Genworth Financial

Genworth Life Insurance Company
[Administrative Office
3100 Albert Lankford Dr.
Lynchburg, Virginia 24501-4948
888.325.5433]

Comprehensive Long Term Care Insurance Policy
Outline of Coverage

from Genworth Life Insurance Company

[Policy form 7037D REV, 7037D-1 REV]

An Approved Participant In
CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE

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.

NOTICE TO BUYER

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

CAUTION

The issuance of the Policy will be based upon Your responses to the questions on Your Application. A copy of Your Application will be attached to Your issued Policy. If Your answers are misstated or untrue, Genworth Life Insurance Company (called We, Us and Our in this Outline of Coverage) may have the right to deny Benefits or rescind the 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 Us at Our Administrative Office at the address shown above.

TAX CONSEQUENCES

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

1. POLICY DESIGNATION

The Policy is an individual policy of insurance.

2. PURPOSE OF THE 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 individual Policy, and not this Outline of Coverage, contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both You and Us. 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

30-Day Free Look Period: You have 30 days from the day You receive the Policy to review and return it to Us at Our Administrative Office, at the address shown above, if You are not satisfied with it for any reason. The full amount of all premiums and fees paid for the Policy will be refunded within 30 days after: (a) return of the Policy during this 30-Day Free Look Period; or (b) Our denial of Your Application.

Unearned Premium Refunds: Unearned Premium will be refunded if the Policy ends due to death, surrender or cancellation.

4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Us. Neither We nor Our agents or 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 home, in the community, or in the home.

This Policy reimburses You for covered long term care expenses You incur. It is subject to an Elimination Period, limitations and other requirements.

6. BENEFITS PROVIDED BY THIS POLICY

(a) Covered Services: Payment of institutional and non-institutional Benefits described below is subject to the provisions, conditions, limitations and exclusions of the Policy. Once the Elimination Period has been satisfied, Benefits are available up to daily or monthly and annual maximums until the applicable Benefit limits are exhausted. When the plan selected pays for less than 100% of the Covered Expenses, You will be responsible for the payment of any expenses not covered by the Policy. The limits and features chosen for Your Policy are shown at the end of this Outline Of Coverage.

(b) Institutional Benefits: These pay for Covered Expenses incurred while confined in a Nursing Facility, Residential Care Facility, or Hospice Care Facility. Bed Reservation coverage is available for temporary absences (up to 60 days per calendar year) from one of these facilities.

(c) Non-Institutional Benefits: These include the following:

Privileged Care© Coordination Services are services that assist in identifying care needs and community resources available to deliver care while You are Chronically Ill. These services are provided by persons who are either employed by, or designated by, a Care Management Provider Agency that has been selected by Us and approved by the California Partnership for Long-Term Care. The Care Management Provider Agency is independent of Us and cannot stand to benefit financially if You receive any other benefits under this Policy for recommended care. These services they will be provided by Us at no cost to You.

The *Home and Community Care Benefit* covers services received at home and in the community for:

- Adult Day Health/Social Care;
- Home Health Care Services provided by state licensed home health care agencies as well as licensed or certified professionals such as Nurses and therapists who are acting within the scope of their licenses or certifications.
- Personal Care Services and Homemaker Services from Formal and Informal Providers
- Non-institutional Hospice Care (as part of a separate Hospice Care Benefit).

The *Respite Care Benefit* provides short-term coverage to relieve the person who normally and primarily provides You with care in Your home on a regular, unpaid basis. It pays for up to 30 days per calendar year.

The *Home Assistance Benefit* covers: home modifications; assistive devices; supportive equipment; emergency medical response systems; and caregiver training. It pays up to a lifetime limit equal to 90 days/3 months worth of full Nursing Facility benefits.

You may also request payment for alternative care to pay for Covered Expenses incurred for services, devices or treatments that are Qualified Long Term Care Services not specifically covered under another Benefit. Payment is subject to mutual agreement and Our prior approval.

The *Contingent Nonforfeiture Benefit* gives You the right to reduce coverage or convert to limited paid-up Benefits in the event of a cumulative Premium increase that is considered to be substantial as determined under the Policy.

(d) International Coverage: This Benefit will pay for Covered Expenses You receive while You are outside the United States. Subject to the Coverage Maximum, it pays: up to 50% of the Nursing Facility Maximum for confinement in an Out-of-Country Nursing Facility; and 25% of the Nursing Facility Maximum (for no more than 365 days) for care at Home. This Benefit terminates four years after the date for which it first makes payment.

