MEDAmerica
INSURANCE COMPANY OF NEW YORK
An Excellus Company
Home Office: Rochester, NY

Home Office:
165 Court Street
Rochester, NY 14647
1-800-544-0327

CAREDIRECTIONS® Premier

INDIVIDUAL LONG-TERM CARE INSURANCE POLICY

This Policy is approved by the New York State Partnership for Long-Term Care.

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. The special eligibility for long-term care protection through the New York State Medicaid program shall be void unless You are eligible to receive approved services under the New York State Medicaid program when such special eligibility occurs. Please refer to Your Consumer Participation Agreement.

POLICY: The Benefits of this policy provide coverage to persons needing assistance for care as shown in the Benefits section of this Policy. **THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.** If You are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from Us. **This Policy is intended to be a qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code and in compliance with section 1117 of the New York Insurance Code.**

GUARANTEED RENEWABLE: This Policy is guaranteed renewable. That means Your coverage will continue for life as long as You pay the premiums within the allowable time. We cannot make any change in the coverage or Benefits without Your consent. We can change Your premium with 30 days written notice, but only if We change the premiums for all persons in the same premium payment class, regardless of where you reside at the time of the premium change. The only changes We can make are those We are obligated to make by government officials due to the participation of this Policy in the New York State Partnership for Long Term Care Program. If, in the future, it is necessary to make changes to this contract to bring it into further compliance with federal tax-qualification requirements, these changes will be offered to You and You may accept or reject them.

30-DAY LOOK: If You feel this Policy does not meet Your needs, You may return it to Us or Your agent within 30 days. If You do so: (1) We will return the premium You paid; and (2) We will not provide any Benefits under this Policy.

DISPUTE RESOLUTION: You have a Binding Arbitration Option in Your Consumer Participation Agreement for resolution of disputes regarding denied claims. Refer to the section in Your Policy entitled General Provisions for details.

CANCELLATION AFTER 30 DAYS: You may cancel this Policy after the first 30 days following Your receipt of it by giving Us written notice. Cancellation will be effective upon receipt of Your notice or on a later date as You may specify in Your notice. Cancellation is without prejudice to any claim originating prior to the effective date of cancellation. Refer to the Extension of Benefits section in Your Policy. We may not cancel this Policy so long as You pay the premiums within the Grace Period.

YOUR APPLICATION: Caution: The issuance of this long-term care Policy is based upon Your responses to the questions on Your application. A copy of Your application is enclosed. If Your answers are incorrect or untrue, or fail to include all material medical information requested, We 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 Us at the above mailing address.

This policy is signed on Our behalf by Our President.

Christopher D. Perna,
President

TABLE OF CONTENTS

SCHEDULE 3

DEFINITIONS 5

LIMITATIONS OR CONDITIONS ON BENEFIT ELIGIBILITY 11

BENEFIT PLANNING 12

APPROVED PROVIDERS 12

BENEFITS 13

LIMITATIONS OR EXCLUSIONS 17

PREMIUM 18

CLAIMS 19

GENERAL PROVISIONS 22

SCHEDULE

Policyholder Name:	**JOHN DOE**
Policy Effective Date:	**XX/XX/XXXX**
Policyholder Issue Age:	**XX**
Rate Group:	**X**
Premium Mode:	**XXXXXXXX**
Policyholder Identification:	**L123456789-01**

Initial Base Premium:	**$XXXX**
[Initial Premium **Shortened Benefit Period Nonforfeiture Rider:]**	**[$XXXX]**
[Initial Premium **Return of Premium Rider:]**	**[$XXXX]**
[Initial Premium **Survivorship Benefit Rider:]**	**[$XXXX]**
Total Premium	**$XXXX**

LIFETIME BENEFIT AMOUNT [$XXXXX]

We will deduct from this amount all Benefits paid for covered services received as outlined in this Policy.

BENEFIT PERIOD 1,095 days (3years)

We will deduct from this amount the days in which Benefits are paid for covered services received as outlined in this Policy.

LIFETIME ELIMINATION PERIOD

[X 0 Days]
[X 30 Days]
[X 100 Days]

DAILY BENEFIT AMOUNT

For Nursing Facility, Alternate Care, Respite Care, Hospice Care Bed Reservation, Care Management
Actual Charges incurred up to [$xx Per Day]

Home Care, Adult Day Care, Assisted Living Facility:
Actual Charges incurred up to [$xx Per Day]

PREMIUM PAYMENT TERM

[_____X_____Lifetime or as long as You wish to keep the Policy in force]
[_____X_____10 Year Paid-in-Full*]
[_____X_____20-Year Paid-in-Full*]
[*If either 10 or 20 Year Paid in Full option is chosen, your policy cannot lapse after satisfaction of payment term.]

[**INFLATION PROTECTION OPTION**

[__X__ None, Benefits remain level.]

