To be retained by the APPLICANT(S)

Policy Form No. 21156 (0112) Comprehensive Long-Term Care Insurance Policy

FEDERAL TAX-QUALIFIED COVERAGE: THIS CONTRACT FOR LONG-TERM CARE INSURANCE IS INTENDED TO BE A FEDERALLY QUALIFIED LONG-TERM CARE INSURANCE CONTRACT AND MAY QUALIFY YOU FOR FEDERAL AND STATE TAX BENEFITS. THE BENEFITS PAYABLE BY THIS POLICY QUALIFY FOR MEDI-CAL ASSET PROTECTION UNDER THE CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE.

ELIGIBILITY FOR MEDI-CAL IS NOT AUTOMATIC. IF AND WHEN YOU NEED MEDI-CAL, YOU MUST APPLY AND MEET THE ASSET STANDARDS IN EFFECT AT THAT TIME. UPON BECOMING A MEDI-CAL BENEFICIARY, YOU WILL BE ELIGIBLE FOR ALL MEDICALLY NECESSARY BENEFITS MEDI-CAL PROVIDES AT THAT TIME, BUT YOU MAY NEED TO APPLY A PORTION OF YOUR INCOME TOWARD THE COST OF YOUR CARE. MEDI-CAL SERVICES MAY BE DIFFERENT THAN THE SERVICES RECEIVED UNDER THE PRIVATE INSURANCE.

CAUTION: The issuance of this Long-Term Care Insurance Policy is based upon Your responses to questions on Your Application. A copy of Your Application is attached to Your Policy when issued. If Your answers are misstated or untrue, New York Life Insurance Company may have the right to deny benefits or rescind Your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact New York Life, Long-Term Care at 6200 Bridge Point Parkway, Suite 400, Austin, Texas 78730-5006.

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

1. The Policy is an individual comprehensive long-term care insurance policy that is issued in the state of California where the Policy was solicited and the application signed.

2. **PURPOSE OF OUTLINE OF COVERAGE.** This Outline of Coverage provides a very brief description of the important features of the Policy. You should compare this Outline of Coverage to outlines of coverage for other policies available to You. This is not an insurance contract, but only a summary of coverage. Only the Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both You and New York Life Insurance Company. Therefore, if You purchase this coverage, or any other coverage, it is important that You **READ YOUR POLICY CAREFULLY!**

3. **TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED.**

   a. **30-Day Free Look.** You have 30 days from the day You receive the Policy to examine it. If You are not satisfied with the Policy for any reason within 30 days of receipt, You may return it to New York Life, Long-Term Care, P. O. Box 149009, Austin, Texas 78714-9955 or to Your producer. Upon Our receipt of any Policy You have returned within the initial 30 days, We will return any premium paid and coverage will be void from the start.

b. **Premium Refund for Voluntary Policy Surrender or Upon Your Death.** If Your Policy terminates for any reason, We will refund to You any premiums that You have paid past the date of termination. Any payments We make after We receive notification of Your death will be made to Your estate.

4. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.** If You are eligible for Medicare, review the Medicare Supplement Buyer's Guide, "Guide to Health Insurance For People With Medicare" available from Us or Your producer. Neither New York Life nor its producers represent Medicare, the federal government or any state government.

5. **LONG-TERM CARE COVERAGE.** Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing facility, in the community or in the home.

   The Policy provides coverage in the form of an expense incurred benefit for covered qualified long-term care expenses, subject to benefit eligibility, policy limitations, elimination periods, and daily and lifetime policy maximums.

6. **BENEFITS PROVIDED BY THE POLICY.**

   a. **Elimination Period and Policy Maximums.**

      (1) **Elimination Period.** The Policy contains an Elimination Period, which is like a deductible. The Elimination Period is the total number of days that You must receive care or services before benefit payments will begin. The Policy will not pay for care or services received or provided during the Elimination Period. Only days on which You receive care or services covered either under this Policy or by Medicare count toward meeting the Elimination Period. Some Benefits are not subject to the Elimination Period and amounts paid for those Benefits will not count toward satisfying the Elimination Period. The Benefit descriptions below indicate if that Benefit is subject to the Elimination Period.

      Once You have met all the conditions of the Eligibility for Payment of Benefits provision and have satisfied the Elimination Period, the Policy will begin paying benefits for covered care or services. The days counted toward Your Elimination Period do not have to be consecutive, but must be accumulated within a nine-month period. Only service days will be counted, subject to the provisions of the Policy.

      The Policy has an Elimination Period of 30 or 90 days. You select the Elimination Period You want for Your Policy at the time of application.

      (2) **Policy Maximums.** The Policy contains maximum benefits that may be paid for certain Benefits.

         (a) **Policy Lifetime Maximum Benefit.** The Policy Lifetime Maximum Benefit is the maximum dollar amount that will be payable for Benefits under the Policy. The Policy Lifetime Maximum Benefit is shown in the Schedule of Benefits of Your Policy. No further benefits are payable once the total benefits paid equals the Policy Lifetime Maximum Benefit except as provided by the Shared Care Rider, if applicable.

