The Lincoln National Life Insurance Company
("the Company")
A Stock Company
Service Office: One Granite Place, PO Box 515, Concord, New Hampshire 03302-0515
(800) 962-1654

Long-Term Care Insurance Outline of Coverage

For Long-Term Care Acceleration of Benefits Rider LR881
and Long-Term Care Extension of Benefits Rider LR882

NOTICE TO BUYER: The riders described in this outline 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 Long-Term Care Acceleration of Benefits Rider and Long-Term Care Extension of Benefits Rider, if applicable, described in this outline is based on the responses to the questions on your application for such rider(s). A copy of your application will be attached to any issued policy. If any answers are incorrect or untrue, the Company has the right to deny benefits or rescind these rider(s). The best time to clear up any questions 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 Long-Term Care Acceleration of Benefits Rider ("LABR") and Long-Term Care Extension of Benefits Rider ("LEBR"), if applicable, described in this outline are 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 LABR and LEBR. 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 riders and the individual life insurance policy to which they are attached contain the governing contractual provisions. This means that the riders 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 RIDERS CAREFULLY!

3. FEDERAL TAX CONSEQUENCES.

The LABR and LEBR are 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 THESE RIDERS MAY BE CONTINUED IN FORCE OR DISCONTINUED.

Renewability

THESE RIDERS ARE NON-CANCELABLE. This means that you have the right, subject to the terms of your policy and rider(s), to continue these riders in force for as long as your policy stays in force. The Company cannot change any of the terms of your policy and rider(s) on its own and cannot increase the monthly rider charges or monthly inflation charges, if applicable.

Waiver of Premium

These riders do not contain a waiver of premium or waiver of rider charge provision.

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE RIDER CHARGES.

The Company cannot increase the monthly rider charges and monthly Optional Inflation Protection charges, as applicable.

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

These riders may be returned for any reason to the insurance agent through whom they were purchased or to the Company at the Service Office address shown above within 30 days after you receive them. If returned, the rider(s) will be considered void from the beginning and the Company will refund all charges paid for these riders.

These riders do not contain provisions providing for a refund or partial refund of rider charges or inflation charges, if applicable, upon the death of the Insured or upon the surrender of the rider(s) or policy.

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the Company. 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 or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home. These services are referred to as Covered Services and are more fully defined in the LABR.

The LABR and LEBR provide coverage by reimbursing costs incurred by the Insured during the period of coverage for Covered Services, subject to the terms and conditions of the riders.

9. BENEFITS PROVIDED BY THESE RIDERS.

Benefits are provided under the LABR until that rider's benefit limit has been exhausted. The LEBR extends the benefits provided by the LABR after the LABR's benefit limit has been exhausted.

For all Covered Services other than Caregiver Training, the Company will pay an amount up to the maximum monthly benefit to reimburse the costs incurred by the Insured during the period of coverage for any Covered Service or combination of Covered Services listed below, subject to the terms and conditions of the rider then in effect. The benefits paid in any one calendar month for any Covered Service or combination of Covered Services (other than Caregiver Training) will not exceed the maximum monthly benefit for the rider then in effect. The total benefits paid will not exceed the benefit limit as defined in each rider. The benefit limit and maximum monthly benefit for the LABR and for the LEBR, if applicable, are shown in the table attached to this Outline of Coverage.

The amount payable for all Caregiver Training provided while the Insured is covered under the LABR and under the LEBR, if applicable ("Caregiver Training Benefit Limit") is shown in the table attached to this Outline of Coverage. Benefits paid for Caregiver Training will not reduce the available maximum monthly benefit or any remaining benefit limit under the riders.

Subject to the terms and conditions of the riders, the Company will reimburse expenses incurred by the Insured for the following Covered Services to the extent that such services are qualified long-term care services prescribed in the plan of care:

INSTITUTIONAL BENEFITS

Assisted Living Facility Services

Services that are provided to the Insured while he or she is confined or living in an Assisted Living Facility. An Assisted Living Facility is a separate facility (or a specifically dedicated section of a facility) which is licensed and operates as an Assisted Living Facility according to the laws of the jurisdiction in which it is located to provide care for Chronically Ill individuals. If the jurisdiction does not license or certify Assisted Living Facilities, then the facility must meet the criteria described in the LABR.

