The Lincoln National Life Insurance Company
(the "Company")
A Stock Company
Service Office: PO Box 21008, Greensboro, NC 27420-1008
(800) 962-1654

Long-Term Care Insurance Outline of Coverage

For Accelerated Death Benefit for Long-Term Care Services Rider
(*Lincoln Care Coverage*® Accelerated Benefits Rider "CCABR")
Rider Form LTC-7059

THIS RIDER DOES NOT QUALIFY FOR MEDICAID ASSET PROTECTION UNDER THE INDIANA LONG-TERM CARE PROGRAM. HOWEVER, THIS RIDER IS AN APPROVED LONG-TERM CARE INSURANCE POLICY UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE INDIANA LONG-TERM CARE PROGRAM, CALL THE SENIOR HEALTH INSURANCE INFORMATION PROGRAM OF THE DEPARTMENT OF INSURANCE AT 1-800-452-4800.

NOTICE TO BUYER: The Accelerated Death Benefit for Long-Term Care Services Rider may not cover all of the costs associated with long-term care incurred by the Insured during the period of coverage. The buyer is advised to review carefully all policy and rider limitations.

CAUTION: The issuance of the CCABR is based on the responses to the questions on your application for the rider and the policy to which it is attached. A copy of your application will be attached to any issued policy. If any answers in your application are incorrect or untrue, the Company has the right to deny benefits or rescind the rider. The best time to clear up any questions as to the accuracy of any answers in your application is now, before a claim arises! If, for any reason, any answers are incorrect, contact the Company at the Service Office address shown above.

1. INDIVIDUAL COVERAGE.

The CCABR is attached to, and made a part of, an individual life insurance policy.

2. PURPOSE OF OUTLINE OF COVERAGE.

This Outline of Coverage provides a very brief description of the important features of the CCABR. You should compare this Outline of Coverage to outlines of coverage for other policies and riders available to you.

This is not an insurance contract, but only a summary of coverage. Only the CCABR and the individual life insurance policy to which it is attached contain the governing contractual provisions. This means that the rider and the policy set forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY AND RIDER CAREFULLY AND IN THEIR ENTIRETY!

3. FEDERAL TAX CONSEQUENCES.

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

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

Renewability

THIS RIDER IS GUARANTEED RENEWABLE. This means that you have the right, subject to the terms of your policy and rider, to continue this rider in force for as long as your policy stays in force.

The Company cannot change any of the terms of your rider on its own. THE RATES USED TO CALCULATE THE MONTHLY RIDER CHARGE ARE SUBJECT TO CHANGE, BUT THE COMPANY WILL NOT INCREASE THOSE RATES ABOVE THE MAXIMUM RATES SHOWN IN YOUR POLICY.

Waiver of Monthly Rider Charges and Fees

The monthly rider charge and monthly administrative fee for the CCABR will be waived on the Monthly Anniversary Day immediately following the date a benefit under the CCABR is paid.

Policy and Rider Lapse Protection

If your policy would otherwise enter the grace period on any Monthly Anniversary Day immediately following the date a benefit under the CCABR is paid, the entire Monthly Deduction described in the policy, including the monthly rider charge and monthly administrative fee for the CCABR, will be waived and the policy and rider will not lapse. The death benefit available if the policy is kept in force under this provision is limited to the remaining LTC Specified Amount minus Debt as defined in the policy. Once benefits under the CCABR are no longer being paid, you may have to pay additional premium and/or repay outstanding Debt to prevent the policy and rider from lapsing.

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE RIDER CHARGE RATES.

The rates used to calculate the monthly rider charge are determined by the Company, but WILL NOT EXCEED THE MAXIMUM RATES SHOWN IN YOUR POLICY. The Company reserves the right to charge less than the maximum rates on a current basis. Any change to the current rates will apply to all riders in the same rider class and duration, and is subject to the guaranteed maximum rates shown in your policy. The Company will provide you with at least 60 days' notice prior to implementing any such change.