[__X__ Compound Inflation Protection

Your Lifetime Benefit Amount and Daily Benefit Amount will each increase on every anniversary of the effective date of this policy. Annual increases will apply to Benefits payable for any expenses You incur on or after the date of the increase. This first increase will be equal to 5% of Your original amounts. Each increase thereafter will be equal to 5% of the increased amounts that applied on the date of the prior increase.]

[___X___SHORTENED BENEFIT PERIOD NONFORFEITURE RIDER]

[___X___RETURN OF PREMIUM RIDER]

[___X___SURVIVORSHIP BENEFIT RIDER]

Refer to the Appropriate
Provisions of Your Policy for Standard Benefits.

DEFINITIONS

ACTIVITIES OF DAILY LIVING (ADL)

Each of the following is an Activity of Daily Living:

Bathing: This means the ability to wash yourself including a sponge bath, with or without extra equipment.

Continence: This means the ability to control bowel and bladder functions voluntarily, or when unable to maintain control of bowel or bladder functions, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag.

Dressing: This means the ability to put on and take off, fasten and unfasten all garments and medically necessary braces or artificial limbs usually worn.

Eating: This means the ability to get food into Your body from a receptacle (such as plate, cup or table) or by a feeding tube or intravenously.

Toileting: This means the ability to go to and from the toilet and maintain a reasonable level of personal hygiene. This includes getting on and off the toilet and caring for clothing.

Transferring: This means the ability to move in and out of a chair, wheelchair or bed.

ADULT DAY CARE CENTER

This is a facility that provides a daytime program of social and health-related services in a community group setting. An Adult Day Care Center does not provide 24-hour care. It must be established, licensed and operated in accordance with any applicable state or local laws.

ASSISTED LIVING FACILITY

A state or federally licensed, accredited or certified Assisted Living Facility operated in accordance with any applicable state or local laws.

A portion, wing, ward or unit of a multi-use facility will qualify as an Assisted Living Facility only if it meets the above criteria. An Assisted Living Facility is NOT:

- A hospital or clinic; or
- A hospital based long term care unit, subacute unit or rehabilitation unit; or
- A place that operates primarily for the treatment of alcoholism, drug addiction or mental illness; or
- A Nursing Facility.

BENEFITS

Coverages described in the "Benefits" section of Your Policy, Your Schedule, and attached riders.

BENEFIT ELIGIBILITY

The section of this Policy that describes the conditions You must meet to qualify for payments under this Policy.

BENEFIT PERIOD

This is the maximum amount of days You are entitled to receive covered services as stated in Your Schedule.

One day is applied to the Benefit Period for each day Benefits are paid for Nursing Facility, Respite Care, Alternate Care, Hospice Care, Bed Reservation, or Consultation Care Management.

One half day is applied to the Benefit Period for each day Benefits are paid for Home Care, Assisted Living Facility or Adult Day Care.

If the actual Benefits paid for Nursing Facility Care, Alternate Care, Hospice Care, Bed Reservation or Care Management are less than the Nursing Facility Daily Benefit Amount, or if Benefits paid for Home Care, Assisted Living Facility Care or Adult Day Care are less than one half of the Nursing Facility Daily Benefit Amount, the unused amount will extend the Benefit Period.

DAILY BENEFIT AMOUNT

This is the maximum amount We will pay for all covered Benefits You receive on any one day as stated in Your Schedule. If Your Schedule states that an Inflation Protection Option is in effect, Your Daily Benefit Amount will increase over time.

FAMILY; FAMILY MEMBER

Your spouse and anyone who is related to You or Your spouse (including adopted, in-law and step-relatives) as a parent, grandparent, child, grandchild, brother, sister, aunt, uncle, first cousin, nephew or niece.

HOME

Any place where You reside other than a Nursing Facility, Assisted Living Facility, hospital or any residential care facility.

HOME HEALTH CARE AGENCY

A state or federally licensed, accredited or certified Home Health Care Agency that provides care and services in Your Home.

HOSPICE PROGRAM

A state or federally licensed, accredited or certified Hospice Program that provides Hospice care to the terminally ill.
The program must be administered by an interdisciplinary team that consists of: a physician, a registered nurse, clergy or counselors, trained volunteers and other appropriate staff having expertise in meeting the needs of Hospice patients.

A Hospice program is designed to provide palliative care. It is also designed to alleviate the physical, emotional, social and spiritual discomforts of a person: (a) who is in the last phases of life due to a terminal disease and (b) who has a physician-certified prognosis of 6 months or less to live.

Hospice Services may be provided in a Nursing Facility, an Assisted Living Facility, or in Your Home.

LICENSED HEALTH CARE PRACTITIONER

This means any of the following: a physician (as defined in section 1861(r)(1) of the Social Security Act), a registered professional nurse, or a licensed social worker.

LIFETIME BENEFIT AMOUNT

This Policy entitles You to the Lifetime Benefit Amount of coverage as shown in Your Schedule. We will deduct from this amount all Benefits paid for covered services You receive under this Policy.

- Benefits paid for Nursing Facility Care, Respite Care, Alternate Care, Hospice Care, Bed Reservation, or Care Management will be deducted based on the actual Benefit paid.

