NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010
New York Life, Long-Term Care Insurance
(800) 224-4582 www.newyorklife.com

Long-Term Care Insurance Policy

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 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.

This Policy is a legal contract between You and New York Life Insurance Company (herein called We, Us, and Our). **Please read this Policy carefully and in its entirety.** It is issued in exchange for Your Application, and payment of required premiums.

This is a long-term care insurance policy that covers Nursing Facility Care, Residential Care Facility, and Home and Community Based Care.

30 Day Free Look Period. Please examine Your Policy promptly. Within 30 days after delivery, You can return the Policy by first class United States mail to New York Life Insurance Company. . Upon our receipt of Your Policy a full premium refund will be made to You within 30 days of the Policy's return and coverage will be void from start.

PARTICIPATING. While this Policy is in effect, except while covered under the Extended Coverage Benefit, it is eligible to share in Our divisible surplus. Each year, We will determine the Policy's share, if any. This share is payable as a dividend on the Policy Anniversary Date if all premiums due before then have been paid. For any year We determine a dividend is payable, the dividend will be used to reduce future premiums. In no event, unless the policy lapses on the Policy Anniversary Date, will the dividend be paid directly to You.

Caution. If the answers on Your Application are misstated or untrue, New York Life Insurance Company may have the right to deny benefits or rescind your coverage.

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 attached to this Policy. Upon receipt, please review carefully the copy of the Application attached to this Policy. Please be sure that the information shown is correct and complete and that no medical history or other information is inaccurate or has been omitted from the Application. This Application is part of the Policy and is part of the legal agreement between You and Us. 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 Us at Our Administrative Offices: New York Life Insurance Company, Long-Term Care Insurance, P.O. Box 64670, St. Paul, MN 55164-0670, 800-224-4582.

Notice to Buyer: This Policy may not cover all of 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 provisions, exclusions and limitations.

Guaranteed Renewable. This Policy is guaranteed renewable. You have the right, subject to the provisions of this Policy, to continue this Policy as long as You pay the premiums on time. We cannot change any of the provisions of this Policy on Our own without Your consent unless required by federal or state law, except that We have the right to change premium rates for this Policy on a Class basis as described below

in the Section titled, **Premium Rate Changes**, and at any time due to a change in the requirements of applicable law.

Premium Rate Changes. We have the right to change the premium rates for this Policy. Premium rate increases are subject to insurance department approval. Premium changes could be necessary if the actual experience of this policy differs from the originally assumed experience that was included in the premiums. Any premium change will be made on a Class basis and will take effect on Your next Policy Anniversary Date. Class means individuals in Your state who are covered under the same policy form with similar benefit design and are classified under the same risks for rating purposes. In the event We change Your premium rate, We will notify You at least 60 days prior to the change taking effect. Premium rates may also change based on any requests you make to change benefits.

Insuring Agreement and Effective Date. Subject to all of the provisions, conditions and limitations of this Policy, We will pay the Benefits as described in this Policy. We make this agreement and issue this Policy in consideration of the statements made in the signed Application and payment of the initial premium. This Policy takes effect at 12:01 A.M. Central Time on the Policy Effective Date shown on the Benefit Schedule.

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.

SIGNED FOR NEW YORK LIFE INSURANCE COMPANY:

CEO and Chairman

Secretary

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Section I. Definition of Terms

Some words or phrases have special meanings when used in this Policy. These words or phrases have been capitalized to help You easily identify them. These words and phrases are either included in this section or defined where they first appear in this Policy.

Activities of Daily Living

Activities of Daily Living means the following basic functions We will use to determine Your functional capacity:

- Bathing means washing Yourself by sponge bath in either a tub or shower, including the task of getting into or out of the tub or shower.
- Continence means Your 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 catheter or colostomy bag).
- Dressing means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- Eating means feeding Yourself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- Toileting means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring means moving into or out of a bed, chair or wheelchair.

Adult Day Care

Adult Day Care means a program which provides medical or nonmedical care on a less than 24 hour basis, provided in a licensed facility outside the residence, for persons in need of personal services, supervision, protection or assistance in sustaining daily needs, including eating, bathing, dressing, ambulating, transferring, toileting, and taking medications.

Adult Day Care Center

Adult Day Care Center means a facility that provides Adult Day Care to adults who do not require 24-hour institutional care, but are not capable of full-time independent living and is properly licensed to do so, if licensing is required in the state where the services are provided. If licensing is not required in the state, an Adult Day Care Center must:

- Operate at least five days per week for five hours per day;
- Maintain daily records for all patients of the care and services provided;
- Have a staff of at least one full-time director and at least one licensed nurse or social worker who is present during operating hours for at least four hours per day; and
- Have documented procedures for obtaining appropriate aid in the event of a medical emergency.

Alternate Plan of Care

Alternate Plan of Care means a Plan of Care that includes treatment or services for Qualified Long-Term Care Services not otherwise included in this Policy that must be mutually agreed upon by You and Us. Such services may include treatment or services provided in a setting or by a provider not otherwise specified in this Policy.

An Alternate Plan of Care will not include coverage of expenses incurred for the services provided through YMCA or similar programs, by private trainers or coaches or through gym memberships.

Ancillary Services

Ancillary Services means physical, occupational, speech and respiratory therapies; wound care; supplies for continence care or other similar care; or related services and supplies that support the Activities of Daily Living. Ancillary Services may also

include other supplies and services necessary to provide skilled nursing and supportive care.

Application — Application means the forms completed by the applicant and furnished to Us to perform the necessary underwriting review required to issue or reinstate this Policy.

Assessment(s) — Assessment(s) means an objective evaluation conducted in Your Home or other appropriate setting and is performed by Our Care Planner or other Licensed Health Care Practitioner to certify or recertify that You are or remain Chronically Ill at the time of initial claim or as needed during the period of time for which You continue to claim Benefits under this Policy. An Assessment may use medically accepted tests that use objective measures and produce verifiable results. Assessments may be performed no more often than once every 12 months, unless the existing certification indicates that chronic illness is expected to last less than 12 months.

Beneficiary — Beneficiary means an individual, trust, or other entity, if any, named as Beneficiary and designated in the appropriate section on the Application or any amendment thereto submitted to Us and approved by Us in writing. We will pay any outstanding Benefits that have not been paid at the time of Your death to Your Beneficiary.

Benefit(s) — Benefit(s) refers to the reimbursement of payments for Qualified Long-Term Care Service(s) as outlined on the Benefit Schedule, subject to the terms and conditions of this Policy.

Benefit(s) Paid or Payable — Benefit(s) Paid or Payable means amounts We pay or have paid under this Policy.

Benefit Schedule — Benefit Schedule means the pages of this Policy with the title "Benefit Schedule" that show the Policy and Benefit selections chosen by You on Your Application. Any policy changes, not including inflation protection increases, made after the Policy Effective Date are effective on the Policy Change Effective Date.