The Policy Lifetime Maximum Benefit is determined by multiplying the Nursing Facility Maximum Daily Benefit by a multiplier. The multiplier is the number of days in the benefit period selected by You at the time of application. The benefit periods and multipliers are: 1 year (365 days), 2 years (730 days), 3 years (1095 days), 4 years (1460 days), 5 years (1825 days), 7 years (2555 days), 10 years (3650 days) and Unlimited (lifetime) (no multiplier).

For example, if You select $180 per day as Your Nursing Facility Maximum Daily Benefit and You select a 2-year benefit period, Your Policy Lifetime Maximum Benefit would be:

$180 X 730 (2 years times 365 days) = $131,400

(b) **Nursing Facility Maximum Daily Benefit.** The Nursing Facility Maximum Daily Benefit is the maximum dollar amount payable for any one day of care in a Nursing Facility. The Nursing Facility Maximum Daily Benefit is selected by You at the time of application and is described below.

(c) **Residential Care Facility Maximum Daily Benefit.** The Residential Care Facility Maximum Daily Benefit is a multiple of the Nursing Facility Maximum Daily Benefit. You select the percentage of the Nursing Facility Maximum Daily Benefit at the time of Application as either 70% or 100%.

(d) **Home and Community-Based Care Monthly Maximum Benefit.** The Home and Community-Based Care Monthly Maximum Benefit is the maximum dollar amount that is payable in any one calendar month for all the Home and Community-Based Care received in that calendar month.

The Home and Community-Based Care Monthly Maximum Benefit is a percentage of the Nursing Facility Maximum Daily Benefit, with that percentage selected by You at the time of application, multiplied by 30 to obtain the monthly maximum amount. The allowable percentages are: 50% to 100% in 10% increments.

(e) Other maximum benefits or limits to benefit payments are described in the Benefit provisions to which they apply. Benefit provisions are described below and are described in more detail in the Policy. The Limitations and Exclusions of the Policy are described both below and in the Policy. In the case of any conflict between descriptions in this Outline of Coverage and the Policy, the Policy language will govern.

b. **Institutional Benefits.**

(i) **Nursing Facility Care or Residential Care Facility Benefit.** We will pay the Eligible Charges for each day that You are confined in a Nursing Facility or Residential Care Facility for up to the Nursing Facility Maximum Daily Benefit or Residential Care Facility Maximum Daily Benefit, as appropriate, provided that Your stay must begin while Your coverage under the Policy is in force.

(a) The Eligible Charges of a Nursing Facility or a Residential Care Facility include only the daily charge to inpatients for room and board and charges for ancillary supplies and services.

(b) The Eligible Charges while confined in a Residential Care Facility may also include charges for any other benefits covered by the Policy up to the Residential Care Facility Maximum Daily Benefit.

(c) The Elimination Period applies to this Benefit, and amounts We pay will count against the Policy Lifetime Maximum Benefit.

Nursing Facility Maximum Daily Benefit (NFMDB): $180 to $400 based on Your selection.

Residential Care Facility Maximum Daily Benefit: 70% or 100% of the NFMDB based on Your selection.

Note: Presently, the Medi-Cal program does not provide for care in a Residential Care Facility on a statewide basis. Should You exhaust the Lifetime Maximum Benefits of the Policy when residing in a Residential Care Facility and become eligible for Medi-Cal, Medi-Cal may not be able to pay for any continued care You may require in a Residential Care Facility in the county in which you reside. Check with your local county office of health or human services for more information.

(ii) **Bed Hold Reservation Benefit.** After You have been approved for and are receiving benefits for Nursing Facility or Residential Care Facility Benefits, We will pay a benefit for each day (up to 30 days per calendar year) to assure a place will be available for You when You return from a temporary absence for any reason.

(iii) **Extended Coverage Benefit.** If You are confined in a Nursing Facility or a Residential Care Facility and You are receiving benefits while the Policy is in force, and You continue to be confined without interruption after the Policy lapses or terminates, We will extend benefits by continuing to pay benefits for such confinement while You remain so confined, up to the Policy Lifetime Maximum Benefit.

c. **Non-Institutional Benefits.**

(i) **Home and Community-Based Care.** For each calendar month You receive Home and Community-Based Care, We will pay the Eligible Charges for the Home and Community-Based Care You receive in that calendar month, up to the Home and Community-Based Care Monthly Maximum Benefit. Home and Community-Based Care includes Home Health Care Services, Adult Day Health/Social Care, Homemaker Services, Personal Care Services and Hospice Care Services.

The Elimination Period applies to this Benefit. Any amounts We pay under this Benefit will be counted against the Policy Lifetime Maximum Benefit.

(a) **Eligibility for Payment of Home and Community-Based Care Benefits.** You will be considered eligible for Home and Community-Based Care on any day when You have satisfied the requirements of the Eligibility for Payment of Benefits section of this Policy.

You are considered eligible for payment of only a portion of the calendar month for Home and Community-Based Care in the following instances:

- You have not incurred any Eligible Charges in that calendar month;
- You have entered either a Nursing Facility or a Residential Care Facility during the calendar month;
- You have satisfied any Elimination Period day(s) during the calendar month; or
- A combination of any of the three instances above.

