

# BANKERS LIFE AND CASUALTY COMPANY

A Legal Reserve Stock Company • Home Office: 222 Merchandise Mart Plaza • Chicago, Illinois 60654-2001  
(312) 396-6000

## IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

Caution: The issuance of this insurance policy is based upon Your responses to the questions on Your application. A copy of Your application will be attached to the policy. If Your answers are incorrect or untrue, We may have the right to deny benefits or rescind Your policy. The best time to clear up any questions is upon delivery of Your policy. If, for any reason, any of Your answers are incorrect, contact Us at the above address.

NAME OF INSURED

POLICY NUMBER

FIRST PREMIUM

ISSUE DATE

FIRST RENEWAL DATE

GR-N565 POLICY FORM

Thank You for choosing Us for Your Limited Benefit Convalescent Care Insurance Coverage.

In this policy, "**We**," "**Our**" and "**Us**" refer to Bankers Life and Casualty Company. "**You**" "**Your**" and "**Yours**" refer to the Insured named in the Schedule. "**Family Member**" means You and Your spouse, if named in the Schedule or added to the policy.

We promise to pay You the benefits provided by this policy. Benefits are subject to this policy's definitions, limitations and exclusions.

## RENEWAL CONDITIONS - GUARANTEED RENEWABLE

This policy is guaranteed renewable and may be renewed for each Family Member on each renewal date for as long as such Family Member lives. To renew, You must pay the renewal premium at the intervals available to You at the time of renewal, by its due date or during the 31 days that follow. We can't refuse to renew this policy or place any restrictions on it if You pay the renewal premium on time.

## PRE-EXISTING CONDITIONS LIMITATION

Pre-existing conditions are those medical conditions for which treatment was given or recommended by a Licensed Health Care Practitioner within 6 months before the effective date of coverage.

Any loss due to a pre-existing condition isn't covered unless the loss begins more than 6 months after the Effective Date of coverage.

## YOUR THIRTY DAY RIGHT TO RETURN THIS POLICY

If You're not satisfied with this policy, You may return it to Us within 30 days after You receive it. You may return it to Us by mail or to the agent who sold it. We'll then void this policy and refund any premium paid.

## EFFECTIVE DATE

This policy begins at 12:01 a.m. Standard Time where You live on the Issue Date shown in the Schedule. It ends, subject to the grace period, at 12:01 a.m. on the date any renewal premium is due.

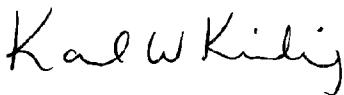
## NOTICE TO BUYER

This policy is a legal contract between You and Us. The insurance it provides may NOT cover all of the costs associated with long term care incurred by You during the period of coverage. You are, therefore, advised to **READ THIS POLICY CAREFULLY AND REVIEW ALL POLICY LIMITATIONS!**

**This policy is not a Medicare Supplement or Long-Term Care Insurance Policy.**

This policy has been signed by Our President and Secretary on its Issue Date.

Secretary



President



Countersigned by \_\_\_\_\_  
Licensed Resident Agent

**LIMITED BENEFIT CONVALESCENT CARE POLICY**  
**Facility Care and Home and Community-Based Care Benefits**

## POLICY GUIDE

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## SCHEDULE

NAME OF INSURED	[JOHN J. DOE]	[999,999,999]	POLICY NUMBER
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NAME OF INSURED SPOUSE [JANE DOE]

FIRST PREMIUM	\$(X,XXX.XX)	JANUARY 1, 2005	[ISSUE DATE]
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FIRST RENEWAL DATE [JANUARY 1, 2006] GR-N565 POLICY FORM

ELIMINATION PERIOD: [30] Days of Services Received  
(Does Not Apply to Hospice Care)

MAXIMUM BENEFIT FOR ANY ONE PERIOD OF EXPENSE:	\$[27,000.00]
Based upon a Maximum Benefit Multiplier Of [270]	

LIFETIME MAXIMUM BENEFIT: \$[54,000.00]

