GENWORTH LIFE INSURANCE COMPANY

SCHEDULE

Policyholder	**Group Policy Number**	**Policy Effective Date**
Chevron Corporation	20803	01/01/2020

Insured	**Certificate Number**	**Certificate Effective Date**
Test Case 1 Chevron TEST TEST CA 55555	20803-100001	01/01/2020

Age on Certificate Effective Date
66

COVERAGE FEATURES AND LIMITS

Coverage is provided 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 Your Certificate. Changes in Your Schedule may be made by Rider.

Elimination Period 90 calendar days
The Elimination Period is satisfied by days You are Chronically Ill beginning with the first day You incur a Covered Expense.

Coverage Maximum	**Nursing Facility Maximum**	**Benefit Increases**
$36,000.00	$1,500.00 per calendar month	3% Compound Benefit Increases 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.

3% Compound Benefit Increases: On each anniversary of Your Certificate Effective Date Your then current Nursing Facility Maximum and the current amounts of other dollar maximums will each increase by 3%.

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.

Benefit Increases cease when: (a) the applicable maximum has been exhausted; (b) they are terminated by You; (c) Your Coverage ends; or (d) Your Coverage is continued under any Nonforfeiture Benefit, if applicable.

Benefits and Services Provided	**We Pay Covered Expenses Up to these Limits (except where otherwise noted)**
Privileged Care Coordination Services	Not subject to coverage limits
Nursing Facility Benefit	Nursing Facility Maximum per calendar month
Residential Care Facility Benefit (Includes room charges)	100% of the Nursing Facility Maximum per calendar month
Bed Reservation Benefit	60 days per calendar year
Home and Community Care Benefit with Homemaker and Chore Care	75% of the Nursing Facility Maximum per calendar month
Home Assistance Benefit (Equipment, modifications & training)	A Certificate total payment maximum equal to 3 times the Nursing Facility Maximum
Informal Family Care Benefit	1% of the Nursing Facility Maximum per day for 30 days per calendar year
Hospice Care Benefit	As stated in the Benefit
Respite Care Benefit	30 days per calendar year
Requested Alternative Benefits	Payment subject to mutual agreement
International Nursing Facility 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.	
Contingent Nonforfeiture Benefit	As stated in the Benefit

The following Riders and Endorsements are attached to, and included in, the Certificate.

Nonforfeiture Benefit.....Included

The maximum total amount payable for all Covered Expenses incurred in a calendar month is limited to the Nursing Facility Maximum. This does not apply to Benefits that are not subject to a daily or monthly maximum.

SCHEDULE
(Continued)

PREMIUM DATA

	Annual Premium
Basic Certificate Coverage	$1,397.90
Nonforfeiture Benefit Rider	$ 159.60
Total First Year Annual Premium	$1,557.50
Insured's Annual Premium Contribution	$1,557.50
Insured's Modal Premium Contribution Semi-Annual	$ 778.75

Rating: Standard

Premium Payment Period: Lifetime

This Schedule reflects changes as of the Print Date: 9/10/2019
Attach it to Your Certificate along with prior Schedule pages

Genworth Life Insurance Company
CALIFORNIA COMPLAINT NOTICE
IMPORTANT INFORMATION TO POLICYHOLDERS

In the event you need to contact someone about this policy for any reason, please contact your agent. If you have additional questions, you may contact the insurance company issuing this policy at the following address and telephone number:

Genworth Life Insurance Company
Administrative Office
P.O. Box 64010
St. Paul, MN 55164-0010
Telephone: 800-416-3624
Internet Web site: www.genworth.com

If the problem is not resolved, you may write to the Consumer Services Division of the Department of Insurance for the State of California. The address, toll-free telephone number and Internet Web site are:

State of California
Consumer Services Division
Department of Insurance
300 South Spring Street, South Tower
Los Angeles, California 90013

Telephone: 1-800-927-4357
Internet Web site: www.insurance.ca.gov

GENWORTH LIFE INSURANCE COMPANY

A Stock Insurance Company (herein called We, Us and Our)
Administrative Office: P.O. Box 64010, St. Paul, MN 55164-0010 Phone Number 800-416-3624

GROUP COMPREHENSIVE LONG TERM CARE INSURANCE CERTIFICATE

Policyholder
Chevron Corporation

Insured
Test Case 1 Chevron

DECLARATIONS

This Certificate has been issued to You (the Insured named above) under the terms of the Group Policy issued to the Policyholder shown above. Your Coverage is subject to the terms of the Group Policy and this Certificate; and may be continued until this Certificate terminates and Your Coverage ends (as described in the Period of Coverage section). Keep this Certificate in a safe place with Your other legal documents.

CAUTION: The issuance of this Certificate is based upon Your responses to the questions on any Application You have submitted. A copy of Your Application, if any, is attached to this Certificate. If Your answers are misstated or untrue, We may have the right to deny Benefits or rescind Your Coverage 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 Group 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. THE GROUP POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from Us.

YOUR COVERAGE IS GUARANTEED RENEWABLE. This means that You have the right, subject to the terms of the Group Policy, to continue Your Coverage in force until Benefits have been exhausted by paying the required Premium when due. We cannot cancel or refuse to renew Your Coverage, except as provided under the Misstatements and Incontestability provision. Subject to the approval of the California Department of Insurance, We can change Your Premium as provided below. We cannot change any other terms of Your Coverage without Your consent, unless the change is required by law.

WE HAVE A LIMITED RIGHT TO CHANGE PREMIUM. We have the right to change Premium becoming due in the future. We can change Premium on a Group Policy or rate class basis; but only if We change Premium for all similar Certificates issued under the Group Policy in the same State as this Certificate. Your rate class consists of You and all other individuals insured under the same form as this Policy who are being charged the same rate for the same Benefits, plan and options. 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.

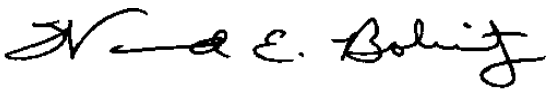
FREE LOOK – 30 DAY RIGHT TO EXAMINE YOUR CERTIFICATE: You have 30 days from the day You receive this Certificate to examine and return it to Us. You can return it for any reason. Simply return it, within that time frame, to the address shown above, or to the agent, producer or office through which it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

The Group Policy is an approved long term care insurance policy under California law and regulations. However, the Benefits payable by the Group Policy will not qualify for Medi-Cal asset protection under the California Partnership for Long Term Care. For information about policies and certificates qualifying under the California Partnership for Long Term Care, call the Health Insurance Counseling and Advocacy Program at the toll-free number, 1-800-434-0222.

