



NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, New York 10010
New York Life, Long Term Care

(800) 224-4582

NURSING FACILITY AND RESIDENTIAL CARE FACILITY ONLY INSURANCE POLICY

Insured: INSURED

Policy No: Policyno

Policy Effective Date: Policydt

FEDERAL TAX-QUALIFIED COVERAGE: THIS CONTRACT FOR LONG-TERM CARE INSURANCE IS INTENDED TO BE A FEDERALLY QUALIFIED LONG-TERM CARE INSURANCE CONTRACT AND MAY QUALIFY YOU FOR FEDERAL AND STATE TAX BENEFITS.

This Policy has many important features. **Please read it carefully!** This Policy is a legal contract between You and New York Life Insurance Company. We have issued this Policy and will pay its benefits in consideration of Your Application and payment of required premiums.

IMPORTANT POLICY PROVISIONS

Guaranteed Renewable

THIS POLICY IS GUARANTEED RENEWABLE. This means You have the right, subject to the terms of this Policy, to continue this Policy as long as You pay the premiums on time. New York Life cannot change any of the terms of this Policy on its own, except that in the future it may increase premiums You pay. We cannot change this Policy without Your consent, unless required by federal or state law, but We may change the premium rates.

Premium Rate Changes

New York Life has the right to change the premium rates for this Policy. Premium rate increases are subject to Insurance Department approval, will be made only on a *Class* basis and will take effect on a Policy Anniversary Date. We will notify You at least 60 days prior to such premium change.

Premiums may also change based on any changes that You request to Benefits, as described in the Increase in Benefits and Lower Benefit Plan provisions of the Policy.

30 Day Right to Examine This Policy

You have 30 days from the day You receive this Policy to examine and return it to Us. If You are not satisfied with this Policy for any reason within 30 days of receipt, You may return it to Us or Your producer. Upon Our receipt of any Policy You have returned within the initial 30 days, We will return any premium paid and coverage will be void from the start.

NOTICES TO INSUREDS

Caution: The issuance of this Long-Term Care Insurance Policy is based upon Your responses to the questions on Your Application. A copy of Your Application is enclosed in this Policy. If Your answers are misstated or untrue, New York Life Insurance Company may have the right to deny benefits or rescind this 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 New York Life Insurance Company, Long-Term Care, PO Box 149009, Austin, Texas 78714-9955.

Notice To Buyer: This Policy may not cover all the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

THIS POLICY IS AN APPROVED LONG-TERM CARE INSURANCE POLICY UNDER CALIFORNIA LAW AND REGULATIONS. HOWEVER, THE BENEFITS PAYABLE BY THIS POLICY WILL NOT QUALIFY FOR MEDI-CAL ASSET PROTECTION UNDER THE CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE.

FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE, CALL THE HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM AT THE TOLL-FREE NUMBER 1 (800) 434-0222.

No Preexisting Condition Limitations

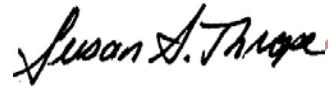
A Preexisting Condition is an injury or sickness for which You received medical advice or treatment during the 6 months prior to the Policy Effective Date. This Policy while it is in force pays benefits for Eligible Charges incurred as a result of Preexisting Conditions.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY: If You are eligible for *Medicare*, review *The Guide to Health Insurance For People With Medicare* available from Us.

This Policy is signed for New York Life Insurance Company by:



President



Secretary

COUNTERSIGNED _____

Licensed Resident Agent (Where required by law)

INFORMATION AND COUNSELING

The California Department of Insurance has prepared a Consumer Guide to Long-Term Care Insurance. This guide can be obtained by calling the California Department of Insurance toll-free number. This number is 1-800-927-HELP. Additionally, the Health Insurance Counseling and Advocacy Program (HICAP), administered by the California Department of Aging, provides long-term care insurance counseling to California senior citizens. Call the HICAP toll-free number 1-800-434-0222 for referral to Your local HICAP office.

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Specimen

Specimen

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GLOSSARY

Some words or phrases have special meanings when used in this Policy. These words or phrases are in *Italics* to help You recognize them where they appear. These words and phrases are either included in the Glossary or defined when they first appear in this Policy.

“You,” “Your,” and “Yourself” refer to the person listed on the Schedule of Benefits as the Insured and may, if the context would indicate, to the Policy Owner if different from the named Insured.

“We,” “Our,” and “Us” refer only to New York Life Insurance Company also herein called New York Life.

Activities of Daily Living (ADLs)

Activities of Daily Living means the basic functions We will use to determine Your functional capacity. The *Activities of Daily Living* used in this Policy are:

1. *Bathing*, means washing Yourself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.
2. *Continence*, means Your ability to maintain control of bowel and bladder functions; or when unable to maintain control of bowel or bladder functions, the ability to perform associated personal hygiene (including caring for 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 Yourself by getting food into Your body from a receptacle (such as a plate, cup or table) 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.

Assessment

Assessment means an evaluation to determine or verify the degree of loss of Your functional capacity or cognitive ability at the time of initial claim and as needed during the period for which You continue to claim benefits under this Policy.

Benefit

Benefit means a policy provision under which benefits may be payable, (e.g. the *Nursing Facility and Residential Care Facility Benefit*). The terms “benefit” and “benefits,” shown in regular type, refer to amounts We pay or have paid under this Policy.

GLOSSARY

Care Coordinator

Care Coordinator means an organization or individual designated by Us, to:

- Conduct the initial *Assessment* We request under this Policy to determine Your eligibility for benefits under this Policy;
- Prepare a *Plan of Care* for Our Insureds;
- Prepare, at Our request, when appropriate, a *Chronically Ill Individual* certification;
- Conduct any additional *Assessments* We request to determine your continued eligibility for benefits during the period of time You may be claiming benefits under this Policy; and
- Perform other duties requested by Us to insure You are eligible for benefits and You are receiving the care and services You need.

The *Care Coordinator* will be a *Licensed Health Care Practitioner* whose profession and training include experience in managing and arranging for Long-Term Care Services, or an organization that includes such health care professionals. Only a *Licensed Health Care Practitioner* can prepare a *Plan of Care* or certify that You are a *Chronically Ill Individual*.

