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

Comprehensive Long Term Care Insurance Outline of Coverage

from Genworth Life Insurance Company

Policy form series [7052 CA REV, 7052-1 CA REV]

This Policy is an approved long term care insurance policy under California law and regulations. However, the benefits payable by this policy will not qualify for Medi-Cal asset protection under the California Partnership for Long Term Care.

For information about policies and certificates qualifying under the California Partnership for Long Term Care, call the Health Insurance Counseling and Advocacy Program at the toll-free number, 1-800-434-0222.

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 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 this address: the Administrative Office 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 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.

The Policy reimburses You for covered long term care expenses You incur. It is subject to an Elimination Period, limitations, exclusions, and other provisions and conditions of the Policy.

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 offered to assist in identifying care needs and community resources available to deliver care while You are Chronically Ill. When You choose to use these services they will be furnished by a Privileged Care Coordination team 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 Care;
- Nurse and Therapist Services;
- Home Health Care or Personal Care Services and Homemaker Services from formal and informal providers. These providers may be nurse's aides, home health aides, and other persons who provide care which is consistent with the needs addressed in Your Plan of Care. They can be independent; and do not need to be associated with an agency or provider organization.
- Non-Institutional Hospice Care (as part of a separate Hospice Care Benefit).

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 of full Nursing Facility Benefits.

The *Hospice Care Benefit* covers services designed to provide palliative care and alleviate Your discomforts when You are both Chronically Ill and Terminally Ill. Benefits are payable up to: the Nursing Facility Maximum for care received in a covered facility; and the limit for the Home and Community Care Benefit when care is received while You are living at home.

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 *International Coverage 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.

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) Eligibility For The Payment Of Benefits: For You to be eligible for the payment of Benefits under the Policy:

- You must be Chronically Ill;
- We must receive a Current Eligibility Certification for You; and
- We must receive ongoing proof which verifies that the Covered Care You receive is needed due to You continually being Chronically Ill.

Conditions: Benefits will only be paid as reimbursement for Covered 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 prescribed by a Licensed Health Care Practitioner.
- 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 being 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); continence (control of bowel and bladder functions); dressing (putting on and taking off clothes and assistive devices); eating (taking nourishment); toileting (including performing associated personal hygiene tasks); and transferring (moving in and out of a bed, chair or wheelchair).

Chronically Ill or *Chronically Ill Individual* refers to a person who has been certified by a Licensed Health Care Practitioner who is Independent of Us, as:

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

Severe Cognitive Impairment is a loss or deterioration in intellectual capacity that: is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and is measured by clinical evidence and standardized tests that reliably measure impairment in the person's: short-term or long term memory; orientation as to people, places or time; deductive or abstract reasoning; and judgment as it relates to safety awareness.

Substantial Assistance is either:

- *Hands-on Assistance* which is the physical assistance (minimal, moderate or maximal) of another person without which You would be unable to perform the Activity of Daily Living; or
- *Standby Assistance* which is the presence of another person within arm's reach of You that is necessary to prevent, by physical intervention, injury to Yourself while You are performing the Activity of Daily Living.

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

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.

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

Elimination Period means the length of time, as determined in the Schedule, before You are eligible for Benefits under the Policy. The Schedule describes how the Elimination Period is satisfied and whether it is based on calendar days or days on which You receive Covered Care. Days used to satisfy the Elimination Period do not need to be consecutive; and can be accumulated over time. Once satisfied, You will never have to satisfy a new Elimination Period for Your Coverage.

Nursing Facility Maximum means the maximum amount We will pay for Confinement in a Nursing Facility. This may be a daily maximum or a monthly maximum. This amount is also used to determine other Benefit maximums.

Qualified Long Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services and maintenance or personal care services which: (1) are required by a Chronically Ill Individual; and (2) are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

OTHER FEATURES AND OPTIONS

(Options 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 and Community 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 to You;
- 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 Covered Expenses that are in excess of the amount paid or payable under:
- Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount); and
- Any other Federal, state or other government health or long term care program, , or law except Medicaid.

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

Coordination with Other Coverage: We will reduce the amount of Benefits We will pay for Covered Care when the total amount payable under this and all Other Long Term Care coverage is greater than the actual expense You incur for that Covered Care.

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

8. RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the costs of long term care services will likely increase over time, You should consider whether and how the Benefits of the Policy may be adjusted. Benefit levels will not increase over time unless the plan You purchase provides Benefit Increases. Unless otherwise described, these increases: will be automatic; will not require proof of good health; will be made without a corresponding increase in Premium; and will continue without regard to Your age, claim status or claim history, or length of time You have been insured under the Policy.

Benefit Increases cease when: (a) the applicable maximum has been exhausted; (b) they are terminated by You; or (c) the Policy ends;.

If You do not purchase a Benefit Increases option at the time the Policy is issued, You may need to provide proof of good health to later increase coverage. Available increase options are described below. They are followed by a graphic comparison of the Benefit levels of coverage that increase Benefits over time with coverage that does not increase Benefits. A similar graphic comparison illustrates Premium for those coverages at a given issue age.

AVAILABLE BENEFIT INCREASE OPTIONS

5%[3%] Compound Benefit Increases: On each anniversary of the Policy Effective Date Your then current Nursing Facility Maximum and the current amounts of other dollar maximums will each increase by **[**5%**][**the selected percentage**]**.