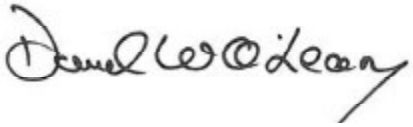
Payment of Benefits is subject to Pre-Existing Conditions Limitations.

This contract for long term care insurance is intended to be a federally qualified long term care insurance contract and may qualify You for federal and state tax benefits.

Signed for Genworth Life Insurance Company.



Secretary



President and Chief Executive Officer

TABLE OF CONTENTS

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

Section	Contents of Section	Page
Schedule	This shows Benefits, services and limitations of the Certificate as of the Certificate Effective Date. It includes Premium information.	SCH
Declarations	This section of Your Certificate includes notices and other important information.	1
Table of Contents	This lists the major sections in this Certificate.	2
Modal Premium Disclosure	This describes the additional charges, if any, associated with paying Premium more frequently than once per year.	3
General Definitions	This provides the definitions of words used in this Certificate that have special meaning when applied to Your Coverage. Additional terms not defined in this section are defined in the provisions in which they are most commonly used.	4
Period of Coverage	This describes how Coverage takes effect and is continued until the Certificate ends.	7
Premium and Renewal	This states: how and when to pay Premium; the importance of paying Premium on time; what happens if it is not paid on time; and how We may change Premium.	9
General Provisions	This tells You: the documents which state all of the contractual agreements; the importance of completing all applicable Applications truthfully; and other rights, obligations and features.	13
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.	15
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.	19
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. The Benefit Provisions may be supplemented by attached riders or endorsements.	21
Attachments	A copy of all applicable Applications made for Your Coverage. Any applicable riders, endorsements and notices.	

MODAL PREMIUM DISCLOSURE

Premium Payment Options

You pay for Your Certificate 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**."

Where applicable, the availability or selection of a Premium Payment Mode will be determined in accordance with the terms of Your Group Policy.

If You have a Premium Payment Mode other than Annual, Your Annual Premium is determined by multiplying the Modal Premium Payment amount by the number of payments to be made during a year. As an example, the following chart compares the total Premium payments for each payment mode and the corresponding Modal Premium that You would pay on each Premium Due Date.

Hypothetical Example:
Yearly Cost Comparison of
Alternate Modal Premium Payments

Premium Payment Mode*	Number of Premium Payments per Year	Amount of Each Modal Premium Payment During the Year	Total of Modal Premium Payments During the Year
Annual	1	$1,200	$1,200
Semi-Annual	2	$600	$1,200
Quarterly	4	$300	$1,200
Monthly	12	$100	$1,200

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

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

Calculation Of Annual Premium

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

- Annual - 1.00
- Semiannual – 2.00
- Quarterly – 4.00
- Monthly – 12.00

When Premium payments are made more frequently than monthly, calculation of Your total Annual Premium is based on the number or Premium payments to be made during a year.

GENERAL DEFINITIONS

This section provides the definitions of words used in this Certificate that have a special meaning when applied to this Certificate. Additional definitions may also appear in this Certificate where they can assist You in understanding related text. For example, most Benefits provided for under this Certificate 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 this Certificate.

Certificate means the certificate issued to You, including all applicable Application(s), and any riders, endorsements, amendments and attachments. It evidences Coverage You have under the Group Policy, including Continuation Coverage described in the Period of Coverage section.

Certificate Effective Date means the date Your Coverage begins. It is shown on the Schedule.

Claim means a request by You for payment of Benefits under Your Coverage.

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 Group Policy as evidenced by this Certificate.

Coverage Maximum means the maximum amount of Benefits We will pay for Your Coverage under the Group 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 Certificate Effective Date.

Covered Care means those Qualified Long Term Care Services for which Benefits are payable, or would be payable 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 by You.

Elimination Period means the length of time, as determined in the Schedule before You are entitled to Benefits under Your Coverage. The Schedule describes how the Elimination Period is satisfied and whether it is based on either calendar days on which You are Chronically Ill, beginning with the first day You incur a Covered Expense; or the days on which You incur a Covered Expense while You are Chronically Ill.

Days used to satisfy the Elimination Period do not need to be consecutive; and can be accumulated over time. Once satisfied, You will never have to satisfy a new Elimination Period for Your Coverage.

Covered Care You receive and related Covered Expenses that are otherwise excluded from Coverage because of the Non-Duplication or Coordination With Other Coverage provisions may be used to satisfy this requirement.

Group Policy means the policy issued under the Group Policy Number shown in the Schedule that has been issued to the Policyholder named in the Schedule.

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 or anyone who is related to You or Your Spouse or Partner as a parent, child, brother, or sister. This includes adopted and step-relatives.

Licensed Health Care Practitioner means any of the following:
- a Physician (as defined in Sec. 1861(r)(1) of the Social Security Act);
- a registered professional nurse;
- a licensed social worker; or
- any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States.

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, as stated in the Schedule. This amount is also used to determine other Benefit maximums.

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.

Premium means the premium identified in the Schedule under Premium Data. Premium may change in accordance with the terms of the Group 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.

Qualified Long Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services and maintenance or personal care services which:

- are required by a Chronically Ill Individual; and
- are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

As used above, "maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which You are Chronically Ill. This includes protection from threats to health and safety due to Severe Cognitive Impairment.

Note: To be eligible for Coverage it is not sufficient for the care and services to only be Qualified Long Term Care Services. Such care and services must also meet the definition of Covered Care.

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

Schedule means the section of this Certificate that states Your Coverage features and limits as of the original Certificate Effective Date and as may be changed over time. Changes in Your Schedule may be made by rider.

Spouse or Partner means the person to whom You:

- are joined by marriage; or
- are joined by 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] (Ax[B/C]), where:
A = The total Premium paid during the Coverage Period.
B = The number of days remaining in the Coverage Period after Your 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 Your Certificate 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.