**BENEFITS:**

Nursing Home Care: Expenses incurred per day up to the Maximum Daily Benefit	\$[100.00]
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Assisted Living Facility: Expense incurred per day up to the Maximum Daily Benefit of	\$[100.00]
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Home and Community-Based Care: Expenses incurred per month up to the Maximum Monthly Benefit	\$[3,100.00]
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OPTIONAL BENEFITS:

[Compound Increases Option -- [5%]	Covered]
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INSURED PREMIUM:

SEX	BIRTHDATE	AGE	PLAN NO.	OPTIONAL BENEFITS	ANNUAL PREMIUM	TOTAL PREMIUM
[Male]	[11/01/50]	[54]	N565		\$(X,XXX.XX)	\$(X,XXX.XX)

[SCHEDULE CONTINUED IN NEXT PAGE .....]

## SCHEDULE

NAME OF INSURED	[JOHN J. DOE]	[999,999,999]	POLICY NUMBER			
NAME OF INSURED SPOUSE	[JANE DOE]					
FIRST PREMIUM	[\$X,XXX.XX]	JANUARY 1, 2005	[ISSUE DATE]			
FIRST RENEWAL DATE	[JANUARY 1, 2006]	GR-N565	POLICY FORM			
ELIMINATION PERIOD: (Does Not Apply to Hospice Care)		[30] Days of Services Received				
MAXIMUM BENEFIT FOR ANY ONE PERIOD OF EXPENSE: Based upon a Maximum Benefit Multiplier Of [270]			\$[27,000.00]			
LIFETIME MAXIMUM BENEFIT:			\$[54,000.00]			
BENEFITS:						
Nursing Home Care: Expenses incurred per day up to the Maximum Daily Benefit			\$[100.00]			
Assisted Living Facility: Expense incurred per day up to the Maximum Daily Benefit of			\$[100.00]			
Home and Community-Based Care: Expenses incurred per month up to the Maximum Monthly Benefit			\$[3,100.00]			
OPTIONAL BENEFITS: [Compound Increases Option -- [5%]						
			Covered]			
INSURED PREMIUM:						
SEX	BIRTHDATE	AGE	PLAN NO.	OPTIONAL BENEFITS	ANNUAL PREMIUM	TOTAL PREMIUM
[Female]	[10/15/51]	[50]	N565		[\$X,XXX.XX]	[\$X,XXX.XX]
TOTAL POLICY ANNUAL PREMIUM						\$[X,XXX.XX]

## CONSIDERATION

We issued this policy in consideration of the application (a copy is attached) and payment of the First Premium. This payment will keep the policy in force until the First Renewal Date. The First Premium and First Renewal Date are shown on the Schedule.

## RENEWAL PREMIUM

We may change the premium rates for this policy only if We change it for all policies like Yours in Your state on a class basis. We'll provide You with written notice of any change in the premium within the time required by Your state.

A change may also be due to addition or removal of any premium discount as provided in any attached rider.

## FAMILY MEMBER ADDITIONS

Your spouse is the only person You may add to this policy. To add Your spouse, send Us a completed application showing his or her eligibility and the needed premium. We'll add Your spouse if We approve the written application and the premium has been paid.

If You die, Your spouse, if covered under this policy, will become the Insured.

## GENERAL DEFINITIONS

*Note: Additional definitions are found in specific benefit provisions.*

**"Calendar Year"** is the period beginning on the Issue Date and ending December 31 of that year. Then it's the period from January 1 through December 31 of each following year.

**"Covered Expenses"** are defined and limited below in the provisions titled FACILITY CARE and HOME AND COMMUNITY BASED CARE, COVERED EXPENSES. Covered Expenses do not include charges for personal, comfort or convenience items such as television, radio or telephone.

**"Home"** means the Covered Person's primary place of residence. Home does not mean a Nursing Home, Assisted Living Facility, Hospital or other institutional setting.

**"Hospital"** means a place defined, and approved for payment, as a Hospital by Medicare, or accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations, the American Osteopathic Association or the Commission on the Accreditation of Rehabilitation Facilities.

"Hospital" doesn't mean a convalescent, nursing, rest or skilled nursing facility, nor a place that primarily treats the aged, drug addiction or alcoholism, including units in a hospital used for such care.

**"Immediate Family"** means You, Your spouse, and the children, brothers, sisters, parents, grandparents and grandchildren of either You or Your spouse.