- Benefits for Home Care, Assisted Living Facility or Adult Day Care will be deducted based on the actual Benefit paid or one half of the Nursing Facility Daily Benefit Amount, whichever is less.

If Your Schedule states that an Inflation Protection Option is in effect, Your Lifetime Benefit Amount will increase over time. The initial Lifetime Benefit Amount is determined by the Daily Benefit Amount multiplied by the number of Benefit Days as listed in Your Schedule.

LIFETIME ELIMINATION PERIOD

This is the number of days shown in Your Schedule for which You must pay expenses for Benefits covered in this Policy before We start to make payments. The Lifetime Elimination Period will be applied only once during the life of the Policy.

A day is credited toward the Lifetime Elimination Period for eligible days paid in part or in full by Medicare. Days used to satisfy Your Lifetime Elimination Period do not need to be consecutive.

There is no Lifetime Elimination Period for Hospice Program, Respite Care or Consultation-Care Management Services. These Benefits may not be used to satisfy the Lifetime Elimination Period. If You are receiving Hospice Program Benefits paid by another insurer We will waive the Lifetime Elimination Period.

MAINTENANCE OR PERSONAL CARE SERVICES

Any care the primary purpose of which is to assist You with the disabilities which caused You to meet the conditions set forth in the Benefit Eligibility section of this Policy.

MEDICAID EXTENDED COVERAGE: You shall be eligible to apply for New York State Medical Assistance ("Medicaid"), without regard to your assets subject to the following conditions:

1. You have met the requirements of the Consumer Participation Agreement which You signed when You applied for this coverage, and

2. We have paid for covered Benefits equal to the benefit period listed in Your Schedule.

Your income will be used to determine your eligibility for Medicaid Extended Coverage. Please read Your Consumer Participation Agreement carefully for details.

MEDICARE The Health Insurance for Aged Act, Title XVIII of the Social Security Act Amendments of 1965, as Constituted and Later Amended.

NURSING FACILITY A state or federally licensed, accredited or certified Nursing Facility, including a nursing home, hospital-based long term care unit, Alzheimer's or Hospice facility.

If a facility or institution has multiple licenses and/or multiple purposes, only the section, wing, ward, unit or bed that is specifically licensed as a Nursing Facility and is authorized to provide nursing care services to inpatients meets this definition.

A Nursing Facility is NOT:

- A hospital or clinic; or
- A place which operates primarily for the treatment of alcoholism, drug addiction or mental illness; or
- An Assisted Living Facility or similar establishment.

PERSONAL CARE ADVISOR This is a health care professional chosen by Us whose profession and training includes experience or expertise in managing and arranging for long-term care services. Where required, he or she must be licensed and acting within the scope of that license.

PLAN OF CARE

This is a written, individualized plan for care and support services for You that:

- Has been prescribed by a Licensed Health Care Practitioner; and
- Has been developed as a result of an assessment and incorporates any information provided by Your personal physician; and
- Fairly, accurately and appropriately addresses Your long-term care and support service needs; and
- Specifies the type, frequency and duration of all services required to meet those needs and the providers appropriate to furnish those services.

The Plan of Care must be updated as Your needs change. It may contain services that You need that are not covered under this Policy. We retain the right to request periodic updated assessments.

POLICY

This is a legal agreement between You and Us. It includes this document, Your application, and any attached riders or endorsements.

QUALIFIED LONG-TERM CARE SERVICES

These are the necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, as well as Maintenance or Personal Care Services, which (a) are required by a person who meets the conditions set forth in the Benefit Eligibility section of this Policy and (b) are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

SEVERE COGNITIVE IMPAIRMENT

This is deterioration or irreversible loss in Your intellectual capacity that requires substantial supervision to protect yourself or others. This is established by clinical evidence and standardized tests that reliably measure Your impairment in the areas of:

- Your short or long-term memory; and
- Your orientation as to person (such as who You and others are), place (such as Your location) and time (such as day, date, and year); and
- Your deductive or abstract reasoning.

Note: Severe Cognitive Impairment can result from Alzheimer's Disease.

SUBSTANTIAL ASSISTANCE

This is Hands-On Assistance or Standby Assistance.

- Hands-On Assistance means the physical assistance of another person without which You would be unable to perform the ADL.
- Standby Assistance means the presence of another person within arm's reach of You to prevent, by physical intervention, injury to You while You are performing the ADL (such as being ready to catch You if You fall while getting into or out of the bathtub or shower as part of bathing, or being ready to remove food from Your throat if You choke while eating).

SUBSTANTIAL SUPERVISION

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

WE, US, OUR

This refers to MedAmerica Insurance Company of New York.

YOU, YOUR, YOURSELF

This refers to the person to whom this Policy is issued and whose name appears in the Schedule.

LIMITATIONS OR CONDITIONS ON BENEFIT ELIGIBILITY

BENEFIT ELIGIBILITY

To start the benefit access process, You must contact Us as soon as You think You might need services covered under this Policy. Please call Our Customer Service Representative at 1-800-544-0327.