PERIOD OF COVERAGE

Coverage Taking Effect

This Certificate is issued in consideration of payment of the required Premium and any applicable Application. Except as provided below, Your Coverage will become effective on the Certificate Effective Date shown in Your Schedule, subject to the timely payment of the First Premium. This Certificate may be continued in force by the timely payment of Premium until it ends in accordance with the terms and conditions described in this Certificate.

Deferred Certificate Effective Date (applicable only to employees)**:**

If Your Coverage is based on Your being an employee, You must be Actively at Work with the employer forming the basis for Your eligibility on the Certificate Effective Date and for the prior 30 calendar day period. If You cannot satisfy this requirement, Your Certificate Effective Date will be deferred until the first day of Your employer's regularly scheduled payroll billing period on which You are Actively at Work, and have been Actively at Work for the prior 30 calendar day period.

Actively at Work means You are an employee who is performing the usual duties of Your job at the usual place of work as required by Your employer on a full-time basis at least 40 hours each week or on a part-time basis at least 20 hours each week. You will be considered Actively at Work while on employer approved vacations, holidays and regularly scheduled days off, or during temporary business closures. You will not be considered to be Actively at Work if You are unable to perform Your usual duties due to a sickness, accident or injury or if You are on a leave of absence, a sabbatical or retired from the same employer.

Your Right To Cancel This Certificate At Any Time

You may cancel this Certificate 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;
- the first day of the calendar month following the date We receive Your written request; 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.

Continuation Coverage

Except if Your Coverage ends as provided for in the "When Your Coverage Ends" provision, Your Coverage will be continued in accordance with the terms of this Certificate even if the Policyholder ceases to sponsor the Group Policy or discontinues coverage for the group of eligible persons to which You belong.

You must pay Us all Premium required for the continuation of Your Coverage. The Premium for the continuation of Your Coverage may change in the future as stated in the Premium and Renewal section.

When Your Coverage Ends

This Certificate terminates and Your Coverage ends on the first to occur of:

- the date of Your death;
- the date Your Certificate is cancelled by You, as stated in the provision entitled Your Right To Cancel This Certificate At Any Time;
- 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;
- the Certificate Effective Date if Your Coverage is rescinded in accordance with the Misstatements and Incontestability provision; or
- the date the Policyholder discontinues sponsorship of the Group Policy or coverage of a group of eligible persons to which You belong, but only if, within 31 days thereafter Your Coverage is replaced by other group coverage that:
  - is effective on the day following the date Your Coverage ends; and
  - provides benefits that are substantially equivalent to or greater than those provided under the replaced Group Policy; and
  - provides immediate coverage to all persons insured under the Group Policy on the date their coverage under the replaced Group Policy is discontinued; and
  - calculates premium based on Your age on Your Certificate Effective Date.

Except as provided in the Extension of Benefits provision below, Your Coverage will not pay for Covered Expenses incurred after the Certificate terminates and Your Coverage ends.

If this Certificate terminates and Your Coverage ends, We will promptly refund any Unearned Premium as stated in the Refund of Unearned Premium provisions.

Extension Of Benefits

If this Certificate terminates and Your Coverage 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 Your Coverage 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 Coverage provided for in this Certificate 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 below.

Premium is payable to Us. The First Premium is due on the Certificate Effective Date. Each subsequent Premium is due on the next Premium Due Date. Your Schedule shows the initial Premium Payment Mode that applies to this Certificate. Premium Payment Modes available under the Group Policy are determined by mutual agreement between the Policyholder 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, payroll deduction, pension deduction, or other automatic payment methods and payment cannot be accomplished for any reason, We will bill You directly.

Premium Rate Changes

As stated on the first page of this Certificate, **We have the right to change Premium becoming due in the future.** We can change Premium on a Group Policy or rate class basis; but only if We change Premium for all similar Certificates issued under the Group Policy in the same State as this Certificate. Your rate class consists of You and all other individuals insured under the same form as this Policy who are being charged the same rate for the same Benefits, plan and options. 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.

If Your Premium is paid by payroll or pension deduction, or other automatic payment methods, either We, or the Policyholder will notify You of a change in Your Premium. If You are paying Premium directly to Us, We will give You written notice at least 60 days before the date a change in Your Premium becomes effective.

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 the increased Premium;
- electing a decrease in Coverage to an available Coverage amount; or
- cancelling or lapsing Your Coverage (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 Your Coverage Ends provision, all other Unearned Premium will be applied as a reduction in future Premium due.

As an exception to the above, any refund of Unearned Premium attributed to Premium paid by the Policyholder will be paid to the Policyholder.

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 Certificate from terminating and Your Coverage from ending. Your Coverage 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 Certificate 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 (lapse) 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. A copy of that notice will also be sent to the Policyholder when the Policyholder is remitting Premium to Us. 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 Certificate remains in force and Your Coverage does not end. 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.

If Your Premium is paid by payroll or pension deduction and You have not made a prior designation, You may make the designation under this provision within 60 days after the date Your Premium is no longer being deducted from a payroll or a pension plan.

Reinstatement

If this Certificate terminates and Your Coverage ends for non-payment of Premium, You may apply to reinstate Your Coverage. 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. This Certificate may only be reinstated as provided below.

This Certificate 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 this Certificate 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 this Certificate 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:

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

We must receive written notice from You that Your Coverage 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 written notice from You, You will be required to provide Us with:
- proof that You met the Eligibility For The Payment of Benefits requirements of this Certificate; 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 Your Coverage had not ended.

Unpaid Premium

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

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;
- a decrease in Your Nursing Facility Maximum to available Nursing Facility Maximum; or
- a conversion of Coverage to a Nursing Facility only or Home Health Care only certificate if We are then issuing those certificates for sale in the State under the Group Policy.

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.

We reserve the right to determine what represents an acceptable decrease under the Group Policy. 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. Except as provided below, any Benefit Increases provision that applied to Your Coverage prior to a reduction in Coverage will apply in the same manner to any reduced maximums.

Where Benefit Increases apply, as stated in the Schedule, You have the right to change or terminate Your Benefit Increases as follows:
- You may reduce Your Coverage to an available Benefit Increase that results in a reduced or less frequent annual increase in Your Nursing Facility Maximum; or
- You may reduce Premium by terminating Your Benefit Increases (where that option is available under the Group Policy);
- If You choose to reduce or terminate Benefit Increases, Your Premium, the Maximums and other payment limits below will be adjusted to the Premium, Maximums and payment limits that would have been in effect if the change had been effective as of the Certificate Effective Date:
  - the Nursing Facility Maximum;
  - the Coverage Maximum; and
  - other payment limits that are based on the Nursing Facility Maximum.