Calendar Month — Calendar Month means the period beginning on the first day through and including the last day of any of the 12 months of a Calendar Year.

Calendar Year — Calendar Year means the period beginning on January 1 and ending on December 31 of that same year.

Caregiver Relief — Caregiver Relief (also known as respite care) is short-term care provided in a Facility, in the Home, or in a community-based program, that is designed to relieve an individual who care for You in Your Home..

Chronically Ill — Chronically Ill means an individual meeting the requirements as prescribed by section 7702B(c)(2) of the Internal Revenue code of 1986, as amended. Under this provision, a Chronically Ill individual means any individual who has been certified within the last twelve Calendar Months by a Licensed Health Care Practitioner as:

- Being unable to perform, without Substantial Assistance from another individual, at least two Activities of Daily Living due to a loss of functional capacity that 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.

Custodial Care

Custodial Care means care that:

- Is provided to a person who is unable to sufficiently or properly care for himself or herself; and
- Is for the purpose of helping that person perform the Activities of Daily Living.

Eligible Charges

Eligible Charges means the billed amounts for Qualified Long-Term Care Services You incur while You meet all the requirements of the Eligibility and Payment of Benefits Provisions under this Policy.

Elimination Period

Elimination Period means the number of days on which You incur Eligible Charges under this Policy and for which no Benefit is payable by Us. The number of days in Your Elimination Period is shown on the Benefit Schedule. Only one Elimination Period needs to be satisfied while Your Policy is in force. The applicability of the Elimination Period to specific Benefits is indicated in each Benefit provision.

The Elimination Period begins on the first day that You meet the eligibility requirements listed under the Eligibility and Payment of Benefits Provisions and incur expenses for eligible Qualified Long-Term Care Services. The days counted for meeting Your Elimination Period do not need to be consecutive, but only days on which You incur expenses for eligible Qualified Long-Term Care Services 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.

Facility

Facility means a Nursing Facility, Residential Facility or Hospice facility as defined in this Policy.

Facility Services

Facility Services means Qualified Long-Term Care Services received by You while You are confined in a Facility including Room and Board, Ancillary Services or Hospice Care provided in a Hospice care facility that is not Your Home.

Facility Services does not include comfort and convenience items which are not Qualified Long-Term Care Services such as televisions, telephone, beauty care and entertainment, or services provided to an individual other than the Insured (e.g. guest meals or Partner charges).

Family Member

Family Member means Your Partner, parents, siblings and children of Your Partner's parents, siblings, and children.

Hands-On Assistance

Hands-On Assistance is the physical assistance of another person without which You would be unable to perform an Activity of Daily Living.

Home

Home means the location where You maintain a permanent, full–time physical address. We reserve the right to request documentation that confirms Your physical address. Such documentation may include Our request for a utility or other household bill. Home does not mean:

- A Nursing Facility;
- A Residential Care Facility;
- A hospital or rehabilitation facility;
- A facility for the treatment of alcoholism or drug addiction;
- Any other facility or institutional setting where You are dependent on others for Substantial Assistance with the Activities of Daily Living or Substantial Supervision due to Severe Cognitive Impairment; or
- The home of the person providing the Homemaker Services or Home Health Care to You, that is not the insured's Home, regardless of whether or not the person is a Family Member or Partner.

Home and Community-Based Care

Home and Community-Based Care means Home Health Care, Adult Day Care, Personal Care Services, Homemaker Services, Hospice Care and Caregiver Relief (also known as respite care).

Home Health Care Agency

Home Health Care Agency means an entity that is properly state licensed to provide Home Health Care to Chronically Ill individuals for an hourly or daily charge by the state in which it operates, where required.

If licensing as a Home Health Care Agency is not required by the state to provide Home Health Care, the entity must meet the following requirements:

- Provide ongoing training to its employees appropriate to the services provided;
- Maintain clinical records including daily records of care provided; and
- Be engaged on a full-time basis in providing Home Health Care as a licensed business entity as required by state law.

Home Health Care

Home Health Care is skilled nursing or other professional services in Your Home or in a Residential Care Facility, including, but not limited to, part-time and intermittent skilled nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker with the appropriate degree or state license.

Homemaker Services

Homemaker Services means assistance with activities necessary to or consistent with Your ability to remain in Your Home or in a Residential Care Facility that is provided by a skilled or unskilled person. Services must be provided under a Plan of Care developed by a Licensed Health Care Practitioner or a multidisciplinary team under medical direction.

Hospice

Hospice means a Facility, agency or organization properly licensed in the state in which care is received to provide Hospice Care in the location where the services are provided (i.e., Your Home or other appropriate setting where Hospice Care services are provided). If licensing as a Hospice is not required, the Facility, agency or organization must provide Hospice Care as defined by Your Policy. Please note the State of California does not license hospice facilities.

Hospice Care

Hospice Care means outpatient services not provided by Medicare, that are designed to provide palliative care, alleviate the physical, emotional, social and spiritual discomforts of individuals who are experiencing the last phases of life due to the existence of a terminal disease, and to provide supportive care to the primary caregiver and the family. A skilled or unskilled person may provide Hospice Care under a Plan of Care developed by a Physician or a multidisciplinary team under medical direction.

In-Home Support Equipment

In-Home Support Equipment means equipment or services included in Your Plan of Care that is purchased or rented for Your use, is functionally necessary, is designed for repeated and prolonged use, is suited for use in the Home or in a Residential Care Facility and is used to assist Your ability to perform the Activities of Daily Living.

Examples of covered In-Home Support Equipment include grab bars, hand rails, ramps, canes, infusion pumps, special hospital-style beds, personal emergency response system, walkers, wheelchairs or other durable medical equipment. In-Home Support Equipment does not include blood, artificial limbs, drugs, medicine or equipment implanted in Your body (temporarily or permanently), sporting/ protective/athletic/exercise equipment, raised floors, construction in or outside your Home or any item purchased solely to assist a caregiver in providing Your care.

Informal Caregiver

Informal Caregiver means the person who has the primary responsibility for providing to You in Your Home Substantial Supervision with Your Activities of Daily Living or Substantial Supervision to protect You from threats to health and safety due to Severe Cognitive Impairment. Your Informal Caregiver must be at least 18 years of age, or else have reached the age of majority in the state where the services are provided if the age of majority is less than 18 years of age.

Instrumental Activities of Daily Living

Instrumental Activities of Daily Living means activities including using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry, and light housekeeping.

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.

Medicaid

Medicaid (known as Medi-Cal in California) is a state medical assistance program under Title XIX of the Social Security Act, as amended.

Medicare

Medicare means the program under the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

No-Fault Motor Vehicle Insurance Benefits

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

Nursing Facility

Nursing Facility means a health Facility or a distinct part of a hospital which provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended or a recurring basis. It provides 24-hour inpatient care and, as a minimum, includes physician, skilled nursing, dietary, pharmaceutical services and an activity program.