Chronically Ill Individual

Under this provision, a *Chronically Ill Individual* means any individual who has been certified by a *Licensed Health Care Practitioner* as:

- Being unable to perform, without *Standby Assistance or Hands-on Assistance* from another individual, at least 2 *Activities of Daily Living* due to a loss of functional capacity which is expected to last at least 90 days; or
- Requiring *Substantial Supervision* to protect You from threats to health and safety due to *Severe Cognitive Impairment*.

Class

Class means individuals in Your state who are:

- Covered under the same policy form with similar benefit design; and
- Classified under the same risks for rating purposes.

Same policy form as used in this Policy refers to policy form series # 5000.

GLOSSARY

Cognitive Impairment

Cognitive Impairment means a deficiency in a person's:

- Short or long-term memory;
- Orientation as to person, place, and time;
- Deductive or abstract reasoning; or
- Judgment as it relates to safety awareness.

The loss or deterioration of intellectual ability is determined using reliable tests and clinical evidence demonstrating the impairment.

Loss of intellectual ability can result from Alzheimer's Disease or similar forms of senility or irreversible dementia or other mental illness.

Cognitive Impairment such that You require continual *Substantial Supervision* to protect Yourself or others from threats to health and safety will be considered *Severe Cognitive Impairment*.

Eligible Charges

Eligible Charges means charges You incur for services for which benefits may be payable under the terms of this Policy.

Elimination Period

Elimination Period means the initial number of days on which You receive care or services covered under this Policy and for which no benefit is payable by Us. The number of days in Your *Elimination Period* is shown on the Schedule of Benefits. The days counted for meeting Your *Elimination Period* do not need to be consecutive, but only service days are counted. Any day You receive care or services covered under this Policy for which payment is made by another payor, such as *Medicare*, will be counted as satisfying a day of Your *Elimination Period*. Only one *Elimination Period* needs to be satisfied during the lifetime of this Policy.

Family Member

Family Member means You, Your spouse, children, brothers, sisters and parents.

Family Member does not include a member of Your family who is a regular employee of an organization which is providing Long-Term Care Services covered by this Policy; and the organization receives the payment for the services; and the member of Your family receives no compensation other than the normal compensation for employees in his or her job category.

Hands-On Assistance

Hands-On Assistance means physical assistance of another person without which You would not be able to perform the *Activity of Daily Living*.

Hospice

Hospice means an agency or organization properly licensed as a *Hospice* in the location where it is located or the services are provided. Hospice may also mean a facility, although the State of California does not license hospice facilities.

GLOSSARY

Hospice Care Services

Hospice Care Services are outpatient services not provided by Medicare, that are designed to provide palliative care, to alleviate the physical, emotional, social and spiritual discomforts of individuals who are experiencing the last phases of life due to the existence of a *Terminally Ill* condition, and to provide supportive care to the primary caregiver and the family. A skilled or unskilled person may provide *Hospice Care Services* under a *Plan of Care* developed by a *Physician* or a multidisciplinary team under medical direction. *Hospice Care Services* must be provided by a *Hospice*. However, the care and services can be provided in a setting other than a *Hospice* facility as long as they are provided by a *Hospice*.

Licensed Health Care Practitioner

Licensed Health Care Practitioner means any physician as defined in section 1861(r)(1) of the Social Security Act, or any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury for non-physicians to certify individuals as *Chronically Ill Individuals*.

Nursing Facility

Nursing Facility means a facility or separate portion of a facility that is operated primarily to provide 24-hour care for *Chronically Ill Individuals* for a daily charge that includes room and board, and is properly licensed as a *Nursing Facility* in the jurisdiction in which it is located.

A facility which is not required to be licensed as such in order to operate as a *Nursing Facility*, must meet all of the following criteria:

- Have beds specifically designated to provide skilled, intermediate and custodial nursing care and services on a 24-hour basis;
- Provide 24 hour a day nursing services under planned programs and procedures;
- Have an appropriately trained and ready-to-respond employee on duty in the facility at all times to provide such care and services or to respond to an emergency ;
- Maintain clinical records for all patients; and
- Have appropriate methods and procedures for administering drugs and biologicals.

Physician

Physician means any person who has earned the degree of Medical Doctor (MD) or Doctor of Osteopathy (DO) and is practicing as such within the scope of a license issued by the jurisdictions in which such person's services are rendered.

Plan of Care

Plan of Care means a written description of long-term care needs and a specification of the type, frequency, and providers of all long-term services, and the cost, if any prescribed for a *Chronically Ill Individual* by a *Licensed Health Care Practitioner*.

GLOSSARY

Policy Lifetime Maximum Benefit

Policy Lifetime Maximum Benefit means the maximum dollar amount of benefits that We will pay over Your lifetime under this Policy. Except as otherwise expressly provided in this Policy, all of the benefits We pay under this Policy count toward the *Policy Lifetime Maximum Benefit*. This amount is shown on the Schedule of Benefits.

Request for Non Listed Benefits

Request for Non Listed Benefits means any *Plan of Care* that is mutually agreed upon by Your *Physician* and Us as an *Request for Non Listed Benefits*. The *Request for Non Listed Benefits* must be a cost effective alternative to care, services or equipment otherwise covered in this Policy.

Residential Care Facility

Residential Care Facility means a facility that is properly licensed as a *Residential Care Facility* to provide *Substantial Assistance* with the *Activities of Daily Living* or *Substantial Supervision* due to *Cognitive Impairment* to inpatients, for a daily charge that includes room and board.

A *Residential Care Facility* is further defined under the California Health and Safety Code, as amended.

If a *Residential Care Facility* is located outside of California, it must:

- meet applicable licensure standards, if any;
- be engaged primarily in providing ongoing care and related services sufficient to support needs resulting from impairment in activities of daily living or impairment in cognitive ability;
- provide care and services on a 24-hour basis;
- have a trained and ready-to-respond employee on duty in the facility at all times to provide care and services;
- provide three meals a day;
- accommodate special dietary needs;
- have agreements to ensure that residents receive the medical care services of a physician or nurse in case of emergency; and have appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications.

Respite Care

Respite Care means care provided to You to allow a respite to those who normally care for You at home (generally family members, friends, or neighbors). Such care may include confinement in a *Nursing Facility* or *Residential Care Facility*.

Eligible Providers for *Respite Care* include a *Nursing Facility* or a *Residential Care Facility*.