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 written approval of Your Application. If Your Coverage is kept in force through a Nonforfeiture Benefit, You cannot also elect reduced Coverage in accordance with the provision.

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

While Premium are being paid You have the right to request to increase Your Coverage at any time. The increase must be to an amount or plan then being offered under the Group Policy. We reserve the right to determine what represents an increase in Coverage. 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.

If Your Application to increase Your Coverage is approved by Us, 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

If We develop new significant or material Benefits or Benefit eligibility criteria for similar California policy forms that are not included in this Certificate and the Policyholder wishes to make available under the Group Policy, We will notify You, of the new Benefits and/or provisions unless You are receiving Benefits or are in the process of satisfying the Elimination Period. However, if You are insured under a Group Policy other than one issued to cover employees of one or more employers, or members of one or more labor unions or associations (sometimes called a discretionary group), the new Benefits will automatically be available to You and consent of the Policyholder will not be necessary. The notification will be made within 12 months of the availability of those changes. You will then be given the opportunity to acquire the new Benefits and/or provisions in one of the following ways chosen by Us:

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

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 Group Policy, its Certificates and the Applications of the Policyholder and each Insured constitute the entire contract between the parties. Any statement made by the Policyholder or an Insured shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall void the insurance or reduce the benefits under the Group Policy or be used in defense of a claim thereunder unless it is contained in a written Application.

This Certificate reflects Your Coverage and is a part of the Group Policy. While the Group Policy is in force, it determines governing contractual provisions. No change in the Group Policy or this Certificate is valid until and unless approved in writing by one of Our officers. That approval must be noted on, or attached to, the Group Policy and, if applicable, Your Certificate. No agent or producer has the authority to change the Group Policy or Your Certificate or waive any of their provisions.

Payment of Premium following:

- a change to Coverage 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 Certificate, We have relied upon the information presented by You in Your Application. Any incorrect or omitted material information in Your Application for Your Coverage, 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 will not be contestable upon the grounds of misrepresentation in Your Application for that Coverage alone; and 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 all 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, this Certificate would not have become effective, We will rescind this Certificate and refund of all Premium paid for it.

Clerical Error and Misstatement of Eligibility

Clerical error, misstatement as to Your eligibility, or delays in making entries on the records by You, the Policyholder, or Us:

- will not void Your Coverage if Your Coverage would otherwise have been in effect; and
- will not cause You to become insured if You are otherwise not eligible; and
- will not extend Your Coverage if Your Coverage would otherwise have ended or been reduced.

If a clerical error or misstatement is found, Premium and Benefits will be adjusted based on the true facts and the provisions of this Certificate.

Time Periods

All time periods start and end at 12:01 a.m. Eastern Time in the United States.

Non-Participating; Dividends Not Payable

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

Conformity With Internal Revenue Code

If on its effective date, this Certificate 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 inform You in writing of any required change in the provisions of this Certificate.

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 Group Policy is governed by the laws of the State in which the Group Policy was issued. This Certificate is governed by the laws of the State having jurisdiction over this Certificate as of the Certificate Effective Date.

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 for payment for Covered Expenses 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

This Coverage 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 Group Policy or this Certificate. If We agree, You may contact Us about this Certificate using electronic means or other technologies. If You agree, We may contact You regarding the Group Policy or this Certificate 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.

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 Certificate 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 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.

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

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.

If You require assistance with Your Claim or Claim forms, You may contact Us.

Claim Forms

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 copies 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 written authorization to evaluate Your Claim.

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

If You or Your Representative do not receive the Claim forms from Us within 15 days after You initiate a Claim, 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 above. The letter must be sent to Us at Our Administrative Office.

If You incur Covered Expenses subsequent to Your submission of Your Claim form, 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 required by the above paragraph. Unless We are provided with proof, in a form satisfactory to Us, that You were incapacitated or incapable of providing Us with Proof of Loss within the one (1) year period, or unless prohibited by law, Your Claim may 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, You will be required to assist Us in periodically updating Your Plan of Care and providing Us with Current Eligibility Certifications. 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.

We may use third party services to assist Us in gathering information related to Our determination of both Your initial and ongoing eligibility for the payment of Benefits. Certain third party providers may be Our affiliates. If We use Our affiliates, We will notify You prior to use. You will have the right to request third party providers who are not affiliated with Us.

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.

Time Of Payment Of Benefits

If We determine that You are eligible for the payment of Benefits, We will promptly pay Benefits for Covered Expenses provided for in the initial Proof of Loss. 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, at Our option, 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 specific 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 this Certificate 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 this Certificate.

Right To Recover An Excess Payment

If, at any time, We make a payment in excess of Benefits payable under this Certificate ("**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 this Certificate 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.

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.

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 60 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 needed) that tells 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 would 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.

This Appeal process applies to all aspects of the claims process, including benefit eligibility, the Plan of Care, services, provider and claim payment amounts.

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.

Legal Actions

You may not bring any legal action against Us seeking Benefit payments under this Certificate 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 this Certificate more than 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 at all, 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 or 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;
  - participation in a felony, riot, or insurrection;
- provided 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 Covered Expenses that are in excess of the amount paid or payable under:

- Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount); and
- Any State or Federal workers' compensation, employer's liability or occupational disease law; and
- Any other Federal, State or other governmental health or long term care program or law, except Medicaid (called Medi-Cal in California).

However, this Non-Duplication provision will not disqualify a Covered Expense from being used to satisfy any Elimination Period requirement.

Coordination With Other Coverage

We will reduce the amount of Benefits We will pay for Covered Expenses when the total amount payable under this and all Other Long Term Care coverage is greater than the actual Covered Expense You incur for Covered Care.

We consider **Other Long Term Care** coverage to be group coverage that provides nursing facility, residential care facility, hospice, or home health care benefits. This applies whether those benefits are payable on an expense reimbursement, indemnity, cash payment or other basis. This also applies to benefits payable in conjunction with life insurance and annuities, but only to the extent that the benefits are payments of Qualified Long Term Care Services and exceed the amount of accelerated life insurance or annuity benefit payments.