6. TERMS UNDER WHICH THE RIDER MAY BE RETURNED AND RIDER CHARGES REFUNDED.

The CCABR may be returned for any reason to the insurance agent through whom it was purchased, to any other insurance agent of the Company, or to the Company at the Service Office address shown above within 30 days after its receipt. If returned, the rider will be considered void from the beginning and the Company will refund all charges paid for the rider as a credit to the policy within 30 days.

Charges and fees deducted for the CCABR on the Monthly Anniversary Day immediately preceding the date the Insured dies will be returned as a credit to the policy.

If the CCABR is attached to a variable life insurance policy and you request to terminate the policy, charges and fees deducted for the rider on the Monthly Anniversary Day immediately preceding the date the policy and rider terminate will be returned as a credit to the policy.

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

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

8. LONG-TERM CARE COVERAGE.

Policies and riders of this category are designed to provide coverage for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home. These services are referred to as "Covered Services" in the CCABR, and are more fully defined in the rider.

The CCABR provides coverage by reimbursing costs incurred by the Insured during the period of coverage for Covered Services, subject to the terms and conditions of the rider.

9. BENEFITS PROVIDED BY THE RIDER.

The CCABR provides coverage for Covered Services by accelerating a percentage of an elected portion of the base policy's Specified Amount ("LTC Specified Amount"). The percentage and LTC Specified Amount you choose at issue, as well as the maximum monthly benefit amount as of the Policy Date available under the rider, are shown in your policy.

Once all Benefit Conditions, including the Elimination Period, listed in the rider and in the "Eligibility For the Payment of Benefits" section below are satisfied, the Company will pay an amount not to exceed the rider's maximum monthly benefit amount each Policy Month until the remaining LTC Specified Amount equals zero to reimburse the costs incurred and actually paid by the Insured for any Covered Service or combination of Covered Services (other than Caregiver Training), subject to the terms and conditions of the rider.

The Elimination Period is the period of time during which the CCABR does not provide benefits, other than benefits for Caregiver Training, as described in the rider. The Elimination Period is shown in your policy. No benefits, other than benefits for Caregiver Training, are payable under the rider during the Elimination Period. Benefits will not be retroactively paid for Covered Services received during the Elimination Period. The Elimination Period must be satisfied only once while the CCABR is in force.

The Elimination Period does not apply to Caregiver Training. The amount payable for all Caregiver Training provided while the rider is in force is limited to no more than the Caregiver Training Benefit Limit shown in your policy. Benefits paid for Caregiver Training will not reduce the available maximum monthly benefit amount or any remaining LTC Specified Amount.

Subject to the terms and conditions of the rider and the policy to which it is attached, the following Covered Services may be available for reimbursement to the extent that such services are qualified long-term care services prescribed in the plan of care:

INSTITUTIONAL BENEFITS

Assisted Living Facility Services

Qualified long-term care services, including room and board, provided to the Insured while he or she is confined to an Assisted Living Facility. An Assisted Living Facility is a facility (or a distinctly separate section of a facility) which is licensed or certified to operate as an Assisted Living Facility under the laws of the state or jurisdiction in which it is located to provide care for Chronically Ill individuals in exchange for monetary compensation. If the state or jurisdiction does not license or certify Assisted Living Facilities, then the facility must meet the criteria described in the rider.

Bed Reservation

The expense incurred by the Insured to reserve the Insured's bed in a Nursing Home while he or she is temporarily absent during a stay in a Nursing Home and is charged to reserve accommodations. The temporary absence can be for any reason with the exception of discharge. This includes, but is not limited to, a hospital stay or spending holidays or other time with family. This benefit is limited to no more than a total of 30 days each calendar year. The amount payable for Bed Reservation cannot exceed 1/30th of the rider's maximum monthly benefit amount for each day that the bed is reserved.

