

# Privileged Choice® **Flex** California Partnership Sample Policy



This sample copy of Genworth Life Insurance Company's Long Term Care Insurance policy is being provided for informational purposes only. **THIS SAMPLE COPY IS NEITHER A CONTRACT OF INSURANCE NOR AN OFFER TO CONTRACT.** This is a sample only; actual policy provisions of an issued policy may differ. In the event a policy is issued to you, please review the policy provisions of the issued policy carefully.

Underwritten by Genworth Life Insurance Company, Richmond, VA  
7037D 02/26/14

# GENWORTH LIFE INSURANCE COMPANY

A Delaware stock insurance company (herein called We, Us and Our)  
 Administrative Office: 3100 Albert Lankford Drive, Lynchburg, VA 24501  
 Phone: 800-456-7766

An Approved Participant In



CALIFORNIA PARTNERSHIP FOR  
 LONG-TERM CARE

## COMPREHENSIVE LONG TERM CARE INSURANCE POLICY

### DECLARATIONS

We are pleased to issue the Policy to You (the Insured named in the Schedule). Keep it in a safe place as it is a legal contract between You and Us.

**CAUTION: The issuance of the Policy is based upon Your answers to the questions on Your Application. A copy of Your Application is attached to the Policy. If Your answers are misstated or untrue, We may have the right to deny Benefits or rescind the Policy subject to the Misstatements and Incontestability provision. 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 the address and telephone number shown above.**

**NOTICE TO BUYER:** The 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 Coverage limitations.

**THIS 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.

**THE POLICY IS GUARANTEED RENEWABLE.** This means that You have the right, subject to the terms of the Policy, to continue the Policy in force until Benefits have been exhausted by paying the required Premium when due. We cannot cancel or refuse to renew the Policy; except as may be provided for under the Misstatements and Incontestability provision. We can change Your Premium as provided below. Upon approval by the California Department of Insurance, We may change the Premium rate or make changes required by law. We cannot change any other terms of the Policy without Your consent.

**WE HAVE A LIMITED RIGHT TO CHANGE PREMIUM. We have the right to change Premium becoming due in the future.** Subject to approval by the California Department of Insurance, We can change Premium; but only if we change the Premium schedule for all California Partnership policies. Premium may be changed due to: a change in Benefits or terms of Coverage; or a change required by any law, regulation, judicial or administrative order or decision. Premium changes may also be based on actual experience, a change in the factors bearing on the risk assumed, or Our estimates for future experience; a change in any of these reasons may occur only once in any 12 month period. Premium will not change due to a change in Your age or health, use of Benefits, or if You divorce. We will give You at least 60 days written notice before We change Premium.

**FREE LOOK – 30 DAY RIGHT TO EXAMINE YOUR POLICY:** You have 30 days from the day You receive the Policy to examine and return it to Us. You can return it for any reason. Simply return it to the address shown above, or to the agent, producer or office through which it was bought. We will refund, directly to You, the full amount of all Premium and fees paid for the Policy within 30 days of such a return. The Policy will then be void from the start; and You will not be insured under the Policy or entitled to any Benefits.

**The Benefits payable by the Policy qualify for Medi-Cal Asset Protection under the California Partnership for Long-Term Care. Eligibility for Medi-Cal is not automatic. If and when You need Medi-Cal, You must apply and meet the asset standards in effect at that time. Upon becoming a Medi-Cal beneficiary, You will be eligible for all medically necessary benefits Medi-Cal provides at that time, but You may need to apply a portion of Your income toward the cost of Your care. Medi-Cal services may be different than the services received under the private insurance.**

The Policy is intended to be a federally tax qualified long term care insurance contract and may qualify You for federal; and State tax benefits.

Signed for Genworth Life Insurance Company.

## TABLE OF CONTENTS

These are the major sections of this Policy in the order in which they appear.

Section	Contents of Section	Page
Declarations .....	This section includes notices and other important information.	1
Table of Contents .....	This lists the major sections in this Policy.	2
Schedule .....	This shows Benefits, services and limitations of the Policy at the time of issue. It includes Premium information.	3
Modal Premium Disclosure .....	This describes the additional charges associated with paying Premium more frequently than once per year.	4
The Partnership and Medi-Cal Asset Protection .....	This explains Medi-Cal Asset Protection under the California Partnership.	5
General Definitions .....	This provides the definitions of words used in the Policy that have special meaning when applied to the Policy. Additional terms not defined in this section are defined in the provisions in which they are most commonly used.	7
Period of Coverage .....	This describes how Coverage takes effect and is continued until Coverage ends.	10
Premium and Renewal .....	This states: how and when to pay Premium; the importance of paying Premium on time; what happens if Premium is not paid on time; and how We may change Premium.	11
Coverage Change Options .....	This tells You options You have to increase or decrease Coverage.	13
General Provisions .....	This tells You: the documents which make up the Policy; the importance of completing all applicable Applications truthfully; and other rights, obligations and features.	15
Benefit Provisions .....	This describes: how You become eligible for Coverage; the conditions under which We pay for Covered Expenses incurred; and how to determine how much and how long Coverage will be payable.	17
Claims Provisions .....	This tells You: when to notify Us of a Claim; how to start a Claim; what to send Us; how We pay Claims; and other related rights and responsibilities.	32
Exclusions and Limitations .....	This states the conditions under which Coverage will be limited, or not available at all, even if You would otherwise qualify for Benefits.	36
Attachments	Any applicable endorsements, riders and notices. A copy of all applicable Applications made for the Policy.	

## SCHEDULE

**Insured**

[John Q. Doe]  
[Apt #1234]  
[1234 Main Street]  
[Anytown, CA 99999]

**Policy Number**

[XXXXXXX]

**Policy Effective Date**

[7/01/2013]

**Issue State**

California

### COVERAGE FEATURES AND LIMITS

Benefits are payable for Covered Expenses that are incurred after the Elimination Period has been satisfied. Payment is subject to the limits determined below and all other provisions of the Policy. Changes in Your Schedule may be made by Rider.

**Elimination Period:** [[30][90] days of Covered Care]

[The Elimination Period is satisfied by days You incur a Covered Expense while You are Chronically Ill.]

OR [[30][90] calendar days]

[The Elimination Period is satisfied by days You are Chronically Ill beginning with the first day You incur a Covered Expense.]

[There is no Elimination Period for the Home and Community Care Benefit. In addition, days for which payment is made under that Benefit will count toward satisfying the Elimination Period.]

**Coverage Maximum**

[\$288,000]

**Nursing Facility Maximum**

[\$6,000 per calendar month]

**Benefit Increases**

[5% Compound]

See below

The Coverage Maximum and amounts based on the Nursing Facility Maximum are: (a) increased when Benefit Increases apply; and (b) exhausted only when the total of all Benefits paid equals the then applicable maximum amount. Benefit Increases that apply are not affected by any Benefits paid for Covered Expenses incurred prior to the date the applicable maximum is exhausted.

[5% Compound Benefit Increases: On each anniversary of the Policy Effective Date Your then current Nursing Facility Maximum and the current amounts of other dollar maximums will each increase by 5%.

These increases will be automatic; will not require proof of good health; and will be made without a corresponding increase in Premium. They will continue without regard to Your age, Claim status or Claim history, or length of time You have been insured under the Policy.

Benefit Increases cease when: (a) the applicable maximum has been exhausted; (b) they are terminated by You; or (c) the Policy ends.]

[OR APPLICANTS AGE 70 AND OLDER MAY CHOSE THE 5% Simple Benefit Increases]

[5% Simple Benefit Increases: On each anniversary of the Policy Effective Date Your then current Nursing Facility Maximum and the current amounts of other dollar maximums will each increase by 5% of the original amount issued. Calculation of the increased amounts is not affected by Benefit payments.

These Benefit Increases will be automatic; will not require proof of good health; and will be made without a corresponding increase in Premium. They will continue without regard to Your age, Claim status or Claim history, or length of time You have been insured under the Policy.

Benefit Increases cease when: (a) the applicable maximum has been exhausted; (b) they are terminated by You; or (c) the Policy ends.]

## SCHEDULE

(Continued)

<b>Benefits and Services Provided</b>	<b>We Pay Expenses Up to these Limits (except where otherwise noted)</b>
Privileged Care Coordination Services .....	Not subject to Coverage limits
Nursing Facility Benefit .....	Nursing Facility Maximum [per day][per calendar month]
Residential Care Facility Benefit .....	[70%/100%] of the Nursing Facility Maximum [per day][per calendar month]
Bed Reservation Benefit .....	60 days per calendar year
Home and Community Care Benefit .....	[50%/100%] of the Nursing Facility Maximum [Multiplied by 30] [per calendar month]
Home Assistance Benefit .....	A Policy total payment maximum equal to
(Equipment, modifications & training)	[[3 times Monthly][90 times Daily] the Nursing Facility Maximum]
Hospice Care Benefit .....	Included
Respite Care Benefit .....	30 days per calendar year
International Coverage Benefit .....	As stated in the Benefit
Waiver of Premium Benefit .....	Included
The Waiver of Premium applies only during periods for which Benefits are payable under the: Nursing Facility Benefit; Residential Care Facility Benefit; Bed Reservation Benefit; Home and Community Care Benefit; or Hospice Care Benefit	
[This also applies when Your Spouse or Partner for Shared Coverage qualifies for Waiver of Premium under this Policy or his or her Policy.]	
Your Right To Request Payment	
For Alternative Care .....	Payment subject to mutual agreement
Contingent Nonforfeiture Benefit.....	Included

### The following Riders are attached to, and included in, the Policy

[Nonforfeiture Benefit .....	Included]
[Shared Coverage Benefit.....	Included with Joint Waiver]
[Transition Benefit .....	A Policy total payment maximum equal to [5 times][20% of] the Nursing Facility Maximum]

The maximum total amount payable for all Covered Expenses incurred [on a day] [in a calendar month] is limited to the Nursing Facility Maximum. This does not apply to the Home Assistance Benefit and Benefits paid for requested alternative care.

**SCHEDULE**  
(Continued)

**PREMIUM DATA**

	Annual Premium
Basic Policy Coverage.....	\$XXX.XX
[Nonforfeiture Benefit Rider .....	\$XX.XX]
[Shared Coverage Rider.....	\$XX.XX
Spouse or Partner for Shared Coverage     Mary Jane Doe]	
[Transition Benefit Rider .....	\$XX.XX]
[Premium Credit for Replacement of Prior Coverage With Us .....	\$XX.XX]
 Total Annual Premium .....	 \$XXX.XX]

<b>First Premium</b> [\$aaa.aa]	<b>Premium Payment Mode</b> [Quarterly]	<b>Modal Premium</b> [\$bbb.bb]
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Premium for Premium Payment Modes other than annual are the following percentage of the Annual Premium:

Semi-Annual = 51%; Quarterly = 26%; Monthly = 9%

The following table shows the Modal Premium and total yearly cost for the available Premium Payment Modes for the Annual Premium that applies on the Policy Effective Date. These costs will change when there is a change in Your Premium. See the Modal Premium Disclosure for additional information.

**Total First Year Premium Payment Options** (including all optional Coverage)

	<u>Annual</u>	<u>Semi-Annual</u>	<u>Quarterly</u>	<u>Monthly</u>
Modal Premium	\$[XXX.XX]	\$[XXX.XX]	\$[XXX.XX]	\$[XXX.XX]
Total Yearly Cost for First Year Premium	\$[XXX.XX]	\$[XXX.XX]	\$[XXX.XX]	\$[XXX.XX]

Premium Payment Period:     Lifetime

Rating:   [Standard] [with [Insured] Couples Discount]

## MODAL PREMIUM DISCLOSURE

### Premium Payment Options

You pay for Your Policy by paying the Premium due in a timely manner. You may have the right to choose one of the following **Premium Payment Modes**:

- Annual in one payment that provides Coverage for twelve (12) Coverage Months;
- Semi-Annual in two payments that provides Coverage for six (6) Coverage Months;
- Quarterly in four payments that provides Coverage for three (3) Coverage Months; or
- Monthly in twelve payments that provides Coverage for one (1) Coverage Month.