**"Licensed Health Care Practitioner"** means any licensed Physician, registered professional nurse or licensed social worker. It doesn't include a member of the Immediate Family.

**"Medicaid"** means the "Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as Then Constituted or Later Amended."

## GENERAL DEFINITIONS (Continued)

**"Medicare"** means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended."

**"Mental Illness "** means a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind. It doesn't mean a demonstrable organic brain disease, such a Parkinson's Disease, Alzheimer's Disease or senile dementia.

**"Physician"** means any licensed practitioner of the healing arts acting within the scope of his or her license in treating any injury or sickness. It doesn't include a member of the Immediate Family.

**"Plan of Care"** means a written individualized program of care developed, supervised and approved in writing by a Licensed Health Care Practitioner. We may require a copy of the initial Plan of Care and any changes later made to it.

**"Week"** means a period of seven (7) days beginning on Sunday and ending on the following Saturday.

## BENEFIT PROVISIONS

*Important defined terms used within the following Benefit Provisions are shown in bold print and with quotation marks.*

### ELIGIBILITY FOR THE PAYMENT OF BENEFITS

Before benefits will be paid for a Family Member's Covered Expenses:

1. a Licensed Health Care Practitioner must certify that such expenses are needed because a Family Member:
  - (a) has a Functional Incapacity; or
  - (b) is Cognitively Impaired; AND
2. the Elimination Period, if any, must be satisfied.

We may periodically review the necessity of care and treatment. Our review may include: (1) diagnosis, symptoms, complaints, and complications of a condition; (2) the reason for the services being rendered; (3) a Licensed Health Care Practitioner's orders; (4) schedule of treatment; (5) the patient's physical limitations and impairments; and (6) the objectives of the Licensed Health Care Practitioner's Plan of Care.

**"Cognitive Impairment"** means there is a deterioration or loss in intellectual capacity which requires Substantial Supervision to protect one's self from threats to health and safety. Cognitive Impairment is measured by clinical evidence or standardized tests which reliably measure impairment in one's:

1. short or long term memory;
2. orientation as to people, place, and time; and
3. deductive or abstract reasoning.

Such loss of intellectual capacity can result from the following covered conditions: Alzheimer's disease, Parkinson's disease, senile dementia or other nervous or mental disorders.

## **BENEFIT PROVISIONS (Continued)**

**"Elimination Period"** means the number of days a Family Member must receive covered Facility Care or Home and Community Based Care services before benefits are payable. The Elimination Period has to be satisfied for Any One Period of Expense for each Family Member under this policy. It does not apply to Hospice Care. It restores when benefits are restored. The Elimination Period is shown in the Schedule.

**"Functional Incapacity"** means the inability to perform two (2) or more of the Activities of Daily Living defined below without the Hands-on Assistance or Standby Assistance of another person. "Activities of Daily Living" are:

**"Bathing"** - washing oneself by sponge bath; or in either a tub or shower, including getting into or out of the tub or shower.

**"Continence"** - maintaining 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 a 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 table, a plate, cup or other receptacle 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"** - moving into or out of a bed, chair or wheelchair.

**"Hands-on Assistance"** means physical assistance without which the individual would be unable to perform an Activity of Daily Living.

**"Standby Assistance"** means another person must be within arm's reach of an individual to prevent, by physical intervention if necessary, injury while performing an activity of daily living.

**"Substantial Supervision"** means continual supervision (which may include cuing by verbal prompting, gestures or other demonstrations) by another person that is necessary to protect a Cognitively Impaired person from threats to his or her own health or safety.

## BENEFIT PROVISIONS (Continued)

### **BENEFIT PAYMENTS**

Subject to the Eligibility For The Payment of Benefits and Conditions On Eligibility For Benefits provisions, We'll pay for the charges incurred, up to: (a) the Maximum Daily Benefit amount, per day, for the total of all Facility Care Covered Expenses; and (b) the Maximum Monthly Benefit amount for the total of all Home and Community Based Care Covered Expenses.

An expense is incurred on the date the service or treatment is given or the supply is bought. To be covered, the expense must be incurred while this policy is in force for the Family Member.