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 30 days each calendar year. The amount payable for this benefit cannot exceed 1/30th of the maximum monthly benefit of the rider then in effect for each day that the bed is reserved.

Nursing Home Care Services

Services that are provided to the Insured while he or she is confined to a Nursing Home. A Nursing Home is a facility or distinctly separate part of a hospital or other institution which is licensed and operates as a Nursing Home according to the laws of the jurisdiction in which it is located. If the jurisdiction does not license or certify Nursing Homes, then the facility must meet the criteria described in the LABR.

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.

Care Planning Services

Services provided for the Insured by a Care Planning Agency under the direction of the 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 by the appropriate state licensing agency as a Care Planning Agency, if the jurisdiction licenses such agencies. If the jurisdiction does not license Care Planning Agencies, then the agency must meet the criteria described in the LABR.

Caregiver Training

Training given to the primary caregiver by a properly accredited medical or instructional institution or by a qualified individual such as a licensed nurse to provide the primary caregiver with the knowledge and skills necessary to care for the Chronically Ill Insured. The amount payable for all Caregiver Training provided while the Insured is covered under the LABR and under the LEBR, if applicable, is limited to no more than the Caregiver Training Benefit Limit shown in the table attached to this Outline of Coverage.

Home Health Care Services

Medical or non-medical services prescribed in the plan of care which are provided by a Home Health Care Agency to the Chronically Ill Insured at the Insured's Home. A Home Health Care Agency is an entity that is primarily engaged in providing residential health care services under policies and procedures established by a group of professionals, including at least one physician and one nurse. The agency must meet at least one of the licensing, accrediting or certification criteria described in the LABR.

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 home, or in a community-based program to provide temporary relief for the primary caregiver. Such services may be provided by skilled or unskilled persons. This benefit is limited to no more than 21 days each calendar year. The amount payable for this benefit cannot exceed 1/30th of the maximum monthly benefit of the rider then in effect for each day of Respite Care Services.

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 plan of care and which your Licensed Health Care Practitioner and the Company mutually agree would be appropriate to meet the Insured's long-term care needs. These services must be provided as an alternative to services otherwise covered under the riders.

Non-Continual Alternative Care Services

Alternative Care Services which are received on a one-time basis, such as expenses for durable medical equipment or for modifications to the Insured's home to accommodate a wheelchair or other device. This benefit is limited to no more than one claim in a 12 month period. The amount payable for this benefit in any 12 month period cannot exceed the maximum monthly benefit of the rider then in effect.

ELIGIBILITY FOR PAYMENT OF BENEFITS

The following conditions must be met to qualify for benefits under these riders:

a. To qualify for benefits under the LABR, the total benefits paid under that rider must not have reduced the LABR's remaining benefit limit to zero. To qualify for benefits under the LEBR:

   1. payments for Covered Services under the LABR must have reduced the remaining benefit limit under the LABR to zero; and

   2. the total benefits paid under the LEBR must not have reduced the LEBR's remaining benefit limit to zero.

b. A Licensed Health Care Practitioner must certify to the Company that the Insured is Chronically Ill and that the illness is expected to continue for at least 90 days. "Chronically Ill" means that the Insured has been certified by a Licensed Health Care Practitioner as:

   1. being unable to perform (without Substantial Assistance as defined below from another individual) at least 2 of the Activities of Daily Living described below, for a period of at least 90 days as a result of loss of functional capacity; or

2. requiring Substantial Supervision to protect the Insured from threats to health and safety caused by Severe Cognitive Impairment, as defined below.

c. A Licensed Health Care Practitioner must prescribe a plan of care in writing prescribing services, including Covered Services, that are to be provided to the Insured. The Insured must receive the Covered Services prescribed under the plan of care while these riders are in force.

d. At least once every 12 months thereafter, and for as long as the Insured continues to be Chronically Ill, a Licensed Health Care Practitioner must again:

   1. certify that the Insured is Chronically Ill. If the Insured's chronic illness is caused by loss of functional capacity, the Licensed Health Care Practitioner must again certify 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 in writing.