(e) Eligibility for the Payment of Benefits: To be eligible for the Benefits provided by this Policy We must receive ongoing proof that Your receipt of the Covered Care is due to Your being qualified for Benefits, as described below.

How To Qualify For Benefits: We will pay for the Qualified Long Term Care Services covered by this Policy if:

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

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

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

Certification that You are a Chronically Ill Individual must be made, within the preceding 12 months, by a Licensed Health Care Practitioner who is Independent of Us; and the certification must be renewed at least every 12 months. This is called a *Current Eligibility Certification* in the Policy.

The services to be paid by the Policy must be prescribed in a written Plan of Care prepared by a Licensed Health Care Practitioner who is either employed by, or is designated by, a Care Management Provider Agency that has been selected by Us and approved by the California Partnership for Long-Term Care. All services covered by the Policy must be Qualified Long Term Care Services.

Conditions: Benefits will be paid as reimbursement for expenses paid on Your behalf that meet all of the following conditions:

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

Meaning Of Terms: The following definitions are being provided to assist You in understanding certain terms used in this Outline Of Coverage. The Policy contains additional definitions not provided for in this Outline of Coverage. The definition of any capitalized term in this Outline Of Coverage is provided for in the General Definitions section of the Policy.

Activities of Daily Living means the following self-care functions: Bathing: Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower. Continence: The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag). Dressing: Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs. Eating: Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously. Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene. Transferring: The ability to move into or out of a bed, chair or wheelchair.

Severe Cognitive Impairment is a loss or deterioration in intellectual capacity that: is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and is measured by clinical evidence and standardized tests prescribed by or approved by the California Partnership for Long-Term Care.

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

Standby Assistance means 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 (such as being ready to catch You if

You fall while getting into or out of the bath, tub or shower as part of bathing, or being ready to remove food from Your throat if You choke while eating).

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

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

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

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

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

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

Elimination Period means the total number of days, as determined in the Schedule, that covered, Formal Long Term Care Services must be received after You are determined to be a Chronically Ill Individual and before You are entitled to Benefits under the Policy. The number of days may be accumulated within any time period after You are determined to be a Chronically Ill Individual. The number of days may be accumulated before the filing of a Claim if it can be established that You were Chronically Ill before filing a Claim. Days used to satisfy the Elimination Period do not need to be consecutive. The Elimination Period need only be met once during Your lifetime. Any day when Covered Expenses are reimbursed by other insurance or Medicare may be counted toward meeting the Elimination Period. Privileged Care Coordination Services and the Respite Care Benefit are not subject to the Elimination Period and cannot be used to satisfy the Elimination Period.

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

A *Formal or Informal Provider* means a skilled or unskilled person who provides care which: is necessary because You are Chronically Ill; and is consistent with the needs addressed in Your Plan of Care as developed by a Physician or a multidisciplinary team under medical direction. This provider may be a nurse's aide, home health aide, or person qualified by training and/or experience to provide such care. The provider may be independent; and does not need to be associated with an agency or provider organization.

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

Nursing Facility Maximum means the maximum amount We will pay for confinement in a Nursing Facility. This amount is also used to determine other benefit maximums.

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

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

OTHER FEATURES AND OPTIONS *(Optional Benefits are available for an additional premium)*

Optional Nonforfeiture Benefit: This Benefit provides for the continuation of the Policy if the Policy ends due to non-payment of Premium after it has been in force for at least three years. Any Benefit Increases will continue; but the Coverage Maximum will be reduced to the greater of: (a) the sum of all Premium paid (and not waived under the Waiver of Premium

Benefit) for the Policy; or (b) the amount equal to one month (30 days) of benefits under the Nursing Facility Benefit in effect at the time of lapse when the Policy has been in force for at least 3 years, or (c) the amount equal to 3 months (90 days) of benefits under the Nursing Facility Benefit in effect at the time of lapse when the Policy has been in force for at least 10 consecutive years. In no event will this amount exceed the unused Coverage Maximum at the time the Policy ends.