**"Maximum Daily Benefit"** means the maximum amount We'll pay per day for each Family Member, after any applicable Elimination Period for Facility Care. The Maximum Daily Benefit is shown in the Schedule.

**"Maximum Monthly Benefit"** means the maximum amount We'll pay per calendar month for each Family Member, after any applicable Elimination Period for Home and Community Based Care. The Maximum Monthly Benefit is shown in the Schedule.

### **CONDITIONS ON ELIGIBILITY FOR BENEFITS**

We won't pay more per day than the Maximum Daily Benefit amount shown in the Schedule for the total of all Facility Care Covered Expenses. We won't pay more per calendar month than the Maximum Monthly Benefit amount shown in the Schedule for the total of all Home and Community Based Care Covered Expenses.

We won't pay more than the Maximum Benefit for Any One Period of Expense for the total of all Covered Expenses. If both Facility Care and Home and Community Based Care expenses are incurred on the same day, only the earliest type of incurred expense for that day will be covered. We won't pay more than the Lifetime Maximum Benefit over the lifetime of the policy.

**"Any One Period of Expense"** begins when a Family Member first incurs a charge for Covered Services under this policy. It ends on the earlier of: (a) the date the Family Member has, for 180 consecutive days, not received or required Covered Services for the same cause or causes for which the previous Period of Expense began; (b) the date the Maximum Benefit has been exhausted; OR (c) the date the Lifetime Maximum Benefit has been exhausted.

**"Lifetime Maximum Benefit "** means the maximum amount of benefits We'll pay a Family Member for all Covered Expenses for all Period of Expenses. This amount is equal to two times the Maximum Benefit Amount for Any One Period of Expense.

**"Maximum Benefit"** means the maximum amount We'll pay a Family Member for the combined total of all Covered Expenses during Any One Period of Expense. This amount is equal to the Maximum Daily Benefit amount times the Maximum Benefit Multiplier. The Maximum Benefit is shown in the Schedule.

**"Maximum Benefit Multiplier"** is the number used to multiply the Maximum Daily Benefit by in order to equal the Maximum Benefit amount payable for Any One Period of Expense. The Maximum Benefit Multiplier is shown in the Schedule.



## BENEFIT PROVISIONS (Continued)

### COVERED EXPENSES:

#### **I. FACILITY CARE COVERED EXPENSES**

##### **A. FACILITY CARE:**

The charges incurred for care (including room, board, services and supplies) provided while confined in a Nursing Home or Assisted Living Facility.

**"Nursing Home"** means a place which:

1. is licensed as a Nursing Home to provide nursing care (skilled or intermediate) for persons at their own expense;
2. has services performed by or under the continual, direct and immediate supervision of a registered nurse, licensed practical nurse or licensed vocational nurse, on-site twenty-four (24) hours per day;
3. has beds for patients who need care; and
4. has a doctor available to furnish emergency service.

Nursing Home also means a wing, area or floor of a Hospital specifically set aside for nursing care.

Nursing Home doesn't mean: a Hospital, a place that primarily treats mental illness, drug addiction or alcoholism, a home for the aged, a rest home, a place that primarily provides domiciliary, residency or retirement care, or a place owned or operated by a member of the Immediate Family.

**"Assisted Living Facility"** is a place providing care (room, board and personal care services) to persons in need of assistance because of a Functional Incapacity or Cognitive Impairment, but given at a level of care less intense than that which would be received in a Nursing Home. An Assisted Living Facility must:

1. provide 24 hour a day care and services to at least 10 inpatients in one location;
2. have a trained and ready-to-respond employee on duty at all times to provide care;
3. provide 3 meals a day and accommodate special dietary needs;
4. be licensed by the appropriate licensing agency (if any) to provide such care;
5. have formal arrangements for the services of a Physician or nurse to furnish emergency medical care and;
6. have appropriate methods and procedures for handling and administering drugs and biologicals.

Assisted Living Facilities may also include Alzheimer facilities or residential health care facilities.

Assisted Living Facility does not include congregate housing, individual residences or independent living units. It also does not include: a Hospital, a Nursing Home, a place that primarily treats mental illness, drug addiction or alcoholism, a home for the aged, a rest home, a place that primarily provides domiciliary, residency or retirement care, or a place owned or operated by a member of the Immediate Family.