Nursing Home Care Services

Qualified long-term care services, including room and board, provided to the Insured while he or she is confined to a Nursing Home. A Nursing Home is a facility or distinctly separate area, section or wing of a hospital or other institution which is licensed or certified to operate as a Nursing Home under the laws of the state or jurisdiction in which it is located, and does so in exchange for monetary compensation. If the state or jurisdiction does not license or certify Nursing Homes, then the facility must meet the criteria described in the rider.

NON-INSTITUTIONAL BENEFITS

Adult Day Care Services

Care provided by a state licensed or certified program, for a specified number of individuals, providing social or health-related services, or both, 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 as defined in the rider.

Care Planning Services

Services provided for the Insured by a Care Planning Agency under the direction of a Licensed Health Care Practitioner. A Care Planning Agency is an agency or organization which is primarily engaged in providing care planning on behalf of its clients. The agency or organization must be licensed as a Care Planning Agency by the appropriate licensing agency in the state or jurisdiction in which care is to be received, if the state or jurisdiction licenses such agencies. If the state or jurisdiction does not license Care Planning Agencies, then the agency must meet the criteria described in the rider.

Caregiver Training

Training given to the Insured's unpaid caregiver by a properly accredited medical or instructional institution or by a qualified individual such as a licensed nurse to provide the unpaid caregiver with the knowledge and skills necessary to care for the Chronically Ill Insured. The Elimination Period does not apply to Caregiver Training. The total amount payable for Caregiver Training is limited to no more than the Caregiver Training Benefit Limit shown in your policy.

Home Health Care Services

Necessary and appropriate Home Health Care services which are prescribed in the Insured's plan of care and which are provided by a Home Health Care Agency to the Chronically Ill Insured at the Insured's Home as defined in the rider. "Home Health Care" means qualified long-term care services described in the rider which are provided to a Chronically Ill individual in his or her Home in exchange for monetary compensation. A Home Health Care Agency is an entity that is in the business of providing Home Health Care. The entity must meet at least one of the licensing, accrediting or certification criteria described in the rider. If an entity does not meet one or more of those criteria, then it must satisfy all of the conditions listed in the rider in order to qualify as a Home Health Care Agency.

Hospice Services

Services given to provide palliative care to alleviate the physical, emotional, social, and spiritual discomforts of the Insured who is in the terminal phases of life.

Respite Care Services

Short-term care services provided for the Insured in an institution, in the Insured's Home as defined in the rider, or in a community- based program to provide temporary relief for the Insured's unpaid

caregiver while the caregiver is unavailable to provide care. This benefit is limited to no more than a total of 21 days each calendar year. The amount payable for each day of Respite Care Services cannot exceed 1/30th of the rider's maximum monthly benefit amount.

Alternative Care Services

Qualified long-term care services that are not covered under any of the Covered Services listed above, but which are prescribed in the Insured's plan of care and which the Insured, the Insured's Licensed Health Care Practitioner and the Company mutually agree would be the most appropriate and cost-effective way to meet the Insured's long-term care needs. Alternative Care Services must be provided as an alternative to services otherwise covered under the rider, meaning that the Insured can not receive benefits under any other provision of the rider while he or she is receiving Alternative Care Services.

Non-Continual Services

Services which are received by the Insured on a non-recurring basis (such as expenses for durable medical equipment or for modifications to the Insured's Home as defined in the rider to accommodate a wheelchair or other device), which are prescribed in the Insured's plan of care, and which the Insured, the Insured's Licensed Health Care Practitioner and the Company mutually agree would be the most appropriate and cost-effective way to meet the Insured's long-term care needs. The total amount payable for Non-Continual Services in any calendar year cannot exceed the rider's maximum monthly benefit amount.