(b) **Calculating Your Home and Community-Based Care Benefit Payment Amount.** If You are eligible for Home and Community-Based Care during the entire calendar month, the benefit amount payable will be all the Eligible Charges during that calendar month up to the Home and Community-Based Care Monthly Maximum regardless of the number of days of care or services that were received during that month.

If You are eligible for Home and Community-Based Care for only a portion of a calendar month the maximum Home and Community-Based Care benefit amount payable for that calendar month will be calculated as follows:

- The number of days in the calendar month that You are eligible for payment of Home and Community-Based Care regardless of the number of days of care or services received; times
- One thirtieth of the Home and Community-Based Care Monthly Maximum Benefit.

(c) **Home Health Care.** Benefits for Home Health Care are only payable if provided by a person who is:

- Employed by a Home Health Agency; or
- Properly licensed to provide such services, if licensure is required by the jurisdiction where the care or services are performed; or
- If licensure is not required is acting within the scope of his or her training or experience in providing such services.

(d) **Adult Day Health/Social Care.** Benefits for Adult Day Health/Social Care are payable for Eligible Charges for care and services provided by an Adult Day Health/Social Care Center.

(e) **Homemaker Services or Personal Care Services.** Benefits for Homemaker Services or Personal Care Services are payable when such services are performed by a person who is:

- Employed by a Home Health Agency; or
- Acting within the scope of his or her training or experience in providing such services.

(f) **Hospice Care Services.** If You become Terminally Ill and You receive care provided by a Hospice, We will pay:

- The Eligible Charges of the Hospice; up to
- The Home and Community-Based Care Monthly Maximum amount for each calendar month of care.
- Provided that You meet all of the requirements of the Eligibility For The Payment Of Benefits provision of the Policy.

The Elimination Period does not apply to this Benefit, and the days on which We pay benefits under this Benefit do not count toward satisfying the Elimination Period. Any amounts We pay for Hospice Care will count toward the Policy Lifetime Maximum Benefit.

(g) **Other Considerations.**

- Since Care Coordination is mandatory the Elimination Period for Home and Community-Based Care will be 30 days regardless of Your selection of a longer Elimination Period.
- You cannot receive benefits under the Home and Community-Based Care Benefit for any day on which We are also paying Nursing Facility Benefits or other benefits because You are confined in a Nursing Facility. However, if You are confined in a Residential Care Facility the Eligible Charges for a Residential Care Facility can include any other Policy benefits in addition to Residential Care Facility benefits up to the Residential Care Facility Maximum Daily Benefit.
- If You have been receiving Home and Community-Based Care and subsequently need to be admitted to a facility (Nursing Facility or Residential Care Facility) the remainder of the Elimination Period, if any, would need to be satisfied before Facility Benefits would be payable. Any benefits payable under the Home and Community-Based Care provision would still be payable, if appropriate, under the terms of the Policy if the confinement were in a Residential Care Facility.

d. **Other Benefits Included in The Policy**

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

(ii) **Care Coordinator Benefit.** We will pay the services for Care Coordination by a Care Coordinator who is employed by a Care Coordination Provider Agency or is the Qualified Official Designee of a Care Coordination Provider Agency to provide Care Coordination. The California Department of Health Services must approve the Care Coordination Provider Agency.

Since Care Coordination is included in this Policy We will reduce the Elimination Period that must be satisfied before the Home and Community-Based Care benefits are payable to 30 days of service, even if a longer Elimination Period was selected. The remaining Elimination Period, if any, must be satisfied before benefits other than Home and Community-Based Care are payable.

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

(iii) **Caregiver Training Benefit.** We will pay the cost of training a person to provide You with Informal Long-Term Care Services in Your residence, up to a lifetime maximum of 5 times the Nursing Facility Maximum Daily Benefit, provided that:

(a) The training must be prescribed in Your Plan of Care;

(b) The training cannot be received while You are confined in a hospital, Nursing Facility or a Residential Care Facility, unless it is expected that You will return home where the person that is receiving the training can care for You; and

(c) We will not pay any benefits to train an individual who will be providing care other than Informal Long-Term Care Services for You.

Informal Long-Term Care Services are care or services where the caregiver is not paid to provide the care or services.

The Elimination Period does not apply to this Benefit. Any benefits We pay under this Benefit do not count against Your Policy Lifetime Maximum Benefit. Days on which any person is being trained under this Benefit do not count toward satisfying the Elimination Period.

(iv) **Contingent Nonforfeiture Benefit.** The contingent nonforfeiture benefit will be triggered if You do not have the Optional Nonforfeiture Benefit Rider in force and if:

(a) We increase the premium rates to a level which results in a substantial cumulative increase in the premiums for the policy; and

(b) This Policy lapses within 120 days of the due date of the premium so increased.

The purchase of additional coverage will not be considered a premium rate increase, nor will a reduction in benefits be considered a premium change.

On or before the effective date of a substantial premium increase that could trigger the Contingent Nonforfeiture Benefit, we will:

(a) Offer to reduce the benefits of the Policy so that the current premium payments are not increased;

(b) Offer to convert the coverage to a paid-up status with a shortened benefit period based on the contingent nonforfeiture benefit amount. This option may be elected at any time during the 120-day period; and

(c) Notify You that a lapse at any time during the 120-day period will be deemed to be the election of the offer to convert to paid-up coverage.

