AdvanceSource ® Accelerated Benefit Rider

Long-Term Care Insurance - Outline of Coverage
Accelerated Benefit Rider for Long-Term Care - Form Series 114930

The issuance of this rider is based upon the Owner's (referred to as You and Your in this Outline of Coverage) and the Insured's (if the Owner is not the Insured) responses to the questions in the application for the policy and the rider. A copy of Your application for the policy and the rider will be attached to the policy. If Your or the Insured's answers are incorrect or untrue, RiverSource Life Insurance Company (referred to as We, Us, and Our) has the right to deny benefits or rescind Your policy and this rider. The best time to clear up any questions is now, before a claim arises. If, for any reason, any of Your or the Insured's answers are incorrect, contact Us at: RiverSource Life Insurance Company, 70100 Ameriprise Financial Center, Minneapolis, MN 55474.

NOTICE TO OWNER: The rider may not cover all of the costs associated with long-term care services incurred by the Insured. You should carefully review all policy and rider provisions and limitations.

1. The AdvanceSource Accelerated Benefit rider is attached to an individual life insurance policy.

2. PURPOSE OF THE OUTLINE OF COVERAGE. This Outline of Coverage provides a very brief description of the important features of the AdvanceSource Accelerated Benefit rider. 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 rider and the individual life insurance policy to which it is attached contain the governing contractual provisions. Therefore, if You purchase this coverage, or any other coverage, it is important that You READ YOUR POLICY AND RIDER CAREFULLY.

3. FEDERAL TAX CONSEQUENCES. The rider is intended to be federally tax-qualified long-term care insurance under

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6. TERMS UNDER WHICH THE RIDER MAY BE RETURNED, AND RIDER CHARGES REFUNDED. If for any reason You are not satisfied with the rider, return it to Us or our representative within 30 days after You receive it. We will then cancel the rider and refund any cost You have paid for it. The rider will then be considered void from its start.

7. THE 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 RiverSource Life Insurance Company nor its agents represent Medicare, the federal government or any state government.

8. LONG-TERM CARE COVERAGE. Policies and riders providing long-term coverage are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as a nursing home, in the community or in the home.

   This rider provides coverage in the form of an indemnity benefit payment for Qualified Long-Term Care Services based on the number of service days, subject to policy and rider limitations, exclusions and Elimination Period requirements. Benefit payments will be paid to You.

9. BENEFITS PROVIDED BY THE RIDER. We will pay an acceleration of the policy death benefit each month, limited by the Maximum Monthly Benefit, as a result of the Insured being a Chronically Ill Individual who is receiving Qualified Long-Term Care Services. We will pay a proportionate amount of the Maximum Monthly Benefit for each date of Qualified Long-Term Care Services rendered. Benefits will be paid until the Rider Specified Amount has been exhausted. All benefits are subject to the provisions of the rider. Rider benefits paid will also change other values of the life insurance policy as provided in the rider.

   Eligibility for Payments of Benefits. We must receive the following documentation before any benefits are payable:

   1. A current written eligibility certification from a Licensed Health Care Practitioner that certifies that the Insured is a Chronically Ill Individual;
   2. Proof that the Insured received or is receiving Qualified Long-Term Care Services pursuant to a Plan of Care;
   3. Proof that the Elimination Period has been satisfied; and
   4. Written Notice of a Claim and Proof of Loss, as described in the Claim Provisions, in a form satisfactory to Us.

   In addition:

   1. Coverage under this rider is In Force on the date(s) care is received; and
   2. The Insured meets the additional requirements specific to any International Benefits claimed.

   Definition of Terms

   Chronically Ill Individual. An individual who has been certified by a Licensed Health Care Practitioner as:

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

   Activities of Daily Living means the following activities: bathing, continence, dressing, eating, toileting and transferring.

   Elimination Period.
   The number of calendar days, beginning the first day the Insured first receives a Qualified Long-Term Care Service and is Chronically Ill, that are required while this rider is In Force before any benefit is available under this rider. The Elimination Period is shown under Policy Data. Once the Elimination Period begins, each calendar day counts toward the Elimination Period as long as the Insured remains Chronically ill, regardless if they receive a Qualified Long-Term Care Service on a day. The calendar days need not be continuous. If the Insured does not remain Chronically Ill during the entire period, multiple occurrences of being Chronically Ill can be used to satisfy the

Elimination Period; however, the Elimination Period must be satisfied within a period of 730 consecutive days. The Elimination Period must be satisfied only once while this rider is In Force. Benefits will not be retroactively paid for the Elimination Period.