ELIGIBILITY FOR PAYMENT OF BENEFITS

The following Benefit Conditions must be met to qualify for benefits under the rider:

a. For all benefits other than Caregiver Training, the Elimination Period described in the rider must be satisfied.

b. The total benefits paid must not have reduced the remaining LTC Specified Amount to zero.

c. The Insured must be Chronically Ill as defined in the rider, due to either being unable to perform (without Substantial Assistance from another individual) at least 2 Activities of Daily Living for a period of at least 90 days as a result of loss of functional capacity, or requiring Substantial Supervision to protect the Insured from threats to health and safety caused by Severe Cognitive Impairment.

d. A Licensed Health Care Practitioner must certify to the Company that the Insured is Chronically Ill and that the Chronic Illness is expected to continue for at least 90 days.

e. A Licensed Health Care Practitioner must develop and prescribe a written plan of care as defined in the rider. The Insured must receive the Covered Services prescribed under the plan of care while the rider is in force.

f. At least once every 12 months after a Licensed Health Care Practitioner initially certifies that the Insured is Chronically Ill, and for as long as the Insured continues to be Chronically Ill, a Licensed Health Care Practitioner must again:

    1. certify to us that the Insured is Chronically Ill and that the Insured's Chronic Illness is expected to continue for at least 90 days; and

    2. either prescribe a new plan of care, or reconfirm the existing plan of care.

"Chronically Ill" means a state of health where the Insured:

1. is unable to perform (without Substantial Assistance as defined below from another individual) at least 2 of the Activities of Daily Living described below:
   a. for a period of at least 90 days; and
   b. as a result of loss of functional capacity; or
2. requires Substantial Supervision to protect the Insured from threats to health and safety caused by a Severe Cognitive Impairment, as defined below.

The 6 **"Activities of Daily Living"** are:

a. Bathing: The Insured's ability to wash himself or herself in a tub or shower (including the task of getting into or out of the tub or shower), or else to wash himself or herself by sponge bath.

b. Continence: The Insured's ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the Insured's ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).

c. Dressing: The Insured's ability to put on and take off all essential items of clothing and any necessary braces, fasteners or artificial limbs.

d. Eating: The Insured's ability to feed himself or herself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

e. Toileting: The Insured's ability to get to and from the toilet, get on and off the toilet, and perform personal hygiene associated with the use of the toilet.

f. Transferring: The Insured's ability to get into or out of a typical bed, chair, or wheelchair.

"Severe Cognitive Impairment" means severe deterioration or severe loss in the Insured's intellectual capacity that is measured and confirmed by objective clinical evidence and standardized tests that reliably identify and measure severe impairment in the following areas:

1. the Insured's short- or long-term memory;
2. the Insured's orientation as to person (such as who they are), place (such as their location), and time (such as day, date, and year); and
3. the Insured's deductive or abstract reasoning, including judgment as it relates to safety awareness.

"Substantial Assistance" means hands-on assistance, or the presence of another person within arm's reach, which is necessary to assist the Chronically Ill Insured with the performance of an Activity of Daily Living by physical intervention, and to prevent injury to the Insured while the Insured is performing an Activity of Daily Living.

"Substantial Supervision" means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person who is physically present with the Chronically Ill Insured that is necessary to protect the Insured from death or serious threats to the Insured's health or safety arising from the Insured's Severe Cognitive Impairment.

10. LIMITATIONS AND EXCLUSIONS.

Pre-Existing Conditions

The rider does not exclude pre-existing conditions.

Non-eligible Facilities or Providers

The rider does not cover services provided by a facility or an agency that does not meet the rider definition for such facility or agency, except as provided under Alternative Care Services. The rider does not cover services provided by unlicensed providers, or services provided by an Immediate Family Member as defined in the rider, unless the Immediate Family Member providing the service meets the criteria described in the rider.

Non-eligible Levels of Care

The rider only covers services that are qualified long-term care services (as defined in the rider) which are prescribed in the plan of care. The rider does not cover services which do not meet those criteria.