If the Contingent Nonforfeiture Benefit becomes effective, then benefits will be payable under the Policy any time You qualify for benefits during the remainder of Your life; subject to all the terms and conditions of the Policy; and will be based on all the Maximum Daily Benefit(s) and Lifetime Maximum Benefit(s) in effect at the time of lapse and not increased after lapse.

The contingent nonforfeiture benefit amount will be the greater of 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits or thirty (30) times the Nursing Facility Maximum Daily Benefit at the time of lapse.

The contingent nonforfeiture benefit amount will not exceed the remaining Policy Lifetime Maximum Benefit at the time the Policy lapses and the Contingent Nonforfeiture Benefit becomes effective.

(v) **Durable Medical Equipment Benefit.** We will pay the charges You incur to purchase or rent Durable Medical Equipment, up to the Durable Medical Equipment Lifetime Maximum Benefit, provided that The Durable Medical Equipment must be prescribed in Your Plan of Care; and

(a) Be first purchased or rented after the Policy Effective Date.

(b) The Durable Medical Equipment must enable You to perform any of the Activities of Daily Living and allow You to remain in Your home for an expected period of at least 90 days after the purchase or rental; and

(c) The Durable Medical Equipment must not materially increase the value of Your home or residence.

Durable Medical Equipment Lifetime Maximum Benefit: $4,000 subject to annual inflation protection increases.

The Elimination Period does not apply to the Durable Medical Equipment Benefit. Any benefits We pay under this Benefit will not be counted against Your Policy Lifetime Maximum.

(vi) **Informal Care Benefit.** We will pay a benefit for each day on which You receive at least four (4) hours of Informal Care and on which day no other covered services are provided. We will pay:

(a) An Informal Care daily indemnity benefit of 50% of the Home and Community-Based Care Monthly Maximum Benefit divided by 30; up to

(b) A lifetime maximum of 365 days while Your coverage is in force under this Policy.

The Plan of Care must document in advance the following for benefits to be payable for Informal Care.

(a) Who the Informal Caregiver will be;

(b) The relationship of the Informal Caregiver to the Insured; and

(c) The days and hours of planned service.

You do not have to satisfy the Elimination Period to use this Benefit and amounts We pay do not count toward satisfying the Elimination Period. Any amounts We pay for Informal Care will count against the Policy Lifetime Maximum Benefit.

NOTE: Amount We pay under the Informal Care Benefit cannot be counted toward Medi-Cal Asset Protection.

(vii) **Plan of Care.** All Qualified Long-Term Care Services for which You claim benefits must be prescribed in a written Plan of Care prepared by a Licensed Health Care Practitioner who is an employee of the Care Coordination Provider Agency or an Official Designee of the Care Coordination Provider Agency.

(viii) **Request for Non Listed Benefits.** Once You have met all of the conditions of the Eligibility For The Payment of Benefits provision, You may request a Request for Non Listed Benefits. The Request for Non Listed Benefits will include a Plan of Care mutually agreed upon by Your Physician (if appropriate and/or You desire), the Care Coordination Provider Agency, and Us. We will pay benefits in accordance with the Request for Non Listed Benefits. The following additional terms apply under this Benefit:

(a) Except as We expressly agree in the Request for Non Listed Benefits, Your rights and Ours will be governed by all of the Policy terms;

(b) All of the benefits We agree to pay under the Request for Non Listed Benefits must be for Qualified Long-Term Care Services as defined in Internal Revenue Code Section 7702B(c); and

(c) We may agree with You only for a set period of time (for example, one year). At the end of that period of time, the Request for Non Listed Benefits will end unless We agree with You to renew it. You may terminate a Request for Non Listed Benefits at any time, by giving Us at least 15 days advance written notice of the termination.

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

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

(f) The Elimination Period applies to this Benefit. Any amounts We pay under this Benefit will be counted against the Policy Lifetime Maximum Benefit.

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

(a) For each day that You receive care and are confined in a Nursing Facility or a Residential Care Facility, We will pay the Eligible Charges of the Nursing Facility or Residential Care Facility, up to the Nursing Facility Maximum Daily Benefit or Residential Care Facility Maximum Daily Benefit, as appropriate.

(b) For each day that You receive Home and Community-Based Care, We will pay the Eligible Charges for Home and Community-Based Care up to the Home and Community- Based Care Maximum Monthly Benefit divided by 30.

The Elimination Period does not apply to this Benefit. Any benefits We pay under this Benefit do not count toward satisfying the Elimination Period. Any amounts We pay for Respite Care will count toward Your Policy Lifetime Maximum Benefit.

(x) **Waiver of Premium Benefit.** After You have satisfied the Elimination Period and are receiving benefits under the Policy, the premium payments which become due will be waived. You do not have to pay any premium payments until You are no longer receiving benefits. If Your premium payment mode is other than monthly, Your premium payment mode will be changed to monthly. If Your premium payment mode is other than monthly when You begin to actually receive benefits, any premium which You have already paid for any coverage during the period for which premiums are waived will be returned to You.