Standby Assistance

Standby Assistance means the presence of another person within arm's reach of You which 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 bath tub or shower as part of *Bathing*, or being ready to remove food from Your throat if You choke while *Eating*).

GLOSSARY

Substantial Assistance

Substantial Assistance means *Hands-On Assistance* or *Standby Assistance*.

Substantial Supervision

Substantial Supervision means supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect You from threats to Your health or safety (such as may result from wandering) if You suffer a *Severe Cognitive Impairment*.

Terminally Ill

Terminally Ill means that a *Physician* has made a medical prognosis that You have a life expectancy of 6 months or less if the illness runs its normal course.

Specimen

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

You will be eligible for the payment of benefits described in this Policy when:

- You have satisfied the Benefit Eligibility provision below;
- The initial *Assessment* We requested has been completed, and We have a copy;
- You have met the *Elimination Period*;
- We have evaluated Your Proof of Loss (claim) forms along with other information provided to Us and determined the care or services are *Eligible Charges* and the provider of the care or services is an eligible provider; and
- The requirements under the Additional Benefit Eligibility Provisions below have been met.

Benefit Eligibility

This portion of the provision explains how You will meet the benefit triggers of this Policy.

You will be eligible for *Benefits* provided by this Policy when We determine that You:

- Are unable to perform without *Substantial Assistance* from another individual 2 or more of the following *Activities of Daily Living*: *Bathing, Continence, Dressing, Eating, Toileting, and Transferring* due to a loss in Your functional capacity which is expected to last at least 90 days; or
- Have suffered a *Severe Cognitive Impairment*.

We consider You are able to perform an *Activity of Daily Living* if You are able to perform that activity with the aid of equipment, but without the *Substantial Assistance* from another individual.

For Us to confirm Your eligibility for benefits You must:

This portion of the provision explains how We will confirm Your eligibility for benefits.

- Have an *Assessment* performed to confirm Your functional and cognitive status;
- Be certified as a *Chronically Ill Individual* and that certification must have been performed within the last 12 months. This certification may be accomplished as part of the *Assessment* We request;
- Have a *Plan of Care* developed by a *Licensed Health Care Practitioner* and that *Plan of Care* must prescribe the types of care, services or supplies that You need; and
- Follow the *Plan of Care*.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

Benefit Assessments

This provision explains Our right to perform the initial *Assessment* and subsequent *Assessments* to confirm Your functional and/or cognitive ability.

We will request an *Assessment* to be performed to determine whether You are eligible for benefits. Therefore, You:

- Should notify Us as soon as You plan to enter a *Nursing Facility* or *Residential Care Facility* or begin receiving other long-term care or services as far in advance as reasonably possible. Prompt notification will enable Us to request the *Assessment* and for the *Assessment* to be completed on a timely basis; and
- Must cooperate with Us and our *Care Coordinator* in the performing of the *Assessment*.

When We request an *Assessment* We may perform it Ourselves or We may use a *Care Coordinator* We select who will perform the *Assessment* for Us. We will pay for the *Assessment*.

We will not pay any benefits under this Policy until the *Assessment* has been completed and We have a copy of that *Assessment* or You have provided the information as described below. We will pay the cost of the *Assessment*.

If You elect to provide Us with a *Chronically Ill Individual* certification and a written *Plan of Care* instead of Our performing the *Assessment*, You must:

- Provide Us notice as soon as you plan to enter a *Nursing Home* or a *Residential Care Facility*, or begin receiving other care or services, as far in advance as reasonably possible, to permit time for Us to provide You with the Proof of Loss forms necessary to begin preparation for evaluating Your claim;
- Provide Us with a *Chronically Ill Individual* certification and a written *Plan of Care* (both completed by a *Licensed Health Care Practitioner* that You choose). We will consider this an *Assessment*.

We will begin evaluating Your eligibility when We have those two items. We may order an *Assessment* performed by Our *Care Coordinator* to verify Your functional incapacity or *Cognitive Impairment*, but that *Assessment* will not delay the processing of Your claim if You have provided Us with a *Chronically Ill Individual* certification and a written *Plan of Care* (both completed by a *Licensed Health Care Practitioner* that You choose).

If there is a conflict between the information You provided and Our *Assessment*, Our *Assessment* will govern. You have the right to appeal any claim decision We make, as described in the *Appealing a Claim* provision of the *Claims* section of this Policy.

Meeting the Elimination Period

This provision explains how You satisfy the *Elimination Period*.

If the *Elimination Period* applies to a *Benefit* included in this Policy, You must satisfy the *Elimination Period* before We will pay any benefits under that *Benefit* provision. We will count only days on which You receive care or services covered under this Policy and You meet all this Policy's requirements for benefits, except that You have not yet met the *Elimination Period*. The *Elimination Period* is shown on the *Schedule of Benefits* and is defined in the *Glossary*.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

Additional Benefit Eligibility Provisions

The following are requirements that must be met before We will pay benefits under the terms of this Policy:

This provision explains the additional requirements that apply before benefits are payable or that apply to the benefits We pay.

- No benefits will be payable if an Exclusion or Limitation described in this Policy applies.
- The benefits We pay under this Policy will count toward Your *Policy Lifetime Maximum Benefit*, except as expressly provided in a *Benefit* provision.
- The care or services for which You claim benefits must be prescribed in Your *Plan of Care*.
- This Policy must remain in force, except as provided for *Nursing Facility* or *Residential Care Facility* confinements that commence while this Policy is in force with benefits being provided under the Extended Coverage Benefit.

Specimen

BENEFITS INCLUDED IN THIS POLICY

This section describes the benefits We will pay once You have met all the requirements of the Eligibility For The Payment Of Benefits section of this Policy.

FACILITY BENEFITS – These *Benefits* are available when You are confined in a *Nursing Facility* or a *Residential Care Facility*.

Nursing Facility or Residential Care Facility Benefit

This provision explains Your coverage while You are confined in a *Nursing Facility* or a *Residential Care Facility*.

We will pay a benefit for each day You are confined in a *Nursing Facility* or a *Residential Care Facility*. We will pay:

- The *Eligible Charges* made by a *Nursing Facility* or a *Residential Care Facility* for that day; up to
- The *Nursing Facility Maximum Daily Benefit* shown on the Schedule of Benefits;

Provided that:

- Your stay must begin while Your coverage under this Policy is in force.

