	100%	74	32%
40-44	100%	75	30%
45-49	100%	76	28%
50-54	100%	77	26%
55-59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

GENERAL PROVISIONS

ENTIRE CONTRACT: The entire contract of insurance consists of:

1. This Policy;
2. The Policy Schedule;
3. Any Benefit Schedule(s);
4. Any attached amendment(s), rider(s) or endorsement(s); and
5. The application and any supplemental application(s).

POLICY CHANGES: No change to this Policy is valid unless and until it is in writing, signed by one of Our officers and attached to this Policy. No one else, including an agent, has the authority to change this Policy or to waive any of its provisions.

CHANGE OF BENEFICIARY: You can contact Us to change the Beneficiary at any time. The request must be in writing, received by Us at Our Home Office, and the change must be approved by Us. The beneficiary's consent is not required for a change of beneficiary, unless the designation of beneficiary is irrevocable. If approved, unless otherwise specified by you, it will go into effect the day You signed the request. The change will not have any bearing on payments made or other action taken before We receive and approve the request.

TERMINATION: This Policy ends when benefits exhaust or when You request cancellation of coverage. You may request termination of this Policy at any time. The request must be in writing and sent to Us at Our Home Office. Termination will become effective on the day We receive the request, or on a later date specified in the request.

TIME LIMIT ON CERTAIN DEFENSES: In issuing this Policy, we relied upon the statements made in Your application. If Your Policy has been in force for less than six (6) months, We may void this Policy or deny any claim for loss which starts within six (6) months of this Policy's Effective Date, if We determine there was material misrepresentation which would have caused the application for this coverage to be declined.

If Your Policy has been in force for at least six (6) months, but less than two (2) years from this Policy's Effective Date, We may void this Policy or deny any claim for loss if We determine there was material misrepresentation which would have caused the application for this coverage to be declined, and which relates to the condition for which benefits are sought.

After two (2) years from the Effective Date only misrepresentations made knowingly and intentionally in the application relating to Your health may be used to void this Policy or deny any claim for loss which starts after the two (2) year period.

With respect to statements in any application requesting an increase in coverage, We rely on the statements made in that application when increasing coverage under the Policy. After the increase in coverage has been in effect for less than six (6) months, We may void the increase in coverage or deny any claim for loss which starts within six (6) months of the increase in coverage Effective Date, if We determine there was material misrepresentation which would have caused the application for the increase in coverage to be declined.

If Your Policy benefits have been increased for at least six (6) months but less than two (2) years from this Policy's increase in coverage Effective Date, We may void the increase in coverage or deny any claim for loss if We determine there was material misrepresentation which would have caused the application for increase in coverage to be declined, and which relates to the condition for which benefits are sought.

After two (2) years from the Policy's increase in coverage Effective Date, only misrepresentations made knowingly and intentionally in the application for increasing coverage relating to Your health may be used to void the increase in coverage or deny any claim for loss which starts after the two (2) year period.

With respect to statements in any application requesting reinstatement, We rely on the statements made in that application when reinstating the Policy. After this Policy has been reinstated, if Your Policy has been reinstated for less than six (6) months, We may void this Policy or deny any claim for loss which starts within six (6) months of this Policy's reinstatement date, if We determine there was material misrepresentation which would have caused the application for reinstatement of this coverage to be declined.

If Your Policy has been reinstated for at least six (6) months but less than two (2) years from this Policy's reinstatement date, We may void this Policy or deny any claim for loss if We determine there was material misrepresentation which would have caused the application for reinstatement of this coverage to be declined, and which relates to the condition for which benefits are sought.

After two (2) years from the reinstatement date, only misrepresentations made knowingly and intentionally in the application for reinstatement relating to Your health may be used to void this Policy or deny any claim for loss which starts after the two (2) year period.

MISSTATEMENT OF AGE: If Your age has been misstated, the Policy benefits will be those the Premium paid would have purchased for the correct age. The Premium rate will be based on Our rates on the Effective Date.

GRACE PERIOD: This Policy has a thirty (30) Day grace period. This means that if a Premium is not paid on or before the due date, it may be paid during the following thirty (30) days. During the grace period, the Policy will stay in force contingent upon the Premium being received by the end of the grace period. A claim incurred during the grace period will only be considered for payment upon the Premium due being paid prior to the end of the grace period. The Policy will terminate on the due date of the unpaid Premium if You do not pay the Premium by the end of the grace period.

We will not end the Policy for nonpayment of Premium unless We have sent written notice to You and, if applicable, Your Authorized Designee, at least thirty (30) days before the Policy will end. This notice will be sent by first class United States mail. Notice will not be given until thirty (30) days after a Premium is due and unpaid. This notice is deemed to have been given as of five (5) days after the date of mailing.