[Optional Shared Coverage Rider: When both You and Your Spouse or Partner named in the Policy's Schedule, have identical policies, if one person exhausts Benefits under his or her Policy, he or she can continue coverage under the other person's Policy. For purposes of this Rider, identical means that both Policies must have the same Shared Coverage Rider form with the same plans, Benefit levels and Benefit options. We guarantee that sharing coverage will not reduce a person's coverage below 50% of its original Coverage Maximum. In addition, upon the death of one person, the survivor's available Coverage Maximum will be the total Coverage Maximum available to both persons at the time of death, considering all claim payments; and Rider Premium ceases. When the Shared Coverage Rider includes Joint Waiver of Premium, Premium for the policies of both persons will be waived when one person qualifies for the Waiver of Premium Benefit.**]**

[Optional Waiver of Home Care Elimination Period: This provides that there is no Elimination Period for the Home and Community Care Benefit; and each day of Covered Care under that Benefit will count towards satisfying the Elimination Period.**]**

7. EXCLUSIONS AND LIMITATIONS

There are no exclusions or limitations for pre-existing conditions disclosed on Your Application. Any incorrect or omitted material information in Your Application for the Policy, or any 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, as stated in the Misstatements/Incontestability provision of the Policy.

Non-eligible Facilities/Providers: A Nursing Facility, Residential Care Facility or Hospice Care Facility must meet the applicable definition stated in the Policy in order to qualify for coverage.

Non-eligible Levels of Care: Coverage is not based on the specific level of care; but is for care furnished for a specific covered reason, by or through the covered facilities and providers. Care from Immediate Family members is covered only when specifically provided for in the Policy.

Exclusions/Exceptions and Limitations: 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 United States of America, its territories and possessions; unless specifically provided for by a Benefit;
- Provided by Your Immediate Family, unless: specifically covered by a Benefit; or he or she is paid as a regular employee of the organization that provides the services;
- Provided by or in a Veteran's Administration or Federal government facility, unless a valid charge is made;
- Resulting from illness, treatment or medical condition arising out of any of the following:
  - War or any act of war, whether declared or not;
  - Attempted suicide or an intentionally self-inflicted injury;
- Provided directly for your alcoholism or addiction to drugs or narcotics (except for an addiction to a prescription medication when administered in accordance with the advice of a physician).

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

- Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount); and
- any other Federal, state or other governmental health or long term care program, or law (except Medicaid/Medi-Cal); and
- any insurance policy (including other long term care insurance policies or certificates), subscriber contract, group coverage through HMOs and other prepayment, group practice or individual practice plans; and

- any state or federal workers' compensation, employer's liability or occupational disease law or any motor vehicle no-fault law.

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

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

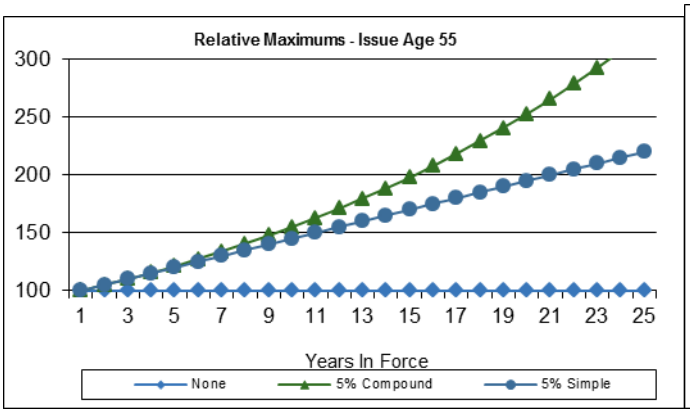
THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

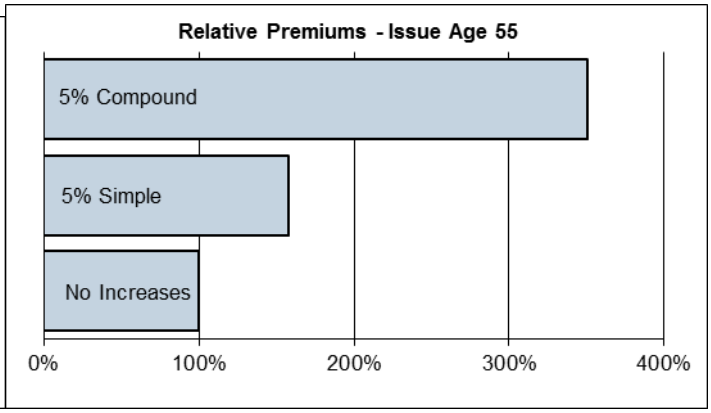
8. RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the cost of long term care services will likely increase over time, You should consider whether and how the Benefits of this plan may be adjusted. The California Partnership for Long-Term Care requires Your Policy to include 5% Compound Increases unless You are at least 70 years of age and apply for 5% Simple Increases. Simple Increases means the daily, monthly and lifetime limits will increase by 5% of their original amounts; and Compound Increases means the daily, monthly and lifetime limits will increase by 5% of the most recent amounts.