When Coverage is reduced, the amount We will pay will be the lesser of:

- the amount We would have paid in the absence of this provision; or
- the difference between the actual Covered Expense and the total amount payable for that Covered Care under:
  - all Other Long Term Care coverage that was effective before this Coverage; plus
  - all Other Long Term Care coverage that does not coordinate its payment with this Coverage.

Pre-Existing Conditions Limitation

We will not pay for Covered Expenses incurred for any care or confinement that is a result of a Pre-Existing Condition when the care or confinement begins within six (6) months following Your initial Certificate Effective Date.

A **Pre-Existing Condition** means a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within six (6) months prior to Your initial Certificate Effective Date.

If the Group Policy or this Certificate replaces another long-term care policy or certificate, We will waive any time periods applicable to pre-existing conditions for similar benefits to the extent that similar limitations or exclusions were satisfied under the original policy.

BENEFIT PROVISIONS
LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

Eligibility For The Payment Of Benefits

For You to be eligible for the payment of Benefits described in this Certificate:

- You must be Chronically Ill;
- We must receive a Current Eligibility Certification for You; and
- We must receive ongoing proof which verifies that the Covered Care You receive is needed due to Your continually being Chronically Ill. The proof can be based on information from care providers, personal Physicians, other Licensed Health Care Practitioners and other sources.

Conditions For Receiving Benefits

Benefits will be paid as reimbursement for expenses paid on Your behalf 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.
- The Covered Care and related Covered Expenses must be consistent with and received pursuant to Your Plan of Care as prescribed by a Licensed Health Care Practitioner.
- Except as stated in the Extension of Benefits provision, Your Coverage must not have ended before 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 Coverage provided for the Benefits being Claimed.
- You must meet the requirements for payment in accordance with all the provisions of this Certificate.
- The care, service, cost or item for which Benefits are payable must meet the definition of Qualified Long Term Care Services.

Right to a Second Assessment

If a Licensed Health Care Practitioner assesses Your condition and it is determined that You are not a Chronically Ill Individual, We will inform You of this. If that determination was made without a personal examination of You by a Licensed Health Care Practitioner, a second assessment will be allowed.

Definitions

Activities Of Daily Living mean the following self-care functions:

- **Bathing:** Washing oneself by sponge bath; or in either a tub or shower, including the act 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.

Chronically Ill and **Chronically Ill Individual** refer to a person who has been certified by a Licensed Health Care Practitioner as:

- being unable to perform, without Substantial Assistance from another individual, at least two (2) Activities of Daily Living due to a loss of functional capacity. In addition, this loss of functional capacity must be expected to exist for a period of at least 90 days; or
- requiring Substantial Supervision to protect the person from threats to health and safety due to Severe Cognitive Impairment.

A **Current Eligibility Certification** is a written certification by a Licensed Health Care Practitioner who is not a member of Your Immediate Family that You meet the above requirements for being Chronically Ill. The certification must be renewed and submitted to Us every 12 months.

Substantial Assistance is either:
- **Hands-on Assistance** which is the physical assistance (minimal, moderate or maximal) of another person without which You would be unable to perform the Activity of Daily Living; or
- **Standby Assistance** which is the presence of another person within arm's reach of You that is necessary to prevent, by physical intervention, injury to Yourself while You are performing 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 that reliably measure impairment in the person's: short-term or long term memory; orientation as to people, places, or time; deductive or abstract reasoning; and judgment as it relates to safety awareness.

Substantial Supervision is 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 **Plan of Care** is a written description of Your needs and a specification of the type, frequency (including duration), and providers of all formal and informal long term care services required by You and the cost, if any.

The Plan of Care will be developed as a result of an assessment and incorporates any information provided by your personal Physician. The final Plan of Care must be as prescribed by a Licensed Health Care Practitioner.

The Plan of Care must be updated as Your needs change. We must receive a copy of the Plan of Care upon its completion and each time it is updated. We retain the right to request periodic updates not more frequently than once every 90 days. We will make a copy of the current Plan of Care available to Your personal Physician, when requested. No more than one Plan of Care may be in effect at a time.

PRIVILEGED CARE® COORDINATION SERVICES

Privileged Care Coordination Services

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 provided by Us at no cost to You. We will pay for these services when You receive them while Your Coverage is in effect. These payments will be at Our expense; and will NOT count against any payment limits.

To receive these services You or Your Representative should contact Us at Our Administrative Office.

About The Privileged Care Coordination Services

These services will provide You with access to a team of qualified individuals who will review Your specific situation and provide the following services:

- Conduct assessments of Your functional and cognitive capabilities and personal needs for care and services on an ongoing basis.
- Work with You to identify the specific care, services and providers required to meet Your needs.
- Develop and suggest initial and subsequent Plans of Care to assist You in meeting Your needs.
- Provide the initial and ongoing Current Eligibility Certifications.
- Assist You in completion of initial Claim forms, upon Your request.
- Monitor Your care needs on an ongoing basis to help You receive appropriate care while You are Chronically Ill.

The **Privileged Care Coordination Team** includes a Licensed Health Care Practitioner who:

- is qualified by training and experience to assess and coordinate the overall care needs of a Chronically Ill Individual; and
- meets standards satisfactory to Us that pertain to quality assurance, reporting and records maintenance requirements.

Privileged Care Coordination Services Are Voluntary

You are not required to use these Privileged Care Coordination Services. You may, at Your own expense, use a Licensed Health Care Practitioner who is not from a Privileged Care Coordination Team to provide a Plan of Care, Current Eligibility Certification, or assist in coordinating services.

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 Coverage 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 medications or any items or services provided for Your comfort or 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 persons who are Confined in the facility 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 all persons who are Confined in the facility.

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 this Certificate.

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 care, support services, meals, and room charges received while You are Confined in the Residential Care Facility. They include facilities and services provided by the Residential Care Facility, care and services 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. They do not include expenses for medications or any items or services provided for Your comfort or 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;
- Have a trained and ready-to-respond employee on duty in the facility at all times to provide care and services;
- Provide three (3) meals a day and accommodate special dietary needs;
- Have agreements to ensure that residents receive the medical care services of a Physician or Nurse in case of emergency; and
- Have appropriate methods and procedures to provide necessary assistance to confined inpatients in managing 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 inpatient, 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 this Certificate.

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 otherwise 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 this Certificate.

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 Care; Nurse and Therapist Services; Home Health Care; Personal Care Services; and Homemaker Services.