(xi) **World Wide Coverage Benefit.** If You become eligible for benefits while outside the United States or its territories, the Policy will pay its benefits in accordance with its terms for Eligible Charges You incur for covered services received outside the United States or its territories, up to a lifetime maximum of 100 times the Nursing Facility Maximum Daily Benefit.

NOTE: Amounts We Pay under the World Wide Coverage Benefit cannot be counted toward Medi-Cal Asset Protection.

e. **Optional Benefits.** The following are optional benefits provided by rider that You may select and which will be provided at an additional premium cost:

(1) **Shared Care Rider.** This optional rider can be selected when both spouses have identical long-term care insurance policies in force with New York Life Insurance Company with the same Policy Effective Dates. If both policies are in force when one of the insured spouse's Policy Lifetime Maximum Benefit is reached, additional benefits will be payable under that insured's policy up to the Shared Care Maximum Benefit. The Shared Care Maximum Benefit of one spouse will be reduced by any benefits previously paid for the other spouse under the Shared Care Rider attached to that person's Policy. This optional rider has additional requirements to keep the rider in force that are described in the termination section of the Rider.

(2) **Couples Additional Benefit Rider.** This optional rider can be selected when both spouses have identical long-term care insurance policies in force with New York Life Insurance Company with the same Policy Effective Dates. This optional rider has additional requirements to keep the rider in force that are described in the termination section of the Rider. Each of the following additional benefits will be payable while the Rider remains in force with respect to that additional benefit:

(a) **Spousal Premium Waiver Benefit.** This Benefit will waive the premiums for the Policy and any attached Riders for any period of time for which Your spouse's premiums are waived due to Waiver of Premium provision of the spouse's Policy. The waiver does not include unscheduled increases in coverage amounts or other changes to the Policy after Spousal Premium Waiver Benefits become payable.

(b) **Spousal Elimination Period Benefit.** This Benefit will allow any day either You or Your spouse is eligible for benefits to count toward Your Elimination Period. Any day You and Your spouse are both eligible for benefits will count as two days toward Your Elimination Period.

(c) **Survivorship Benefit.** This Benefit provides that if Your spouse dies after Your spouse's Policy has remained in effect for at least 10 years while this Benefit remains in force, then Your Policy, including any attached Riders, will become paid-up and no further premium payments will be required. This Benefit will terminate on the earliest of the following to occur:

- You become eligible for benefits under the Policy within the first 10 years it is in force;
- Your spouse becomes eligible for benefits under Your Spouse's Policy within the first 10 years it is in force; or
- The Couples Additional Benefit Rider terminates.

(3) **Return of Premium Upon Death Benefit Rider.** This Benefit provides that if You die while this Rider and Your Policy are in force a Return of Premium Upon Death Benefit will be paid in one lump sum to Your estate. The amount payable will be calculated as follows:

(a) The sum of all premiums paid for Your Policy (with no accumulation for interest and excluding any premiums waived);

(b) Less the amount of any benefits paid or payable under Your Policy.

Coverage under this Rider will terminate when the first of the following occurs:

(a) Your coverage under the Policy ends;

(b) The first day of the following month after You notify Us in writing that You wish to terminate Your coverage under this Rider;

(c) The Premium Due Date of any premium for this Rider not paid by the end of the Grace Period; or

(d) The first day You become eligible for an Optional Nonforfeiture Benefit or the Contingent Nonforfeiture Benefit.

No Return of Premium Upon Death Benefit will be paid if You die after this Rider terminates.

NOTE: The payment of the Return of Premium Upon Death Benefit may have Federal Income Tax consequences. New York Life Insurance Company does not give legal or tax advice. However, We do recommend that You consult a qualified tax professional or attorney to determine any tax implications.

(4) **Optional Nonforfeiture Benefit Rider.** If this optional rider is selected, the Rider will provide for a period of paid-up long-term care insurance coverage after the Policy lapses after having been in force for five (5) years. During this paid-up period, benefits will be payable in the same manner as if the Policy had remained in force. The daily and monthly Benefit maximums in effect at the time of lapse will increase over time in accordance with the Inflation Protection provision included in the policy and shown on the Schedule of Benefits. The total amount payable for claims after the Policy lapses will be limited to the nonforfeiture benefit amount. The nonforfeiture benefit amount will be equal to the amount described below reduced by any claims already paid.

(a) If the policy has been in force at least 5 years but less than 10 years at the time of lapse the Nonforfeiture Benefit Amount will be:

(i) In the 5th year equal to 10 times the initial Nursing Facility Maximum Daily Benefit.

(ii) In the 6th year equal to 20 times the initial Nursing Facility Maximum Daily Benefit.

(iii) In the 7th year equal to 30 times the initial Nursing Facility Maximum Daily Benefit.

(iv) In the 8th year equal to 50 times the initial Nursing Facility Maximum Daily Benefit.

(v) In the 9th year equal to 80 times the initial Nursing Facility Maximum Daily Benefit.

(b) If the Policy has been in force for 10 years, the Nonforfeiture Benefit Amount at the time of lapse will equal 90 times the Nursing Facility Maximum Daily Benefit in force on the date of lapse, reduced by the amount of any claims already paid.