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 requirements:

- Is a separate facility or a distinct part of another health care facility;
- Provides 24-hour per day Skilled, Intermediate or Custodial Care under the supervision of a full-time RN or a Physician;
- Is recognized by Medicare as a Nursing Facility;
- Has documented methods and procedures for administering drugs and biologicals; and
- Maintains ongoing clinical records for all patients.

Nursing Facility also means a Facility that is licensed as a specialized Alzheimer's unit in all states where such licensure exists. If a Facility has multiple licenses, a portion, wing, ward, or unit may qualify as a Nursing Facility only if it meets all of the above criteria; is authorized to provide nursing care to inpatients; and is engaged principally in providing such nursing care in accordance with that license.

A Nursing Facility is not: an acute care unity of a hospital (unless a distinct part of a hospital meeting the above definition of Nursing Facility); Residential Care Facility; a government or veteran's facility or any other facility where the patient is not required to pay for services; or a facility that exists specifically to treat alcoholism and drug addiction.

Owner

Owner means the Insured.

Our Care Planner

Our Care Planner means an organization, individual or group of individuals, who is designated by Us but independent of Us and are not an employee or compensated in any manner that is linked to the outcome of the certification. Our Care Planner will do the following:

- Conduct the initial Assessment We require under this Policy to determine that Your condition satisfies the Eligibility and Payment of Benefits Provisions under this Policy;
- Prepare a Plan of Care for Our Insureds;
- Prepare, when appropriate, a certification that You are Chronically Ill;
- Conduct any additional Assessments We require to determine Your continued eligibility for Benefits during the period of time You may be claiming Benefits under this Policy. Certification shall be renewed every 12 months; unless the existing certification indicates that the chronic illness is expected to last less than 12 months;
- Review any records, including medical records, We deem necessary to determine Your continued eligibility for Benefits. Certification shall be renewed every 12 months; unless the existing certification indicates that the chronic illness is expected to last less than 12 months; and

- Perform other duties requested by Us to verify that You are eligible for Benefits and You are receiving the care and services as prescribed in Your Plan of Care.

Our Care Planner will be a Licensed Health Care Practitioner whose profession and training include experience in managing and arranging for Qualified Long-Term Care Services or an organization that includes such Licensed Health Care Practitioners.

Partner

Partner means another individual who resides in the same household with You and shares living expenses; and with whom You are:

- Legally married;
- In a committed relationship that has been documented in a valid certificate, license, civil union, or domestic partnership that exhibits an intent to remain in a lifelong relationship; or
- In a committed domestic relationship for the most recent three years and that relationship is intended to be lifelong.

You and Your Partner must not be:

- In any other legally recognized or committed relationship with another individual;
- Separated or divorced at the time You applied for this Policy; or
- Related in any way that would prohibit marriage in the state where You live.

You may only have one Partner for the purposes of this Policy.

Personal Care Services

Personal Care Services means assistance with the Activities of Daily Living, including Instrumental Activities of Daily Living, provided by a skilled or unskilled individual under a Plan of Care developed by a Licensed Health Care Practitioner or a multidisciplinary team under medical direction.

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 state where and at the time 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 care services, and the cost, if any,prescribed for a Chronically Ill individual by a Licensed Health Care Practitioner. A Plan of Care must be completed for Benefits to be payable. We will not pay charges for care or services which are not included in or are inconsistent with Your prescribed Plan of Care. The Plan of Care may be modified as appropriate to reflect Your changing care needs.

Policy

Policy means the contract between You and Us.

Policy Anniversary Date

Policy Anniversary Date means the Policy Anniversary Date shown on the Benefit Schedule.

Policy Effective Date

Policy Effective Date means the date this Policy first takes effect as shown on the Benefit Schedule.

Policy Lifetime Maximum

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

Preexisting Condition

Preexisting Condition means an injury or sickness for which You received medical advice or treatment during the six months prior to the Policy Effective Date. This Policy does not contain any Preexisting Condition provisions, limitations or exclusions.

Proof of Loss

Proof of Loss means an itemized invoice or invoices from the provider(s) who furnished care to You that documents, at a minimum, the daily, weekly and monthly charges for the care and the type of care provided to You.

Qualified Long-Term Care Services

Qualified Long-Term Care Services means services that meet the requirements of Section 7702B(c)(1) of the Internal Revenue Code of 1986, as amended as follows: necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or Personal Care Services, which are required by You when You are Chronically Ill, and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

For purposes of this Policy, Qualified Long-Term Care Services will include In-Home Support Equipment.

Residential Care Facility

Residential Care Facility means a facility licensed as a residential care facility for the elderly or a residential care facility as defined in the Health and Safety Code. Outside California, eligible providers are facilities that meet applicable licensure standards, if any, and:

- engage 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 and 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.

Residential Care Facility is not: an acute care unit of a hospital; Nursing Facility; a government facility or any other facility that does not impose charges for Your confinement; a facility that exists specifically to treat alcoholism and drug addiction.

Rider Effective Date

Rider Effective Date means the date(s) on which the coverage for any Rider(s) attached to this Policy begin(s).

Room and Board

Room and Board means charges for lodging, utilities and food provided to a Chronically Ill individual in a Facility. Room and Board does not include:

- Items of comfort such as toiletries, television rental, laundry charges, beauty and hair charges, which are not Qualified Long-Term Care Services; or
- Charges for Ancillary Services that are not Qualified Long-Term Care Services; or
- Charges for or incurred by any person other than You.

Severe Cognitive Impairment	Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that is (a) comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia, and (b) measured by clinical evidence and standardized tests that reliably measure impairment in the individual's (i) short or long-term memory, (ii) orientation as to people, places, or time, and (iii) deductive or abstract reasoning.
Standby Assistance	Standby Assistance means the physical 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 the Activities 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).
Substantial Assistance	Substantial Assistance means Hands-On Assistance or Standby Assistance.
Substantial Supervision	Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures or other demonstrations) by another person that is necessary to protect You or others from threats to health or safety if You suffer from a Severe Cognitive Impairment.
We, Us, or Our	We, Us or Our means New York Life Insurance Company.
Workers' Compensation Benefits	Workers' Compensation Benefits means Benefits Paid or Payable under any state or federal workers' compensation, employers' liability, or occupational accident or disease law.
You, Your or Yourself	You, Your or Yourself means the person listed on the Benefit Schedule as the Insured and, if the context indicates, it may mean the Owner if different from the named Insured.