Increases will occur on each anniversary of the Policy's effective date. Increased amounts will apply to each day Benefits are payable on or after the date of the increase. Your Premium will not increase due to a change in age or the automatic benefit increases. Below is a graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. A similar graphic comparison illustrates premium for those types of policies.

INFLATION PROTECTION – GRAPHIC COMPARISONS





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

(a) RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE. This means You have the right, subject to the terms of the Policy, to continue the Policy until Benefits are exhausted, by paying Your Premium on time. We cannot change any of the terms of the Policy on Our own, except that, in the future, **WE MAY INCREASE THE PREMIUM YOU PAY**.

(b) WAIVER OF PREMIUM: Premium will be waived for each coverage month while You are receiving Benefits that qualify for this waiver as described in the Schedule at the end of this Outline Of Coverage.

(c) TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS: We have the right to change Premium becoming due in the future. Subject to approval by the California Department of Insurance, We can change Premium; but only if we change the Premium schedule for all California Partnership policies. Premium may be changed due to: a change in Benefits or terms of Coverage; or a change required by any law, regulation, judicial or administrative order or decision. Premium changes may also be based on experience, a change in the factors bearing on the risk assumed, or Our

estimates for future cost factors; 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.

10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

Coverage is provided for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses subject to the same exclusions, limitations and provisions applicable to other Covered Care.

11. PREMIUM

Options and Premium	Annual Premium for Selected Option [Applicant A	Applicant B]
[Plan Selected	[Plan A]	[Plan A]]
Policy with any Benefit Increases	$_____	[$_____]
[O Nonforfeiture Benefit	$_____]	[$_____]
[O Shared Coverage Rider with Joint Waiver O Yes O No	$_____]	[$_____]
[O Waiver of Home Care Elimination Period	$_____]	[$_____]
Anticipated Discounts	$ _____	[$_____]
Total if paid annually	$ _____	[$_____]
Modal Payment Factor*	__.___	[__.___]
Modal Premium (After Factor)	$ _____	[$_____]
Annual Total Modal Premium	$ _____	[$_____]
Premium Payment Period:	O Lifetime	O Lifetime

* You may have the right to choose one of the following Premium Payment Modes: annual in one payment; semi-annual in two payments; quarterly in four payments; or monthly in twelve payments. If You elect a Premium Payment Mode other than annual, You will pay additional charges for electing that Premium Payment Mode. The additional charges associated with paying more frequently than once a year are calculated by multiplying the Annual Modal Premium by the applicable modal premium factor. The modal premium factors are: 1.00 for annual; .51 for semi-annual; .26 for quarterly; and .09 for monthly.

12. ADDITIONAL FEATURES

The **California Partnership for Long-Term Care** is the program, authorized in Section 22000, et seq. of the California Welfare and Institutions Code, between the State of California and participating insurance companies that offer long term care insurance policies, and provide Medi-Cal Asset Protection, that are approved as Partnership policies. This is a Partnership Policy. As described below, the amount of assets protected under the California Partnership for Long-Term Care is equal to the amount of benefits paid on Your behalf under this Policy. This means that if You receive benefits under this Policy, Your assets will be protected, with the specific dollar amount of Your assets to be protected being dependent upon the amount of benefits You, as an individual, receive.

Medi-Cal Asset Protection is the right extended to You by California law when You use the benefits of this Policy. This right allows You to protect one dollar of assets for every dollar this Policy pays out in benefits, in the event You later apply for Medi-Cal benefits or other qualifying State long term care benefits. The amount of this asset protection at any time is equal to the sum of all benefit payments, excluding any payments made under the International Coverage benefit, made for Your care by this Policy. Should You later apply for Medi-Cal benefits or other qualified long term care benefits, You will not be required to expend Your protected assets prior to becoming eligible for these public benefits. Your protected assets will also be exempt from any claim the State of California may have against Your estate to recover the cost of State-paid long term care or medical services provided to You.

When Benefits Earn Medi-Cal Asset Protection: Benefits, excluding those paid under International Coverage, paid to You or a provider of Covered Care on Your behalf can count toward Your Medi-Cal Asset Protection for purposes of Medi-Cal eligibility for California's Medi-Cal Program.

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

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

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 increase future benefits.

Underwriting: We will underwrite Your Application by reviewing the information submitted on Your application and any other information You authorize Us to obtain.