##### **B. BED RESERVATION:**

The charges incurred to reserve the Family Member's bed while the Family Member is temporarily absent from a Nursing Home or Assisted Living Facility. The Bed Reservation benefit will be paid if:

1. We are paying benefits for Facility Care; and
2. The Nursing Home or Assisted Living Facility continues to charge the Family Member to reserve the bed.

## **BENEFIT PROVISIONS (Continued)**

We'll pay up to the Maximum Daily Benefit, not to exceed 21 days each Calendar Year. Any unused days cannot be carried forward into the next year.

### **II. HOME AND COMMUNITY-BASED CARE COVERED EXPENSES**

#### **A. HOME HEALTH CARE:**

The charges incurred for the following services and supplies provided by a Home Health Care Agency or a Qualified Home Health Care Provider under a Plan of Care:

1. Visits by: licensed nurse; licensed nutritional specialist; medical social worker; Home Health Aide; legally qualified physical, occupational, speech or inhalation therapist;
2. Prescription drugs, medicines, medical supplies and laboratory services which are of a type customarily provided in a Hospital or Nursing Home;
3. Rental (not to exceed purchase price) of a wheelchair, hospital bed or other durable portable equipment used for therapeutic treatment;
4. Personal Care Services; and
5. Homemaker Services Incidental to Personal Care Services.

**"Home Health Aide"** means a licensed or certified home health care worker, other than a Physician, nurse or professional therapist, who performs Personal Care Services.

**"Home Health Care Agency"** means an agency or organization that:

1. Specializes in giving nursing care or therapeutic services in the Home;
2. Is licensed to provide such care or services by the appropriate licensing agency where performed or is certified as a Home Health Care Agency under Title XVIII of the Social Security Act of 1965, as amended;
3. Is operating within the scope of its license or certification; and
4. Maintains a complete medical record and Plan of Care for each patient.

**"Homemaker Services Incidental to Personal Care Services"** means only the following services when received in conjunction with Personal Care Services:

1. domestic or cleaning services;
2. laundry services;
3. food shopping and errands;
4. meal preparation and cleanup;
5. transportation assistance to and from medical appointments;
6. heavy cleaning which involves thorough cleaning of the Home to remove hazardous debris or dirt; and
7. meals from formal Home delivered meals programs.

**"Personal Care Services"** means assistance with performing Activities of Daily Living used to measure Functional Incapacity.

## BENEFIT PROVISIONS (Continued)

**"Qualified Home Health Care Provider"** means an individual or organization licensed or certified to provide home health care services. The Qualified Home Health Care Provider must be included in the Plan of Care as the provider of home health care services.

### B. HOSPICE CARE:

The charges incurred by a Terminally Ill Family Member for services and supplies given by a Hospice.

**"Terminally Ill"** means that a Physician certifies that the Family Member: (a) has no reasonable prospect of cure; (b) has a life expectancy of less than 6 months; (c) needs Hospice services for palliation or management of the terminal illness and related conditions; and (d) would have to be confined in a Hospital or Nursing Home if Hospice care services weren't available.

Benefits payable for Hospice Care are not subject to the Elimination Period nor will they count toward satisfying the Elimination Period.

**"Hospice"** means an agency meeting the regulatory requirements for a hospice in the state where the services are given. If such state has no regulatory requirements, the agency must: (a) be primarily engaged in providing pain relief, symptom management and support service to dying persons and their families; and (b) provide nursing care under the supervision of a registered nurse.

### C. ADULT DAY CARE:

The charges incurred for the following services provided at an Adult Day Care Facility:

1. Visits by a licensed nurse;
2. Occupational, physical or speech therapy;
3. Social, recreational and educational events designed to improve the patient's self-awareness and level of functioning;
4. Training and help with the regular and customary activities of adult daily living;
5. Transportation to and from the Adult Day Care Facility; and
6. Meals provided by the Adult Day Care Facility.