Section II. Eligibility and Payment of Benefits Provisions

Payment of Benefits

We will only pay Benefits under this Policy when We can verify that all of the following have occurred:

- You have satisfied the requirements of both the Eligibility for the Payment of Benefits and Additional Benefit Eligibility Provisions set forth below;
- You have initiated a claim and undergone an Assessment as described in the Benefit Assessment provision below and all requested information including, but not limited to, medical records and care notes, have been provided to Us;
- You are certified by a Licensed Health Care Practitioner as a Chronically Ill individual and that certification has been performed within the last twelve Calendar Months. This certification may be accomplished as part of the Assessment We request;
- You have a Plan of Care developed by a Licensed Health Care Practitioner and that Plan of Care must prescribe the types, frequency and expected duration of care, services or supplies that You need;
- We have evaluated Your Proof of Loss forms along with other information provided to Us and determined the care or services You have received are Eligible Charges and the provider of the care or services is an eligible provider;
- The Qualified Long-Term Care Services You receive are provided to You pursuant to a Plan of Care;
- Your coverage under this Policy was in force on the date(s) the Qualified Long-Term Care Services were received, except when the Facility Services commence while the Policy is in force and Benefits are provided under the Extended Coverage Benefit;
- You have satisfied any applicable Elimination Period under this Policy;
- You have not exhausted any applicable daily, monthly, annual or lifetime maximums under this Policy or any attached riders; and
- You have met the requirements under the Claims section of this Policy.

Eligibility for the Payment of Benefits

You will be eligible for Benefits provided by this Policy when We determine that You are (i) Chronically Ill or (ii) have a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (i).

Additional Benefit Eligibility Provisions

The following are additional requirements that must be met before We will pay Benefits under the provisions of this Policy. This Policy must be in force, except in the case where:

- Facility Services commenced while this Policy was in force; and
- Benefits are being provided under the Extended Coverage Benefit.

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, except as provided in a Benefit provision.

Benefit Assessment

We may request an Assessment to be performed when and as often as We may reasonably require, provided that at least 90 days have passed since the date You were last certified as Chronically Ill. The Assessment will be performed promptly, with the necessary certification completed quickly in order to ensure that Benefits to which You are entitled are not delayed. The Assessment will be used to determine whether Benefits should be paid and will not count against the Policy Lifetime Maximum. Assessments may be performed no more often than once every 12 months, unless the existing certification indicates that chronic illness is expected to last less than 12 months.

You should notify Us as soon as You plan to enter a Facility or begin or plan to begin receiving other Qualified Long-Term Care 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.

You may submit a certification from a Licensed Health Care Practitioner chosen by You or You may submit a Notice of Claim and request that We arrange for an Assessment to be performed by Our Care Planner.

When We request an Assessment or re-Assessment, We may use Our Care Planner to perform the Assessment for Us. We will pay for the Assessment or re-Assessment. If a Licensed Health Care Practitioner determines that You are not Chronically Ill, and the Licensed Health Care Practitioner did not personally examine You, You are entitled to a second Assessment by personal examination. The requirement for a second Assessment shall not apply if the initial Assessment was performed by a Licensed Health Care Practitioner who personally examined You.

All Assessments will be performed by a Licensed Health Care Practitioner who is not Our employee and will not be compensated in any manner that is linked to the outcome of the certification.

Notification of New Benefits

We will notify You of the availability of new benefits or benefit eligibility within 12 months of the date the policy series is made available in California. To be eligible for an upgrade of Your existing Policy, You must not 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 premium credits for past premiums paid; or
- By replacing Your existing Policy with a new Policy based on Your original issue age.

Increases in Benefits

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

- The Benefit Period; or
- The Facilities Services Maximum Daily Benefit;
- The Policy Lifetime Maximum; or
- The Home and Community-Based Care Daily Maximum Benefit.

Provided that You:

- Meet any underwriting requirements; and
- Pay the additional premium for the increase in benefits. Additional benefits will be priced 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 based on the addition of benefits noted above. The increases applicable to this provision are in addition to any other contractual increases.

No Preexisting Condition Exclusion

This Policy does not contain a Preexisting Condition exclusion.

Section III. Benefits Included In This Policy

This section describes the Benefits We will pay after You have met all of requirements described in the Eligibility and Payment of Benefits section.

Facility Services Benefits

We will pay Benefits while You are confined in a Facility and receiving Facility Services, provided Your stay begins while Your coverage under this Policy is in force.

We will pay Eligible Charges incurred at the Facility while You are confined in an amount no greater than the Facility Services Maximum Daily Benefit shown on the Benefit Schedule.

Eligible Charges if confined in a Residential Care Facility include all expenses incurred for Qualified Long-Term Care Services and shall be covered and payable, up to but not to exceed the Facility Services Maximum Daily Benefit. Qualified Long-Term Care Services do not need to be provided by the Residential Care Facility and may be provided by any qualified provider, as long as the expenses are incurred while You are confined in the Residential Care Facility.

Eligible Charges if confined in a Nursing Facility include only the daily charge to inpatients for Room and Board and charges for Ancillary Services.

The Elimination Period applies to Benefits provided for Facility Services.

All services and Facilities required to be available in the state where the Policy was issued will be covered even if the state licenses, certifies or registers the provider of services under another name.

Facility Bed Reservation Benefit

We will pay the Eligible Charges of a Facility to reserve Your place if You are receiving Facility Services and are temporarily absent from the Facility for any reason, but only after You have been formally admitted to the Facility and have been confined for at least one night.

We will pay the Facility's normal charge to reserve Your place up to Your Facility Services Maximum Daily Benefit for a maximum of 60 days in any Calendar Year.

The Elimination Period applies to this Benefit.

Extended Coverage Benefit

Lapse or termination of Your Policy will not end Benefits Payable for Facility Services if Your confinement in a Facility begins while Your Policy is in force and confinement continues without interruption after Your Policy lapses or terminates. We will continue to pay for the Facility Services You incur, provided that only Eligible Charges for Facility Services will be covered and only so long as You remain continuously confined. If there is an interruption or end to Your confinement for any reason or You no longer qualify for Benefits under the Eligibility and Payment of Benefits Provisions of Your Policy, Your Policy will be of no further force and effect and no further Benefits will be payable.

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.

Home and Community-Based Care Benefit

For each day on which You receive Home and Community-Based Care, We will pay the Eligible Charges for the Home and Community-Based Care You receive on that day up to the Home and Community-Based Care Maximum Daily Benefit amount shown on the Benefit Schedule. Home and Community-Based Care includes Home Health Care,

Adult Day Care, Personal Care Services, Homemaker Services, Hospice Care and Caregiver Relief (also known as respite care). The total amount payable under this Benefit each day on which you receive covered care will not exceed the Home and Community-Based Care Maximum Daily Benefit amount shown on the Benefit Schedule.

Benefits for Home Health Care are only payable if provided by a person who is employed by a Home Health Agency or holds the appropriate degree or state license to provide such services in the jurisdiction where the care or services are performed.

Benefits for Adult Day Care are payable for Eligible Charges for care and services provided by an Adult Day Care Center.

We will require the provider of Home Health Care or Adult Day Care to provide Us with sufficient information in order for Us to determine whether their charges for any services provided to You are Eligible Charges before paying any Benefits for Home Health Care or Adult Day Care. We will require the provider of Home Health Care of Adult Day Care to give evidence of their licensure if licensure is required by the state in which the care or services are provided.