REINSTATEMENT: If the Premium is not paid before the grace period ends, this Policy will lapse. You may request reinstatement up to six (6) months after the Policy has lapsed. We may or may not reinstate Your Policy at Our option. Later acceptance of Premium by Us without requiring an application for reinstatement, will reinstate this Policy.

If We require an application at the time We received the Premium, You will get a conditional receipt. If the application is approved, this Policy will be reinstated as of the approval date. Lacking such approval, this Policy will be reinstated on the forty-fifth (45th) Day after the date of the conditional receipt unless We previously notified You in writing of Our disapproval.

In the event of lapse due to Severe Cognitive Impairment or Functional Incapacity, You, or any person authorized to act on Your behalf, may request reinstatement of this Policy. Such request must be made within six (6) months after this Policy lapsed.

If proof of Severe Cognitive Impairment or Functional Incapacity is provided and We receive past due Premium, We will reinstate the Policy. The reinstated Policy will cover loss occurring from the date of lapse. Payment of Premium must be made within fifteen (15) Days following Our request.

In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated Policy.

EFFECTIVE DATE: This Policy begins at 12:01 a.m. Standard Time where You live on the Effective Date shown in the Policy Schedule. It ends, subject to the grace period, at 12:01 a.m. on the date any Premium is due and not paid or on or after the date We are notified by You to end this coverage.

EFFECT OF LEGISLATION CHANGES: The risk We assumed on this Policy's Effective Date is based on the laws and regulations governing the system for the delivery and financing of health insurance then in effect. It is possible that the federal government or state legislation may change the system and therefore change the nature of the risk We assumed. If this occurs, We will make any necessary change to Policy benefits.

Before making any such change, We will get the necessary approval from the agency in Your state that regulates insurance. We will tell You if such coverage change needs a Premium change. Until the effective date of any coverage change, benefits will be based upon the risk We assumed on this Policy's Effective Date.

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice of claim must be given within sixty (60) days after a covered loss starts or as soon as possible. The notice can be given to Us at the address shown on page 1 of this Policy. Notice should include Your name and the Policy number.

CLAIM FORMS: When We get notice of claim, We will send You forms for filing proof of loss. If these forms are not given to You within fifteen (15) days, You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss. We must get this statement within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: For periodic payment of a continuing loss, You must give Us written proof of loss within ninety (90) days after the end of each period for which We are liable. For any other loss, You must give Us written proof within ninety (90) days after the end of such loss.

If it was not reasonably possible for You to give Us proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than one year from the time specified unless You were legally unable to act.

TIME OF PAYMENT OF CLAIMS: After We receive proper written proof of loss for services received, benefits payable under this Policy will be paid within the time required by Your state's law.

PAYMENT OF CLAIMS: Benefits will be paid to You. Any benefits due and unpaid at Your death may be paid to (1) Your Beneficiary, if any; or (2) Your estate.

If benefits are payable to Your estate, We can pay up to \$1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

No assignment of benefits, regardless of whether made before loss or after loss, shall transfer any rights under the Policy of insurance.

OVERPAYMENT OF CLAIM: We reserve the right to recover any overpayment of claims or benefits. We can request the overpayment to be repaid in a lump sum to the Company; or, We can reduce a future claim payment(s) by the amount of the overpayment. In the event of Your death, We may request the overpayment to be repaid to the Company from Your estate.

INFORMATION ON DENIAL OF CLAIM: In the event We deny benefits under this Policy, You have the right to receive a written explanation of the reason(s) a claim was denied. Write to Our Claim Review Department at the address shown on page 1 of this Policy. We will respond within sixty (60) days after receiving Your request.

APPEALS PROCESS: This Policy provides for an internal appeals process and, if required by the law of the State of Issue, will also provide an external appeal process. Any appeals process will be consistent with the applicable laws and/or regulations of the State of Issue.

INTERNAL APPEALS PROCESS: You may appeal to Us for a full and fair review of a denied claim by: (1) requesting a review in writing within 120 days of receipt of a claim denial; and (2) submitting issues and comments in writing.

If We need more information to make a determination about Your appeal, we shall request information from You. Upon receipt of all necessary information upon which a final determination can be made, We shall send within the time required by Your State of Issue written determination on the appeal to You which shall: (1) include specific reasons for the decision; and (2) be written in a manner calculated to be understood by You. If We uphold the adverse determination, You will be given the opportunity to submit new or additional information for reevaluation.

EXTERNAL APPEALS PROCESS: After You exhaust Our internal appeals process, if the State of Issue requires an external appeals process for review of claims decisions involving eligibility for payment of benefits, We will notify You at the time of Our claim decision of the procedures and time deadlines for You to request an external review.

PHYSICAL EXAMINATION: We, at Our expense, have the right to have You examined as often as reasonably necessary while a claim is pending.