(c) For each additional year after the 10th year, the "90" factor will be increased by 1. For example, if the Policy had been in force for 12 years at the time of lapse, the factor would be "92". The Nonforfeiture Benefit Amount would be 92 times the Nursing Facility Maximum Daily Benefit on the date of lapse reduced by any claims already paid.

No Nonforfeiture benefits are payable under this Optional Nonforfeiture Benefit Rider if Your Policy lapses before this Policy and this Benefit have been in effect for at least five (5) years.

f. **Eligibility for Payment of Benefits.**

(1) **How to Qualify for Benefits.** You will be eligible for benefits provided by the Policy during any period when You are determined to be a Chronically Ill Individual and You are receiving Qualified Long-Term Care Services prescribed for You in a written Plan of Care. You will be considered a Chronically Ill Individual when You meet one of the following criteria:

(a) You are not able to perform, without Standby Assistance or Hands-on Assistance from another individual, 2 or more of the following 6 Activities of Daily Living: Bathing, Dressing, Eating, Continence, Toileting and Transferring due to loss of functional capacity and Your loss of functional capacity is expected to last at least 90 days; or

(b) You have suffered a Severe Cognitive Impairment requiring Substantial Supervision to protect You from threats to health and safety.

(c) You must also:

(i) Have been certified, within the past 12 months, as a Chronically Ill Individual by a Licensed Health Care Practitioner; and

(ii) Have a written Plan of Care that prescribes the types of care, services and supplies for which You claim benefits.

The Licensed Health Care Practitioner must be employee of the Care Coordination Provider Agency or an Official Designee of a Care Coordination Provider Agency to prescribe the Plan of Care and certify You as a Chronically Ill Individual.

(2) **Definitions of Terms Used in Benefit Eligibility.**

(a) **Activities of Daily Living.** These are the basic functions You must be able to perform to remain independent. You are able to perform an Activity of Daily Living if You are capable of performing that activity without Standby or Hands-on Assistance from another person. The Activities of Daily Living used to determine benefit eligibility are:

(i) *Bathing*, means cleaning the body using a tub, shower, or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, and reaching head and body parts for soaping, rinsing, and drying.

(ii) *Continence*, means Your ability to control bowel and bladder as well as use ostomy or catheter receptacles, and apply diapers and disposable barrier pads.

(iii) *Dressing*, means You putting on, taking off, fastening, and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings or garments, and artificial limbs or splints.

(iv) *Eating*, means reaching for, picking up, and grasping a utensil and cup; getting food on a utensil, and bringing food, utensil, and cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meals.

(v) *Toileting*, means getting on and off a toilet or commode, and emptying a commode, managing clothing and wiping and cleaning the body after toileting, and using and emptying a bedpan and urinal.

(vi) *Transferring*, means moving from one sitting or lying position to another sitting or lying position, for example, from a bed to or from a wheelchair or sofa, coming to a standing position, or repositioning to promote circulation and prevent skin breakdown.

(b) **Standby Assistance –** shall mean the presence of another person within arm's reach which is necessary to prevent, by physical intervention, injury to You while You are performing an Activity of Daily Living (such as getting ready to catch the person if he/she should fall getting into or out of the tub or shower as part of Bathing, or being ready to remove food from the person's throat if choking while Eating).

(c) **Hands-on Assistance –** shall mean physical assistance from another person without which the person would not be able to perform the Activity of Daily Living.

(d) **Severe Cognitive Impairment –** shall mean Cognitive Impairment where the person requires Substantial Supervision to protect himself/herself for threats to health and safety.

7. LIMITATIONS AND EXCLUSIONS.

a. **Preexisting Conditions.** The Policy while it is in force will pay benefits for Eligible Charges that are the result of preexisting conditions.

b. **Non-Eligible Facilities and Providers.** The Policy will not pay for Eligible Charges that are provided by facilities or providers that do not meet the requirements for that type facility or provider as described in the Policy.

c. **General Limitations and Exclusions.**

(1) Due to war, whether declared or undeclared;

(2) Due to attempted suicide, or any intentionally self-inflicted injury;

(3) As a result of voluntary participation in a riot or attempting to commit an assault or felony;

(4) For care received outside of the United States or its territories except as provided in the World Wide Coverage Benefit;

(5) Which would not be made in the absence of this insurance;

(6) For treatment of alcoholism and drug addiction unless the drug addiction was a result of the administration of drugs as part of as treatment by a Physician;

(7) For treatment provided in a government facility unless We are required by law to cover the charges;

(8) For treatment of an injury or sickness which would entitle You to benefits under any state or federal workers' compensation, employers' liability or occupational disease law;

(9) From Family Members unless the Family Member is a regular employee of an organization which is providing the services, and the organization receives the payment for the services; and the Family Member receives no compensation other than the normal compensation for employees in his or her job category;

(10) For prescription drugs, unless You incur such charges while a resident in a Nursing Facility or a Residential Care Facility and the facility charges include such prescription drugs;

(11) To the extent that benefits are payable by Medicare or would be payable except for the application of a deductible or coinsurance amount; or

(12) For items of comfort such as toiletries, television rental, beauty and hair charges.

d. **Specific Limitations and Exclusions.**

(1) **Maximum Benefits.** The maximum benefits We will pay are shown on the Schedule of Benefits of the Policy. We will not pay for Home and Community-Based Care on any day that You are confined in a Nursing Facility. Home and Community-Based Care benefits may be paid on any day You are confined in a Residential Care Facility provided the total benefits payable for that day will not exceed the Residential Care Facility Maximum Daily Benefit.