Benefits for Personal Care Services or Homemaker Services are payable if provided by a person (skilled or unskilled) who is employed by a Home Health Care Agency or is properly licensed to provide such services when licensure is required by the jurisdiction where the care or services are performed. Personal Care Services or Homemaker Services will not be paid when they are provided by a Family Member or Partner who lives in Your home or residence. The Plan of Care must document in advance who the skilled or unskilled individual will be; his or her relationship to You; and the days and hours of planned care. We will not pay Benefits for Personal Care Services or Homemaker Services You may have received prior to Our receipt of Your Notice of Claim.

Benefits for Home and Community-Based Care will not be paid if provided by an unlicensed person in a state where licensure is required by law.

The Elimination Period applies to the Home and Community-Based Care Benefit and Benefits Payable will be counted against the Policy Lifetime Maximum, except as otherwise indicated in the Benefit provision.

In-Home Support Equipment Benefit

We will pay the Eligible Charges You incur to purchase or rent In-Home Support Equipment up to the In-Home Support Equipment Lifetime Maximum Benefit shown on the Benefit Schedule. We will pay the Eligible Charges provided that such equipment must:

- Be prescribed in Your Plan of Care and first purchased or rented after the Policy Effective Date;
- Enable You to perform any of the Activities of Daily Living and allow You to remain in Your Home for an expected period of at least 90 days after the purchase or rental;
- Include an itemized bill for the purchase or rental showing the date the equipment was purchased or rented;
- Not materially increase the value of Your Home; and
- Not be for the use of any other person in Your Home.

The Elimination Period does not apply to this Benefit. The amounts We pay will not be considered daily Benefits, and do not count against the Policy Lifetime Maximum, but will count against Your In-Home Support Equipment Lifetime Maximum Benefit. In no event will In-Home Support Equipment Benefits be paid if We have paid Benefits equal to the Policy Lifetime Maximum.

Care Plan Benefit

We will pay the charges to certify that You are, or continue to be, Chronically Ill and for Our Care Planner to prescribe a Plan of Care for You, except as provided below.

If You request a Plan of Care from Our Care Planner, You may still, at any time and 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 Our Care Planner.

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

While You are following the Plan of Care prescribed by Our Care Planner, We will determine Your Home and Community-Based Care Benefit payment amount on a monthly, rather than a daily basis and will pay Eligible Charges You incur for Home and Community-Based Care Benefits in any Calendar Month, up to 31 times the Home and Community-Based Care Maximum Daily Benefit as shown on the Benefit Schedule.

A Plan of Care must be provided before Benefits will be payable. A Care Planner must certify that You remain Chronically Ill and prescribe a Plan of Care for You at least annually.

There is no Elimination Period to use the Care Plan Benefit. The amounts We pay under the Care Plan Benefit do not count against Your Policy Lifetime Maximum. You must, however, satisfy the applicable Elimination Period before We will pay Benefits for the Qualified Long-Term Care Services Our Care Planner prescribes and develops, and the Benefits We pay for such Qualified Long-Term Care Services will count against the Policy Lifetime Maximum unless otherwise specified in the Policy.

Caregiver Training Benefit

We will pay the cost of training an individual to provide You with Personal Care Services in Your Home, up to a lifetime maximum of five times the Facility Services Maximum Daily Benefit as shown on the Benefit Schedule provided that:

- The training is prescribed in Your Plan of Care;
- The Plan of Care must document in advance who the person will be; his or her relationship to You; and the days and hours of planned service;
- The training cannot be received while You are confined in a hospital or Facility, unless it is expected that You will return Home where the person that is receiving the training can care for You; and
- The Benefits payable to train an individual are only the costs associated with the training and not the cost for Personal Care Services as stated under the Home and Community-Based Care Benefit provision in this Policy.

The Caregiver Training Benefit may be used to train an Informal Caregiver. That person must be designated as required in Your Plan of Care and may not be employed by a Home Health Care Agency.

The Elimination Period does not apply to this Benefit. The Benefits Payable are not considered a daily Benefit, and days on which any person is being trained under this Benefit do not count toward satisfying the Elimination Period under this Policy. The Benefits We pay will count against the Policy Lifetime Maximum.

Caregiver Relief Benefit

We will pay a Benefit for each day of Caregiver Relief that You receive up to a maximum of 30 days per Calendar Year.

Benefits Payable will be the actual charges You incur for Facility Services or Home and Community-Based Care, up to the Facility Services or Home and Community-Based Care Maximum Daily Benefit shown on the Benefit Schedule.

You do not have to meet the Elimination Period to use this Benefit and the days for which We pay Eligible Charges do not count toward satisfying the Elimination Period under this Policy. The Benefits We pay will count against the Policy Lifetime Maximum.

Hospice Care Benefit

If You are receiving outpatient services, not paid by Medicare, that are designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts due to the existence of a terminal disease with a life expectancy of less than six months, We will pay the Eligible Charges You incur for Hospice Care provided to You in a Facility up to the Facility Services Maximum Daily Benefit amount.

For Hospice Care provided in a location other than a Facility, We will pay the Eligible Charges of the services, up to the Home and Community-Based Care Maximum Daily Benefit shown on the Benefit Schedule.

You do not have to meet the Elimination Period to use this Benefit and the days for which We pay Eligible Charges do not count toward satisfying the Elimination Period under this Policy. The Benefits We pay will count against the Policy Lifetime Maximum.

World Wide Coverage Benefit

Provided You have satisfied the Elimination Period and You become eligible for Benefits while outside the United States, this Policy will pay Benefits for Eligible Charges You incur for covered services received outside the United States up to the World Wide Coverage Lifetime Maximum Benefit shown on the Benefit Schedule.

The premium will not be waived and no further Benefits will be payable under the World Wide Coverage Benefit once You exhaust the World Wide Coverage Lifetime Maximum Benefit. Provided Your Policy remains in force, once Your World Wide Coverage Lifetime Maximum Benefit is exhausted, no additional Benefits are available unless and until You return to the United States and incur Eligible Charges for which Benefits are payable within the United States.

The World Wide Coverage Benefit does not apply when You are receiving Personal Care Services and Homemaker Services..

For purposes of the Policy, the United States means the 50 US states, the District of Columbia and US territories.

Waiver of Premium Benefit

Provided You have satisfied the Elimination Period, premiums will be waived beginning on the first day that Benefits are payable under this Policy. The Waiver of Premium Benefit will continue until You have not incurred Eligible Charges for 45 consecutive days.

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

You must resume paying premiums on the first day in which premiums are due after the first consecutive 45 day period during which no Benefits are payable under this Policy.

If Benefits are being paid under the World Wide Coverage Benefit, We will not waive the premiums under this Policy. You will not be eligible for the Waiver of Premium Benefit unless and until You return to the United States and incur Eligible Charges for which Benefits are payable within the United States.

The Waiver of Premium Benefit does not apply when You are only receiving Personal Care Services, Homemaker Services, Benefits under the In-Home Support Equipment Benefit or Hospice Care Benefit.