LEGAL ACTION: No legal action can be taken against Us to receive benefits under this Policy:

1. Within sixty (60) days after written Proof of Loss has been furnished in accordance with the requirements of this Policy; or
2. More than three (3) years from the time written Proof of Loss is required to be given.

In the event that any part of this provision is in conflict with the applicable law and/or regulation of the State of Issue, this provision shall be administered in accordance with such applicable state law or regulation.

CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS:

This Policy was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards.

Any provision of the Policy that, on its Effective Date, is in conflict with the applicable Interstate Insurance Product Regulation Commission standards for this product type, in effect as of the provision's effective date of Commission approval of the Policy, is hereby amended to conform to the applicable Interstate Insurance Product Regulation Commission standards in effect as of the provision's effective date of Commission approval of the Policy.

PREMIUM PROVISIONS

PAYMENT OF PREMIUM: The first Premium is due on the Effective Date of this Policy. Each Premium after the first is due on the last day of the term for which the most recent Premium was paid and must be accepted by Us at Our Home Office.

This Policy will not be in force until the first Premium is accepted by Us. If We accept a Premium, this Policy will continue in force until the end of the term for which that Premium was due.

The amount of the Premium is shown in the Policy Schedule and is based on Your initial mode of payment. The amount of each Premium after the first is based on Your then current mode of payment and the Premium then being charged for policies of this form number and Class issued in the same State of Issue. If You do not pay Your Premium when due or within the grace period, coverage under this Policy will terminate.

Exception: During the time, if any, that it is agreed between You and Us that Premiums will be billed and remitted through payroll deduction or credit union share account deduction, Premium is due in Our Home Office on the due date indicated in the billing provided to the administrator coordinating Premium payments on Your behalf.

TRANSFER FROM PAYROLL DEDUCTION: If this Policy was issued on a payroll deduction payment method as designated in Your application and if, after at least one Premium payment, Premiums cease to be remitted through a valid payroll group, You may continue Your insurance by remitting Premium through one of Our other payment methods then available.

Currently, Our other payment methods include:

1. Monthly deduction from a checking or savings account; and,
2. Direct bill for an annual, or semi-annual Premium.

The Premium rate will not be changed because of this transfer.

PREMIUM REFUND UPON DEATH OR POLICY CANCELLATION: You may cancel this Policy at any time by delivering or sending Us written notice. Cancellation will be effective on the date We get notice or on the date shown in the notice, whichever is later. We will promptly return the unearned portion of any Premium paid. Unearned Premiums will also be returned in the event Premium is paid beyond Your date of death. The earned Premium shall be computed on a pro-rata basis.

BANKERS LIFE AND CASUALTY COMPANY
Home Office: [111 East Wacker Dr., Suite 2100, Chicago, IL 60601-4508]
Telephone: [(312) 396-6000]

POLICY SCHEDULE

DO NOT DETACH FROM POLICY AND OR RIDER(S)

POLICYOWNER

[John Doe]

[123 Main Street]

[Any City, GA]

STATE OF ISSUE: [state]

If you (a) need the assistance of the governmental agency that regulates insurance or (b) have a complaint you have been unable to resolve with your insurer you may call the [Insert State] Insurance Department at [(xxx) xxx-xxxx].

POLICY ACCOUNT NUMBER [123456789]	POLICY EFFECTIVE DATE [1/1/2023]	MODE OF PAYMENT [MONTHLY]	MODAL PREMIUM [\$703.82]	ANNUAL PREMIUM [\$8,189.71]
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Effective Date	Description of Coverage	Form Number	Premiums
[1/1/2023]	[Facility Care/Home Health Care] [Policyowner Name]	[ICC23B1001]	[\$4,199.85]
[XX/XX/XXXX]	[Non-Forfeiture Benefit Rider]	[XXXXXXXX]	[\$XXX.XX]
[1/1/2023]	[Return of Premium Upon Death Indemnity Rider]	[ICC23R1005]	[\$3,898.86]
Total Premium			[\$8,189.71]

Maximum Benefit	[\$109,500.00], based upon the Maximum Benefit Multiplier
Maximum Benefit Multiplier	[730] Days
Elimination Period (satisfied one time. Does not apply to hospice care)	[30] Days of Covered Expenses
Facility Care	Covered Expenses per Day up to the Maximum Daily Benefit, [\$150.00]
Home and Community Based Care	Covered Expenses per month up to the Maximum Monthly Benefit, [\$4,650.00]
Annual Compound Increase Benefit Option – [Elected: Effective Date] or [Not Elected]	[0%] Compound
[Guaranteed Purchase Option]	[[3%] increase Maximum Daily Benefits], [Maximum Guaranteed Purchase Age: [79]]

[State Required LTC Partnership Disclosure]