To be eligible for Benefits provided by this Policy, We must receive periodic proof from a Licensed Health Care Practitioner that You are a person who meets the following conditions:

- You need Substantial Assistance from another person to perform at least two of the Activities of Daily Living (ADL) (Bathing, Dressing, Eating, Toileting, Transferring, Continence) for a period expected to last at least 90 days; or
- You need Substantial supervision to protect You from threats to health and safety due to Severe Cognitive Impairment.

We will work with You, Your family and Your physician when We need information about Your condition. We will review the status of Your Activities of Daily Living (ADL) and cognitive function. We will use this information to make an evaluation of Your condition to determine whether You qualify or continue to qualify for Benefits under this Policy. This information may be gathered by Us or one of Our representatives. You may contact Us with any questions regarding Our determination.

We must receive certification from a Licensed Health Care Practitioner at least every 12 months that You meet the above conditions.

LIFETIME ELIMINATION PERIOD

This is the number of days shown in Your Schedule for which You must pay expenses for services covered in this Policy before We start to make payments. Your Lifetime Elimination Period is based on service days. A day is credited to Your Lifetime Elimination Period for each day You receive covered services under this Policy. The Lifetime Elimination Period will be applied only once during the life of the Policy.

A day is credited toward the Lifetime Elimination Period for eligible days paid in part or in full by Medicare. Days used to satisfy Your Lifetime Elimination Period do not need to be consecutive. There is no Lifetime Elimination Period for Hospice Program, Respite Care, or Consultation-Care Management Services. These Benefits may not be used to satisfy the Lifetime Elimination Period. If You are receiving Hospice Program Benefits paid by another insurer We will waive the Lifetime Elimination Period.

A Lifetime Elimination Period based on service days minimizes premium's due to the fact that only the days in which you are eligible to receive benefits <u>and</u> actually use services are counted toward Your Lifetime Elimination Period.

BENEFIT PLANNING

BENEFIT PLANNING

You may use the services of Our Personal Care Advisor. These services are provided at no cost to You. Our Personal Care Advisor is available to help You and/or Your family members plan for Your care by:

- Assisting in developing a written Plan of Care to identify the type and frequency of services You need; and
- Assisting in arranging needed services for You.

Although We will assist You in obtaining long-term care services, We do not guarantee that any agency or facility will accept You as a patient. The Approved Providers are responsible for the quality of care.

We are not liable for any death, injury, illness or other condition that occurs while You are receiving services shown in the Plan of Care.

APPROVED PROVIDERS

APPROVED PROVIDERS

Qualified Long-Term Care Services must be provided by Approved Providers in order to be reimbursed. Approved Providers are any of the following:

- Nursing Facility; or
- Assisted Living Facility; or
- Hospice Program; or
- Home Health Care Agency; or
- Adult Day Care Center.

BENEFITS

MAXIMUM DAILY BENEFIT AMOUNT

The maximum amount We will pay for all covered Benefits You receive on any one day, whether under one or more of the categories of Benefits described below, is the Daily Benefit Amount shown in Your Schedule.

CONSULTATION - CARE MANAGEMENT SERVICES

If You meet Benefit Eligibility, We will provide Benefits for Consultation-Care Management Services at 100% of the actual charges incurred up to the Daily Benefit Amount shown in Your Schedule. This Benefit provides You with the option to seek the Consultation Services of a Licensed Health Care Practitioner of your choice, in addition to the optional Benefit Planning Services provided by Our Personal Care Advisor.

Consultation Services may provide You with assistance and advice in choosing and applying for long term care services. This may include services such as, but not limited to providing information about Your coverage and potential long-term care resources. This benefit is not subject to, and may not be used to satisfy, the Lifetime Elimination Period.

This Benefit is equal in value to two (2) covered nursing home days per calendar year.

NURSING FACILITY

If You meet Benefit Eligibility, We will provide Benefits at 100% of the actual charges incurred up to the Daily Benefit Amount shown in Your Schedule for services provided in a Nursing Facility that are Qualified Long-Term Care Services.

ASSISTED LIVING FACILITY

If You meet Benefit Eligibility, We will provide Benefits at 100% of the actual charges incurred up to the Daily Benefit Amount shown in Your Schedule for services provided in an Assisted Living Facility that are Qualified Long-Term Care Services.

HOSPICE PROGRAM

If You meet Benefit Eligibility, We will provide Benefits at 100% of the actual charges incurred up to the Daily Benefit Amount shown in Your Schedule for services provided by a Hospice Program that are Qualified Long-Term Care Services.

Benefits for Hospice Program services that are provided in other than an inpatient setting will be paid up to the Daily Benefit Amount for Home Care.

This benefit is not subject to, and may not be used to satisfy, the Lifetime Elimination Period.