Alternate Plan of Care Benefit

You may request an Alternate Plan of Care for the use of facilities, providers or other items not otherwise covered by this Policy such as additional equipment; additional home safety devices; or stays in other types of facilities. We will review Your request with You and, if all parties agree, approve the additional Qualified Long-Term Care Services set forth in the Alternate Plan of Care. The Alternate Plan of Care will be developed with a Licensed Health Care Practitioner.

The following terms apply under this Benefit:

- Except as We expressly agree in the Alternate Plan of Care, Your rights and Ours will be governed by all of the Policy provisions;
- The Alternate Plan of Care Benefit may only be available if You are otherwise eligible to receive Qualified Long-Term Care Services;
- The Benefits We agree to pay under the Alternate Plan of Care must be for Qualified Long-Term Care Services as defined in the Internal Revenue Code Section 7702B(c); and
- The Alternate Plan of Care Benefit will not be approved unless and until You and We agree to the Qualified Long-Term Care Services and other terms to be provided under and governed by such Benefit. We reserve the right in Our sole discretion not to provide such Benefit if You and We cannot agree.

The additional services under the Alternate Plan of Care will only be available for a mutually agreed upon period of time (for example, one year). At the end of the mutually agreed upon period of time, the Alternate Plan of Care will end unless We agree to renew it. You may terminate an Alternate Plan of Care at any time by giving Us at least 15 days advance written notice of the termination.

Coverage for services, providers, or places of care under an Alternate Plan of Care shall be in addition to, not in lieu of, coverage for services, providers or places of care that are specifically defined as covered services, providers, or places of care under this Policy. If an Alternate Plan of Care is adopted, it replaces any existing plan of care, including any previously adopted Alternate Plan of Care. No Benefits are payable for services provided pursuant to a Plan of Care after it is replaced by an Alternate Plan of Care.

An Alternate Plan of Care may be replaced by a new Plan of Care at any time. If a new Plan of Care is not an Alternate Plan of Care, We do not need to agree to the changes in advance and will provide Benefits according to the provisions of Your Policy. If the new Plan of Care is an Alternate Plan of Care (either a new or amended), We have the right to approve or disapprove the new or amended Alternate Plan of Care. No Benefits are payable for services provided pursuant to an Alternate Plan of Care after it is replaced by a new Plan of Care.

After an Alternate Plan of Care terminates, We will resume paying Benefits for Eligible Charges You incur according to all of the provisions of this Policy.

We reserve the right to decline any request for an Alternate Plan of Care, but We will carefully and objectively consider all requests. If We and You cannot agree on the terms of an Alternate Plan of Care, We will provide a written explanation as to the specific reason why the request for an Alternate Plan of Care was declined, within 60 days of Our determination that an agreement cannot be reached.

Contingent Nonforfeiture Benefit Upon Lapse

Your Policy includes a Contingent Nonforfeiture Benefit Upon Lapse and is effective on the date on which this Policy is issued to You. The Contingent Nonforfeiture Benefit Upon Lapse provides limited coverage if Your Policy lapses within 120 days of the premium due date of the increased premium following a Substantial Cumulative Premium Increase. A Substantial Cumulative Premium Increase in the annual premium is one equal to or exceeding the percentage of Your initial annual premium set forth below based on Your issue age. Additionally:

- The purchase of additional coverage shall not be considered a premium rate increase. However, for purposes of the calculations of the ratio shown below of Percentage Increase Over Initial Premium, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.
- If You decrease Your Benefits, the initial annual premium will be reduced by the amount of the decrease in Your premium.

If Your Policy has been in effect for 20 years, You do not need to meet the issue age or percentage increase amount shown in the table below to be eligible for the Contingent Nonforfeiture Benefit Upon Lapse.

Contingent Nonforfeiture

Substantial Cumulative Premium Increase Over Initial Premium That Qualifies for Contingent Nonforfeiture (Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.

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

You will be notified at least 60 days prior to the date of any premium rate change.

On or before the effective date of Substantial Cumulative Premium Increases that trigger the Contingent Nonforfeiture Benefit Upon Lapse, We will:

- Offer to reduce Policy Benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;
- Offer to convert the coverage to a paid-up status with a shortened Benefit Period based on the Contingent Nonforfeiture Benefit Amount. 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.

If the Contingent Nonforfeiture Benefit Upon Lapse becomes effective according to the above provisions, Benefits will be payable under the Policy any time You qualify for Benefits during the remainder of Your life subject to all of the provisions and conditions of the Policy. Benefits will be based on all of the Benefit limits in effect at the time of lapse, but may not be increased thereafter.

The Benefits Payable will not exceed the Contingent Nonforfeiture Benefit Amount which is the greater of:

- 100% of the total of all premiums paid while Your Policy was in force, regardless of Benefit changes up to the date You request the Contingent Nonforfeiture Benefit Amount; or
- Thirty times the Facility Services Maximum Daily Benefit amount at the time of lapse.

The Contingent Nonforfeiture Benefit Amount will not exceed the remaining Policy Lifetime Maximum at the time the Policy lapses and the Contingent Nonforfeiture Benefit Upon Lapse becomes effective.

If you elected the Optional Nonforfeiture Benefit Rider, and Your Policy is continued in accordance with any Optional Nonforfeiture Benefit, this Policy's Contingent Nonforfeiture Benefit will not apply.

Section IV. Conditions, Limitations And Exclusions

This section explains the conditions under which We will not pay Benefits or will reduce the Benefits We pay. 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.

General Exclusions and Limitations

No Benefits will be paid and the Elimination Period will not be satisfied for any confinement, care, treatment or service(s) included in this Policy for charges You incur:

- Due to war, whether declared or undeclared;
- Suicide, whether or not the person had mental capacity to control what he or she was doing, attempted suicide, or intentionally self-inflicted injury;
- Due to conditions resulting from illness or injury received while participating in a felony, riot or insurrection;
- For care received outside of the United States 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 for which Benefits are available under any state or federal Workers' Compensation Benefits, employers' liability or occupational disease law;
- From a Family Member or Partner, except as explicitly provided for elsewhere in this Policy;
- For non-Qualified Long-Term Care Services, which may include medications or supplements; items of comfort such as toiletries, television rental, laundry charges, beauty and hair charges; and transportation costs, emergency or non-emergency, including transfers from Your Home to a Physician's office or transfers provided by an ambulance service.
- 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;
- Transportation expenses incurred by an individual who is currently providing care to You under the Home and Community-Based Care Benefit provisions of this Policy are also excluded; or
- For services provided to or for the benefit of anyone other than You, except as expressly provided elsewhere in this Policy.

Specific Exclusions and Limitations

Facility Services Maximum Daily Benefit: The Facility Services Maximum Daily Benefit shown on the Benefit Schedule is also the maximum amount We will pay under this Policy and any attached riders for any day You incur Eligible Charges except as specifically indicated elsewhere in this Policy. This limitation applies even if Benefits would be payable under more than one of the provisions included in this Policy and any attached riders.