"**Activities of Daily Living**" are the 6 functional abilities which relate to the Insured's ability to live independently. They are:

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

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 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 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 associated personal hygiene.

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

"**Severe Cognitive Impairment**" means significant deterioration or significant loss in the Insured's intellectual capacity that is measured and confirmed by clinical evidence and standardized tests that reliably measure 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 that is necessary to prevent, by physical intervention, injury to the Insured while the Insured is performing the Activities of Daily Living.

"**Substantial Supervision**" means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the Severely Cognitively Impaired Insured from threats to his or her health or safety (such as may result from wandering).

10. LIMITATIONS AND EXCLUSIONS.

Pre-Existing Conditions

These riders do not exclude pre-existing conditions.

Non-eligible Facilities or Providers

These riders do 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. These riders do not cover services provided by unlicensed providers, or services provided by a member of the Insured's or owner's immediate family or for which no charge is normally made in the absence of insurance, unless the immediate family member providing the service meets the criteria described in the LABR.

Non-eligible Levels of Care

These riders only cover services that are qualified long-term care services (as defined in the LABR) which are prescribed in the plan of care. These riders do not cover services which do not meet those criteria.

Exclusions, Exceptions and Limitations

These riders will not provide benefits for:

a. treatment for alcoholism or drug addiction (unless the drug addiction is a result of medication taken in doses as prescribed by a physician);

b. treatment arising out of an attempt (while sane 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 these riders do 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 provided under the LABR as described 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; and

g. services provided by a member of the Insured's or Owner's immediate family or for which no charge is normally made in the absence of insurance, unless the immediate family member providing the service meets the criteria described in the LABR.

International Benefits

The LABR 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 LABR. The amount payable each calendar month for such services is limited to the maximum monthly benefit available under the LABR. No benefits are payable under the LABR for any Covered Services received outside of the United States other than Nursing Home Care Services or Assisted Living Facility Services.

No benefits are payable under the LEBR for any Covered Service, confinement or care received outside of the United States.

THESE RIDERS 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 these riders may be adjusted.

The LABR and LEBR provide for Optional Inflation Protection coverage. If you don't reject Optional Inflation Protection by signing the rejection statement in the application for these riders, the maximum monthly benefit and benefit limit for the LABR and the LEBR, if applicable, will automatically increase on each policy anniversary while the rider(s) are in force. The amount of the annual increase will depend upon the Optional Inflation Protection option that is in effect. The available options are 3% Compound Increases and 5% Compound Increases.

The monthly rider charges and monthly inflation charges will remain level and will not increase annually as rider benefits increase.