Definitions

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

Nurse and Therapist Services means health care services provided in Your Home by a Nurse, or a licensed physical, occupational, respiratory, or speech therapist.

Home Health Care means skilled nursing or other professional services in Your Home, including, but not limited to, part-time and intermittent skilled nursing services, home health aide services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.

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 Physician or a multidisciplinary team under medical direction.

Personal Care Services means assistance with the Activities of Daily Living, including the instrumental activities of daily living, provided by a skilled or unskilled person under a Plan of Care developed by a Licensed Health Care Practitioner. “Instrumental activities of daily living” include using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry and light housekeeping.

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 this Certificate.

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

INFORMAL FAMILY CARE BENEFIT

The Benefit

Subject to the Payment Limitations below, We will pay for Covered Expenses incurred for Informal Family Care, as described below.

Covered Expenses

Covered Expenses means expenses You incur for Informal Family Care that is:

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

Definition

Informal Family Care means health and personal care assistance a member of Your Immediate Family provides to You, in Your Home, because You are Chronically Ill.

The Immediate Family member providing the assistance must be someone who:

- did not reside with You in Your Home at the time You first satisfied the Eligibility for the Payment of Benefits provision; and
- is not compensated, as an employee, by any organization that is paid to provide such assistance.

The assistance may be in the form of:

- help with simple health care tasks, personal hygiene, or managing medications;
- Substantial Assistance in performing Activities of Daily Living; or
- Substantial Supervision when You have Severe Cognitive Impairment.

Your Plan of Care must specify the type, frequency and duration of Informal Care required.

Payment Limitations

This Benefit will not be paid for any day for which payment is made under the Home and Community Care Benefit.

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 this Certificate.

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, alleviate the physical, emotional, social and spiritual discomforts You are experiencing in the last phases of life due to the existence of a terminal disease (having six 6 months or less to live, as determined by a Physician); and to provide supportive care to Your primary care giver and family. Care may be provided by a skilled or unskilled person under a Plan of Care developed by a Physician or 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.

Payment Limitations

Payment of this Benefit is subject to:

- the Coverage Maximum;
- the payment limit shown in the Schedule for the Nursing Facility Benefit 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 this Certificate.

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 short-term care provided in an institution, in Your Home, or in a community based program that is designed to relieve a primary caregiver 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 during which Respite Care is to be provided; and
- the Covered Care You will require to replace care normally provided by the unpaid caregiver.

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 an 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 this Certificate.

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.

REQUESTED ALTERNATIVE BENEFIT

The Benefit

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

Covered Expenses

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

- 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 this Certificate;
- 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, 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 requirement 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 this Certificate.

The Mutual Agreement may be discontinued at any time, by either You or Us, without affecting Your right to Benefits otherwise remaining under this Certificate.

Payment Limitations

Payment under this Benefit 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 this Certificate.

INTERNATIONAL NURSING FACILITY BENEFIT

The Benefit

Subject to the Conditions below, We will pay for Covered Expenses incurred during Your Confinement in an Out-of-Country Nursing Facility, as described below.

Covered Expenses

Covered Expenses for International Nursing Facility Care means expenses You have paid for care and support services (including room and board) provided to You by an Out-of-Country Nursing Facility 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:

- We will not provide Privileged Care Coordination Services in connection with this Benefit.
- 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 Confinement 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 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 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 post-secondary 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: An Out-of-Country Nursing Facility is NOT any of the following:

- A hospital (including any sub-acute or rehabilitation hospital) or clinic.
- A Residential Care 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 of this Certificate.

Payment for care in an Out-of-Country Nursing Facility will not exceed 75% of the Nursing Facility Maximum.

This Benefit will not be payable at the same time as any other Benefit.

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 Benefit. This waiver applies to the entire Premium for this Certificate (including all applicable Riders).

This waiver stops when You no longer incur Covered Expenses 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 it becomes due in accordance with this Certificate's Premium Payment Mode.

If this Certificate terminates and Your Coverage 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 provision.

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 this Certificate.

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 at least 60 days prior to the date the Premium increase is to take effect:

- offer to reduce Your current level of coverage without proof of insurability so that the required Premium for this Certificate is not increased;
- offer to convert this Certificate 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*

Issue Age	Increase Over Initial Premium	Issue Age	Increase Over Initial Premium	Issue Age	Increase Over Initial Premium
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 & 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, this Certificate 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 any Benefit Increases provision. The amount of reduced Coverage Maximum will be the greater of:

- 100% of all Premium paid for this Certificate, 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 for this Certificate.

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 this Certificate, while it was in force prior to conversion, is limited to the maximum amount that would have been paid if this Certificate had remained in Premium paying status. This Benefit will not apply if this Certificate is continued in accordance with any other Nonforfeiture Benefit.

Please keep this Certificate in a safe place with Your other important documents.

ENDORSEMENT

This Endorsement amends the Right To Reduce Coverage And Lower Premium provision of the PREMIUM AND RENEWAL section of the Certificate.

The following language is deleted from the Right To Reduce Coverage And Lower Premium provision of the Certificate:

> Where Benefit Increases apply, as stated in the Schedule, You have the right to change or terminate Your Benefit Increases as follows:
> - You may reduce Your Coverage to an available Benefit Increase that results in a reduced or less frequent annual increase in Your Nursing Facility Maximum; or
> - You may reduce Premium by terminating Your Benefit Increases (where that option is available under the Group Policy);
> - If You choose to reduce or terminate Benefit Increases, Your Premium, the Maximums and other payment limits listed below will be adjusted to the Premium, Maximums and payment limits that would have been in effect if the change had been effective as of the Certificate Effective Date:
>   - the Nursing Facility Maximum;
>   - the Coverage Maximum; and
>   - other payment limits that are based on the Nursing Facility Maximum.