Policy Lifetime Maximum: No additional Benefits are payable under this Policy once We have paid Benefits equal to the Policy Lifetime Maximum except as may be provided under the Shared Care Rider, if selected.

Chronic Illness Certification: No Benefits are payable under this Policy for charges You incur on any day for which You are not certified as a Chronically Ill individual.

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 Plan of Care or Alternate Plan of Care.

Section V. Effect Of Other Coverage

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 all charges that are covered by Us and Medicare (except when Medicare is a secondary payor), We will reduce Your Benefits under this Policy so that the Policy's Benefits plus Medicare benefits are equal to 100% of all charges up to the Facility Services Maximum Daily Benefit. As required by Internal Revenue Code Section 7702B(b), the Medicare benefits We consider payable in determining Our payment will include all deductible and coinsurance amounts Medicare did not pay.
- 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).

Effect of Medicaid

Medicaid (also known as Medi-Cal in California) is a state administered program and sets its own guidelines regarding eligibility and services. You should be aware that if You have Medicaid and Benefits become payable under this Policy, the state may require that We pay the state directly (in lieu of Our payment to You), if the state has made payments for Your long-term care.

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 Policy 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.

Section VI. Claims

This section explains how to file a claim and how the claim will be paid. In order for Us to process Your claim in a timely manner, please review the following information.

Notice of Claim

To file a claim for Benefits, We must be notified within 60 days, or as soon as reasonably possible if You are incapable of giving notice within 60 days, after a covered loss occurs or begins. Notice of Claim must include at a minimum Your name and Policy Number or other information sufficient to identify You if the Policy Number is not available, and can be given to Us via mail or by phone at Our Administrative Offices.

Claim Forms

When We receive Your Notice of Claim, We will give You the forms for filing proof of benefit eligibility. If We do not provide these forms to You within 15 days after We receive Your Notice of Claim, You need not use such forms if, instead, You give Us written proof of the nature and extent of the loss.

Our Rights to Perform Assessments

Before We approve a claim for Benefits, We may examine You or request Our Care Planner to perform an Assessment of You when and as often as We may reasonably require, provided that at least 90 days have passed since the date You were last certified as Chronically Ill, before paying any Benefit. Any such examination or Assessment will be at Our expense. We may also request other information related to Your health in addition to the Assessment. Assessments may be performed no more often than once every 12 months, unless the existing certification indicates that chronic illness is expected to last less than 12 months.

Providing Proof of Loss

Upon completion of any Assessment and if all other requested information has been provided to Us, We will determine whether You are eligible for payment of Benefits. In order to be eligible, You must submit Proof of Loss to Our Administrative Offices within 90 days after the date of loss. For any periodic Benefit payment contingent upon continuing loss, Proof of Loss must be given to Us within 90 days after the termination of each period for which We are liable. Failure to give Us the Proof of Loss within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give Proof of Loss within such time. However, the Proof of Loss 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 of Loss is otherwise required.

Payment of Claims

We will immediately pay Benefits for any loss covered by this Policy only after We have received complete written Proof of Loss. We will pay Benefits on a daily (or monthly, if applicable) basis after We have been provided with the Proof of Loss.

While You are living, all Facility Services Benefits will be paid to You or at Your request, or when required by law, to a provider who has furnished covered services to You. All Benefit for on-facility services You receive will be paid to You

Any outstanding Facility Services Benefits or Benefits for non-facility services that have not been paid at the time of Your death will be paid to Your designated Beneficiary (if any), otherwise to Your estate, unless otherwise required by law. At Our option, if the Benefit payable at Your death is $1,000 or less, We may pay this amount to an alternative payee, such as a surviving Partner or adult child.

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 three years from the date the Proof of Loss is required to be given. Any legal actions with respect to any Benefits under this policy will be consistent with the applicable laws of the state in which the policy is delivered or issued for delivery.

Appealing a Claim

We will inform You in writing if a claim or any part of a claim is denied and provide You with an explanation of the reasons for the denial. Upon Your request, We will make available to You all information directly related to the denial. We will provide this information within 60 days of Your request.

If You believe that Our claim decision is in error, You may appeal Our decision within 120 days of receipt of Our denial by sending Us a written letter explaining the basis for Your appeal. You should include any documentation available to support Your position, such as additional information from any health care professionals, Licensed Health Care Practitioners, Your Physician, or Your medical records. You should also provide the names, addresses and telephone numbers of Licensed Health Care Practitioners, other health care professionals or facilities where You received care, treatment, services, equipment and any information You think We should consider in reviewing Your physical or mental condition. You may authorize, in writing, someone else to act for You in the appeal process. 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.

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.

This Policy provides an internal appeals process, and if required by the state of jurisdiction, a review of the claim decision by an independent review organization. All claim decisions and the appeals process for resolution of any claim disputes will be consistent with the applicable laws and regulations in the state of jurisdiction.

Section VII. Premiums and Reinstatement

Premium Rates

The premium rates for the Benefits included in this Policy are shown on the Benefit Schedule.

Payment of Premiums

The initial premium payment is due on the Policy Effective Date. Each premium, after the initial premium payment, is due on the Premium Due Date shown on the Benefit Schedule and is subject to the Grace Period. 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. Premiums must be paid to Our Administrative Offices, or to any other address that We designate.

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 paying premiums more frequently than annually.

Changes in Premiums

We have the right to increase Your premium rates on any Policy Anniversary Date on or after the third Policy Anniversary Date. Any such increase 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 also change Your premium rates at any time due to a change in the requirements of applicable law. Any premium rate increase is subject to approval by the California Department of Insurance.

Grace Period

This Policy has a 31-day Grace Period. This means that if any premium after the initial premium is not paid in full by the Premium Due Date, it may be paid in full during the 31-day period following that date. During the Grace Period, this Policy will stay in effect. You will receive a lapse notice mailed 30 days after the Premium Due Date. The notice will be given by first class United States mail, postage pre-paid and notice will be deemed to have been given five days after the date We mail it. You will therefore have a total of 35 days from the date of the lapse notice to pay all premiums due. If the overdue premiums are not paid and received by Us within that 35-day period, this Policy will terminate with a termination date of the Premium Due Date on which You failed to pay Your premium in full, resulting in the lapse of the Policy.

If You have designated a third party to receive lapse and termination notices, we will also mail a copy of the lapse or termination notice to the last address You provided to Us in writing for the person You have so designated. We will notify You at least once every two years of Your right to change or update this third party designation.

Reinstatement

Coverage After Lapse for Non-Payment of Premium. Within 6 months from the date on which Your Policy has lapsed for non-payment of premium, You may request in writing to reinstate Your Policy. If you pay all past due premiums within 30 days from the date on which the Policy has lapsed, We will not require that You provide Us with proof of insurability for Your Policy to be reinstated.