The *Eligible Charges* of a *Nursing Facility* or a *Residential Care Facility* include only the daily charge to inpatients for room and board and charges for ancillary supplies and services. *Eligible Charges* while You are confined in a *Residential Care Facility* may also include charges for any other benefits covered by this Policy up to the *Nursing Home Maximum Daily Benefit*. We will not pay *Nursing Facility* and *Residential Care Facility Benefits* on the same day.

The *Elimination Period* applies to this *Benefit* and amounts We pay will count against Your *Policy Lifetime Maximum Benefit*.

Bed Hold Reservation Benefit

This provision explains how We will pay to hold Your place for You in a *Nursing Facility* or a *Residential Care Facility* while You are temporarily absent.

After You have been approved for payment of benefits and We begin paying benefits under the *Nursing Facility or Residential Care Facility Benefit*, We will pay a benefit for each day You incur *Eligible Charges* to assure that a place will be available for You when You return to a *Nursing Facility* or a *Residential Care Facility* after a temporary absence for any reason. We will pay:

- The facility's normal charge to reserve Your place; up to
- Your *Nursing Facility Maximum Daily Benefit*; and up to
- A maximum of 30 days in any calendar year.

The *Eligible Charges* of a *Nursing Facility* or a *Residential Care Facility* include the facility's normal charge to reserve Your place during a temporary absence for any reason.

Extended Coverage Benefit

This provision explains how Your benefits may be extended if you are receiving facility benefits when this Policy lapses.

If You are confined in a *Nursing Facility* or a *Residential Care Facility* and We begin paying benefits while this Policy is in effect and You continue to be confined, without interruption, after this Policy lapses or terminates, We will extend benefits by continuing to pay *Nursing Facility and Residential Care Facility Benefits* for such confinement while You remain so confined.

All of the provisions of this Policy will continue to apply while Your coverage is being extended under this *Benefit*. In no event will We pay benefits in excess of the *Policy Lifetime Maximum Benefit*.

BENEFITS INCLUDED IN THIS POLICY

OTHER BENEFITS INCLUDED IN THIS POLICY – These *Benefits* are available when You receive care or services of the type described below.

Care Coordinator Benefit

This provision describes the services of a *Care Coordinator*.

We will pay the *Care Coordinator's* charges to prescribe a *Plan of Care* for You, if You request the *Care Coordinator Benefit*. We will pay the charges for the *Care Coordinator*, except as provided below.

If You request a *Plan of Care* from the *Care Coordinator*, You may still, at any time but at Your own expense, obtain another written *Plan of Care* from a *Licensed Health Care Practitioner* You choose, if You prefer not to follow the *Plan of Care* prescribed by the *Care Coordinator*.

If You elect to provide Us with a *Plan of Care* from a *Licensed Health Care Practitioner* instead of the *Care Coordinator*, We will evaluate Your claim and pay benefits in accordance with this Policy's provisions.

While You are following the *Plan of Care* prescribed for You by the *Care Coordinator*, We will also pay:

- The *Care Coordinator's* charges to certify that You remain a *Chronically Ill Individual* and to prescribe a current *Plan of Care* for You at least annually; and
- The *Care Coordinator's* charges to coordinate the services You receive under Your *Plan of Care*.

You do not have to meet the *Elimination Period* to use the *Care Coordinator*, and the amounts We pay the *Care Coordinator* do not count against Your *Policy Lifetime Maximum Benefit*. You must, however, satisfy the applicable *Elimination Period* before We will pay benefits for any care or services the *Care Coordinator* coordinates, and the benefits We pay will count against the *Policy Lifetime Maximum Benefit* as provided in each *Benefit*.

Informal Caregiver Training Benefit

This *Benefit* provides training for an informal caregiver to provide periods of *Informal Care*.

We will pay the cost of training a person to provide You with informal care in Your residence; up to a lifetime maximum of 5 times the *Nursing Facility Maximum Daily Benefit* shown on the Schedule of Benefits;

Provided that:

- The training must be prescribed in Your *Plan of Care*;
- The training cannot be received while You are confined in a hospital, *Nursing Facility* or a *Residential Care Facility*, unless it is expected that You will return home where the person that is receiving the training can care for You; and
- We will not pay any benefits to train an individual who will be providing care other than *Informal Care* for You.

You do not have to meet the *Elimination Period* to use this *Benefit*. The benefits We pay under this *Benefit* are not considered a daily benefit, and days on which any person is being trained under this *Benefit* do not count toward the *Elimination Period*.

BENEFITS INCLUDED IN THIS POLICY

Respite Care Benefit

This *Benefit* provides coverage for a temporary *Nursing Facility* or *Residential Care Facility* confinement.

We will pay a benefit for each day You receive care, up to a maximum of 21 days per calendar year, to allow those caring for You at home to get temporary relief (for example, for a holiday, vacation, or emergency).

- For each day that You receive care and are confined in a *Nursing Facility* or *Residential Care Facility*, We will pay the *Eligible Charges* of the *Nursing Facility* or *Residential Care Facility*, up to the *Nursing Facility Maximum Daily Benefits* shown on the Schedule of Benefits.

Eligible Providers for *Respite Care* include a *Nursing Facility* or a *Residential Care Facility*.

You do not have to meet the *Elimination Period* before We will pay benefits under this *Benefit* and the days for which We pay benefits under this *Benefit* do not count toward satisfying the *Elimination Period*.

Hospice Care Benefit

This Benefit provides coverage for care You receive from a Hospice.

If You become *Terminally Ill*, for each day You receive care provided by a *Hospice*, We will pay:

- The *Eligible Charges* of the *Hospice*; up to
- The *Nursing Facility Maximum Daily Benefit* amount.

Provided that:

You meet all of the requirements of the Eligibility For The Payment Of Benefits section of this Policy.

The *Elimination Period* does not apply to this *Benefit*, and the days on which We pay benefits under this *Benefit* do not count toward satisfying the *Elimination Period*.

World Wide Coverage Benefit

If You become eligible for benefits while outside the United States or its territories, this Policy will pay its benefits in accordance with its terms for *Eligible Charges* You incur for covered services received outside the United States or its territories up to a lifetime maximum of 100 times the *Nursing Facility Maximum Daily Benefit* shown on the Schedule of Benefits.