Each individual payment is a "**Modal Premium Payment**".

If You have elected a Premium Payment Mode other than Annual, You will pay additional charges for electing that Premium Payment Mode (the "Additional Payment Charges"). As an example, the following chart compares the total Premium payments for each payment mode and the corresponding Additional Payment Charges that You would pay during the year based on a policy with a \$1,000 Annual Premium.

**Hypothetical Example:  
Yearly Cost Comparison of  
Additional Payment Charges for Alternate Modal Premium Payments**

<b>Premium Payment Mode*</b>	<b>Number of Premium Payments per Year</b>	<b>Amount of Each Modal Premium Payment During the Year (Including Additional Payment Charges)</b>	<b>Total of Modal Premium Payments During the Year (Including Additional Payment Charges)</b>	<b>Total Additional Payment Charge During the Year (In Dollars)</b>
Annual	1	\$1,000	\$1,000	\$0
Semi-Annual	2	\$510	\$1,020	\$20
Quarterly	4	\$260	\$1,040	\$40
Monthly	12	\$90	\$1,080	\$80

\*The availability of certain Premium Payment Modes will vary based on the method of payment selected (e.g. electronic funds transfer (EFT)).

**Notice:** Each Modal Premium Payment is a payment, in advance, for insurance Coverage. Coverage continues until the next Premium Due Date.

### Calculation Of Modal Premium

The Modal Premium Payment amounts are calculated by multiplying the Annual Modal Premium by the applicable modal Premium factor:

- Annual - 1.00;
- Semiannual - .51;
- Quarterly - .26;
- Monthly - .09.

As the above chart illustrates, if Your Premium Payment Mode is other than Annual, Your total Premium paid in a year will be more than if You made a single payment using the Annual Premium Payment Mode.

## THE PARTNERSHIP AND MEDI-CAL ASSET PROTECTION

This section describes the Partnership, the advantages of Medi-Cal Asset Protection, and how to qualify for Medi-Cal Asset Protection.

### The California Partnership For Long-Term Care

The **California Partnership for Long-Term Care** is the program, authorized in Section 22000, et seq. of the California Welfare and Institutions Code, between the State of California and participating insurance companies that offer long term care insurance policies that provide Medi-Cal Asset Protection and are approved as Partnership policies.

This is a Partnership Policy. As described below, the amount of assets protected under the California Partnership for Long-Term Care is equal to the amount of Benefits paid on Your behalf under the Policy. This means that if You receive Benefits under the Policy, Your assets will be protected, with the specific dollar amount of Your assets to be protected being dependent upon the amount of Benefits You, as an individual, receive.

### Medi-Cal Asset Protection

**Medi-Cal Asset Protection** is the right extended to You by California law when You use the Benefits of the Policy. This right allows You to protect one dollar of assets for every dollar the Policy pays out in Benefits, in the event You later apply for Medi-Cal Benefits or other qualifying State long term care Benefits.

The amount of this asset protection at any time is equal to the sum of all Benefit payments made by Us on Your behalf for Your care by the Policy.

Should You later apply for Medi-Cal Benefits or other qualified long term care Benefits, You will not be required to expend Your protected assets prior to becoming eligible for these public benefits. Your protected assets will also be exempt from any claim the State of California may have against Your estate to recover the cost of State-paid long term care or medical services provided to You.

### When Benefits Earn Medi-Cal Asset Protection

Benefits paid to You or a provider of Covered Care on Your behalf can count toward Your Medi-Cal Asset Protection for purposes of Medi-Cal eligibility for California's Medi-Cal Program.

We will send You a quarterly statement, while You are receiving Benefit payments under the Policy, showing the total amount of Benefits paid for Long Term Care Services Which Count Toward Your Medi-Cal Property Exemption.

### Medi-Cal Property Exemption

The **Medi-Cal Property Exemption** is the total equity value of real and personal property not otherwise exempt under Medi-Cal regulations, equal to the sum of qualifying insurance Benefit payments made by Us on Your behalf for Long Term Care Services Which Count Toward Your Medi-Cal Property Exemption.



**Long Term Care Services Which Count Toward Your Medi-Cal Property Exemption**

All services covered by the Policy for which We have paid Benefits will qualify for the Medi-Cal Property Exemption. These services include the following:

- Nursing Facility Benefits;
- Residential Care Facility Benefits;
- Bed Reservation Benefits;
- Home Assistance Benefits; Hospice Care Benefits
- Respite Care Benefits; and
- any other Benefits paid for Covered Care You receive, including Benefits paid as a result of Your exercising Your Right to Request Payment for Alternative Care

**How To Stay Qualified For Medi-Cal Asset Protection Under the Partnership**

You must have been a resident of California both at the time You applied for the Partnership Policy and on the Effective Date of the issued Partnership Policy.

While You may elect to reduce Your Coverage and lower Premium as stated in the Coverage Change provisions, the reduction in Coverage cannot be below the minimums required to retain status as a Partnership Policy.

You can accumulate Medi-Cal Asset protection whenever the Policy pays Benefits. If You need to access Medi-Cal to pay for Your care and You want to utilize the Medi-Cal Asset protection You have earned, You must apply to California's Medi-Cal program. You must be a California resident to qualify for Medi-Cal benefits.

SAMPLE

## GENERAL DEFINITIONS

This section provides the definitions of words used in the Policy that have a special meaning when applied to the Policy. Additional definitions may also appear on the Policy where they can assist You in understanding related text. For example, most Benefits provided under the Policy have definitions for covered care, services and/or providers. To help You recognize defined terms, they are printed in **bold** where they are defined and the first letter of each word is capitalized wherever it appears.

**Application** means the written or electronic form(s) provided by Us and completed and signed, in written or electronic form, by You when You apply for Coverage.

**Benefit** means each of the benefits identified in the Schedule under "Benefits and Services Provided." Benefits may change in accordance with the terms of the Policy.

**Confinement** or **Confined** means You are present as a resident inpatient in a facility, other than Your Home, during a period in which You incur Covered Expenses.

**Coverage** means the Benefits available under the Policy.

**Coverage Maximum** means the maximum amount of Benefits We will pay for Your Coverage under the Policy, as determined from the Schedule. The Coverage Maximum will change as described in the Schedule and when You elect changes.

**Coverage Month** means the monthly period that begins and ends on the same day of the month as the Policy Effective Date.

**Covered Care** means those Qualified Long Term Care Services for which the Policy pays Benefits or would pay Benefits in the absence of an Elimination Period or payment limits.

**Covered Expenses** means costs You incur for Covered Care. Each Benefit defines the Covered Expenses under that Benefit. An expense is considered to be incurred on the day on which the care, service or other item forming the basis for it is received.

**Elimination Period** means the total number of days that covered, Formal Long Term Care Services must be received after You are determined to be a Chronically Ill Individual and before You are entitled to Benefits under the Policy. The number of days may be accumulated within any time period after You are determined to be a Chronically Ill Individual. The number of days may be accumulated before the filing of a Claim if it can be established that You were Chronically Ill before filing a Claim. Days used to satisfy the Elimination Period do not need to be consecutive. The Elimination Period need only be met once during Your lifetime.

Any day when Covered Expenses are reimbursed by other insurance or Medicare may be counted toward meeting the Elimination Period.

Privileged Care Coordination Services and the Respite Care Benefit are not subject to the Elimination Period and cannot be used to satisfy the Elimination Period.

The Schedule describes how the Elimination Period is satisfied and whether it is based on calendar days or days on which You receive Covered Care. Each Benefit states the extent to which payment is subject to the Elimination Period.

**Formal Long Term Care Services** means long term care services for which the provider is paid.

**Home** means the place where You live or stay. This could be a: house; condominium; apartment; unit in a congregate care community; or similar residential environment. Your Home does NOT include a: hospital; Nursing Facility; Residential Care Facility; or Hospice Care Facility.

**Immediate Family** means Your Spouse or Partner, parent, brother, sister, or child (including an adopted child).

**Informal Long Term Care Services** means long term care services for which the provider is not paid.

**Medicaid** (called Medi-Cal in California) means any State medical assistance program under Title XIX of the Social Security Act, as amended.

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

**Nurse** means someone who is licensed as a Registered Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN) and is practicing within the scope of that license.

**Nursing Facility Maximum** means the maximum amount We will pay when You are Confined in a Nursing Facility, as stated in the Schedule. This may be a daily maximum or a monthly maximum. This amount is also used to determine other Benefit maximums. When Covered Expenses for any given day or month equal less than the daily or monthly maximum stated in the Schedule, any unused Benefit amount will remain in Your Coverage Maximum.

**Partner** means someone with whom You live in a committed relationship. He or she can be unrelated to You, or a relative in Your same family generation (such as Your brother, sister or first cousin). You and Your Partner cannot be joined to anyone else by: (a) marriage; or (b) a relationship legally recognized under state law.

**Partnership Long Term Care Insurance Policy** or **Partnership Policy** means any long term care insurance policy approved by the Department of Health Care Services and approved by the Department of Insurance for issue or delivery to California residents as meeting the requirements set forth in Section 22005 of the Welfare and Institutions Code.

**Physician** has the same meaning as that set forth in Sec. 1861(r)(1) of the Social Security Act; and means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs such function or action.

**Policy** means the Policy issued to You, including all of Your Applications and any Riders, Endorsements or attachments.

**Policy Effective Date** means the date the Policy begins. It is shown in the Schedule.

**Policy Issue State** means the Issue State identified in the Schedule.

**Premium** means the Premium identified in the Schedule under Premium Data. Premium may change in accordance with the terms of the Policy.

**Premium Due Date** means the end of the period for which a Modal Premium Payment provides Coverage and the date on which Premium is due to be paid to Us.

**Representative** means a person or entity legally empowered to represent You.

**Schedule** means the section of the Policy that states the Policy features and limits as of the original Policy Effective Date. Changes in Your Schedule may be made by rider.

**Spouse** means the person to whom You are joined by: (a) marriage; or (b) a relationship legally recognized under state law as entitled to the same rights and benefits of married persons.

**State**, unless otherwise indicated, refers to the District of Columbia, any territory or possession of the United States, or any one of the 50 states (or commonwealths) within the United States,

**Unearned Premium** equals A multiplied by [B divided by C] ( $A \times [B/C]$ ), where:

A = The total Premium paid during the Coverage Period.

B = The number of days remaining in the Coverage Period after Coverage has ended.

C = The total number of days in the Coverage Period.

The amount of Unearned Premium will be rounded to the nearest penny. Once the Policy has become paid-up, there is no Unearned Premium.

As used above, **Coverage Period** is the period that begins on the most recent Premium Due Date and ends on the next Premium Due Date.

**United States** includes all fifty (50) States, the District of Columbia and any territory or possession recognized by the United States as a territory or possession of the United States.

**We, Us, Our** and the **Company** mean Genworth Life Insurance Company.

**You, Your** or **Yourself** means the person named as the Insured in the Schedule.

SAMPLE

## PERIOD OF COVERAGE

### Policy Taking Effect And Consideration

The Policy is issued in consideration of Your Application and payment of Premium. The Policy will become effective on the Policy Effective Date shown in Your Schedule, subject to the timely payment of the First Premium. The Policy may be continued in force by the timely payment of Premium until it ends in accordance with the terms and conditions of the Policy.

### Your Right To Cancel The Policy At Any Time

You may cancel the Policy at any time by sending written notice to Us at Our Administrative Office. The effective date of Your cancellation will be the later of:

- the cancellation date requested by You; or
- the date We receive Your written request.