If Your payment of all past due premiums is not received by Us within 30 days of the date on which Your Policy has lapsed, you must apply for reinstatement and provide Us with proof of insurability that is acceptable to Us so that We may determine whether We will reinstate Your Policy. To apply for reinstatement, You must submit an Application for reinstatement and pay all past due premiums.

Upon receipt of Your Application and all past due premiums from You, We will issue a coverage agreement for the past due premiums while we consider Your Application for reinstatement. If Your Application for reinstatement is approved, Your Policy will be reinstated. If Your Application for reinstatement is disapproved, We will inform You of the disapproval in writing within 45 days from the date on which we issue the coverage replacement for Your past due premiums and return any past due premiums paid. If We fail to so inform You, Your Policy will be reinstated by Us on the 45th day following the issuance of the coverage replacement for Your past due premiums. Later acceptance of the premium by Us, without requiring an application for reinstatement, will reinstate the Policy.

The effective date of the reinstatement of Your Policy will be the date on which We approve Your Application for reinstatement. The reinstated Policy shall provide coverage for cognitive impairment or loss of functional capacity, as described in Section II of the Policy, that occurs after the date of reinstatement. In all other respects, Your rights and Our rights will remain the same, subject to any provisions noted in or attached to the reinstated Policy.

Upon approval of Your Application for reinstatement, a new Contestability Period, as described in the General Provisions of this Policy, will begin.

Coverage after Lapse due to Severe Cognitive Impairment or Functional Loss of two or more Activities of Daily Living. No proof of insurability or Application for reinstatement will be required by Us if this Policy terminates because of Your failure to pay premium due to a Severe Cognitive Impairment or a functional loss of two or more Activities of Daily Living, provided You request reinstatement within 5 months of the date of such termination.

The policy will be reinstated without proof of insurability if:

- You are the Insured;
- You furnish Us with proof of Severe Cognitive Impairment or a functional loss of two or more Activities of Daily Living; and
- You pay all past due premiums.

If Your Policy is reinstated, any covered losses incurred between the date on which Your Policy lapsed and the date on which Your Policy was reinstated will be paid by Us subject to the terms of Your Policy.

Right to Reduce Coverage and Lower Premiums

You have the right to reduce Your premiums by electing one or more of the following:

- Reducing the Policy Lifetime Maximum Benefit;
- Reducing the Facility Services Maximum Daily Benefit;
- Reducing the Home and Community-Based Care Maximum Daily Benefit;
- Reducing the Benefit Period; or
- Removing an optional rider, such as inflation protection, from Your Policy.

The request must be given to Us in writing at Our Administrative Offices and must be received and accepted by Us before any change will become effective. The notice must include at a minimum Your name, Policy number, the Benefit You are requesting to reduce and the reduced amount of the Benefit.

We may limit any reduction in coverage to plans and options available at the time You elect to reduce Benefits. If You choose to reduce Your Benefits or remove an optional rider, premium payments due after You reduce Your Benefits or remove an optional rider will be based on the premium payments that would have been in effect as of Your Policy Effective Date, including any premium increases that may be applicable under the Changes in Premiums provision of Your Policy.

You will not be entitled to a refund for any Premium paid prior to the effective date of the reduction in Benefits.

If Your Policy is about to lapse due to non-payment of premium, We will provide written notice of Your option to lower Your premium by reducing coverage. You will have 30 days to elect this option.

Section VIII. Coverage Provisions

When Coverage Begins

Your coverage begins on the Policy Effective Date shown on the Benefit Schedule, provided that We must deliver this Policy and You must pay the initial premium in full.

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 and the Shared Care Rider Benefits, if selected.

When Coverage Ends

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

- You do not pay Your premium when due (see the provision captioned Grace Period);
- The day the Policy Lifetime Maximum is exhausted and any Shared Care Rider Benefits are exhausted, if selected;
- The first day of the following month after You notify Us in writing that You wish to terminate Your coverage; or
- The day immediately following 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 designated Beneficiary, if any, otherwise to Your estate.

Section IX. General Provisions

Policy Ownership

The Owner is the person named as the Insured on the Benefit Schedule, unless another person is named the Owner on the Application and Benefit Schedule. 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 his or her death, 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.

The Owner may designate another Owner of this Policy at any time in writing while this Policy remains in force. This change will take effect as of the date the current Owner signed the request, excluding any payment We made or action We took prior to recording the change. When this change takes effect, all rights of Ownership will pass to the new Owner.

Assignment

This Policy may not be assigned.

Change of Beneficiary

While You are living, You may change the designated Beneficiary by notifying us in writing. The notice must be signed by You and clearly state the Beneficiary designation and the information We require, including but not limited to, Your Policy number, the Beneficiary's name, address, and social security number. Any change You request will take effect as of the date You signed the written notice, unless otherwise specified by You. The Beneficiary's consent is not required for any change, unless the designation of the Beneficiary is irrevocable.

Misstatement of Age or Gender

If Your age or gender has been misstated, the Benefits under this Policy will be those that the premium paid would have purchased at Your correct age and gender.

Entire Contract and Changes

This Policy, together with Your Application and any optional riders or attached documents, is the entire contract of insurance. Any Application used to modify this Policy (including, but not limited to, a request for reinstatement) will be attached to and made a part of the entire contract. Only our Chairman, President, Secretary, or a designated Vice President is authorized to change the contract, and then, only in writing. To be valid, any such change must also be endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions. If We change Our address or any toll-free telephone number, We will notify You.

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 Law

This Policy is subject to the laws of the state where the Policy is issued and requirements of any federal law or regulation. We reserve the right to correct any errors in this Policy including any misstatements of Policy values of which We may advise You while this Policy is in effect.

On the Effective Date of this Policy, if any provision is in conflict with the requirements of any state or federal law or regulation, that provision is automatically amended to conform to the minimum requirements of such laws and regulations. We may amend the Policy at any time necessary to meet the requirements of the law pertaining to qualified long-term care insurance contracts. If We are required to make such a change, We will notify You of such changes and You will have the opportunity to accept or reject the change required. If You reject such a change, the Policy may no longer be tax-qualified under the Internal Revenue Code. You should consult with a financial planning professional about the implications of any change to Your coverage.

If the Policy may be amended in more than one way to meet these requirements, We may determine how best to do so.

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 including amendments thereto, any successor law, or any applicable regulations. If any such amendment affects the risk We assumed, We may make an equitable premium increase.

Cross Border Rules

This Policy will pay Benefits for similar services obtained in a state of the United States other than the Policy state of issue if Benefits for those services would have been paid in the Policy state of issue, provided such Benefits are paid in accordance with the terms of this Policy.

Contestability Period

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

After the Policy has been in effect for two years, We may not rescind it or deny an otherwise valid claim unless You knowingly and intentionally misrepresented relevant facts relating to Your health in Your Application. If this Policy is rescinded after We have paid Benefits, We may not recover the Benefit payments already made.

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.