BENEFITS INCLUDED IN THIS POLICY

Request for Non Listed Benefits

This *Benefit* provides for a cost effective alternative plan mutually agreed upon.

Once You have met all of the conditions of the Eligibility For The Payment Of Benefits section, You may request a *Request for Non Listed Benefits*. If We agree, We will pay benefits in accordance with the *Request for Non Listed Benefits*.

Examples: A *Request for Non Listed Benefits* may call for the use of facilities, providers or other items not otherwise covered by this Policy such as:

- Additional equipment;
- Additional home safety devices;
- Stays in other types of facilities.

The following additional terms apply under this *Benefit*:

- Except as We expressly agree in the *Request for Non Listed Benefits*, Your rights and Ours will be governed by all of the Policy terms;
- All of the benefits We agree to pay under the *Request for Non Listed Benefits* must be for Qualified Long-Term Care Services as defined in Internal Revenue Code Section 7702B(c); and
- We may agree with You only for a set period of time (for example, one year). At the end of that period of time, the *Request for Non Listed Benefits* will end unless We agree with You to renew it. You may terminate a *Request for Non Listed Benefits* at any time, by giving Us at least (15) days advance written notice of the termination.

After a *Request for Non Listed Benefits* terminates, We will resume paying benefits for expenses You incur in accordance with all of the terms of this Policy.

Requests for Non Listed Benefits are necessarily unique to each insured, and We reserve the right to decline to agree to any such request, or to any proposed term of a *Request for Non Listed Benefits*, but We will consider all requests for a *Request for Non Listed Benefits* on a non-discriminatory basis.

Waiver of Premium Benefit

This *Benefit* waives Your premiums after You have satisfied the *Elimination Period* and You are receiving benefits.

If You have satisfied the *Elimination Period* and are receiving benefits under this Policy, We will waive any premium coming due beginning on the first day for which benefits are actually payable under this Policy and continuing until no benefits have been payable under this Policy for thirty (30) consecutive days.

If Your premium payment mode is other than monthly We will change Your premium payment mode to monthly.

If Your premium payment mode is other than monthly when You begin to actually receive benefits under this Policy, We will refund the portion of any premiums You have already paid which are attributable to coverage during the period for which benefits are payable.

You must start paying premiums again beginning with premiums coming due on the first day after the first consecutive thirty-day period during which no benefits are payable under this Policy.

BENEFITS INCLUDED IN THIS POLICY

**Contingent
Nonforfeiture Benefit**

The *Contingent Nonforfeiture Benefit* will be triggered if You do not have the Optional Nonforfeiture Benefit Rider in force and if:

- We increase the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of your initial annual premium set forth below based on Your issue age; and
- This Policy lapses within 120 days of the due date of the premium so increased.

Unless otherwise required, You shall be notified at least sixty (60) days prior to the due date of the premium reflecting the rate increase.

Issue Age	Percentage Increase Over Initial Premium	Issue Age	Percentage Increase Over Initial Premium
29 and Under	200%	72	36%
30 - 34	190%	73	34%
35 - 39	170%	74	32%
40 - 44	150%	75	30%
45 - 49	130%	76	28%
50 - 54	110%	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%

BENEFITS INCLUDED IN THIS POLICY

On or before the effective date of a substantial premium increase which triggers the *Contingent Nonforfeiture Benefit*, we will:

- Offer to reduce Policy Benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments will not be increased;
- Offer to convert the coverage to a paid-up status with a shortened benefit period. This option may be elected at any time during the 120-day period; and
- Notify You that a default or lapse at any time during the 120-day period shall be deemed to be the election of the offer to convert to paid-up coverage.

The nonforfeiture credit will be 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The minimum nonforfeiture credit shall not be less than thirty (30) times the *Nursing Facility Maximum Daily Benefit* at the time of lapse.

If this Policy is converted to paid-up status by the triggering of the *Contingent Nonforfeiture Benefit*, the same benefits (amounts and frequency in effect at the time of lapse, but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars of benefit payable under the paid-up benefits is equal to the nonforfeiture credit as described above.

Increases in Benefits

On each Policy Anniversary Date, You have the right to elect any or all of the following increases in Your Benefits:

- Increase the *Policy Lifetime Maximum Benefit*; or
- Increase the *Nursing Facility Maximum Daily Benefit*.

Provided that You:

- Meet any underwriting requirements; and
- Pay the additional premium.

All increases in benefits approved will be issued as a rider to this Policy at Your attained age. Benefits cannot be increased beyond the age or maximum benefits allowed for a new policy. Premium for the previously purchased coverage will not be affected. The increases applicable to this provision are in addition to any other contractual increases.

BENEFITS INCLUDED IN THIS POLICY

Notification of New Benefits/ Provisions

We will notify You within 12 months if We develop any new *Benefits*, new Benefit Eligibility, or new provisions not in Your Policy. To be eligible for an upgrade of Your existing Policy, You must not have filed a claim, be receiving benefits, or be within the *Elimination Period* of that Policy.

In the event You are eligible for an upgrade, We will offer You the opportunity to upgrade Your Policy, as approved by the California Department of Insurance, subject to Our underwriting requirements for the upgraded coverage, and as may be appropriate in one of the following ways:

- By adding a rider or endorsement to Your Policy, which may or may not have an additional premium, based on Your attained age at that time. The premium for Your original Policy will remain unchanged based on Your age at issue; or
- By replacing Your existing Policy with a subsequent Policy based on Your attained age and subject to a premium credit for past premiums paid; or
- By replacing Your existing Policy with a subsequent Policy based on Your original issue age.

The premium credit for the replacement Policy, issued at Your attained age, shall not be less than 5 percent of the annual premium paid for the prior Policy for each full year the prior Policy was in force, but cumulative credit allowed will not exceed 50 percent.

Restoration Benefit

For each complete year following Your recovery from a loss for which benefits have been paid under this Policy, We will add to Your *Policy Lifetime Maximum Benefit* 100 times the *Nursing Facility Maximum Daily Benefit* shown on the Schedule of Benefits.

The *Policy Lifetime Maximum Benefit* will never be greater than it would have been if no benefits had been payable under this Policy. Only Your *Policy Lifetime Maximum Benefit* is affected by this *Benefit*. Any other Limitations and Exclusions on individual benefit payments contained in this Policy remain unaffected by this provision.