HOME CARE

If You meet Benefit Eligibility, We will provide Benefits at 100% of the actual charges incurred up to the Daily Benefit Amount shown in Your Schedule for services provided by a Home Health Care Agency that are Qualified Long-Term Care Services and are:

- nursing services; or
- physical, occupational, respiratory and speech therapy; or
- home health aide or personal care attendant services including such things as: personal hygiene, performing Activities of Daily Living (ADL) , managing medications, and other related supportive services; or
- homemaker services including light work, household tasks, preparing meals, doing laundry and other incidental household tasks that do not require the services of a trained aide or attendant.

ADULT DAY CARE

If You meet Benefit Eligibility, We will provide Benefits at 100% of the actual charges incurred up to the Daily Benefit Amount shown in Your Schedule for Qualified Long-Term Care Services provided by an Adult Day Care Center.

ALTERNATE CARE

If You meet Benefit Eligibility, We will provide Benefits at 100% of the actual charges incurred up to the Nursing Facility Daily Benefit Amount shown in Your Schedule for services that are Qualified Long-Term Care Services provided in a hospital setting while you are waiting for access to a Nursing Facility or for Home Care services, subject to the Lifetime Elimination Period.

BED RESERVATION

If You are hospitalized temporarily while we are paying for Benefits in a Nursing Facility and that facility charges You a fee to reserve Your bed, We will pay to reserve Your bed for up to 20 days per calendar year.

We will pay the actual charges to reserve Your bed, up to the Nursing Facility Daily Benefit Amount shown in Your Schedule.

You must continue to meet Benefit Eligibility. Your eventual need to return to the facility where the bed is reserved must be expected and documented by Your physician.

RESPITE CARE

Respite Care services provide temporary care for You while Your regular caregiver in the Home takes a brief rest.

If You meet Benefit Eligibility, We will pay Benefits for Qualified Long-Term Care Services for Respite Care provided in Your Home, in a Nursing Facility, or in an Assisted Living Facility.

We will reimburse Respite Care Services at the Nursing Facility Daily Benefit Amount shown in Your Schedule for a maximum Benefit of 14 days per calendar year. Payments made under this Benefit are deducted from Your Lifetime Benefit Amount.

This benefit is not subject to, and may not be used to satisfy, the Lifetime Elimination Period.

WORLDWIDE COVERAGE

This Policy covers Qualified Long-Term Care Services provided to You anywhere in the world by Approved Providers certified by applicable governmental bodies where required.

LIMITATIONS OR EXCLUSIONS

EXCLUDED SERVICES

Expenses for the following will not be covered under this Policy:

1. Treatment for Alcoholism and/or drug addiction.

2. Treatment for illness or medical condition arising out of war or any act of war, declared or undeclared.

3. Services for intentionally self-inflicted injury.

4. Treatment provided in a government facility except as otherwise required by State or Federal law.

5. Services provided by a member of Your immediate family.

6. Services for which no charge is normally made in the absence of insurance.

7. Expenses for Medications, prescription and/or non-prescription.

NON-DUPLICATION

We will not pay Benefits for services or expenses to the extent that they are reimbursed under Medicare or under any other federal, state, or other governmental health care plan or law (except Medicaid).

This exclusion also applies to services or expenses that would be reimbursed by Medicare but have been applied to a deductible or coinsurance amount.

PREMIUM

PREMIUM AMOUNT	The initial premium is shown in Your Schedule. If there is any change to the amount, We will notify You 30 days in advance. No change will be made to the premium amount unless We change the premium rates for all persons in the same premium payment class, regardless of where you reside at the time of the premium change.
PAYMENT	The premium is to be paid in advance of the payment period indicated on the premium statement.
GRACE PERIOD	An initial Grace Period of 30 days will be granted for each premium that is unpaid on the date due. After 30 days, a notice will be sent to You explaining that a payment has been missed and that Your Policy risks lapsing. If You have designated an individual to be notified of lapse, We will send the notice to the address You provided for that designee. You will have an additional 35 days from the date We mail notice to You during which any unpaid premium must be paid. Payment will allow Your Policy to continue in force without interruption. Failure to pay any unpaid premium by the end of this Grace Period will result in the termination of Your Policy as of the premium due date.
REINSTATEMENT	If Your Policy ends for non payment of premium within the Grace Period, You may request reinstatement with no break in coverage. If We honor this request, Your Policy will be reinstated retroactive to the date Your Policy terminated. Once reinstated, You must pay the premium due retroactive to the date Your Policy terminated.
EXTENDED REINSTATEMENT BENEFIT FOR SEVERE COGNITIVE IMPAIRMENT AND LOSS OF FUNCTIONAL CAPACITY	If You failed to pay Your premium within the Grace Period, because of a condition that would qualify You for Benefits under this Policy, You may request reinstatement up to 5 months after termination of Your Policy. A Licensed Health Care Practitioner must submit proof that You are a person who meets the conditions set forth in the Benefit Eligibility section of this Policy. We will make a Benefit Eligibility Assessment before deciding on reinstatement. If Your Policy is reinstated, You must pay the premium due retroactive to the date Your Policy terminated.
PREMIUM WAIVER	Your premium payments will be waived on a monthly basis starting: • on the first day of policy-paid Benefits in a Nursing Facility, or Hospice Program; • on the 91st day of policy-paid Benefits for Home Care, Assisted Living Facility, or Adult Day Care.
UNEARNED PREMIUM	When We are notified of Your death, We will refund to Your estate any premium paid for the period beyond Your death.