Continuation for Lapse Due to Cognitive or Functional Impairment: If the Policy terminates due to non-payment of Premium, We will provide a retroactive continuation if, within seven (7) months of the termination date, You provide Us with proof that You were Chronically Ill, beginning on or before the end of the Grace Period. All past due Premium must be paid within such seven (7) month period. In that event, any Benefits for which You qualified during the continuation period will be paid to the same extent they would have been paid if the Policy had not ended.

Reminder: This Outline Of Coverage is not a contract; and the only contract under which Coverage will be provided is the Policy issued when Your Application is approved. The Policy will set forth in detail the Benefits and Services provided and the Premium and conditions required to continue the Policy until it ends.

13. INFORMATION AND COUNSELING

The California Department of Insurance has prepared a Consumer Guide to Long Term Care Insurance. This guide can be obtained by calling the Department of Insurance toll-free telephone number. This number is 1-800-927-HELP (4357). 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 telephone number 1-800-434-0222 for a referral to your local HICAP office.

Local HICAP Office:_____

Agency Name

_____

Agency Address Agency Phone Number

SCHEDULE

(Complete to show coverage selected)

	Applicant A	Applicant B
[Shared Coverage Rider (Selections for both applicants must be identical) **[**Includes Joint Waiver of Premium **[O** Yes **O** No**]]**	**[O** Yes **O** No**]**	**[O** Yes **O** No**]**
Elimination Period – [Days of Covered Care][Calendar Days]	**[O**30 **O**60 **O**90**]** **[O** Covered Care Days **O** Calendar Days**]**	**[O**30 **O**60 **O**90**]** **[O** Covered Care Days **O** Calendar Days**]**
[Waiver of Home Care Elimination Period**]**	**[O** Yes **O** No**]**	**[O** Yes **O** No**]**
Nursing Facility Maximum - per [day]**[**Calendar Month**]**	$_____	$_____
Residential Care Facility Maximum As a % of the Nursing Facility Maximum	**[O**100% **O**70% **]**	**[O**100% **O**70%**]**
Home and Community Care Maximum (a monthly maximum) As a % of the Nursing Facility Maximum for a month (30 days)	**[O**100% **O**75% **O**60% **O**50%**]**	**[O**100% **O**75% **O**60% **O**50%**]**
Benefit Multiplier - **[**Years worth of benefits Based on 12 months per year**]**	**[O1** Year **O**2 Years **O**3 Years **O**4 Years **O**5 Years **O**6 Years]	**[O1** Year **O**2 Years **O**3 Years **O**4 Years **O**5 Years **O**6 Years]
Coverage Maximum [(Nursing Facility Maximum X Benefit Multiplier)**]**	$_____	$_____
Benefit Increases The Coverage Maximum and amounts based on the Nursing Facility Maximum are increased when Benefit Increases apply and exhausted only when the total of all Benefits paid equals the then applicable maximum amount. Benefit Increases that apply are not affected by any Benefit payments.	5% Compound unless age 70 or older and choosing the following: **O**5% **Simple**(age 70+)	5% Compound unless age 70 or older and choosing the following: **O**5% **Simple**(age 70+)

Benefits And Services Provided	**We Pay Covered Expenses Up To These Limits**
Privileged Care Coordination Services:	Not subject to coverage limits
Nursing Facility Benefit:	Nursing Facility Maximum per **[**day**][**calendar month**]**
Residential Care Facility Benefit: (Includes room charges in a Residential Care Facility)	**[**The selected % of the**]** Nursing Facility Maximum per **[**day**][**calendar month**]**
Bed Reservation Benefit:	60 days per calendar year
International Benefit:	As stated in the Benefit
Home and Community Care Benefit: (Covers Formal and Informal Care Providers)	The calendar month maximum determined above
Home Assistance Benefit: (Covers equipment, modifications & training)	A Policy total payment maximum equal to the Nursing Facility Maximum payable for 90 days/3 months
Hospice Care Benefit:	Included
Respite Care Benefit:	Up to 30 days per calendar year
Contingent Nonforfeiture Benefit:	Included
Waiver of Premium Benefit:	Included
The Waiver of Premium applies only when benefits are payable under the:	Nursing Facility Benefit; Residential Care Facility Benefit; Bed Reservation Benefit[; Home and Community Care Benefit; or Hospice Care Benefit].
Your Right to Request Payment For Alternate Care Benefit:	Payment subject to mutual agreement

Coverage includes a Contingent Nonforfeiture Benefit and any applicable Features and Optional Benefits.

The maximum total amount payable for all Covered Expenses incurred in a calendar month is limited to the maximum amount payable for one month/30 days under the Nursing Facility Benefit. This does not apply to the Home Assistance Benefit and Benefits paid for requested alternative care.