This cancellation will not affect any Claim for Covered Expenses incurred before the effective date of the cancellation.

### When The Policy Ends

The Policy ends (terminates) on the first to occur of:

- the date of Your death;
- the date the Policy is cancelled by You, as stated above;
- the date the Coverage Maximum is exhausted;
- the date on which Premium is due, when the Premium is not received by Us by the end of the Grace Period; or
- the Policy Effective Date if the Policy is rescinded in accordance with the Misstatements and Incontestability provision of the Policy.

Except as provided in the Extension of Benefits provision below, the Policy will not pay for Covered Expenses incurred after the Policy ends.

If the Policy ends, We will promptly refund any Unearned Premium, as stated in the Refund of Unearned Premium provision.

### Extension Of Benefits

If the Policy ends due to failure to pay Premium while You are Confined in a Nursing Facility, a Residential Care Facility, or a Hospice Care Facility, We will pay Benefits for Covered Expenses in the same manner as if the Policy had not ended. This Extension of Benefits stops and all extended Coverage ends on the earliest of:

- the date when You no longer meet the requirements of the Conditions For Receiving Benefits provision (see the first page of the Benefit Provisions);
- the date You are no longer Confined in a Nursing Facility, a Residential Care Facility or a Hospice Care Facility; or
- the date the Coverage Maximum is exhausted.

## PREMIUM AND RENEWAL

### Paying Premium

Each Premium paid continues the Policy in force until the next Premium Due Date, except as stated in the Grace Period provision. Premium is subject to change as described in the Premium Rate Changes provision and on the first page of the Policy. Premium is payable to Us. The First Premium is due on the Policy Effective Date. Each subsequent Premium is due on the next Premium Due Date. Your Schedule shows the initial Premium Payment Mode that applies to the Policy. Premium Payment Modes available under the Policy are determined by mutual agreement between You and Us.

### Notifying Us Of Changes

You are responsible for notifying Us if Your method of Premium payment changes. You must notify Us within 30 days of the effective date of the change. If payments are being made through electronic funds transfer or other automatic payment methods, and the payment cannot be accomplished for any reason, We will bill You directly.

### Premium Rate Changes

As stated on the first page of the Policy, **We have the right to change Premium becoming due in the future.** Subject to approval by the California Department of Insurance, We can change Premium; but only if we change the Premium schedule for all California Partnership policies. Premium may be changed due to: a change in Benefits or terms of Coverage; or a change required by any law, regulation, judicial or administrative order or decision. Premium changes may also be based on actual experience, a change in the factors bearing on the risk assumed, or Our estimates for future experience; a change in any of these reasons may occur only once in any 12 month period. Premium will not change due to a change in Your age or health, use of Benefits, or if You divorce. We will give You at least 60 days written notice before We change Premium.

### Your Options If Premium Rates Increase

If Your Premium increases as a result of Our right to change Premium, You will have the option of:

- maintaining Your current Coverage at an increased Premium;
- electing a decrease in Coverage and Benefits to an available Coverage amount; or
- canceling or lapsing the Policy (subject to any rights You may have under a Contingent Nonforfeiture Benefit).

### Refund Of Unearned Premium

**Refunds Due to Your Death:** In the event of Your death We will refund Unearned Premium. The refund will be paid within 30 days of Our receipt of written notice and proof of Your death. It will be paid to Your beneficiary or estate.

**All Other Refunds:** Except as provided in the When the Policy Ends provision, all other Unearned Premium will be applied as a reduction in future Premium due.

### Grace Period

The Grace Period is the period of time specified below during which any unpaid Premium payment, after the First Premium, must be paid in order to keep this Policy from ending. This Policy will remain in effect during the Grace Period; however, Our failure to receive due and unpaid Premium by the end of the Grace Period will result in termination of this Policy as of the Premium Due Date.

If on the Premium Due Date, the Premium payment has not been received by Us, the Grace Period will begin. After a period ending 31 days following the Premium Due Date, We will send a written notice of termination for non-payment of Premium to You and to any person You have designated to be notified in case of lapse, at the address(es) You have provided.

This notice will explain that a Premium payment has been missed; and will show the Premium amount that You must pay no later than the end of the Grace Period so that this Policy does not end. It will also explain Your right to reduce Your Coverage and lower your future Premiums. This notice will provide an additional 35 days from the date the written notice was mailed to pay any due and unpaid Premium.

### **Protection Against Unintentional Lapse**

You have the right to designate at least one person, in addition to Yourself, who is to receive notice of termination for non-payment of Premium. You may change this designation at any time. To do so, You must send written notice to Us at Our Administrative Office. Every two (2) years, We will remind You in writing of this opportunity.

### **Reinstatement**

If the Policy ends for non-payment of Premium, You may apply to reinstate the Policy. To apply for reinstatement You must submit an Application and pay all past due Premium. The completed Application must be received by Us at Our Administrative Office within one year after the end of the Grace Period. The Policy may only be reinstated as provided below.

The Policy will be reinstated upon either:

- Our written approval of the Application; or
- the 45th day after the date We receive Your Application and all past due Premium, if We have not given You prior written notice of Our disapproval of the Application.

If the Policy is reinstated in accordance with this Reinstatement provision, We will only pay Benefits relating to Covered Expenses incurred after the date of reinstatement. In all other respects Your rights and Our rights will remain the same; subject to any provisions noted on or attached to the Policy upon reinstatement.

### **Continuation For Lapse Due To Alzheimer's Disease And Other Forms of Cognitive Or Functional Impairment**

We will provide a retroactive continuation of Coverage, if:

- the Policy ends due to non-payment of Premium (lapse); and
- within seven (7) months after the Policy ends We are given proof that You were Chronically Ill and met the Eligibility For The Payment of Benefits requirements of the Policy, beginning on or before the end of the Grace Period.

We must receive written notice from You or Your Representative, that the Policy should be continued under this Continuation For Lapse Due to Alzheimer's Disease And Other Forms of Cognitive Or Functional Impairment provision. Upon receipt of such notice, You or Your Representative will be required to provide Us with:

- proof that You met the Eligibility For The Payment of Benefits requirements of the Policy; and
- all past-due Premium;

within that seven-month period. The proof must be in the form of an assessment from a Licensed Health Care Practitioner (or other proof approved by Us), which demonstrates that You were Chronically Ill. In addition, We require a Current Eligibility Certification. Any Covered Expenses incurred during this continuation period will be paid to the same extent they would have been paid if the Policy had not ended.

### **Unpaid Premium**

When Benefits for Covered Expenses are payable under the Policy, any Premium due and unpaid will be deducted from the amount We pay.

## COVERAGE CHANGE OPTIONS

### Right To Reduce Coverage And Lower Premium

You have the right to reduce Your future Premium at any time by requesting:

- deletion of an option or feature for which an additional Premium is charged;
- a decrease in the Coverage Maximum to an available Coverage Maximum (but not below the minimum required to retain status as a Partnership Policy);
- a decrease in the Nursing Facility Maximum to an available Nursing Facility Maximum (but not below the minimum required to retain status as a Partnership Policy) and thus also reducing the maximum for Home and Community Care and other Benefit limits that are based on the Nursing Facility Maximum;
- converting to a "Nursing Facility Only" or "Home Care Only" policy, if We are then issuing those policies for sale in California.

To reduce Your future Premium in this manner, You must give Us a signed written request in a form acceptable to Us. You will not be required to provide proof of insurability.

Reducing Your Nursing Facility Maximum may result in a proportional decrease in: (a) the Coverage Maximum; (b) other payment limits that are based on the Nursing Facility Maximum; and (c) future Premium.

Reducing Your Coverage Maximum alone will not change Your Nursing Facility Maximum and related payment limits; but will reduce the period during which the full Nursing Facility Maximum can be paid for Covered Expenses.

The Premium reduction associated with any reduction in Coverage will be based on the Premium applicable to the Coverage being reduced. You will not be entitled to a refund for any Premium paid prior to the effective date of the reduction in Coverage, as outlined below. Any change in Coverage or Premium under this Right to Reduce Coverage and Lower Premium provision will become effective on the Premium Due Date following Our receipt of Your written request.

We will send You written notice of:

- the reduction in Coverage;
- the effective date of the reduction; and
- the amount of Premium due as of the Premium Due Date following Our receipt of Your written request.

Once Coverage is reduced, it may not be increased without Our approval of Your written Application.

### You May Request An Increase In Your Coverage With Proof Of Insurability

While Premium is being paid You have the right to request an increase in Your Coverage as of any anniversary of the Policy Effective Date. The increase may be in the form of:

- Increasing Your Nursing Facility Maximum in increments of ten dollars (\$10) for daily Benefits amounts and \$300 for monthly Benefit amounts. An increase in Your Nursing Facility Maximum will result in a proportionate increase in the maximum for Home and Community Care and other Benefit limits that are based on the Nursing Facility Maximum. AND/OR
- Increasing Your Coverage Maximum.

The increase must be to an amount or plan then being offered under the Policy. You will be required to provide an Application and proof of insurability in a form and manner acceptable to Us. The Premium for the amount of increased Coverage will be based on Your age as of the date the increase in Coverage becomes effective. Premium for any previously purchased Coverage will not be affected.



However, You cannot apply to increase Your Coverage if You:

- are currently receiving Benefits;
- have filed a Claim;
- have been determined to be eligible for Benefits; or
- are continuing Coverage under a Nonforfeiture Benefit.

We will send You written notice of the increase in Benefit amounts, the effective date of the increase and the amount of Premium due or to be applied to future Premium.

### **Upgrading To Newer Plans**

This provision applies in the event We develop new significant or material Benefits or Benefit eligibility criteria for similar California policy forms. Except as stated below, We will notify You, within twelve (12) months after We receive approval by the California Department of Insurance of such new Benefits or Benefit eligibility. We will then offer You the opportunity to upgrade to the new Benefits or Benefit eligibility criteria, or the new policy containing them, in one of the following ways, chosen by Us:

- You may add a rider to this Policy and pay any additional Premium for the rider based on Your attained age. The Premium that You paid for the Benefits which You previously had under this Policy will continue to be based on Your age at time of those Benefits became effective.
- You may replace this Policy with a new policy issued by Us. Consideration for Your past insured status will be recognized by providing a premium credit toward the annual premium for the new policy. The premium credit shall be equal to 5% of the annual Premium of this Policy for each full year this Policy was in force. The premium credit shall be applied toward all future premium payments for the new policy. The maximum premium credit shall not exceed 50% of the Premium for this Policy. In no event will the premium credit reduce the premium for the new policy to less than the Premium for this Policy. No premium credit is available if: (1) the premium for the replacement policy is less than or equal to the Premium for this Policy; or (2) any Claim was filed under this Policy.
- You may replace this Policy with a new policy issued by Us, where consideration for Your past insured status is recognized by providing a premium for the new policy that is based on Your issue age as of the original effective date of this Policy.

No offer will be made if:

- You are receiving Benefits (including Nonforfeiture Coverage) under this Policy; or
- You are in the process of satisfying the Elimination Period.

To qualify for the upgraded Coverage, We may require submission of a new Application and require You to undergo the same underwriting as applies to new applicants. Once We have approved the change, We will notify You of the effective date of the change.

## GENERAL PROVISIONS

### Entire Contract; Changes

The entire contract between You and Us is as stated in the Policy. No change in the Policy will be valid until and unless approved in writing by one of Our officers. That approval must be noted on or attached to the Policy. No agent has the authority to change the Policy or waive any of its provisions.

Payment of Premium following:

- a change to the Policy requested by You; or
  - a change in Premium as provided in the Premium Rate Changes provision;
- shall constitute acceptance by You of any such change.