(2) **Policy Lifetime Maximum Benefit.** This is the maximum dollar amount that is payable by the Policy during the lifetime of the Policy except as provided under the Shared Care Rider, if applicable.

(3) **Chronically Ill Individual Certification.** This is a certification, at least once every 12 months, made by a Licensed Health Care Practitioner, certifying that You are a Chronically Ill Individual per the provisions of the Policy. No benefits are payable unless You are certified as a Chronically Ill Individual.

(4) **Care Not Included in a Plan of Care.** The Policy does not pay benefits for care or services unless such care and services are prescribed in a written Plan of Care prepared by a Licensed Health Care Practitioner who is an employee of a Care Coordination Provider Agency or is an Official Designee of a Care Coordination Provider Agency.

(5) **Requirement for Developing a Plan of Care.** Your personal Physician will not be able to develop a Plan of Care for the Policy unless he is also employed by a Care Coordination Provider Agency or is a Qualified Official Designee of a Care Coordinator Provider Agency. However, Your personal Physician may offer an opinion regarding what may be necessary for Your Plan of Care.

(6) **Effect of Federal Law.** No benefits are payable under the Policy which would cause the Policy to fail to qualify as a Qualified Long-Term Care Insurance Contract under Sections 7702B(b) of the Internal Revenue Code of 1986, as amended.

THE POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

8. **RELATIONSHIP OF COST OF CARE AND BENEFITS.** Because the costs of the long-term care services will likely increase over time, You should consider whether and how the benefits of the Policy may be adjusted.

a. **Inflation Protection.** This Benefit provides for the annual increase of benefits to help offset the effects of inflation. The 5% Compounded Annually for Life Inflation Protection applies to all Benefits of the Policy, unless You were age 70 or over at the time the Policy was issued AND You elected the 5% Simple Annual Inflation Protection. The 5% Simple Annual Inflation Protection applies to all Benefits of the Policy.

(1) **5% Compounded Annually for Life Inflation Protection.** We will increase the Policy Lifetime Maximum, Nursing Home Maximum Daily Benefit, Residential Care Facility Maximum Daily Benefit, Home and Community-Based Care Monthly Maximum Benefit, and other Benefits provided by the Policy including Durable Medical equipment and any attached riders, on the first anniversary date of the Policy and on each subsequent Policy Anniversary by **5 percent of the benefit amounts of the previous year.**

(2) **5% Simple Annual Inflation Protection.** We will increase the Policy Lifetime Maximum, Nursing Home Maximum Daily Benefit, Residential Care Facility Maximum Daily Benefit, Home and Community-Based Care Monthly Maximum Benefit, and other Benefits provided by the Policy including Durable Medical equipment and any attached riders, on the first anniversary date of the Policy and on each subsequent Policy Anniversary by **5 percent of the benefit amounts at the time the Policy was issued.**

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

(1) Increase the Policy Lifetime Maximum Benefit;

(2) Increase the Nursing Facility Maximum Daily Benefit and Residential Care Facility Maximum Daily Benefit;

(3) Increase the Residential Care Facility Maximum Daily Benefit; or

(4) Increase the Home and Community-Based Care Monthly Maximum Benefit.

Provided that You:

(1) Meet any underwriting requirements; and

(2) Pay the additional premium.

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

c. **Notification of New Benefits or Benefit Eligibility.** We will notify You within 12 months if We develop a new benefit or new benefit eligibility. You will have the opportunity to upgrade Your current benefits to any benefits or benefit eligibility that becomes available subject to underwriting by replacing the existing policy with a new policy and granting recognition of past-insured status with premium credits toward the new policy if no claim has been made. Provided You are not:

(1) Currently receiving benefits; or

(2) Within the Elimination Period.

d. **Requests for Additional Coverage.** You can at any time after the Policy is issued, conditioned on Your continued good health, apply for increases in daily benefit levels and/or increases in Lifetime Maximum Benefits. We will apply Our then applicable underwriting standards to evaluate Your insurability for the increased coverage. You may be approved for the additional coverage You applied for, or You may be declined due to a deterioration of Your health. Your premium would increase based on Your attained age for the new coverage approved.

e. **Lower Benefit Plan.** After one year from the Effective Date of this Policy, You have the right to reduce Your premiums by lowering the Policy Lifetime Maximum Benefit, Nursing Facility Maximum Daily Benefit, Residential Care Facility Maximum Daily Benefit, or the Home and Community Based Maximum Daily Benefit. We will notify You of this opportunity to reduce coverage when Your Policy is about to lapse, and whenever the premiums are increased. You will have another right to change to a lower benefit plan whenever We increase premiums. The Premium payments for the reduced plan will be based on the reduced amount of coverage and Your age as of the Effective Date of the Policy. You have the right to reduce Your coverage, but not below the minimum required to retain status as a Partnership policy.