It is replaced by:

> For purposes of this section only, Your Nursing Facility Maximum and other payment limits that are based on the Nursing Facility Maximum will be collectively referred to as "maximum coverage amounts." The reference to "maximum coverage amounts" is distinct from and does not include Your Coverage Maximum.
>
> Where Benefit Increases apply, as stated in the Schedule, You have the right to change or terminate Your Benefit Increases as follows.
>
> > Depending on the Benefit Increase option(s) available under the Group Policy and selected by You, You may be able to reduce Your Premiums by changing Your Benefit Increase option. You may be able to change Your Benefit Increase option by:
> >
> > (a) terminating Your Benefit Increases;
> > (b) reducing Your Benefit Increase percentage; or
> > (c) selecting another available Benefit Increase option that results in a reduced or less frequent annual increase in Your Nursing Facility Maximum (for example, you may be able to reduce your Coverage by changing from a Compound Benefit Increase to a Simple or Equal Benefit Increase).
> >
> > If You change Your Benefit Increase option, Your "maximum coverage amounts" will remain at the then current increased levels (or slightly above due to system rounding), reflecting all Benefit Increases as of the date Your reduced Benefit Increase election becomes effective pursuant to the terms of the Certificate.
> >
> > If You (a) terminate Your Benefit Increases, Your Premium going forward will be calculated as if Your current "maximum coverage amounts" were Your original "maximum coverage amounts." Your new resulting Coverage Maximum will be no less than Your then current increased amount.
> >
> > If You (b) reduce Your Benefit Increase percentage or (c) select another available Benefit Increase option that results in a reduced or less frequent annual increase in Your Nursing Facility Maximum, Your Premium going forward will be based on the original "maximum coverage amounts" needed, as of Your Certificate Effective Date, to reach Your current

"maximum coverage amounts" with Your new reduced Benefit Increase option. Your new resulting Coverage Maximum will be no less than Your then current increased amount. Your "maximum coverage amounts" and Coverage Maximum will continue to increase pursuant to the terms of Your Certificate and Schedule at Your new reduced Benefit Increase option.

If You choose to reduce Your Premiums by changing Your Benefit Increase option as described above, You may also then reduce Your Coverage to available Coverage amounts.

Where Benefit Increases apply, as stated in the Schedule, You may elect to reduce Your Coverage to available Coverage amounts without changing or terminating Your Benefit Increases. Your Premium going forward will be calculated as if the reduced Coverage amounts were in effect on the Certificate Effective Date. While Your Benefit Increase percentage will remain the same as before, the annual dollar amount of Your Benefit Increases, both retroactive and going forward, will be a lower annual dollar amount than prior to Your reduction in Coverage since Your Benefit Increase percentage is being applied to lower original "maximum coverage amounts" and a lower original Coverage Maximum. Your "maximum coverage amounts" and Coverage Maximum will continue to increase pursuant to the terms of Your Certificate and Schedule.

This Endorsement becomes a part of the Certificate. It takes effect on the Certificate Effective Date and ends when the Certificate ends.

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

Signed for Genworth Life Insurance Company.
Administrative Office: P.O. Box 64010, St Paul, MN 55164-0010

Secretary

President and Chief Executive Officer

NONFORFEITURE BENEFIT RIDER

This Rider adds the following Nonforfeiture Benefit to Your Certificate.

NONFORFEITURE BENEFIT

The Benefit

Subject to the Payment Limitations below, this Benefit provides a continuation of Your Coverage if the Certificate terminates and Your Coverage ends because the Premium due is not received by Us by the end of the Grace Period (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 the Certificate, 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 months (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 Coverage is subject to the following conditions:

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

Payment Limitations

Coverage under this Benefit ends when the first of the following occurs:

- the total Covered Expense paid under this Benefit equals the Nonforfeiture Allowance; or
- Your Coverage Maximum, as determined from the Schedule, is exhausted.

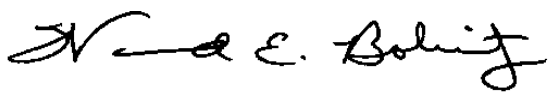
When this Rider is in Force

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

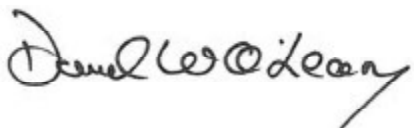
- the date the Certificate terminates and Your Coverage ends, subject to the provisions of this Rider; or
- the Premium Due Date following Our receipt of Your written request to terminate this Rider.

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

Signed for Genworth Life Insurance Company.



Secretary



President and Chief Executive Officer

NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1067.02(b)(2)(C)

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O. Box 16860
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

Genworth Life Insurance Company
Genworth Life Insurance Company of New York

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Effective Date: This notice became effective on September 23, 2013.

This Notice of Privacy Practices (the "Notice") describes your rights concerning your Protected Health Information ("PHI"). PHI is information that may identify you and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you. This Notice also describes how we may use and disclose your PHI.

The Health Insurance Portability and Accountability Act ("HIPAA") requires us to:

- Provide you with this notice of our legal duties and privacy practices with respect to PHI.
- Maintain the privacy of your PHI.
- Comply with the terms of our privacy notice that is in effect.

We reserve the right to change this Notice as permitted by law, and such change will apply to all medical information that we maintain, including PHI that was received by us before the effective date of the new notice. If we make a material change to this Notice, we will post a copy of the revised Notice of Privacy Practices on our web site at www.Genworth.com and:

- In our next annual mailing to you, provide information about the material change and how you may obtain the revised Notice of Privacy Practices, or
- Communicate the changes in such other ways that HIPAA then allows.

This Notice applies only to individual or group products that provide, or pay the cost of, medical care including long-term care insurance policies, certain long-term care insurance riders on life insurance policies, and Medicare Supplemental insurance. It does not apply to products (such as a life insurance or disability insurance) that may involve some use or disclosure of health information, but whose primary function is not the reimbursement of the costs of medical care.

<u>Use And Disclosure Of PHI Without Your Written Authorization</u>

Below is a description of ways in which we may use and disclose the PHI we receive about you without your specific permission. Where state law provides additional restrictions on how we can use and disclose information, we will follow applicable state laws.

- **Uses and Disclosures for Payment.** We may use or disclose your PHI for payment-related purposes. Payment related disclosures may include disclosures necessary for: making claim decisions, care coordination activities, coordinating benefits with other insurers or payers,

and billing. For example, we may use your PHI to determine if you are eligible for benefits under the terms of a long term care insurance policy.

- **Uses and Disclosures for Health Care Operations.** We may use or disclose your PHI to support our health insurance operations. These functions include, but are not limited to: quality assessment and improvement, making claim decisions, billing, related health care data processing, licensing, business planning, care coordination activities, and business development. For example, we may use your information to respond to your customer service inquiry or to offer an enhancement to your existing coverage. We also may use and disclose your information for underwriting and premium rating our risk for health coverage (although, outside of long term care insurance, we are prohibited from using or disclosing any genetic information for these underwriting purposes).