Maximum Monthly Benefit. The maximum monthly amount payable is the lesser of:

1. The Rider Specified Amount multiplied by the Monthly Benefit Percent;
2. The monthly equivalent of the per diem limit allowed by the Health Insurance Portability and Accountability Act; or
3. The Remaining Amount to be Accelerated.

Licensed Health Care Practitioner. A Physician, registered professional nurse, a licensed social worker, or any other individual who meets the requirements as provided by the U.S. Secretary of the Treasury.

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

1. Required for treatment of a Chronically Ill Individual;
2. Provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner; and
3. Provided in a Nursing Home Facility, an Assisted Living Facility, an Adult Day Care Center, Hospice Care Facility, Home Health Care Agency, or by an approved Independent Home Health Care Provider.

Nursing Home Facility. A facility that provides skilled nursing care, intermediate care, or custodial care, and is licensed or certified by the appropriate state licensing agency. If the facility is not licensed, it must meet certain criteria listed in the rider.

Assisted Living Facility. A licensed facility that is engaged primarily in providing ongoing care and related services to inpatients in one location. If not licensed or certified by the state, it must meet certain criteria listed in the rider.

Home Health Care Provider. Either a Home Health Agency or an Independent Home Health Care Provider that provides Home Health Care.

Hospice Care Facility. A facility that is appropriately licensed or certified to provide Hospice Care in the state in which it operates.

Adult Day Care Center. A facility that provides a protective environment and preventive, remedial and restorative services for part of the 24-hour day and meets the criteria listed in the rider.

10. LIMITATIONS AND EXCLUSIONS.

(a) Pre-existing conditions. No benefits will be provided under this rider during the first six months for Qualified Long-Term Care Services received by the Insured due to a pre-existing condition. A pre-existing condition is a condition for which medical advice or treatment was received by or recommended to the Insured from a provider of health care services within six months preceding the effective date of the rider. Calendar days of services received by the Insured for a pre-existing condition during the first six months that this rider is In Force will not be counted toward the satisfaction of the Elimination Period.

(b) Non-eligible Facilities/Providers and Level of Care. The rider does not cover services provided by a facility or an agency that does not meet the rider definition of such facility or agency.

(c) Exclusions, Exceptions, and Limitations. The rider does not cover treatment or care:

1. Provided to the Insured when the business or organization providing such care is owned or operated by an Immediate Family member;
2. Provided by the Insured's Immediate Family unless:
   a. the Immediate Family member is an employee of the business or organization providing the treatment, service or care; and
   b. the business or organization received payment for the treatment, service or care.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, You should consider whether and how the benefits of this plan may be adjusted. The rider does not include inflation protection coverage and therefore the benefit level will not increase over time.

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS. The rider will cover Qualified Long-Term Care Services resulting from a clinical diagnosis of Alzheimer's disease or related degenerative and dementing illnesses that result in the Insured's Severe Cognitive Impairment.

13. RIDER CHARGES. The charge for the rider is included in the total policy's value as long as the rider is In Force, but not while rider benefits are being paid and not beyond the age where the policy cost of insurance is no longer charged. The rate for the rider varies by the Insured's sex, issue age, risk class, duration and the monthly benefit percentage selected as shown under Policy Data.

14. ADDITIONAL FEATURES.
Underwriting. Issuance of this coverage may depend upon certain medical information about the Insured. This is generally known as medical underwriting.

Reinstatement. If the policy and rider Terminate due to lapse and the rider was In Force on the date of lapse, We will provide a retroactive continuation of coverage if, within five months of the date of lapse, the Insured, or the Insured's representative, provides satisfactory proof to Us that the Insured was a Chronically Ill Individual on the date of lapse and We receive the required reinstatement payment amount.

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

Phone: 1-866-234-4582 or 317-232-2197
Fax: 317-232-5251
www.longtermcareinsurance.in.go

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.