**"Adult Day Care Facility"** means an organization that provides a program of adult day health care and:

1. Is state licensed, if the state in which it is located licenses Adult Day Care Facilities;
2. Operates at least 5 days a week for a minimum of 6 hours a day and is not an overnight facility;
3. Maintains a written record for each client that includes a Plan of Care and a record of all services provided;
4. Has established procedures for obtaining appropriate aid in the event of a medical emergency;
5. Has formal arrangements for providing the services of: a dietician; a licensed physical therapist; a licensed speech therapist and a licensed occupational therapist;
6. Its staff includes a full-time director and one or more nurses in attendance during operating hours for at least 4 hours a day; and
7. Is not owned or operated by a member of the Immediate Family.

## **BENEFIT PROVISIONS (Continued)**

### **OPTIONAL BENEFIT INCREASE**

If the following option applies, it will be shown on the Schedule.

#### **ANNUAL COMPOUND INCREASES BENEFIT OPTION**

If this option is shown as "COVERED" in the Schedule and the policy is then in force, We will increase all policy maximum benefit amounts (Maximum Daily Benefit, Maximum Monthly Benefit, the Maximum Benefit for Any One Period of Expense, and the Lifetime Maximum Benefit) on each policy anniversary by the percentage shown in the Schedule. We'll apply the policy's percentage increase to the then current amounts for each maximum benefit amount shown in the Schedule. Annual benefit increases will be made without regard to claims.

If the resulting benefit amount is not a multiple of \$0.25, We will round the amount to the next highest multiple of \$0.25.

During Any One Period of Expense, We'll pay any increased benefit amount that becomes effective as of the next policy anniversary.

### **PATIENT CARE COORDINATION**

A Patient Care Coordination program is available at no extra cost to You. Under this program, We can assign a Patient Care Coordinator who is a specialist pre-approved by Us. This Coordinator is qualified by license, training or experience to help the Family Member select providers of care and services best suited for the type of care or treatment needed.

The Family Member, a member of the Immediate Family or a Licensed Health Care Practitioner can contact Us at or before the time a Family Member begins to incur Covered Expenses under this policy, even before an Elimination Period has been met. We will then direct you to a Patient Care Coordinator.

### **EXCLUSIONS**

We won't pay for expenses incurred:

1. Due to war or act of war;
2. To the extent they are paid under Medicare or any other government insurance plan (except Medicaid);
3. For services or supplies provided by a member of the Immediate Family or a person who ordinarily lives in Your Home;
4. Due to Mental Illness or nervous disorders without demonstrable organic disease; (Loss due to Parkinson's Disease, Alzheimer's Disease or senile dementia is covered.)
5. For services and supplies not included in the Plan of Care;
6. For which no charge is customarily made in the absence of insurance.

## **BENEFIT PROVISIONS (Continued)**

### **EXTENSION OF POLICY BENEFITS**

Termination of this policy will not affect any claim for loss that begins while this policy is in force and continues beyond the date of termination. Benefits payable under the Extension of Policy Benefits provision are limited to this policy's Maximum Benefit for Any One Period of Expense. Also, benefits payable under this provision will never exceed the Lifetime Maximum Benefit.

### **RESTORATION OF POLICY BENEFITS**

This policy's Maximum Benefit for Any One Period of Expense will be restored when a Family Member no longer requires or receives treatment or services for 180 consecutive days for the same cause or causes for which a previous Period of Expense began. If this policy includes the Annual Benefit Increase Option, the amount restored will be inclusive of any accumulated benefit increases as of the policy's last anniversary. The Lifetime Maximum Benefit does not restore.

## **BENEFIT AND PREMIUM CHANGE**

The risk We assumed on this policy's Issue Date is based on the laws and regulations governing the system for the delivery and financing of health insurance then in effect. It's possible that the federal government or state legislation may change the system and therefore change the nature of the risk We assumed. If this occurs, We'll make any necessary change to policy benefits. We'll make such a change by adding: (a) an amendment to the policy; (b) a new schedule page; or (c), both (a) and (b).

Before making any such change, We'll get the necessary approval from the agency in Your state that regulates insurance. We'll tell You if such coverage change needs a premium change. Until the effective date of any coverage change, benefits will be based upon the risk We assumed on this policy's Issue Date.