- **Business Associates.** We contract with individuals and entities (known as "business associates") to perform various functions on our behalf or to provide certain types of services. These business associates may include insurance agents, claim payment administrators, information technology service, and others. We may disclose PHI to a business associate if they need the PHI to provide a service to us. We enter into contracts with these business associates concerning the privacy and security of your PHI and these Business Associates are obligated to follow federal rules concerning privacy and security.

- **Plan Sponsor.** If you are insured under a group long-term care insurance policy, we may also disclose your PHI to the sponsor of your benefit plan.

Other Possible Uses and Disclosures of PHI

The following is a description of other possible ways in which we may (and are permitted to) use or disclose your PHI without your authorization. We may disclose your PHI without your authorization:

- To a health oversight agency for activities authorized by law, such as audits; investigations; civil, administrative, or criminal proceedings or actions;
- As federal, state, or local law requires the use or disclosure;
- To a public health authority or cooperating foreign government official for public health activities;
- To a government authority authorized to receive reports of abuse, neglect, or domestic violence;
- In the course of any judicial or administrative proceeding; in response to an order of a court or administrative tribunal; and in response to a subpoena, a discovery request, or other lawful process;
- To law enforcement officials for law enforcement purposes;
- To a coroner or medical examiner, funeral directors, or for organ or tissue donation purposes;
- As allowable by law, for research purposes;
- If we believe that the disclosure is necessary to prevent or lessen a serious threat to the health or safety of a person or the public;
- For activities deemed necessary by appropriate military command authorities or for national security and intelligence activities;

- If you are an inmate of a correctional institution, to the correctional institution or to a law enforcement official; and
- To comply with workers' compensation laws and other similar programs.

Others Involved in Your Health Care. Unless you object, we may disclose your PHI to a friend or family member that you have identified as being involved in your health care. If you are not present or able to agree to these disclosures of your PHI, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

Required Disclosures of Your PHI

The following is a description of disclosures that we are required by law to make.

- **Disclosures to the Secretary of the U.S. Department of Health and Human Services. We** may be required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Regulations.

- **Disclosures to You.** We are required to disclose to you most of your PHI in a "designated record set" when you request access to this information.

Your Authorization To Use and Disclose PHI

We will not use or disclose your PHI without your written authorization unless the use or disclosure is described in this Notice. For example, most (but not all) uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of PHI, require your authorization. Most disclosures of psychotherapy notes cannot be made without your authorization. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect, or for any other situation where we have already acted in reliance on the authorization.

Your Rights

The following is a description of your rights with respect to your PHI.

- **Right to Request a Restriction.** You have the right to request a restriction on the PHI we use or disclose about you for payment or health care operations. We are not required to agree to any restriction that you may request. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you. You may request a restriction by writing. In your request tell us: (1) the information whose disclosure you want to limit and (2) how you want to limit our use and/or disclosure of the information.

- **Right to Request Confidential Communications.** If you believe that a disclosure of all or part of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you can ask that we only contact you at your work address or via your work e-mail.

You may request an alternative means of communication by writing. In your request tell us: (1) the parts of your PHI that you want us to communicate with you in an alternative manner or at an alternative location and (2) that the disclosure of all or part of the information in a manner inconsistent with your instructions would put you in danger.

- **Right to Inspect and Copy.** You have the right to inspect and obtain a paper or electronic copy of your PHI that is contained in a "designated record set." Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or information we compile in anticipation of a claim or legal proceeding.

  To inspect and obtain a copy your PHI that is contained in a designated record set, you must submit your request in writing to Genworth Group Processing Privacy Office, St. Paul, MN 55164-0010: 1-800-416-3624. If you would like to specify a particular form or format for the information, we will try to accommodate your request if it can readily be produced in that manner; otherwise, we will provide a paper copy or other form or format that we agree upon. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

  We may deny your request to inspect and obtain a copy of your PHI in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the denial.

- **Right to Amend.** If you believe that your PHI is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by writing, and should include the reason the amendment is necessary.

- **Right of an Accounting.** You have a right to an accounting of certain disclosures of your PHI that are for reasons other than payment or health care operations. An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

  You may request an accounting by submitting your request in writing. Your request may be for disclosures made up to 6 years before the date of your request. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to accept this Notice electronically. To fulfill any of the above requests in writing, send the description of your request to: Genworth Group Processing Privacy Office, St. Paul, MN 55164-0010: 1-800-416-3624.

- **Right to be Notified Following a Breach of Unsecured PHI.** You have the right to and will receive a notification if we or one of our business associates has a breach of information security involving your unsecured PHI.

- **Filing a Complaint.** You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by writing to: Genworth Group Processing Privacy Office, St. Paul, MN 55164-0010: 1-800-416-3624.

  You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem. We will not penalize or in any other way retaliate against you for filing a complaint with the Secretary or with us.

Genworth Life Insurance Company
Long Term Care Division
Home Office: Richmond, Virginia
Administrative Office Address: P. O. Box 64010, St. Paul, MN 55164-0010

Submit a completed copy with application.
Keep a copy for applicant's records.

Applicant Copy

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG TERM CARE INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to the information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with long term care coverage, issued by Genworth Life Insurance Company. Your new coverage provides 30 days within which you may decide, without cost, whether you desire to keep the coverage. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new coverage.

You should review this new coverage carefully, comparing it with all accident and sickness or long term coverage you now have, and terminate your present coverage only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new coverage. This could result in denial or delay in payment of benefits under the new coverage, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new coverage for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy or certificate. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present coverage and replace it with the new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny future claims and to refund your premium as though your coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

IF AN AGENT/PRODUCER ASSISTS WITH THE APPLICATION, HE OR SHE MUST COMPLETE THE FOLLOWING.

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved with this transaction materially improves your position. My conclusion has taken into account the above considerations, which I have reviewed with you.

Agent/Producer's Signature	Print Name	Date *(mm/dd/yyyy)*

Applicant: The above "Notice to Applicant" was delivered to me on the date this form is signed.

Applicant A's Signature	Print Name	Date *(mm/dd/yyyy)*
Applicant B's Signature	Print Name	Date *(mm/dd/yyyy)*