CLAIMS

NOTICE OF CLAIM

Written notice of claim must be given to Us within 60 days after the date Your loss starts, or as soon thereafter as is reasonably possible. The notice should include at least Your name, Your Policy Identification Number, and the address to which the claim form is to be sent. Notice must be given by You or on Your behalf to Us at:

MedAmerica Insurance Company of New York
165 Court Street
Rochester, NY 14647

HOW TO FILE A CLAIM

CLAIM FORMS: We will send claim forms to You upon receipt of a written notice of claim. If such forms are not sent within 15 days after giving of notice, You will be deemed to have met the timeliness of claim filing requirements upon submitting, within the time fixed in this Policy for filing proof of loss, a letter describing the occurrence, the character and the extent of the loss for which claim is made.

At a minimum, the description should include Your name and address, Your Policy Identification number, the type of Benefits You are claiming, the names and addresses of Your physicians, the services You required, Your diagnosis, and the periods for which You are claiming Benefits.

WHEN TO FILE A CLAIM

PROOF OF LOSS: Written proof of loss must be received by Us within 90 days after the end of each month for which Benefits may be paid. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

CONDITIONS FOR RECEIVING CLAIM PAYMENT

If You meet Benefit Eligibility, We will pay Benefits subject to the terms, limitations and exclusions described in this Policy. The following conditions also apply:

- Your Policy must be in force when the care is approved and received; and
- You have completed the Elimination Period, if it applies; and
- The service is covered under this Policy; and
- The service is included in the Plan of Care developed for You; and
- You have not exhausted the Lifetime Benefit Amount shown in Your Schedule.

PAYMENT OF CLAIMS: All Benefits will be paid to You, Your Power of Attorney or to the Approved Provider upon Your request. You may request in writing no later than the time proof of loss is filed that payment be made to the Approved Provider. Any Benefits unpaid at Your death will be paid to Your estate.

HOW AND WHEN CLAIMS ARE PAID

TIME OF PAYMENT OF CLAIM: Upon receipt of the proper written proof of loss, any Benefits then due will be paid:
(1) monthly, when the loss is expected to result in ongoing Benefits and (2) promptly, when Our liability has ended.

Such payment will be made within 30 days after having received the proper written proof of loss.

If We contest a claim or a portion of a claim, You or Your assignee will be notified in writing that the claim is contested or denied within 30 days after we have received Your claim.

The notice that the claim is contested will identify the contested portion of the claim and the reasons for contesting the claim.

Upon receiving any additional information requested by Us, the contested claim or portion thereof will be paid or denied within 30 days.

RECOVERY OF OVERPAYMENT

If an error in processing a claim results in an overpayment, We will explain the overpayment to You. You must return the amount of overpayment within 60 days of Our request. Any overpayment that is not returned to Us within 60 days of Our request will be deducted from future claim payments.

WHEN YOU HAVE CLAIM QUESTIONS

If You would like an explanation of Our claim payment, please call, write or visit Us.

YOUR APPEAL RIGHTS

If You do not agree with a claim determination because We have partially or fully denied Benefits, You may file an appeal. Include the reason for the appeal and any documents that You feel are pertinent to the situation. The request should be sent to Our office within 3 years of the time of filing written notice of proof of loss for the claim being appealed.

We will make a benefit determination, independent of the original, using medical records and the provisions of this Policy. We will send You Our written decision within 60 days of Our receipt of Your appeal request.

PHYSICAL EXAMINATION

We, at Our expense, can have You examined as often as reasonably needed while a claim is pending.

TIME LIMIT FOR LEGAL ACTION

You cannot begin legal action before 60 days after written proof of loss has been given to Us. The time limit for legal action is 3 years after the time written proof of loss is furnished.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES

This Policy document, Your application and any Riders and attached papers establish the entire contract of insurance between You and Us. Any change must be approved by one of Our officers and mutually agreed to by You. It must also be endorsed on or attached to this Policy. No insurance agent has the authority to change this Policy or to waive any of its provisions.

YOUR BENEFITS

Only You can receive the Benefits under this Policy.

WHEN YOUR POLICY COVERAGE BEGINS

The date that Your Policy begins is shown in the Schedule. All time periods begin and end at 12:01 a.m. standard time at Your residence.

WHEN YOUR POLICY COVERAGE ENDS

When one of the following occurs, You will no longer be entitled to Benefits under this Policy:

- Nonpayment of premium (subject to the Grace Period); or
- Maximum Benefits are exhausted; or
- You elect to cancel this Policy; or
- Your death.