### Misstatements and Incontestability

In issuing this Policy, We have relied upon the information presented by You in Your Application. Any incorrect or omitted material information in Your Application for the Policy, or an increase in Coverage, may cause the Coverage that became effective as a result of Your Application to be rescinded (voided) or a Claim to be denied.

**Time Limit on Certain Defenses:** For any portion of Your Coverage that has been in effect for less than six (6) months, We may rescind it or deny an otherwise valid Claim upon a showing of a misrepresentation in Your Application for that Coverage that is material to Our acceptance of the Application. Failure to disclose material information is considered a misrepresentation.

For any portion of Your Coverage that has been in force for at least six (6) months but less than two (2) years, We may rescind it or deny an otherwise valid Claim upon a showing of a misrepresentation in Your Application for that Coverage that is both material to the acceptance of the Application and pertains to the conditions for which Benefits are sought.

Any portion of Your Coverage that has been in force for two (2) years may be contested only upon a showing that You knowingly and intentionally misrepresented relevant facts relating to Your health.

Any Benefits We pay will not be recovered by Us in the event the Policy or a portion of Your Coverage is rescinded.

### Misstatement Of Age

If Your age was misstated in Your Application, We will pay the Benefits that the Premium paid would have purchased at Your true age. If based on Your true age, the Policy would not have become effective, We will only be liable for the refund of all Premium paid for the Policy.

### Time Periods

All time periods start and end at 12:01 a.m. at Your residence address.

### Non-Participating; Dividends Not Payable

The Policy does not participate in Our profits or surplus earnings, has no cash value, and will not earn dividends at any time.

### Our Intent That This Be A Federally Tax-Qualified Contract

The Policy is intended to be a federally tax qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986 (as amended by the Health Insurance Portability and Accountability Act of 1996 – Public Law 104-191).

**Conformity With Internal Revenue Code**

If on its effective date, the Policy does not comply with the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, it will be treated as if it had been changed to comply with those requirements. We will, after obtaining necessary regulatory approval, inform You in writing of any required change in the provisions of the Policy. You will then have the choice of accepting the change or retaining the Policy without change.

**Actions In The Event Of A Publicly Funded National Or State Plan**

If a non-Medicaid (called Medi-Cal in California) national or state long term care program created through public funding substantially duplicates Benefits provided by Your Coverage, We will offer You the following options:

- to reduce Your future Premium payments; or
- to increase future Benefits.

The amount of Premium reductions and future Benefit increases to be made by Us will be based on the extent of the duplication of covered Benefits, the amount of past Premium payments, and Our claims experience. Our Premium reduction and Benefit increase plans will first be filed with and approved by the California Department of Insurance.

**Governing Jurisdiction**

The Policy is governed by the laws of the Policy Issue State.

**Currency**

All payments by or to Us will be in the lawful money of the United States of America. Any foreign exchange rate will be as determined by Us based on:

- the date on which the Claim is received by Us; and
- the exchange rate for that date, as reported by a licensed bank or other financial institution designated by Us.

**No Cash Values, Borrowing, Or Use As Collateral**

The Policy does not provide for a cash surrender value, or other money that can be: borrowed; or paid, assigned or pledged as collateral for a loan.

**Communications Through Electronic Means Or Other Technologies**

We reserve the right to designate the form and means of all communications, notices or proofs required by the Policy. If We agree, You may contact Us about the Policy using electronic means or other technologies. If You agree, We may contact You regarding the Policy using electronic means or other technologies. Except where prohibited by State or federal law, electronic communications have the same legal effect, validity and enforceability as other forms of communication.

## BENEFIT PROVISIONS

### LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

#### Benefit Eligibility - Eligibility For The Payment Of Benefits

For You to be eligible for the Benefits provided by this Policy We must receive ongoing proof, from a Licensed Health Care Practitioner, that Your receipt of the Covered Care is due to Your being qualified for Benefits, as described below.

#### How To Qualify For Benefits

We will pay for the Qualified Long Term Care Services covered by this Policy if:

- You are a Chronically Ill Individual; and
- the Qualified Long Term Care Services are prescribed for You in a written Plan of Care.

You will be considered a **Chronically Ill Individual** and **Chronically Ill** when one of the following criteria is met:

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

A Current Eligibility Certification must be made by a Licensed Health Care Practitioner.

The services to be paid by this Policy must be prescribed in a written Plan of Care prepared by a Licensed Health Care Practitioner. All services covered by this Policy must be Qualified Long Term Care Services.

#### Definitions

The following definitions of terms will help explain how You qualify for Benefits under this Policy.

**Activities Of Daily Living** (ADLs) means the following self-care functions:

- **Bathing:** Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- **Continence:** The 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:** Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- **Eating:** Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
- **Toileting:** Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- **Transferring:** The ability to move into or out of a bed, chair or wheelchair.

**Standby Assistance** means the presence of another person within arm's reach of You that 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).

**Hands-on Assistance** means the physical assistance of another person without which You would be unable to perform the Activity of Daily Living.

**Severe Cognitive Impairment** is a loss or deterioration in intellectual capacity that:

- is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and
- is measured by clinical evidence and standardized tests prescribed by or approved by the California Partnership for Long-Term Care.

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

A **Current Eligibility Certification** is a certification by a Licensed Health Care Practitioner that You are a Chronically Ill Individual. The certification must be made within the preceding 12 months and must be renewed at least every 12 months.

A **Licensed Health Care Practitioner** means any physician (as defined in section 186(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury. The Licensed Health Care Practitioner must be employed by a Care Management Provider Agency or be a Qualified Official Designee of a Care Management Provider Agency.

A **Plan of Care** is a written individualized plan of services prescribed by a Licensed Health Care Practitioner which specifies the type, frequency and providers of all Formal and Informal Long Term Care Services required for the individual, and the cost, if any, of any Formal Long Term Care Services prescribed. Changes in the Plan of Care must be documented to show that such alterations are required by changes in the client's medical situation, functional and/or cognitive abilities, behavioral abilities or the availability of social supports.

**Qualified Long Term Care Services** are necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or Personal Care Services which are needed to assist You with the disabling conditions that cause You to be Chronically Ill.

#### **Conditions For Receiving Benefits**

Benefits will be paid for expenses incurred by You only if all of the following conditions have been satisfied:

- You must meet the above Eligibility for the Payment of Benefits requirements.
- The expenses must qualify as Covered Expenses under the Policy.
- The Covered Care and related Covered Expenses must be consistent with and received pursuant to Your Plan of Care as prepared by a Care Management Provider Agency that has been selected by Us and approved by the California Partnership for Long-Term Care. It should be noted that the Policy may not cover everything described in Your Plan of Care.
- Except as stated in the Extension of Benefits provision, the Policy must be in force on the date(s) the Covered Care is received.
- Any applicable Elimination Period must be satisfied.
- You must not have exhausted the Coverage Maximum or any daily, monthly, annual or lifetime limits applicable to the specific Benefits Claimed.
- You must meet the requirements for payment in accordance with all the provisions of Your Policy.
- The care, service, cost or item for which Benefits are payable must meet the definition of Qualified Long Term Care Services.

## Overview Of The Process

Once You have met the Chronically Ill Individual criteria and expect to incur expenses covered by this Policy, a Plan of Care must be prepared. A Licensed Health Care Practitioner who is either employed by or is designated by a Care Management Provider Agency will develop the Plan of Care as a result of a face-to-face assessment.

The Plan of Care will be updated periodically, as appropriate based on Your condition. The Care Management Provider Agency or Licensed Health Care Practitioner will be required to provide Us with a copy of Your Plan of Care immediately upon its completion and updating, or as soon thereafter as is reasonably possible.

An assessment conducted pursuant to this provision must be performed promptly with any certification completed as quickly as possible to ensure that Your Benefits are not delayed. We will inform You in the event a Licensed Health Care Practitioner makes a determination that You do not meet the definition of a Chronically Ill Individual.

**Notes:** Your personal physician will not be able to develop the Plan of Care for this Policy unless he or she is either employed by or is designated by a Care Management Provider Agency.

A **Care Management Provider Agency** means an agency or other entity selected by Us and approved by the California Partnership for Long-Term Care that provides Privileged Care Coordination Services and meets the standards established for participation in the California Partnership for Long-Term Care.

A **Qualified Official Designee of a Care Management Provider Agency** is an individual who meets the qualifications to act on behalf of the Care Management Provider Agency as required by the California Partnership for Long-Term Care.

## **PRIVILEGED CARE® COORDINATION SERVICES**

### **About Privileged Care Coordination Services**

You are required to use these services to access Benefits under this Policy. To receive these services You or Your Representative should contact Us at Our Administrative Office.

These services are available when You qualify as being Chronically Ill and require Covered Care. These services are intended to help You identify Your care needs and community resources available to deliver care when You are Chronically Ill. These Privileged Care Coordination Services are furnished by a Privileged Care Coordination Team selected by Us, and approved by the California Partnership for Long-Term Care.

We will pay for these services when You receive them while the Policy is in effect. These payments will be at Our expense; and will NOT count against any payment limits.

**Privileged Care Coordination Services** include, but are not limited to the following:

- The performance of a comprehensive individualized face-to-face assessment conducted in Your place of residence.
- The development of a Plan of Care by a Licensed Health Care Practitioner.
- Provide the initial and ongoing Current Eligibility Certifications.
- The performance of a comprehensive, individualized reassessment as required by the California Partnership for Long-Term Care.
- When desired by You and determined necessary by the Care Management Provider Agency, coordination of appropriate services and ongoing monitoring of the delivery of such services.
- Help, upon request, with completion of initial Claims forms required to obtain payment under this Policy.
- The development of a discharge plan when the Care Management Provider Agency's services, or this Policy's Benefits, are about to be terminated and further care is needed. If You are immediately eligible for Medi-Cal, the Care Management Provider Agency will prepare a transition plan.

These services take an all-inclusive look at a person's total needs and resources, and links the person to a full range of appropriate services using all available funding sources.

### **Eligible Privileged Care Coordination Services Providers**

Privileged Care Coordination Services are provided by persons who, either alone, or as part of a team, are responsible for performing assessments and reassessments, developing Plans of Care, coordinating the provision of care, and monitoring the delivery of services.

These providers are either employed by, or designated by, a Care Management Provider Agency that has been selected by Us and approved by the California Partnership for Long-Term Care. The Care Management Provider Agency is independent of Us and cannot stand to Benefit financially if You receive any other Benefits under this Policy for recommended care.

### **Benefits Paid Will Not Reduce Any Payment Limits**

Expenses paid for Privileged Care Coordination Services will not reduce the amount available under Your Coverage.

### **Payment Limitations**

Payment for these services is NOT subject to: any Elimination Period requirement; the Coverage Maximum; or any other payment limits. It cannot be used to satisfy any Elimination Period requirement; and does not qualify You for any Waiver of Premium Benefit.

## NURSING FACILITY BENEFIT

### The Benefit

Under this Benefit We will pay for Covered Expenses incurred during Your Confinement in a Nursing Facility, as described below.

### Covered Expenses

Covered Expenses for Nursing Facility care means expenses You incur for care and support services (including ancillary supplies and services), meals, and room charges provided by the Nursing Facility. They include expenses for: private duty Nursing Care provided by a Nurse who is not employed by the facility; and all levels of care (including skilled, intermediate and custodial care) provided by the Nursing Facility. They do not include expenses for any items or services provided for Your comfort and convenience, such as: transportation; televisions; telephones; beauty care; guest meals; and entertainment.

### Definitions

**Nursing Care** means care, furnished on a Physician's orders, which requires the specialized skills of a Nurse or must be performed by or under the continual, direct and immediate supervision of a Nurse to meet a person's need to: (a) improve or maintain health; and (b) receive Substantial Supervision when needed due to Severe Cognitive Impairment, or Substantial Assistance with Activities of Daily Living.