Alzheimer's Disease, Organic Mental Disorders or Any Other Mental Illnesses

We will pay for the care and services You receive in connection with Alzheimer's Disease, Parkinson's Disease, senility or reversible dementia, any brain disorder with demonstrable organic cause, or any other mental illness. The benefits paid will be on the same basis as any other care and service You receive under this Policy. The Benefits and Eligibility for Payment of Benefits provisions of this Policy apply. You must satisfy the *Elimination Period* and any amounts We pay will count against the *Policy Lifetime Maximum Benefit*.

EXCEPTIONS AND LIMITATIONS

This section explains the General and Specific Exclusions and Limitations that apply to all of the *Benefits* included in this Policy. We will not pay any benefits, or will reduce the benefits We pay whenever an Exclusion or Limitation applies to Your claim. We will not apply any Exclusion or Limitation where not permitted by law. Whenever an Exclusion or Limitation applies to eliminate or reduce Our payment, only the actual amount We pay will count against the *Policy Lifetime Maximum Benefit*.

General Exclusions and Limitations

Benefits included in this Policy will not cover charges You incur:

- Due to war, whether declared or undeclared;
- Due to attempted suicide, or any intentionally self-inflicted injury;
- As a result of voluntary participation in a riot or attempting to commit an assault or felony;
- For care received outside of the United States and its territories except as provided in the World Wide Coverage Benefit;
- Which would not be made in the absence of this insurance;
- For treatment of alcoholism and drug addiction unless the drug addiction was a result of the administration of drugs as part of treatment by a *Physician*;
- For treatment provided in a government facility unless We are required by law to cover the charges;
- For treatment of an injury or sickness which would entitle You to benefits under any state or federal workers' compensation, employers' liability or occupational disease law;
- From *Family Members* unless the *Family Member* is a regular employee of an organization which is providing the services, and the organization receives the payment for the services; and the *Family Member* receives no compensation other than the normal compensation for employees in his or her job category;
- For prescription drugs, unless You incur such charges while a resident in a Nursing Facility or a Residential Care Facility and the facility charges include such prescription drugs;
- To the extent that benefits are payable by *Medicare* or would be payable except for the application of a deductible or coinsurance amount;
- To the extent that benefits are payable under no-fault motor vehicle insurance benefits;
- For items of comfort such as toiletries, television rental, beauty and hair charges.

EXCEPTIONS AND LIMITATIONS

Specific Exclusions and Limitations

Maximum Benefits	The maximum benefits We will pay are shown on the Schedule of Benefits of this Policy.
Policy Lifetime Maximum Benefit	No additional benefits are payable under this Policy once We have paid benefits equal to the <i>Policy Lifetime Maximum Benefit</i> except as provided under the Shared Care Benefit Rider, if applicable.
Chronically Ill Individual Certification	No benefits are payable under this Policy for charges You incur on any day for which You are not certified as a <i>Chronically Ill Individual</i> . You are responsible for keeping Your certification current.
Care Not Included in a Plan of Care	No benefits are payable under this Policy for charges You incur for care, services or equipment unless the care, services or equipment is included in Your current <i>Plan of Care</i> .
Effect of Federal Law	No benefits are payable under this Policy which would cause this Policy to fail to qualify as a Qualified Long-Term Care Insurance Contract under Section 7702B(b) of the Internal Revenue Code.

Specimen

EFFECT OF OTHER COVERAGE

This section explains how other coverage You may have, including *Medicare*, will affect the benefits We pay under this Policy.

Effect of Medicare

The benefits payable under this Policy will not duplicate any benefits provided by *Medicare*. When You are eligible for *Medicare*, We will pay as follows:

- For types of charges covered by this Policy and by *Medicare* (other than as a secondary payor), We will reduce Your benefits under this Policy so that this Policy's benefits plus *Medicare* benefits are equal to 100% of all such charges up to the *Nursing Facility Maximum Daily Benefit* shown on the Schedule of Benefits. To the extent required under Internal Revenue Code Section 7702B(b), Your *Medicare* benefits will be treated as including amounts not reimbursable by *Medicare* due to the application of a deductible or coinsurance amount.
- For types of charges covered by this Policy, but not covered by *Medicare* or covered by *Medicare* only as a secondary payor, We will pay the regular benefits due under this Policy.
- When You are eligible for *Medicare*, We will pay benefits under this Policy based on Your having full *Medicare* coverage (Part A and Part B). We will not pay any benefits which would cause this Policy to fail to be a Qualified Long-Term Care Contract under Internal Revenue Code Section 7702B(b).

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended. You are eligible for *Medicare* – Part A, if You are either enrolled in *Medicare* Part A, or could become enrolled by making application. You are eligible for *Medicare* – Part B if You are either enrolled in *Medicare* Part B, or could have become enrolled by making application and paying any required premium, even if You currently would have to wait to enroll in or to become covered under *Medicare* Part B.

Effect of No-Fault Motor Vehicle Insurance and Workers' Compensation Benefits

The benefits provided under this Policy will not duplicate *No-Fault Motor Vehicle Insurance* or *Workers' Compensation Benefits*. If You receive care or services, or incur charges for which benefits may be available under any *Benefit* provision, on account of a motor vehicle accident or occupational injury or sickness, benefits will be payable under this Policy only in excess of Your *No-Fault Motor Vehicle Insurance Benefits* or *Workers' Compensation Benefits*.

No-Fault Motor Vehicle Insurance Benefits means the minimum level of personal injury benefits which applicable state law requires to be offered under motor vehicle insurance policies and which are payable, or would be paid if claims had been made for such benefits, regardless of fault.

Workers' Compensation Benefits means benefits paid or payable under any state or federal workers' compensation, employers' liability, or occupational accident or disease law.

CLAIMS

This section explains how to make Your claims under this Policy, and how they will be paid.