9. **TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.**

   a. RENEWABILITY: THE POLICY IS GUARANTEED RENEWABLE. This means You have the right, subject to the terms of the Policy, to continue the Policy as long as You pay premiums on time. New York Life cannot change any of the terms of the Policy on its own, except that, in the future, **IT MAY INCREASE THE PREMIUM YOU PAY.**

   b. WAIVER OF PREMIUM. After You have satisfied the Elimination Period and are receiving benefits under the Policy, the premium payments which become due will be waived. This means that You would not have to pay premiums for the Policy until You are no longer receiving benefit payments. If Your premium payment mode is other than monthly Your premium payment mode will be changed to monthly. If Your premium payment mode is other than monthly when You begin to actually receive benefits, any premium which You have already paid for any coverage during the period for which premiums are waived will be returned to You.

   c. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS. Changes in Premiums: New York Life has the right to change the premium rates for the Policy. Premium rate increases are subject to Insurance Department and California Partnership for Long-Term Care approval, will be made only if a premium change is also made for all other California Partnership policies and will take effect on a Policy Anniversary Date. We will notify You at least 60 days prior to such premium change.

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

10. **PREMIUM**

a. **Modal Premium Disclosure**. There is an additional cost if You decide to pay premiums other than on an annual basis or once per policy year. The total premium You will pay in a policy year, if You pay more frequently than annually, will be greater than if You pay on an annual basis or once per policy year. The total premium You will pay can be determined by looking at the chart below. For premium payments made more frequently than annually (semi-annually, quarterly, and monthly), multiply the annual premium by the following percentages:

Payment Frequency	**Percentage of Annual Premium**
Semi-annual:	51%
Quarterly:	26%
Monthly:	9%

For example, if the annual premium is $1,000, and You elect to pay semi-annually, You will make two payments of $510 (.51 X $1,000 = $510) during the policy year for a total of $1,020 ($510 + $510) or $20 more than if You paid on an annual basis or once per policy year.

b. **The annual premium for the Policy with the benefits and premium payment frequency You selected is:**

Applicant 1 $_____ Applicant 2 $_____

c. **The annual premium for the policy and additional benefits is:**

Applicant 1 $_____ Applicant 2 $_____, which consists of:

	Applicant 1	**Applicant 2**
Base Policy	_____	_____
Shared Care Rider	_____	_____
Couples Rider	_____	_____
Return of Premium Upon Death Rider	_____	_____
Optional Nonforfeiture Rider	_____	_____

11. **Medical Underwriting for the Policy is based on Your Health Status.** Experienced underwriters will determine whether Your Application will be approved by reviewing Your Application, Eligibility Questions and Health Statement. The Physicians You list in Your Application may be contacted to provide information about Your health, including copies of Your medical records. We may also ask You additional questions by telephone, personal interview and/or written questionnaire. We have the right to request additional underwriting information, as well as to decline to cover individuals who, in Our opinion, do not meet Our underwriting requirements. Your application will be reviewed and if a declination is appropriate, such declination will be on a non-discriminatory basis.

12. **Medi-Cal Asset Protection.** The Policy provides Medi-Cal Asset Protection for each dollar that policy benefits are paid for qualified long-term care or services. All benefits paid by the Policy, except the Informal Care Benefit, are considered qualified long-term care or services. Should You later apply for Medi-Cal benefits or for other qualifying public long-term care benefits, You will not be required to expend the protected assets prior to becoming eligible for these public benefits. Your protected assets will also be exempt from any claim the State of California may have against Your estate to recover the costs of State-paid long-term care or medical services provided to You. Once benefit payments begin, We will send You on a quarterly basis a report called Medi-Cal Property Exemption Report. The report will provide You with the qualified long-term care or services benefits that have been paid both that quarter and on a cumulative basis. When Policy benefits are nearing depletion, We will have the Care Coordinator create a Transition Plan for Your use in transitioning to Medi-Cal. We will provide You with a Service Summary of all the qualified long-term care or services paid by the Policy. The Service Summary along with the Medi-Cal Property Exemption Report will be useful in Your application for Medi-Cal Benefits.

    NOTE: Payments made under the Informal Care Benefit and World Wide Coverage will not earn Medi-Cal Asset Protection.

13. **California Partnership for Long-Term Care.** California Partnership for Long-Term Care is a program, between the State of California and New York Life that offers long-term care insurance Policies and provides Medi-Cal Asset Protection. Our Policy is approved by the Partnership in the State of California. A Partnership Policy, in addition to providing qualified long-term care or services, gives You Medi-Cal Asset Protection. That means that for each dollar paid in Partnership Policy benefits (except Informal Care) a dollar of assets is protected from consideration at the time of initial Medi-Cal eligibility and also for possible estate recovery.

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

    Information about Your Local HICAP office provided by Your agent:

    Local HICAP office address:

    _____
    Street Address

    _____
    City, State Zip

    Local HICAP office telephone number: _____