A **Nursing Facility** is a facility, that is engaged primarily in providing continual (24 hours-a-day, every day) Nursing Care to all of its Confined inpatients in accordance with the authority granted by a license issued by the federal government or the State in which it is located. The facility must have at least one full-time (at least 30 hours per week) Nurse. A Nurse must be on duty or on call in the facility at all times. The facility must maintain a daily record of all care and services provided to its Confined inpatients.

If a facility has multiple licenses or purposes, and has a separate ward, wing or unit in which You are Confined, We will consider You to be in a Nursing Facility only if that ward, wing or unit satisfies the above definition of a Nursing Facility.

### Payment Limitations

Payment of this Benefit is subject to:

- the Elimination Period requirement;
- the Coverage Maximum;
- the payment limit shown in the Schedule for this Benefit; and
- all other provisions and conditions of the Policy.

With the exception of Privileged Care Coordination Services and Caregiver Training payments, this Benefit will not be payable at the same time as any other Benefit.



## RESIDENTIAL CARE FACILITY BENEFIT

### The Benefit

Under this Benefit We will pay for Covered Expenses incurred during Your Confinement in a Residential Care Facility, as described below.

### Covered Expenses

Covered Expenses for care in a Residential Care Facility means expenses You incur for Qualified Long Term Care Services received while You are Confined in the Residential Care Facility. This includes care and services:

- provided by the Residential Care Facility (including ancillary supplies and services, meals, and room charges);
- covered under other Benefits of the Policy; and
- any other care and services that are needed to assist You with the disabling conditions that caused You to be Chronically Ill.

Covered Expenses does not include expenses for any items or services provided for Your comfort and convenience, such as: transportation; televisions; telephones; beauty care; guest meals; or entertainment.

### Definitions

**Residential Care Facility** means a facility licensed as a "Residential Care Facility for the Elderly" or a "residential care facility" as defined in the California Health and Safety Code.

Outside California, eligible providers are facilities that meet applicable licensure standards, if any, and are 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 and which also:

- provide care and services on a 24-hour basis; and
- have a trained and ready-to-respond employee on duty in the facility at all times to provide care and services; and
- provide three (3) meals a day and accommodate special dietary needs; and
- 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.

If a facility has multiple licenses, certifications or purposes and has a separate ward, wing, or unit in which You are a Confined, We will consider You to be in a Residential Care Facility only if such ward, wing, or unit satisfies the above definition of a Residential Care Facility.

### Payment Limitations

Payment of this Benefit is subject to:

- the Elimination Period requirement;
- the Coverage Maximum;
- the payment limit shown in the Schedule for this Benefit; and
- all other provisions and conditions of the Policy.

With the exception of Privileged Care Coordination Services and Caregiver Training payments, this Benefit will not be payable at the same time as any other Benefit.

## **BED RESERVATION BENEFIT**

### **The Benefit**

Under this Benefit We will pay for Covered Expenses incurred to reserve Your accommodations when You are temporarily absent from a:

- Nursing Facility;
- Residential Care Facility; or
- Hospice Care Facility.

### **Covered Expenses**

Covered Expenses for Bed Reservation Benefits means the expenses You incur for reserving Your room accommodations in a Nursing Facility, Residential Care Facility, or Hospice Care Facility when Your Confinement is interrupted by a temporary absence.

The temporary absence can be for any reason, including, but not limited to, hospital stays as well as spending holidays or other time with Your family.

### **Payment Limitations**

We will pay up to the lesser of:

- the Covered Expenses You incur to reserve Your accommodations; or
- the amount We would have paid if You had remained in the Nursing Facility, Residential Care Facility, or Hospice Care Facility.

Payment of this Benefit is subject to:

- the Elimination Period requirement;
- the Coverage Maximum;
- the payment limit shown above;
- the maximum payment period (days per calendar year) shown in the Schedule for this Benefit; and
- all other provisions and conditions of the Policy.

With the exception of Privileged Care Coordination Services and Caregiver Training payments, this Benefit will not be payable at the same time as any other Benefit.

## HOME AND COMMUNITY CARE BENEFIT

### The Benefit

Under this Benefit We will pay for Covered Expenses incurred for Home and Community Care, as described below.

### Covered Expenses

Covered Expenses for Home and Community Care means expenses You incur for:

- Adult Day Health/Social Care;
- Home Health Care Services;
- Personal Care Services; and
- Homemaker Services.

### Definitions

**Adult Day Health/Social Care** means a structured, comprehensive program which provides a variety of Community-Based Adult Services including health, social, and related supportive services in a protective setting on a less than 24-hour basis. These community-based services are designed to meet the needs of functionally impaired adults through an individualized service plan, and include the following: personal care and supervision as needed; the provision of meals, as long as the meals do not meet a full daily nutritional regimen; transportation to and from the service site; and social, health and recreational activities.

In California, providers of this care may include the following facilities:

- Adult Day Care Facilities, and Adult Social Day Care Facilities, which are licensed by the Department of Social Services;
- Adult Day Health Care Facilities licensed by the Department of Health Care Services; and
- Alzheimer Day Care Resource Centers administered by the Department of Health Care Services.

**Home Health Care Services** means skilled nursing or other professional services in Your Home, 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.

Home Health Care Services may be provided by a Nurse, or a licensed physical, occupational, respiratory or speech therapist, audiologist, personnel from home health care agencies, or directly by individuals who are licensed or certified to provide those services if no home health care agency exists in the area.

**Homemaker Services** means assistance with activities necessary to or consistent with Your ability to remain in Your Home, that is provided by a skilled or unskilled person under a Plan of Care developed by a Licensed Health Care Practitioner.

Homemaker Services may be provided by a nurses aide, a home health aide, or a person qualified by training and/or experience to provide care in accordance with the Plan of Care.

**Personal Care Services** means:

- Ambulation assistance, including help in walking or moving around (i.e. wheelchair) outside or inside the place of residence, changing locations in a room, moving from room to room to gain access for the purpose of engaging in other activities. Ambulation assistance does not include movement solely for the purpose of exercise.
- Bathing and grooming, including cleaning the body using a tub, shower or sponge bath, including getting a basin for water, managing faucets, getting in and out of tub or shower, reaching head and body parts for soaping, rinsing and drying. Grooming includes hair combing and brushing, shampooing, oral hygiene, shaving and fingernail and toenail care.
- Dressing, including putting on and taking off, fastening and unfastening garments and undergarments, and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.
- Bowel, bladder and menstrual care including assisting the person on and off toilet or commode and emptying commode, managing clothing and wiping and cleaning body after toileting, assistance with using and emptying bedpans, ostomy and/or catheter receptacles and urinals, application of diapers and disposable barrier pads.
- Repositioning, transfer skin care, and range of motion exercises, including moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, or sofa, coming to a standing position and/or rubbing skin and repositioning to promote circulation and prevent skin breakdown. Motion exercises shall include the carrying out of maintenance programs, i.e. the performance of the repetitive exercises required to maintain function, improve gait, maintain strength or endurance, passive exercises to maintain range of motion in paralyzed extremities, and assistive walking.
- Feeding, hydration assistance, including reaching for, picking up, grasping utensils and cup; getting food or utensil; bringing food, utensil, cup to mouth, and manipulating food on plate. Cleaning face and hands as necessary following meal.
- Assistance with self-administration of medications.
- Assistance with instrumental activities of daily living, which include:
  - domestic or cleaning services;
  - laundry services; reasonable food shopping and errands;
  - meal preparation and cleanup;
  - transportation assistance to and from medical appointments;
  - heavy cleaning which involves thorough cleaning of the Home to remove hazardous debris or dirt; and
  - using the telephone.

Personal Care Services may be provided by nurse aides, home health aides, or persons qualified by training and/or experience to provide care in accordance with the Plan of Care. It is not required that the provider of these services be at a level of certification or licensure greater than what is required to provide the service, or that the services be provided by Medicare-certified agencies or providers.

**Payment Limitations**

Payment of this Benefit is subject to:

- the Elimination Period requirement, unless stated otherwise in the Schedule;
- the Coverage Maximum;
- the payment limit shown in the Schedule for this Benefit; and
- all other provisions and conditions of the Policy.

## HOME ASSISTANCE BENEFIT

### The Benefit

Under this Benefit We will pay for Covered Expenses incurred for Home Assistance services and items, as described below.

### Covered Expenses

Covered Expenses for Home Assistance means expenses You incur (including tax, delivery, installation and labor costs) for the following services and items:

- Home Modifications, Assistive Devices and Supportive Equipment;
- Emergency Medical Response Systems; and
- Caregiver Training.

These services and items must be:

- intended to enable You to remain safely in Your Home; and
- stated in, and furnished in accordance with, Your Plan of Care.

### Definitions

**Home Modifications, Assistive Devices and Supportive Equipment** means items that are intended to relieve Your need for direct physical assistance; and (as stated in Your Plan of Care) are expected to enable You to remain safely in Your Home for at least 90 days after the date of purchase or first rental. This may include:

- ramps to permit Your movement from one level of Your Home to another;
- grab bars to assist You in toileting, bathing or showering;
- hospital beds, wheelchairs or crutches for You alone;
- adaptive equipment to enable independent feeding and dressing (specialized utensils and fasteners); and
- pumps and other devices for intravenous injection.

This does NOT include expenses for:

- home repair or remodeling;
- the purchase, rental, installation or servicing of an elevator, escalator, garage door opener, swimming pool, hot tub, Jacuzzi or whirlpool type tub, or other similar items or services;
- items that will, other than incidentally, increase the value of Your Home; and
- artificial limbs, teeth, corrective lenses, hearing aids, or equipment placed in Your body, temporarily or permanently.

**Emergency Medical Response Systems** means the installation of, and any ongoing fees for, any type of medical alert system.

**Caregiver Training** means the training of a family member, friend, or other person to provide care for You in Your Home when that person will not be paid to care for You. Caregiver Training consists of training in the proper use and care of a therapeutic device or an appropriate care giving procedure. It does not include training received when You are Confined in a hospital, Nursing Facility or Residential Care Facility, unless it is reasonably expected that the training will make it possible for You to return to Your Home, where You can be cared for by the person receiving the training.

### Payment Limitations

Payment of this Benefit is subject to: the Coverage Maximum; the payment limit shown in the Schedule for this Benefit; and all other provisions and conditions of the Policy. Payment of this Benefit is not subject to any Elimination Period requirement; and cannot be used to satisfy any Elimination Period requirement.

## HOSPICE CARE BENEFIT

### The Benefit

Under this Benefit We will pay for Covered Expenses incurred for Hospice Care, as described below.

### Covered Expenses

Covered Expenses for Hospice Care means expenses You incur for:

- Hospice Care received while You are living at Home; and
- Hospice Care and related care and support services (including room charges) provided by a Hospice Care Facility.

Covered Expenses for Hospice Care do not include:

- the cost of medications, supplies, equipment or Physician visits; and
- any charges for: transportation; televisions; telephones; beauty care; guest meals; or entertainment.

### Definitions

**Hospice Care** means services, not paid by Medicare, that are designed to provide:

- palliative care and alleviate the physical, emotional, social and spiritual discomforts You are experiencing when You are Chronically Ill and in the last phases of life because You are Terminally Ill; and
- supportive care to Your primary caregiver and family.

Care may be provided in a Hospice Care Facility, or by a skilled or unskilled person under a Plan of Care developed by a Licensed Health Care Practitioner or a multidisciplinary team under medical direction.

**Hospice Care Facility** means a facility that provides a formal Hospice Care program directed by a Physician on an inpatient basis. A Hospice Care Facility must be licensed or certified by the state in which it is located, if such license or certification is required (not required in California). A Hospice Care Facility may be licensed or certified as a Nursing Facility, Residential Care Facility, or other type of health care facility. A Hospice Care Facility does not mean a hospital, clinic, a community living center, or a place that provides residential or retirement care only.