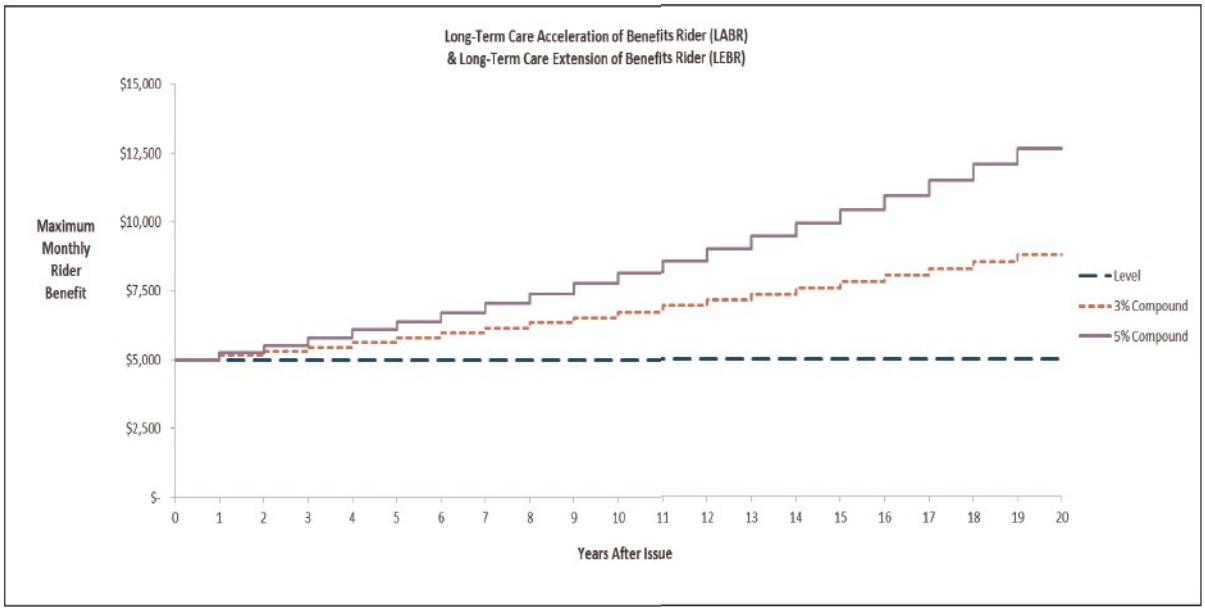
If you reject Optional Inflation Protection by signing the rejection statement in the application for these riders, you will not be able to increase your benefits later. These riders do not provide a guaranteed option to buy additional insurance.

The chart below gives examples of the monthly Optional Inflation Protection charges for each available option. The example shown is for a maximum monthly benefit of $5,000 with a 2 year LABR duration and a 2 year LEBR duration issued with Standard rates.

Your actual monthly Optional Inflation Protection charges will be different from the examples shown if your rate class is other than Standard, or if you select a different combination of LABR duration and LEBR duration. The Optional Inflation Protection charges based upon the rider durations and Optional Inflation Protection option, if any, you chose are shown in the table attached to this Outline of Coverage.

Monthly Optional Inflation Protection Charges for $5,000 of Maximum Monthly Benefit LABR Duration is 2 Years; LEBR Duration is 2 Years				
Issue Age	Inflation Protection			
	3% Compound Increases		5% Compound Increases	
	LABR	LEBR	LABR	LEBR
Male 45	$141.06	$50.40	$326.31	$138.60
Male 55	$147.54	$48.12	$328.48	$129.96
Male 65	$153.68	$49.32	$331.41	$130.44
Male 75	$173.42	$59.64	$343.69	$153.24
	LABR	LEBR	LABR	LEBR
Female 45	$220.85	$147.12	$531.14	$297.12
Female 55	$222.54	$134.16	$581.46	$277.92
Female 65	$251.49	$136.08	$585.13	$268.44
Female 75	$282.32	$161.76	$596.73	$339.36

The graph below provides a comparison of the maximum monthly benefit provided by each rider with the options available to you: level benefits (no Optional Inflation Protection); 3% Compound Increases; and 5% Compound Increases.



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

These riders 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 charges and monthly inflation charges, for the LABR and the LEBR, as applicable will be deducted each month from the cash value of the policy to which they are attached. These charges, and the time period during which they are assessed, are shown in the table attached to this Outline of Coverage, and will also be shown on the policy schedule of the issued policy.

14. ADDITIONAL FEATURES.

Medical Underwriting

The issuance of these riders is subject to medical underwriting.

Nonforfeiture

The Nonforfeiture Benefit provision in each rider provides for a limited amount of paid-up long-term care insurance if the policy and rider(s) lapse after having been in force for at least 3 years, subject to the terms and conditions of the provision. There is no additional charge for this benefit.

15. CONTACT THE STATE AGENCY LISTED IN "A SHOPPER'S GUIDE TO LONG-TERM CARE INSURANCE" OR THE CHOICES PROGRAM AT (800) 994-9422 IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE LINCOLN NATIONAL LIFE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING THE LONG-TERM CARE ACCELERATION OF BENEFITS RIDER OR LONG-TERM CARE EXTENSION OF BENEFITS RIDER DESCRIBED IN THIS OUTLINE.