Any premium change may be made only after We give You the appropriate advance notice required by Your state.

In the event We increase premium, We will offer You the following options, as they apply to this policy, at least 30 days before a premium increase becomes effective:

1. Pay the increased premium and continue the policy in force as is; or
2. Reduce the policy's benefits to a level such that Your premium will not increase (subject to state law minimum standards).

## UNIFORM PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This policy with any attached papers is the entire contract between You and Us. No change in this policy will be effective until approved by one of Our officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions. The application is a part of this policy.

**TIME LIMIT ON CERTAIN DEFENSES:** a) After 2 years from the effective date of coverage, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred which starts after the 2 year period; (b) No claim for loss incurred which starts after 2 years from the effective date of coverage will be reduced or denied because a sickness or physical condition, not excluded by name or specific description before the date of loss, had existed before the effective date of coverage.

**GRACE PERIOD:** This policy has a 31 day grace period. This means that if a premium isn't paid on or before the date it's due, it may be paid during the following 31 days. During the grace period this policy will stay in force.

We won't end the policy for nonpayment of premium unless We have sent written notice to You and, if applicable, Your Authorized Designee (the person You designate to receive such notice) at least 30 days before the policy will end. Notice will not be given until 30 days after a premium is due and unpaid. You may change Your Authorized Designee at any time by sending Us written notice. We will notify You of Your right to change Your Authorized Designee no less often than once every two years.

**REINSTATEMENT:** If the premium isn't paid before the grace period ends, this policy will lapse. Later acceptance of premium by Us (or by any agent authorized to accept payment) without requiring an application for reinstatement, will reinstate this policy.

If We or Our agent require an application You'll get a conditional receipt for the premium. If the application is approved, this policy will be reinstated as of the approval date. Lacking such approval, this policy will be reinstated on the 45th day after the date of the conditional receipt unless We previously notified You in writing of Our disapproval.

The reinstated policy will cover only losses due to conditions that begin after the date of reinstatement. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

## UNIFORM PROVISION (Continued)

**NOTICE OF CLAIM:** Written notice of claim must be given within 60 days after a covered loss starts or as soon as possible. The notice can be given to Us at the address shown on page 1 of this policy or to any one of Our agents. Notice should include Your name and the policy number.

**CLAIM FORMS:** When We get notice of claim, We'll send You forms for filing proof of loss. If these forms aren't given to You within 15 days, You'll meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss. We must get this statement within the time limit stated in the Proof of Loss section.

**PROOF OF LOSS:** For periodic payment of a continuing loss, You must give Us written proof of loss within 90 days after the end of each period for which We are liable. For any other loss, You must give Us written proof within 90 days after the end of such loss.

If it wasn't reasonably possible for You to give Us proof in the time required, We won't reduce nor deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than one year from the time specified unless You were legally unable to act.

**TIME OF PAYMENT OF CLAIMS:** Benefits payable under this policy will be paid as soon as We receive proper written proof of loss.

**PAYMENT OF CLAIMS:** Benefits will be paid to You. Any benefits due and unpaid at Your death may be paid to Your estate.

If benefits are payable to Your estate, We can pay up to \$1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We'll be discharged to the extent of any such payment made in good faith.

**INFORMATION ON DENIAL OF CLAIM:** In the event We deny benefits under this policy, a Family Member has the right to: (a) receive a written explanation of the reason(s) a claim was denied; and (b) all information directly relating to the claim denial. Write to Our Claim Review Department, 222 Merchandise Mart Plaza, Chicago, Illinois 60654-2001. We will respond within 60 days after receiving Your request.

**PHYSICAL EXAMINATION:** We, at Our expense, have the right to have a Family Member examined as often as reasonably necessary while a claim is pending.

**LEGAL ACTION:** No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after 3 years from the time written proof of loss is required to be given.

**CONFORMITY WITH STATE STATUTES:** Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which You live on that date is amended to conform to the minimum requirements of such laws. This insurance contract and claims arising under it are governed by the laws of the state where this contract has been delivered to the insured, exclusive of such state's choice of laws provisions.

**LIMITED BENEFIT CONVALESCENT CARE POLICY**

**Facility Care and Home and Community Based Care Benefits**