**Terminally Ill** means having six (6) months or less to live, as determined by a Physician.

### Payment Limitations

Payment of this Benefit is subject to:

- the Coverage Maximum;
- the payment limit shown in the Schedule for the Nursing Facility Maximum when Hospice Care is received in a Hospice Care Facility;
- the payment limit shown in the Schedule for the Home and Community Care Benefit for Hospice Care received while You are living at Home; and
- all other provisions and conditions of the Policy.

Payment of this Benefit is not subject to any Elimination Period requirement; and cannot be used to satisfy any Elimination Period requirement.

With the exception of Privileged Care Coordination Services and Caregiver Training payments, this Benefit will not be payable at the same time as any other Benefit.

## RESPITE CARE BENEFIT

### The Benefit

Under this Benefit We will pay for Covered Expenses incurred for Respite Care, as described below.

### Covered Expenses

Covered Expenses for Respite Care means expenses You incur for Respite Care that would be payable under the following if there were no Elimination Period requirement:

- the Nursing Facility Benefit;
- the Residential Care Facility Benefit; and
- the Home and Community Care Benefit.

### Definition

**Respite Care** means temporary care You receive in order to provide short-term relief for the person who normally and primarily provides You with care in Your Home on a regular, unpaid basis.

Your Plan of Care must state:

- the name of the unpaid caregiver for whom the respite is being provided;
- the period of respite; and
- the Covered Care You will require to replace care normally provided by the unpaid caregiver.

Providers of Respite Care include, but are not limited to: a Nursing Facility, a Residential Care Facility, community-based programs such as an Adult Day Health/Social Care provider, persons employed by a home health agency, or a person who is qualified by training and/or experience to provide the care.

### Payment Limitations

Payment of this Benefit is subject to:

- the Coverage Maximum.
- the payment limit shown in the Schedule for the Nursing Facility Benefit for Respite Care received in a Nursing Facility;
- the payment limit shown in the Schedule for the Residential Care Facility Benefit for Respite Care received in a Residential Care Facility;
- the payment limit shown in the Schedule for the Home and Community Care Benefit for Respite Care received while You are living at Home;
- the maximum payment period (days per calendar year) shown in the Schedule for this Benefit; and
- all other provisions and conditions of the Policy.

Payment of this Benefit is not subject to any Elimination Period requirement; and days of Covered Care under it cannot be used to satisfy any Elimination Period requirement.

## INTERNATIONAL COVERAGE BENEFIT

### The Benefit

Subject to the Conditions below, We will pay for Covered Expenses incurred outside the United States, as described below.

### Covered Expenses

Covered Expenses for International Coverage means expenses You have paid for care and support services received outside of the United States that are provided:

- in a Home and would otherwise have been payable under the Home and Community Care Benefit; or
- to You by an Out-of-Country Nursing Facility (including room and board) under the Conditions stated below.

Covered Expenses do not include expenses for prescription medications or any items or services provided for Your comfort and convenience, such as: transportation; televisions; telephones; beauty care; guest meals; and entertainment.

### Conditions

Payment of this Benefit is subject to all of the following conditions:

- The Waiver of Premium Benefit will not apply to any period for which payment is made under this Benefit.
- We must receive proof, satisfactory to Us, that You are eligible for Benefit payments. At Your own expense, You must obtain and furnish Us with complete documentation in English. Such documentation shall include, but is not limited to:
  - A Current Eligibility Certification from a Licensed Health Care Practitioner that You are Chronically Ill.
  - A satisfactory Plan of Care prescribing the need for Covered Care due to Your being Chronically Ill.
  - Properly completed Claims forms, billing statements, and supporting medical and care documentation acceptable to Us as verifiable proof of loss and payment.
  - A copy of Your passport, airline ticket or other proof acceptable to Us that You are outside of the United States at the time You are receiving care.

We may require that You provide Us with all of the above information at reasonable intervals. We will not require this more frequently than monthly.

This Benefit will not be payable if it is prohibited by the United States Government sanctions as specified by the United States Department of the Treasury's Office of Foreign Assets Control (or its successor organization). This includes, but is not limited to, care delivered in a foreign country to which travel is prohibited under Federal law.

### Definition

An **Out-of-Country Nursing Facility** is an institution, not excluded below, that:

- is located outside of the United States; and
- is a legally operated facility that is engaged primarily in providing continual (24 hours-a-day, every day) nursing care to all of its residents or inpatients; and
- satisfies all of the following requirements.

**Requirements:** To satisfy this Out-of-Country Nursing Facility definition, such facility, or a separate portion, ward, wing or unit thereof, must at all times:

- provide such nursing care in accordance with the authority granted by a license or similar accreditation acceptable to Us that has been issued by the national or requisite political subdivision of the country in which it is located to provide the levels of care for which Benefits would be payable under the Nursing Facility Benefit;



- employ at least one full-time (at least 30 hours per week) Graduate Nurse;
- have a Graduate Nurse on duty or on call in the facility at all times;
- have an awake employee on duty in the facility who is:
  - trained and ready to provide its residents with scheduled and unscheduled care and services sufficient to support needs resulting from inability to perform Activities of Daily Living or Severe Cognitive Impairment; and
  - aware of the whereabouts of the residents;
- provide three (3) meals a day and accommodate special dietary needs;
- have arrangements with a Physician or Graduate Nurse to furnish medical care and services in case of an emergency;
- have the appropriate methods and procedures to provide necessary assistance to residents in managing prescribed medications; and
- have accommodations for at least 10 resident inpatients in that location.

For the purposes of this definition, a **Graduate Nurse** is a person who has:

- completed a nursing care training program; and
- a current license to provide skilled nursing care to sick or infirm individuals under the direction of a Physician.

**Excluded Places:** The definition of an Out-of-Country Nursing Facility does NOT include any of the following:

- A hospital (including any sub-acute or rehabilitation hospital) or clinic.
- An Assisted Living Facility.
- A place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness.
- Your Home or other residential establishment or environment, including an ocean going vessel.

### **Payment Limitations**

Payment of this Benefit is subject to: the Elimination Period requirement; the Coverage Maximum; the limits determined below; and all other provisions and conditions applicable to the Policy.

This Benefit will not be payable at the same time as any other Benefit. Payment for care in an Out-of-Country Nursing Facility will not exceed 50% of the Nursing Facility Maximum.

Payment under this Benefit for Covered Care at Home will not exceed 50% of the amount payable for care in an Out-of-Country Nursing Facility and is limited to payment for 365 days on which You receive Covered Care at Home.

No payment will be made under this Benefit for expenses incurred more than 4 years after the date the first expense payable under this Benefit is incurred.

If this Benefit is subject to a monthly maximum, payment for periods of less than a full calendar month will be pro-rated based on: a 30-day month; and the number of days for which payment is being made.

## WAIVER OF PREMIUM BENEFIT

### The Benefit

The Schedule specifies the Benefits for which this waiver applies. We will waive Your Premium payments for each Coverage Month that begins while You are receiving Covered Care for which payment will be made under any such Benefits. This waiver applies to the entire Premium for the Policy (including all applicable Riders).

This waiver stops when You are no longer incurring Covered Expense for which payment will be made under any of the Benefits to which it applies. Any Premium paid for Coverage Months during which the waiver applies will be credited toward Your future Premium. When this waiver stops You will be required to resume and continue paying Premium as they become due in accordance with the Policy's Premium Payment Mode.

If the Policy ends and You have paid Premium for Coverage Months during which the waiver applies, any Unearned Premium will be refunded as provided in the Refund of Unearned Premium provisions.

## YOUR RIGHT TO REQUEST PAYMENT FOR ALTERNATIVE CARE

### The Benefit Option

When You meet the Benefit Eligibility provisions and Conditions for Benefit Payments, You may request payment for care or services not otherwise covered by this Policy. We may, at Our sole discretion, determine that providing Benefits for those expenses is appropriate and payable under this Policy.

### Covered Expenses

Covered Expenses for which You may request payment are expenses You incur for Qualified Long Term Care Services that:

- are included in the list of "Long Term Care Services Countable Toward the Medi-Cal Property Exemption" as published by the California Department of Health Care Services (or its successor organization);
- are furnished in accordance with a Mutual Agreement;
- are not specifically covered under another Benefit;
- are not specifically excluded from payment;
- are cost-effective alternatives to care and services available under the Policy;
- are clearly specified in Your Plan of Care and in the Mutual Agreement;
- are received after Our written approval of the Mutual Agreement; and
- are received while the Mutual Agreement is in effect.

### Definition

The **Mutual Agreement** is a written document agreed to by You or Your Representative, Your personal Physician and Us which sets forth:

- the care and services, devices and treatments that will be considered as Covered Care under this Benefit;
- how any Elimination Period affects payment under this Benefit; and
- the duration and payment maximums for Covered Care under this Benefit.

The Mutual Agreement will not waive any rights You or We have with respect to the Policy. The Mutual Agreement may be discontinued at any time, by You or Us, without affecting Your right to Benefits otherwise available under the Policy.

### Payment Limitations

Payment under this provision is subject to:

- the Elimination Period requirement, if any, set forth in the Mutual Agreement;
- the Coverage Maximum;
- the payment limits set forth in the Mutual Agreement; and
- all other provisions and conditions of the Policy.

## CLAIMS PROVISIONS

### Notifying Us About A Claim And Initiating The Claim Process

In order to initiate Your Claim with Us, You or Your Representative must contact Us at Our Administrative Office by phone or in writing and provide Us with the following:

- Your name;
- Your Policy Number (as shown in the Schedule); and
- an address to which Our Claim forms should be sent.

Once You contact Us to initiate Your Claim, We will send to You within 7 days the Claim forms You will need to file with Us in order for Us to determine: Your eligibility for the payment of Benefits; and whether Benefits are payable for Covered Expenses. If You or Your Representative do not receive the Claim forms from Us within 7 days, We can begin reviewing Your Claim without the Claim forms. To review a Claim in this manner, You must provide Us with a letter that includes the information outlined below in the Claim Forms and Required Documentation provision. The letter must be sent to Us at Our Administrative Office.

You must initiate the Claim process within 30 days of the date Covered Expenses are incurred, or as soon as reasonably possible thereafter. Providing early notification to Our Claims department can help greatly with the Claims process. Early notice may also provide additional time to plan for Your Covered Care. You or Your Representative may contact Us when You first become Chronically Ill, even before You have incurred Covered Expenses.

In addition, We will make available certain information to help You or Your Immediate Family plan for long term care. Please see the Information and Referral Services provision below.

### Assistance With Completing Claim Forms

You may phone Us or contact Us in writing if You require assistance with Your Claim or completing Claim forms.

### Claim Forms And Required Documentation

Our Claim forms will include instructions explaining the information You must provide to Us and how to submit the Claim forms to Us. Review the Claim forms and instructions carefully. Answer all questions and send all required information to the address on the Claim forms. The information You submit to Us must be in the form of written documentation acceptable to Us and must:

- describe and confirm that You are Chronically Ill;
- include a Current Eligibility Certification from a Licensed Health Care Practitioner;
- describe and confirm the Covered Care You are receiving;
- include a copy of Your Plan of Care
- include copies of itemized bills, paid invoices and, if necessary, cancelled checks or other verifiable proof of payment for Covered Expenses ("**Proofs of Loss**");
- include copies of documents and explanations of benefits related to any Medicare coverage, coverage under any other federal, state, or other government health care program or law, except Medicaid, or any Other Long Term Care coverage, applicable to Your Claim; and
- provide Us with the written authorization to evaluate Your Claim which is included in the Claim forms.