Notice of Claim	Written Notice of Claim must be given to Us at New York Life Insurance Company, Long-Term Care, P.O. Box 149009, Austin, Texas 78714-9955. The notice must include at a minimum Your name and Policy Number. The notice must be given to Us within 60 days after a covered loss occurs or begins, or as soon as reasonably possible.
Proof of Loss (Claim) Forms	When We receive Your Notice of Claim, We will give You the forms for filing Proof of Loss. This proof must be given to Us within the time limit stated in the Proof of Loss provision. If We do not provide these forms to You within 15 days after We receive Your Notice of Claim, You need not use such form if, instead, You give Us written proof of the nature and extent of the loss. Whether or not Our claim form is used, Proof of Loss will also include copies of medical records from Your primary <i>Physician(s)</i> and provider(s) of health care services.
Proof of Loss	Proof of Loss must be given to Us in writing at New York Life Insurance Company, Long-Term Care, P.O. Box 149009, Austin, Texas 78714-9955. In case of a loss for which this Policy provides any periodic payment contingent upon continuing loss, Proof of Loss must be given to Us within ninety (90) days after the termination of the period for which We are liable. In the case of a claim for any other loss, proof must be given to Us within ninety (90) days after the date of loss. Failure to give Us the proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, the proof must be given as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.
Time of Payment of Claims	We will pay benefits for any loss covered by this Policy only after We have received written due Proof of Loss. We will pay benefits for each month after services have been rendered.
Manner of Payment	While You are living all <i>Nursing Facility</i> and <i>Residential Care Facility Benefits</i> will be paid to You or at Your request, or when required by law, to a provider who has furnished covered services to You. Any outstanding <i>Nursing Facility</i> and <i>Residential Care Facility Benefits</i> that have not been paid at the time of Your death will be paid to Your estate unless otherwise required by law. At the death of the insured, We may pay any benefit of \$1,000 or less to an alternative payee or legal representative.
Physical Examination and Our Rights to Perform Assessments	We may examine You or request a <i>Care Coordinator</i> to perform an <i>Assessment</i> of You when and as often as We may deem reasonable before paying any benefit. Any such examination or <i>Assessment</i> will be at Our expense. You must cooperate with the examinations or <i>Assessment</i> .
Legal Actions	With respect to any claim under this Policy, no legal action may be taken against Us during the 60 days after receipt of the written Proof of Loss, or after 3 years from the date the proof of loss is required to be given.

CLAIMS

Appealing a Claim

We will inform You in writing within 40 days of receipt of all required information necessary to process the claim, if the claim or any part of the claim is accepted or denied or if We require more time to make a determination. If applicable, we will inform you of the reason for our inability to make a determination and specify any additional information needed. Once we have notified you of the reason for being unable to make a determination and requested any additional information, written notice of the status of the claim will be provided every 30 days until a determination is reached.

If You believe that Our claim decision is in error, We will reconsider Your claim. You have the right to appeal all aspects of the claim process, including the benefit eligibility determination, *Assessment, Plans of Care*, services and providers, and reimbursement payments. You must send Us a written letter explaining why We should change Our decision. You may authorize someone else to act for You in the appeal process.

Your letter should include the names, address and telephone numbers of all *Physicians*, care coordinators, other health care professionals or facilities where You received care, treatment, services, equipment and other items that You think We should consider in reviewing Your physical or mental condition.

Once We have completed Our review We will notify You in writing of Our decision and pay any benefits due as a result of Our reconsideration.

Specimen

PREMIUMS AND REINSTATEMENT

This Section explains how You will pay Your premiums.

Initial Premium Rates The initial premium rates for the *Benefits* included in this Policy are shown on the Schedule of Benefits.

Payment of Premiums Payment of the initial premium will keep this Policy in effect for the initial premium payment period. This period starts at 12:01 A.M. on the Policy Effective Date. It ends at midnight of the day before the next Premium Due Date, subject to the Grace Period provision. The mode, or the period, of premium payment is shown on the Schedule of Benefits. The above times refer to Standard Time at the place where You then reside. Each premium after the first, is due at the end of the period for which the preceding premium was paid.

Premiums must be paid to New York Life Insurance Company, Long-Term Care, P.O. Box 149009, Austin, Texas 78714-9955, or to any other address that We designate. Payment of a premium will not keep this Policy in effect beyond the period for which it is paid, except as may be otherwise provided in this Policy.

Modal Premium Disclosure

You may change the mode of premium payment You selected at the time of Your Application with Our consent by giving Us written notice of the desired change. There is an additional charge for premium payment frequencies greater than one per year included in the charge for these modes (semi-annually, quarterly and monthly). We will only accept premiums monthly through an electronic funds transfer (EFT) arrangement with Your bank or other direct payment arrangement We may approve (for example, payroll deduction).

Changes in Premiums

We have the right to increase Your premium rates as of any Policy Anniversary Date on or after the 3rd Policy Anniversary. Any increase on or after that date will only be made on a class basis, and will take effect on a Policy Anniversary Date.

We will mail You written notice of Your new premium rates at least 60 days before the Premium Due Date on which the new premium first becomes payable.

We may change Your premium rates due to a change in the requirements of applicable federal and state law, as explained in the *Conformity with State and Federal Laws and Regulations* and the *Tax-Qualification under Federal Law* provisions.

Grace Period

This Policy has a 31-day Grace Period. This means that if a premium after the initial premium is not paid in full by the date it is due, it may be paid during the 31-day period following that date. During the Grace Period this Policy will stay in effect. You and any person(s) designated by You will receive a termination notice mailed 30 days after the Premium Due Date. Notice will be deemed to have been given five days after the date We mail it. You will have a total of 35 days from the date of the termination notice to pay all premiums that are due.

If the overdue premiums are not paid within that 35-day period this Policy will terminate with a termination date of the Premium Due Date of the premium in default.

PREMIUMS AND REINSTATEMENT

Lower Benefit Plan

After one year from the Policy Effective Date of this Policy, You have the right to reduce Your premiums by changing to a lower benefit plan.

- Electing a lower *Policy Lifetime Maximum Benefit* (without changing the *Nursing Facility Maximum Daily Benefit*; or
- Reducing the *Nursing Facility Maximum Daily Benefit* as well as the *Policy Lifetime Maximum Benefit*.

We will notify You of the options to reduce coverage of the premiums applicable to the reduced coverage and the premiums applicable to the reduced coverage amounts when Your Policy is about to lapse, and whenever the premiums are increased.

The premium payments for the reduced plan will be based on the reduced amount of coverage and your age as of the Policy Effective Date of this Policy.

Reinstatement

If a renewal premium is not paid before the end of its Grace Period, this Policy will terminate. The termination date will be the Premium Due Date of the premium in default.