EXTENSION OF BENEFITS

If, on the date this Policy is cancelled, You are totally disabled or You are receiving Qualified Long-Term Care Services covered under this Policy, We will continue to pay for Your care without interruption of Benefits until the first of the following dates:

- It is determined that You are no longer eligible for Benefits under this Policy; or
- You have used up Your Lifetime Benefit Amount; or
- A date We determine You are no longer totally disabled; or
- In the case of Home Care Benefits, twelve (12) months from termination of Your coverage.

We will not pay for more care than You would have been entitled to receive if Your Policy had not terminated.

You will not be entitled to Benefits after termination if the reason Your Policy terminated was due to You reaching Your maximum Lifetime Benefit Amount.

INCONTESTABLE PERIOD

During the first 6 months Your Policy is in force, We may rescind Your Policy or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation by You that was material to Our acceptance of You.

After 6 months but before 2 years of coverage, We may rescind Your Policy or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that was both material to Our acceptance of You and which pertained to the condition for which Benefits are sought.

After Your Policy has been in force for 2 years, We may rescind Your Policy or deny an otherwise valid long-term care insurance claim only upon a showing that You knowingly and intentionally misrepresented relevant facts relating to Your health.

CLERICAL ERROR

Clerical error, whether by You or Us, will not void Your insurance if that insurance would otherwise have been in effect. Neither will it extend Your insurance if that insurance would otherwise have ended or been reduced as provided in this Policy.

MISSTATEMENT OF AGE

If Your age was misstated on Your Application, Your premium will be changed retroactively to correspond to Your correct age.

NON-PARTICIPATING

This Policy does not participate in Our profits or surplus earnings.

CONFORMITY WITH FEDERAL AND STATE STATUTES

Any provision of this Policy that does not comply with a law to which it is subject is amended to conform to the minimum requirement of such law.

BINDING ARBITRATION OPTION FOR RESOLUTION OF DISPUTES

In Your Consumer Participation Agreement You have the option to resolve a claim dispute through a process of binding arbitration. If You are notified by the Partnership that Your claim might have been denied in error, You may elect to resolve Your dispute through this process of binding arbitration. The cost of all arbitration fees will be paid by Us. The decision rendered thereby shall be binding on both You and Us.

Arbitration has the advantage of being a faster and less costly way to resolve a disputed benefit authorization request (BAR). You should consult the Consumer Participation Agreement, which You signed, for further details.

NATIONAL LONG-TERM CARE PROGRAM CONVERSION PRIVILEGE

If a national long-term care program is created through public funding, and this national program duplicates benefits provided by this Policy, We will implement one or a combination of the following amendments to this policy, based on mutual agreement between the Insurance Commissioner of the State of New York and Us:

A. Reduce premiums to the extent that benefits under this Policy have been duplicated by the national program.

B. Increase benefits under this Policy to make up for benefits that have been duplicated by the national program.

MEDAmerica
INSURANCE COMPANY OF NEW YORK
An Excellus Company
Home Office: Rochester, NY

Home Office:
165 Court Street
Rochester, NY 14647
1-800-544-0327

RETURN OF PREMIUM RIDER

Subject to the terms and conditions contained in Your Policy and the payment of the required premium, You are entitled to the benefits described in this Return of Premium Rider.

This Rider is a part of Your Policy and is subject to all of its terms and conditions. Terms used in this Rider and not defined here have the meanings given to them in the Definitions section of Your Policy.

RETURN OF PREMIUM BENEFIT

Upon notification of Your death, We will refund to your estate a portion of the premiums paid less any benefits paid or payable. The amount of the refund is determined by multiplying (*A*) by (*C*) and then subtracting (*B*). (*A*), (*B*) and (*C*) are defined as follows:

(*A*) = Your total premiums paid, not including any premiums which were waived, less any unearned premiums refunded at Your death.

(*B*) = Your total benefits paid or payable.

(*C*) = The applicable factor from the Schedule of Factors shown below. It is determined based on Your age on the birthday preceding the date of death.

Schedule of Factors

Age of Insured at Death	Factors
65 or younger	100%
66	90%
67	80%
68	70%
69	60%
70	50%
71	40%
72	30%
73	20%
74	10%
75 or older	No refund is made

The factors shall be further reduced on a monthly basis by one-twelfth of 10% for each attained month of age preceding the date of death.

TERMINATION

This Return of Premium Rider will terminate immediately on the earliest of the following:

1. Termination of Your Policy; or
2. Termination of Your coverage under Your Policy (except as specifically provided under the terms of this Rider); or
3. Failure to pay any premium for this Rider when due.

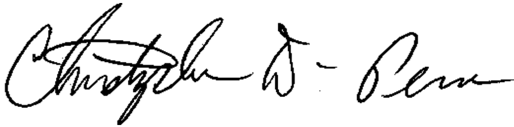
This Rider will also terminate as of the next premium due date for this Rider following Our receipt of Your written notice of termination of this Rider.

OTHER PROVISIONS

All of the terms, conditions, limitations and exclusions of Your Policy also apply to the benefits of this Rider, except where specifically changed by this Rider.