Exclusions, Exceptions and Limitations

The rider will not provide benefits for:

a. treatment or care due to alcoholism or drug addiction;

b. treatment arising out of an attempt (whether sane, mentally or psychologically impaired, or insane) at suicide or an intentionally self-inflicted injury;

c. treatment provided in a Veteran's Administration or government facility, unless the Insured or the Insured's estate is charged for the confinement or services or unless otherwise required by law;

d. loss to the extent that benefits are payable under any of the following:

   1. Medicare (including that which would have been payable but for the application of a deductible or a coinsurance amount). This means that the rider does not pay for the Insured's Medicare deductibles or coinsurance;
   2. other governmental programs (except Medicaid);
   3. state or federal workers' compensation laws;
   4. employer's liability laws;
   5. occupational disease laws; and
   6. any motor vehicle no-fault laws;

e. confinement or care received outside the United States or its territories and possessions, other than benefits for Nursing Home Care Services and Assisted Living Facility Services as described in the "International Benefits" provision below;

f. services provided by a facility or an agency that does not meet the rider definition for such facility or agency, except as provided under Alternative Care Services;

g. services provided by an Immediate Family Member, unless the Immediate Family Member providing the service meets the criteria described in the rider; and

h. services for which no charge is or would normally be made in the absence of insurance.

International Benefits

The rider provides for benefits for Nursing Home Care Services or Assisted Living Facility Services received outside of the United States or its territories and possessions (collectively, "United States"), subject to the terms and conditions described in the rider. The amount payable each Policy Month for such services is limited to the rider's maximum monthly benefit amount. No benefits are payable under the rider for any Covered Services received outside of the United States other than Nursing Home Care Services or Assisted Living Facility Services.

Reduction of Benefit Payment Due to Debt

A benefit paid under the rider will first be used to repay a portion of any outstanding Dept as described in the rider.

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

11. RELATIONSHIP OF COST OF CARE AND BENEFITS.

Because the cost of long-term care services will likely increase over time, you should consider whether and how the benefits provided under the rider may be adjusted. The LTC Specified Amount will not automatically increase over time, and you cannot request to increase the LTC Specified Amount after the policy is in force.

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

The rider will provide benefits for qualified long-term care services prescribed in the plan of care resulting from a clinical diagnosis of Alzheimer's Disease or related degenerative and dementing illnesses.

13. RIDER CHARGES.

The monthly rider charge and monthly administrative fee for the CCABR will be deducted as part of the policy's Monthly Deduction. The monthly administrative fee for the rider and the guaranteed maximum cost of insurance rates used to calculate the monthly rider charge are shown in your policy.

14. ADDITIONAL FEATURES.

Medical Underwriting

The issuance of the rider is subject to medical underwriting.

15. State Health Insurance Assistance Program (SHIIP)

Indiana Department of Insurance
311 W. Washington St.
Indianapolis, IN 46204

Phone: 800-452-4800
Local: 317-232-3616
Fax: 317-234-9633
www.medicare.in.gov

SHIIP is a free health insurance counseling program for Indiana's seniors. SHIIP counselors can assist with questions regarding Medicare, Medicare Supplement insurance, Medicare Advantage Plans, Medicare Prescription Drug Plans, and Long Term Care insurance.

Indiana Long Term Care Insurance Program (ILTCIP)
Indiana Department of Insurance
311 W. Washington St.
Indianapolis, IN 46204

Phone: 1-866-234-4582 or 317-232-2187
Fax: 317-232-5251
www.longtermcareinsurance.in.gov

The ILTCIP (also known as the Indiana Partnership Program) is an innovative public-private partnership pairing the State government agencies of Insurance and Medicaid with private long term care insurance companies. Indiana Partnership long-term care insurance policies include the state-added benefit of Medicaid Asset Protection at no additional cost. Medicaid Asset Protection protects assets from Medicaid spend down and Medicaid estate recovery. This protection is important should the policyholder use up all his/her policy benefits, continue to need care, and choose to access Medicaid assistance.