A final determination regarding Your eligibility for payment of Benefits and whether Benefits are payable for Covered Expenses cannot be made until We receive the above information. You may also be required to provide Us with copies of other records and documents, such as hospital records, which We may reasonably require in addition to the information above before a final determination can be made .

Except as required by law, documentation relating to Your Claim must be provided to Us in English.

### **Proofs Of Loss – Denial Of Claim For Failure To Timely Provide Proofs Of Loss**

If You incur Covered Expenses subsequent to Your submission of Your Claim forms, You are required to provide Us with Proofs of Loss with respect to those Covered Expenses no later than 90 days after the end of the Coverage Month in which the Covered Expenses were incurred. If it is not reasonably possible to provide Us with Proofs of Loss within the 90 days, You must provide Proofs of Loss as soon as reasonably possible after the 90 days.

We will not deny Your Claim for failure to provide Us with timely Proofs of Loss if We are provided with Proofs of Loss no later than one (1) year from the date Proof is otherwise required. Your Covered Expense is incurred. Unless We are provided with proof, in a form satisfactory to Us, that You were incapacitated or incapable of providing Us with Proofs of Loss within the one (1) year period, or unless prohibited by law, Your Claim will be denied for failure to provide Us with Proofs of Loss within the one (1) year period.

### **How We Determine Your Initial And Ongoing Eligibility For The Payment Of Benefits**

In order for Us to determine Your initial eligibility for the payment of Benefits, We:

- must be in receipt of completed Claim forms and Proofs of Loss; and
- will obtain information about You from Your personal Physician and You directly.

In addition, at Our expense, We may:

- consult with any Licensed Health Care Practitioners, agencies and other care providers You have used or are currently using; and
- require You to participate in a medical or physical examination or assessment.

In order for Us to determine Your ongoing eligibility for the payment of Benefits, at periodic intervals, We may:

- obtain information about You from: Your personal Physician; and You directly;
- consult with any Licensed Health Care Practitioners, agencies and other care providers You have used or are currently using; or
- at Our expense, require You to participate in a medical or physical examination or assessment.

In addition to an initial face-to face assessment to determine Your eligibility for Benefits, You will also be required to undergo subsequent reassessments as provided by the California Partnership for Long-Term Care. You will also be required to provide Us with a copy of Your Medicare Explanation(s) of Benefits (or similar form for other plans or programs subject to the Non-Duplication, coordination or other provisions of the Exclusions and Limitations section) to help Us determine which Covered Expenses (if any) are excluded from Coverage under the Policy.

In certain instances, to assist Us in determining initial or ongoing eligibility for the payment of Benefits or whether You incurred Covered Expenses, We may require that You participate in a sworn recorded interview or a formal proceeding.

We will notify You in writing of Our determination regarding Your eligibility for the payment of Benefits. Prior to making such determination, We will keep You reasonably informed of the status of Your Claim by communicating with You, in writing, not less frequently than every thirty (30) days.

### **Appealing A Claim Decision**

We will inform You, in writing, if a Claim, or any part of a Claim, is denied and the reason for the denial as soon as reasonably possible after Our receipt of all information needed to make a decision regarding Your Claim.

Within 60 days of Your receipt of Our written explanation for denying Your Claim, You may make a written request for additional information regarding the denial. Within 45 days of the date of Our receipt of Your written request We will:

- provide You with a written explanation of the reasons for the denial; and
- make available to You the information We used to determine the denial.

Within 120 days of Your receipt of Our written explanation above, if You believe that Our determination to deny Your Claim is in error, You may **"Appeal"** Our determination to deny Your Claim as follows:

- You must send Us a written Appeal (no special form is required) that explains to Us why We should change Our decision to deny Your Claim. You may authorize someone else to act for You in this Appeal process.
- The written Appeal should include the names, addresses and phone numbers of any care providers You think We should contact to learn more about Your Eligibility for the Payment of Benefits and the Covered Care You received. This should include any Physician, health care professionals and other care providers who treated You; and the facilities from which You received care, treatment, services, equipment or other items.

Following Your Appeal, You will be sent written notice and explanation of Our final determination within 30 days of Our receipt of all necessary information upon which a final determination can be made. In the event We change Our determination to deny Your Claim, We will promptly pay any Benefits due to You.

### **Time Of Payment Of Benefits**

If We determine that You are eligible for the payment of Benefits, We will pay Benefits for Covered Expenses provided for in the initial Proof of Loss promptly. In the event that Benefits are payable in the future, and upon Our receipt of subsequent Proofs of Loss, We will pay Benefits for Covered Expenses You incur at the end of each monthly period following Our first Benefit payment date.

### **To Whom Benefits Are Paid**

While You are living, all Benefit payments for Covered Expenses will be payable to You unless otherwise assigned in accordance with the Assignment of Benefits provision below. To the extent that Your Coverage provides for additional Benefits beyond Your death, those Benefits are payable in accordance with the beneficiary designation in effect at the time of Your death. If no beneficiary designation is in effect at the time of Your death, the Benefits will be paid to Your estate. Any other Benefits for Covered Expenses that are unpaid at Your death may be paid either to Your beneficiary or estate.

If, upon Your death, Benefits are payable to an estate, We may pay up to \$5,000 of those Benefits directly to someone related to You by blood or marriage who is deemed by Us to be entitled to receive the Benefit payment. We will be discharged from any liability to the extent of any such payment made in good faith.

We may pay all or a portion of any Benefits for Covered Expenses You incur to the provider of the Covered Care, unless You direct Us to do otherwise in writing by the time Proof of Loss is provided to Us. We do not require that Covered Care be provided by a specifically named facility, entity or person.

### **Beneficiary Designations**

Unless You have named an irrevocable beneficiary, You have the right to name and change a beneficiary at any time by providing a written request to Us. Unless otherwise specified by You, the designation of a new beneficiary will take effect on the date You signed the written request to make the change. Your request to designate a new beneficiary does not affect any payment made, or other action taken, by Us prior to Our receipt of Your written request to make the change. Consent of any beneficiary will not be required for surrender or assignment of the Policy, change of beneficiary, or any other change. The terms of an irrevocable beneficiary designation cannot be changed or revoked without the consent of that beneficiary.

### **Direct Payment Of Benefits To Providers - Assignment Of Benefits**

You may instruct Us, in writing, to pay Benefits You are due under the Policy directly to a Nursing Facility, Residential Care Facility, Hospice Care Facility, or home health agency providing the care to You for which We are paying Benefits for Covered Expenses. The care provider must also agree to the Assignment of Benefits in writing. You must notify Us in writing of any change or termination of any such Assignment of Benefits. We do not assume any responsibility for the validity or effect of an Assignment of Benefits. Our payment of Benefits pursuant to an Assignment of Benefits will fully satisfy any obligations We may have for payment of Benefits under the Policy.

### **Information And Referral Services**

You and Your Immediate Family may contact Us to request information or referral services related to long term care resources or the development of a long term care plan. We will provide certain information or services to You or Your Immediate Family, at no cost, to assist You or Your Immediate Family with assessing individual long term care needs or identifying local long term care service providers. Additional information or services may also be made available to You or Your Immediate Family that You or Your Immediate Family may choose to purchase at an additional cost.

The information or services made available to You or Your Immediate Family under this provision may be provided by independent, non-affiliated entities. These entities are solely responsible to You for the provision of any information or services offered, or accessed, by You or Your Immediate Family and We make no warranties or promises regarding any providers, services or information offered, or accessed, by You or Your Immediate Family.

If You choose to purchase additional information or services outside of the information or services offered by Us, any cost incurred by You is Your responsibility. No Policy Benefits are payable for any costs You may incur as a result of Your purchase of any additional information or services.

### **Right To Recover An Excess Payment**

If, at any time, We make a payment in excess of Benefits payable under the Policy ("**Excess Payment**"), We have the right to recover such Excess Payment from any person to whom, or for whom, or with respect to whom, such Excess Payment was made. In the event that such Excess Payment is not returned to Us within 60 days of Our request to return the Excess Payment, We may deduct the Excess Payment from Your future Benefit payments, if applicable and where permitted by law.

Except in the event that the Policy is rescinded in accordance with the Misstatements and Incontestability provision, We have the right to recover any payment for Benefits made by Us in error and any payment for Benefits made as a result of fraud by any party, including, but not limited to, You or Your care providers.

### **Legal Actions**

You may not bring any legal action against Us seeking Benefit payments under the Policy until 60 days after Proof of Loss has been received by Us. You may not bring any legal action against Us seeking Benefit payments under the Policy after three (3) years from the date Proof of Loss has been received by Us.

## EXCLUSIONS AND LIMITATIONS

This section states the conditions under which Benefit payments will be limited, or not available, even if You otherwise qualify for Benefits.

### Exclusions

We will not pay Benefits for any expenses incurred for any Covered Care:

- for which no charge is normally made in the absence of insurance;
- provided outside the fifty (50) United States, the District of Columbia, and any territory of possession of the United States of America; unless specifically provided for by a Benefit;
- provided by Your Immediate Family, unless a Benefit specifically states that a member of Your Immediate Family can provide Covered Care. We will not consider care to have been provided by a member of Your Immediate Family when:
  - He or she is a regular employee of the organization that is providing the services; and
  - Such organization receives payment for the services; and
  - He or she receives no compensation other than the normal compensation for employees in her or his job category;
- provided by or in a Veteran's Administration or Federal government facility, unless a valid charge is made to You or Your estate;
- resulting from illness, treatment or medical condition arising out of any of the following:
  - war or any act of war, whether declared or not;
  - attempted suicide or an intentionally self-inflicted injury;
- provided directly for Your alcoholism or addiction to drugs or narcotics (except for an addiction to a prescription medication when administered in accordance with the advice of a Physician).

### Non-Duplication

Benefits will be paid only for expenses incurred for Qualified Long Term Care Services covered by this Policy that are in excess of the amount available under all Other Plans.

**"Other Plans"** means:

- Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount); and
- any other Federal, state or other governmental health or long term care program, **[including the Community Living Assistance Services and Support Act – Class Act]** or law (except Medicaid/Medi-Cal); and
- any insurance policy (including other long term care insurance policies or certificates), subscriber contract, group coverage through HMOs and other prepayment, group practice or individual practice plans; and
- any state or federal workers' compensation, employer's liability or occupational disease law or any motor vehicle no-fault law.

If You have any Other Plans under which You are entitled to Benefits for expenses for Covered Care, Benefits will be paid under this Policy:

- only after Benefits for like expenses are paid under those Other Plans; and
- only to the extent that the Benefits under this Policy, together with the amount of Benefits paid under those Other Plans (including amounts that would be reimbursable under Medicare but for the application of a deductible or coinsurance amount), do not exceed the actual expenses incurred for the care or services received.

## CONTINGENT NONFORFEITURE BENEFIT

### The Benefit

This Benefit allows You to convert to a Shortened Benefit Period if We make a substantial increase in the Premium for the Policy.

### How This Benefit Works

If We make a substantial increase in Your Premium, as determined by the following Table, We will do all of the following:

- offer to reduce Your current level of Coverage without proof of insurability so that the required Premium for the Policy are not increased;
- offer to convert the Policy to a paid-up status with a Shortened Benefit Period as described below. This option may be elected at any time during the 120-day period following the date of the Premium increase; and
- notify You that a default or lapse at any time during the 120-day period following the date of the Premium increase will be deemed to be the election of the preceding offer to convert. A default or lapse is Your failure to pay the required Premium within the Grace Period.