This Rider shall not otherwise vary, alter or extend the terms of Your coverage under Your Policy.

This Rider shall not be effective unless it is signed by the Authorized Officer of MedAmerica Insurance Company of New York as set forth below.



Christopher D. Perna,
President

MEDAmerica
INSURANCE COMPANY OF NEW YORK
An Excellus Company
Home Office: Rochester, NY

Home Office:
165 Court Street
Rochester, NY 14647
1-800-544-0327

SHORTENED BENEFIT PERIOD NONFORFEITURE RIDER

Subject to the terms and conditions contained in this Policy and the payment of the required premium, You are entitled to the benefits described in this Shortened Benefit Period Nonforfeiture Rider.

This Rider is part of Your Policy and is subject to all of its terms and conditions. Terms used in this Rider and not defined here have the meanings given to them in the Definitions section of Your Policy.

SHORTENED BENEFIT PERIOD NONFORFEITURE BENEFIT

We will continue the coverage provided by this Policy, subject to a reduced Lifetime Benefit Amount, if Your coverage under this Policy has been in force for three (3) years or more and Your coverage lapses due to cancellation or non-payment of premium. This reduced Lifetime Benefit Amount is called Your Nonforfeiture Maximum Benefit. If the eligibility requirements are met, We will provide benefits at 100% of the actual charges incurred for any Qualified Long-Term Care Services, otherwise covered under Your Policy, up to Your Nonforfeiture Maximum Benefit.

AMOUNT OF BENEFIT

Your Nonforfeiture Maximum Benefit will be the greater of:

1. The sum of all premiums paid for Your coverage under this Policy and any attached Riders; or
2. Thirty (30) times the Amount of Daily Benefit in effect on the date Your coverage under this Policy lapses.

However, Your Nonforfeiture Maximum Benefit can never be greater than Your Policy Lifetime Benefit Amount at time of lapse.

TERMINATION

This Shortened Benefit Period Nonforfeiture Rider will terminate when the first of the following events occurs:

1. Our receipt of written notice from You to cancel this Rider. This cancellation will be effective as of the next premium due date;
2. You die;
3. We pay this Rider's Nonforfeiture Maximum Benefit;
4. Your coverage under this Policy terminates (except as specifically provided under the terms of this Rider); or
5. You fail to pay any premium for this Rider when due.

OTHER PROVISIONS

All of the terms, conditions, limitations and exclusions of Your Policy also apply to the benefits of this Rider, except where specifically changed by this Rider.

NOTICE: Extended Medicaid coverage is available only when your Policy is kept in force and all Policy benefits are paid and exhausted. If you terminate or lapse your Policy prior to that time, and benefits are payable under this rider, extended Medicaid coverage will not be available.

This Rider shall not otherwise vary, alter or extend the terms of Your coverage under Your Policy.

This Rider shall not be effective unless it is signed by the Authorized Officer of MedAmerica Insurance Company of New York as set forth below.

Christopher D. Perna,
President

MEDAmerica
INSURANCE COMPANY OF NEW YORK
An Excellus Company
Home Office: Rochester, NY

Home Office:
165 Court Street
Rochester, NY 14647
1-800-544-0327

SURVIVORSHIP BENEFIT RIDER

Subject to the terms and conditions contained in this Policy and the payment of the required premium, You are entitled to the benefits described in this Survivorship Benefit Rider.

This Rider is part of Your Policy and is subject to all of its terms and conditions. Terms used in this Rider and not defined here have the meanings given to them in the Definitions section of Your Policy.

BENEFIT

We will not require the payment of premium under this Policy after both of the following events have occurred:

- Your Policy and Your spouse's Policy have been in force with Us for ten (10) consecutive years; and
- Your spouse is deceased.

DISCONTINUATION OF RIDER AND/OR LAPSE OF BASE POLICY

You may choose at any time to discontinue both Your Policy **and** this rider, **or** to discontinue **only** this rider. The following conditions apply:

1. If You cancel this rider, Your spouse's rider is automatically canceled. You and Your spouse each have the option to retain Your base Policies.
2. If You cancel both Your base Policy and this rider, Your spouse's rider is automatically canceled. Your spouse can retain his or her base Policy.
3. Your rider and Your spouse's rider are automatically canceled as of the date of a divorce or annulment.

SURVIVORSHIP PURCHASE REQUIREMENTS

At the time You apply for Your Policy, You and Your spouse must agree to purchase the same benefit features. These benefit features include: the daily benefit amount, lifetime benefit amount, any options and riders.

Both You and Your spouse must also agree to purchase this rider and choose the same payment terms. The effective date of both Policies must also be identical.

OTHER PROVISIONS

All of the terms, conditions, limitations and exclusions of Your Policy also apply to the benefits of this Rider, except where specifically changed by this Rider.

This Rider shall not otherwise vary, alter or extend the terms of Your coverage under Your Policy.

This Rider shall not be effective unless it is signed by the Authorized Officer of MedAmerica Insurance Company of New York as set forth below.

Christopher D. Perna,
President