If We later accept and retain a premium, without requiring an application for reinstatement, this Policy will be reinstated. If We require an application, We will issue a conditional receipt for the premium paid. If the application is approved, and all unpaid overdue premiums have been paid, this Policy will be reinstated as of the approval date. If it is disapproved, We will inform You in writing within 45 days after the date of the conditional receipt. If We fail to so inform You, this Policy will be reinstated upon such 45th day.

The reinstated Policy will cover only loss due to an injury sustained or physical or mental condition which begins after the date of reinstatement. Except for this and any new provisions added in connection with reinstatement, Your rights and Ours under the reinstated policy would be the same as they were just before this Policy terminated. For purposes of this provision only, an illness, physical or mental condition will be considered to have begun when advice is supplied or treatment is recommended by or received from a *Physician*.

Third Party Designation

If You have made a Third Party Designation in Your Application or at a later time, We will notify You and the person that was designated 30 days after the Premium Due Date for which premiums were not paid and allow an additional 35 days from the date of that notification for overdue premiums to be paid.

Added Protection Against Lapse

If this Policy terminates because You did not pay the premium due to a *Cognitive Impairment* or a functional loss of 2 or more *Activities of Daily Living*, We will reinstate this Policy if You request reinstatement within 5 months of the date of termination and You meet both of the following:

- You furnish Us with satisfactory proof of a *Cognitive Impairment* or a functional loss of 2 or more *Activities of Daily Living*, and
- You pay all the unpaid overdue premiums.

This provision applies only to the named Insured.

COVERAGE PROVISIONS

The following provisions explain when Your coverage under this Policy starts, how long it continues, and when it will end.

When Coverage Begins

Your coverage begins on the Policy Effective Date shown on the Schedule of Benefits; provided that, We must deliver this Policy and You must pay the initial premium, in full. You may only pay the initial premium before or within 30 days after the Policy Effective Date, after which We may decline to deliver this Policy and cancel it as of the Policy Effective Date. In this case, Your coverage will never become effective.

Continuation of Coverage

Your coverage will continue as long as You pay the required premiums under this Policy and do not exhaust the *Policy Lifetime Maximum Benefits* and the Shared Care Rider benefits, if applicable.

When Coverage Ends

Your coverage under this Policy will end when the first of the following occurs:

- The Premium Due Date of any premium not paid by the end of the Grace Period;
- The day the *Policy Lifetime Maximum Benefit* is exhausted and any Shared Care Rider benefits are exhausted, if applicable;
- The first day of the following month after You notify New York Life in writing that You wish to terminate Your coverage; or
- The date of Your death.

If You have paid the premium for coverage beyond the termination date, We will promptly refund any of the unearned premiums to You.

Any payment We make after We receive notification of Your death will be payable to Your estate.

GENERAL PROVISIONS

This Section contains general policy provisions that apply to Your coverage under this Policy.

- Policy Ownership** The Owner is the person named on the Schedule of Benefits. If the Insured is not the Owner and the Owner dies before the Insured, the Insured will become the new Owner unless the Owner, before death or the Insured, designates another person to become the Owner. The Owner has all rights and privileges granted by Ownership of this Policy during the Insured's lifetime.
- Misstatement of Age** If Your age has been misstated, the *Benefits* included in this Policy will be those that the premium paid would have purchased at Your correct age. If We would not have issued a Policy had Your age been correctly stated, Our liability under this Policy would be limited to a refund of the premiums paid.
- Entire Contract and Changes** This Policy, together with Your Application and any optional riders or attached documents, is the entire contract of insurance. No change in this Policy will be valid until approved by Our President or Secretary. To be valid, such approval must also be endorsed on or attached to this Policy. No producer has authority to change this Policy. If We change Our address or any toll-free telephone number, We will notify You.
- Assignment** This Policy may not be assigned.
- Protection Against Creditors** Payments made under this Policy are, to the extent law permits, exempt from the claims, attachments, or levies of any creditors.
- Conformity with State and Federal Laws and Regulations** Any provision of this Policy which, on the Policy Effective Date, is in conflict with the requirements of any federal law or regulation or any law or regulation of the state in which You reside on that date is amended to conform to the minimum requirements of such laws and regulations. If this Policy may be amended in more than one way to meet the foregoing requirements, We may determine how to best do so. If any such amendment affects the risk We assumed, We may make an equitable premium adjustment.
- Tax-Qualification under Federal Laws** This Policy is intended to be a Qualified Long-Term Care Insurance Contract under Internal Revenue Code Section 7702B(b). We may amend it at any time as necessary to meet the requirements of that law, any successor law, or any applicable regulations. If this Policy may be amended in more than one way to meet the foregoing requirements, We may determine how to best do so. If any such amendment affects the risk We assumed, We may make an equitable premium adjustment.

GENERAL PROVISIONS

Time Limit on Certain Defenses/Misrepresentation

We relied on the information presented in Your Application when issuing this Policy. If any material information in your Application for the Policy (or an increase in coverage) was omitted or incorrect, it may cause Your coverage to be rescinded or a claim to be denied. Failure to disclose material information may constitute misrepresentation.

If this Policy has been in effect for less than six months, We may rescind it or deny an otherwise valid claim if the Application contained a misrepresentation that is material to the acceptance of Your Application.

If this Policy has been in effect for at least six months but less than two years, We may rescind it or deny an otherwise valid claim if the Application contained a misrepresentation that is both:

- Material to the acceptance of Your Application; and
- Pertains to the condition for which the claim is made.

After two years from the issue date of the Policy, no misstatements, except fraudulent misstatements, made by the Applicant in the Application for the Policy shall be used to void the Policy or deny a claim commencing after the expiration of the two year period.

If this Policy is rescinded after We have paid benefits, We may not recover the payments already made.

Reimbursement

We have the right to recover any benefit payments made because of an injury to You caused by a *Third Party's* wrongful act or negligence and which You later monetarily recover from the *Third Party* or the *Third Party's* insurer.

Third Party means another person or organization.

Right to Recovery

If We make payments with respect to benefits in a total amount which is, at any time, in excess of the benefits payable under the provisions of this Policy, We will have the right to recover such excess from You, or from any persons or providers to, or for, or with respect to whom, such payments were made. We may withhold future benefit payments in order to do so.