**Table Indicating a Substantial Premium Increase\***

<u>Issue Age</u>	<u>Increase Over Initial Premium</u>	<u>Issue Age</u>	<u>Increase Over Initial Premium</u>	<u>Issue Age</u>	<u>Increase Over Initial Premium</u>
29 and under	200%	66	48%	79	22%
30 – 34	190%	67	46%	80	20%
35 – 39	170%	68	44%	81	19%
40 – 44	150%	69	42%	82	18%
45 – 49	130%	70	40%	83	17%
50 – 54	110%	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%		

\* Percentage increase is cumulative from date of original issue. It does NOT include any increases attributed to later changes or Your election of additional or increased Benefit levels.

### Shortened Benefit Period

If You convert in accordance with the above, the Policy will continue with a reduced Coverage Maximum. It will have the same Benefits, Elimination Period requirements and other payment limits that were in effect at the time of lapse or election to convert. These limits will not be affected by the Benefit Increases provision. The amount of reduced Coverage Maximum will be the greater of:

- 100% of all Premium paid for the Policy, excluding any waived Premium; or
- the maximum amount in effect at the time of default or lapse for one month (30 days) under the Nursing Facility Benefit.

It will not be reduced by any Benefits previously paid under the Policy.

### Payment Limitations

Payment is subject to the limits determined above for the Shortened Benefit Period plan. In addition, the total amount payable under this Benefit and the Policy, while it was in force prior to conversion, is limited to the maximum amount that would have been paid if the Policy had remained in Premium paying status. This Benefit will not apply if the Policy is continued in accordance with any other Nonforfeiture Benefit.



### **COMPLAINT NOTICE:**

**Please contact Your agent, or write Us at Genworth Life Insurance Company, if You feel that a problem You are having with Your insurance is not being resolved satisfactorily.**

**If We cannot resolve the problem, You may contact the Department of Insurance; however, they should be contacted only after Your contacts between Us and Our agent or other representatives have failed to produce a satisfactory solution to the problem.**

**You may contact the Department of Insurance by:**

**writing to:           California Department of Insurance  
                              Consumer Communications Bureau  
                              300 South Spring Street  
                              Los Angeles, CA 90013**

**or calling :           (800) 927-4357 (inside CA) or  
                              (213) 897-8921 (outside CA and area codes 213, 310 and 818)**

**Please keep this Policy and attachments in a safe place with other important documents.**

**SAMPLE**

# GENWORTH LIFE INSURANCE COMPANY

Administrative Office: 3100 Albert Lankford Drive, Lynchburg, VA 24501



## **NONFORFEITURE BENEFIT RIDER** *This Rider adds the following to the Policy.*

### **The Benefit**

As described below, this Benefit provides a continuation of Your Policy if Your Policy ends due to non-payment of Premium (lapse) before the Coverage Maximum has been exhausted.

### **Nonforfeiture Allowance**

As used below, the Nonforfeiture Allowance is the greater of:

- the sum of all Premium paid for Your Policy, excluding any waived Premium;
- the amount equal to one month (30 days) of Benefits under the Nursing Facility Benefit that is in effect at the time of lapse when the lapse occurs after this Benefit has been in force for at least 3 consecutive years; or
- the amount equal to three month (90 days) of Benefits under the Nursing Facility Benefit that is in effect at the time of lapse when the lapse occurs after this Benefit has been in force for at least 10 consecutive years.

### **Conditions**

The continuation of Your Policy is subject to the following conditions:

- This Benefit must have been in force for at least 3 consecutive years when the Policy lapses.
- Your Policy will be continued under a paid-up status (with no further Premium becoming due); subject to all of the terms and conditions of Your Policy.
- Except as stated below, Your Policy will have the same Benefits, Elimination Period requirement and other payment limits that were in effect at the time of lapse.
- Any Benefit Increases provision that was in effect will continue to apply.

### **Payment Limitations**

Payment under this Benefit ceases when the first of the following occurs: the total amount payable under this Benefit equals the Nonforfeiture Allowance; or Your Coverage Maximum is exhausted.

### **When This Rider Is In Force**

This Rider is a part of the Policy. It has been issued in consideration of Your Application and payment of the Premium shown in the Schedule. This Rider takes effect on the Policy Effective Date. It continues until terminated. It automatically terminates on the earliest of:

- the date Your Policy ends, subject to the provisions of this Rider; or
- the Premium Due Date following Our receipt of Your written request to terminate this Rider.

**In all other respects the provisions and conditions of the Policy remain the same.**

**Signed for Genworth Life Insurance Company.**

# GENWORTH LIFE INSURANCE COMPANY

An Approved Participant In

Administrative Office: 3100 Albert Lankford Drive, Lynchburg, VA 24501



CALIFORNIA PARTNERSHIP FOR  
**LONG-TERM CARE**

## SHARED COVERAGE RIDER

*This Rider adds the following Shared Coverage Provisions to the Policy.*

### Shared Coverage Provisions

Subject to the Conditions below, We will automatically continue Your Spouse or Partner's Coverage using the remaining Coverage Maximum of Your Policy when his or her Coverage terminates because the Coverage Maximum of his or her Policy has been exhausted. In this event, the person named as Your Spouse or Partner will be covered under the Policy the same as You. Your Spouse or Partner for the purposes of this Rider is the person named as such in the Schedule of Your Policy.

If the Schedule in Your Policy states that this Rider is:

- "Included With Joint Waiver" - We will waive Premium payments for both You and Your Spouse or Partner while either You or Your Spouse or Partner qualifies for a Waiver of Premium Benefit. This includes waiving Premium for:
  - Both You and Your Spouse or Partner while Premium is being waived under either person's policy; and
  - Your Policy when Your Spouse or Partner qualifies for the Waiver of Premium Benefit while continuing Coverage under Your Policy.
- "Included Without Joint Waiver" – This rider will have no effect on the waiver of Premium for Your Spouse or Partner's policy. In addition, Premium for Your Policy will only be waived when You qualify for the Waiver of Premium Benefit. Your Spouse or Partner cannot qualify for the Waiver of Premium under Your Policy even if he or she becomes the sole Insured upon Your death.

### Conditions

Coverage under this Rider is subject to all of the following conditions:

- Your Policy with Us and You and Your Spouse or Partner's policy with Us must be identical. This means they must both have the same Shared Coverage Rider form with the same plans, benefit levels and benefit options.
- You must be named as the Spouse or Partner for Shared Coverage in the Schedule of Your Spouse or Partner's policy; and he or she must be named as the Spouse or Partner for Shared Coverage in the Schedule of Your Policy.
- Your Policy will only pay for Covered Expenses Your Spouse or Partner incurs after the date his or her Policy has exhausted its Coverage Maximum.
- Benefits under Your Policy on behalf of Your Spouse or Partner will be paid according to the applicable benefits, limits, Claims payment provisions and all other provisions of Your Policy on the date the expense is incurred; and count against the Coverage Maximum of Your Policy.
- No Elimination Period requirement will apply to the continuation of Your Spouse or Partner's Coverage under Your Policy.
- Continuation of Your Spouse or Partner's Coverage under Your Policy will terminate when the Coverage Maximum of Your Policy is exhausted.
- We will give You written notice when Your Spouse or Partner has begun to access Coverage under Your Policy.

### Coverage Maximum Transfer/Continued Sharing Upon Death

**Coverage Maximum Transfer:** If You die while both You and Your Spouse or Partner have Shared Coverage Riders in force, upon written notification of Your death, the remaining Coverage Maximum of Your Policy will be added to the Coverage Maximum of Your Spouse or Partner's Policy.

**Continued Sharing:** If You die while this Rider is in force and Your Spouse or Partner is sharing Coverage under Your Policy at time of Your death, he or she may continue Coverage under Your Policy subject to the terms of this Rider.

**Affect on Premium:** When You die and either the Coverage Maximum Transfer or Continued Sharing apply to Your Spouse or Partner Coverage, Premium for the Policy under which the survivor is then insured will no longer include the cost of this Rider.

**Guaranteed Minimum Benefit**

**Guaranteed Minimum:** 50% of Your Coverage Maximum in effect on the Policy Effective Date.

To ensure that at least the Guaranteed Minimum is available to pay Benefits for You, We will not count Benefits payable on behalf of Your Spouse or Partner when they would reduce the Benefits payable for Your care below the Guaranteed Minimum.

**Impact On Medi-Cal Asset Protection When Coverage Is Shared**

The amount of assets You can protect under a Partnership-approved Policy is equal to the amount of Benefits paid for Your care. Medi-Cal Asset Protection is ONLY available to the individual actually receiving the Benefits. This means that if You receive Benefits under the Policy the specific dollar amount of assets You can protect is dependent upon (limited to) the amount of Coverage You, as an individual, use for Your long-term care services.

If one Spouse or Partner is accessing Benefits under the Policy, the other Spouse or Partner will NOT receive Medi-Cal Asset Protection for that care. Medi-Cal Asset Protection is NOT transferable between Spouses or Partners.

**When This Rider Is In Force**

This Rider is a part of the Policy. It has been issued in consideration of Your Application and payment of the Premium shown in the Schedule. This Rider takes effect on the Policy Effective Date. It can be continued in force by the timely payment of Premium until it is terminated.

Except as provided in the "Note" below, this Rider will automatically terminate on the earlier of:

- The date the Policy ends or is continued under any Nonforfeiture Benefit.
- The date of death of Your Spouse or Partner.
- The date the identical Shared Coverage Rider on Your Spouse or Partner's Policy ends for any reason other than exhausting the Coverage Maximum applicable to his or her Policy.
- The date We reset Your Coverage Maximum as provided under the Guaranteed Minimum Benefit.
- The date the Benefit levels and Benefit options under the Policies of both You and Your Spouse or Partner are no longer identical due to a change in coverage elected by either You or Your Spouse or Partner.
- The Premium Due Date following Our receipt of Your written request to terminate this Rider.

**Note:** This Rider cannot be terminated if Your Spouse or Partner has begun to access Benefits under Your Policy until he or she is no longer eligible for continued Benefits under Your Policy.

**In all other respects the provisions and conditions of the Policy remain the same.**

**Signed for Genworth Life Insurance Company.**

# GENWORTH LIFE INSURANCE COMPANY

Administrative Office: 3100 Albert Lankford Drive, Lynchburg, VA 24501



## TRANSITION BENEFIT RIDER

*This Rider adds the following Transition Benefit to the Policy.*

### The Benefit

Subject to the Payment Limitations below, We will pay for Covered Expenses incurred while You are satisfying the Elimination Period, as described below.

### Covered Expenses

Covered Expenses for this Transition Benefit means expenses You incur for Qualified Long Term Care Services received during the Elimination Period.

The amount determined from the Schedule for this Benefit will be paid as a lump sum once We have verified that You have: (a) satisfied the Eligibility for the Payment of Benefits provision; and (b) begun to satisfy the Elimination Period. You may use this payment to cover costs associated with care received during the Elimination Period.

### Payment Limitations

This is a one-time Benefit. Payment of this Benefit is subject to:

- the Coverage Maximum;
- the payment limit shown in the Schedule for this Benefit; and
- all other provisions and conditions of the Policy.

Payment of this Benefit is not subject to any Elimination Period requirement.

**Notice Regarding Tax Law** - Payment of this Benefit may have tax implications. You are advised to review this Benefit with a qualified tax professional to determine any such tax impact.

### When This Rider Is In Force

This Rider is a part of the Policy. It has been issued in consideration of Your Application and payment of the Premium shown in the Schedule. This Rider takes effect on the Policy Effective Date. It continues until terminated. It automatically terminates on the earliest of:

- the date Your Policy ends; or
- the Premium Due Date following Our receipt of Your written request to terminate this Rider.

**In all other respects the provisions and conditions of the Policy remain the same.**

**Signed for Genworth Life Insurance Company.**

**Genworth Life Insurance Company**

LONG TERM CARE INSURANCE

6620 West Broad Street  
Richmond, VA 23230

Insurance and annuity products:	Are not deposits.	Are not guaranteed by a bank or its affiliates.
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