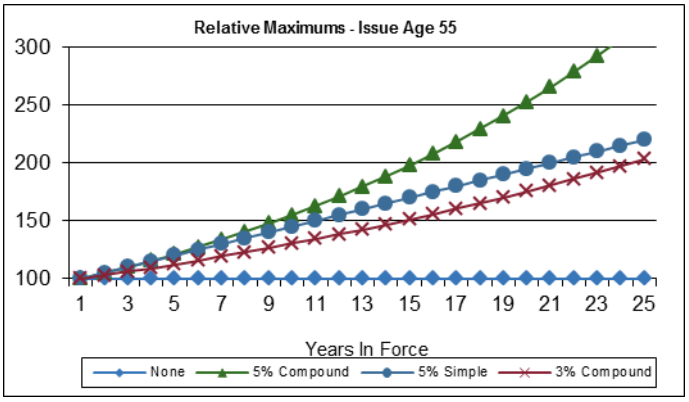
[5% Simple Benefit Increases: On each anniversary of the Policy Effective Date Your then current Nursing Facility Maximum and the current amounts of other dollar maximums will each increase by 5% of their respective amounts in effect on the Policy Effective Date. Calculation of the increased amounts is not affected by Benefit payments.**]**

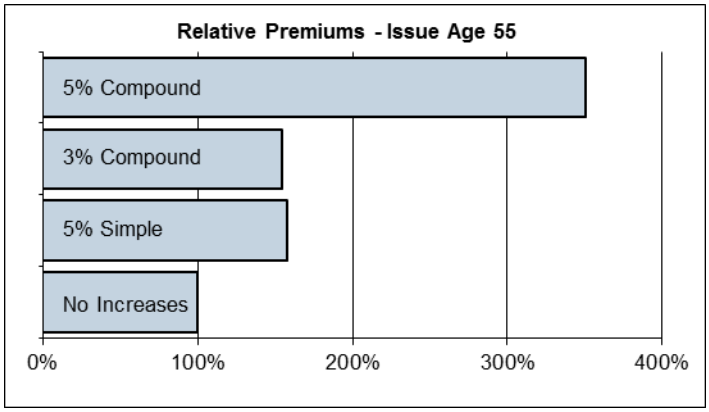
[5%][3%] Future Purchase Options: These provide a way to increase Your Benefit maximums on every 3rd anniversary of the Policy Effective Date. Increases will not be available or effective, and may be revoked or rescinded, if You are Chronically Ill or otherwise eligible for Benefits on the date the offer is accepted.

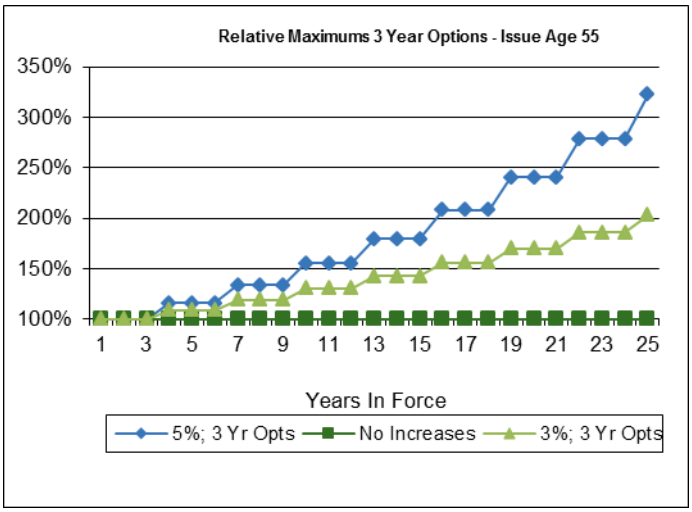
You will be given the option to purchase additional coverage equal to **[**5%**][**3%**]** compounded annually for the 3 year period (an approximate increase of **[**XX.x%**]**). The increases will apply to Your then current Nursing Facility Maximum and the current amounts of other dollar maximums. The additional Premium for an increase will be based on: (1) the amount of the increase; and (2) Your age and the Premium in effect for the Policy on the date the increase takes effect.

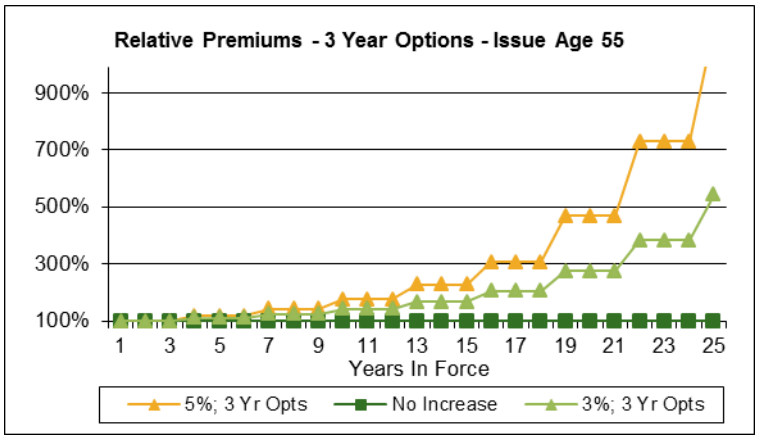
Offers and Benefit Increases cease when: (a) You have refused/declined three consecutive options to increase Benefit maximums; (b) the applicable maximum has been exhausted; (c) they are terminated by You; or (d) the Policy ends; or (e) the Policy is continued under any Nonforfeiture Benefit, if applicable. **]**

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 PREMIUM: 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 on a class basis; but only if We change Premium for all similar policies issued in California on the same form as the Policy. A class consists of all persons, with policies issued on the same form as this Policy, who have the same Premium and Benefits, and are subject to the same state regulations with respect to rate increases. 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:	Lifetime	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 AND REMINDERS

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.

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 following option to reduce Your future premium payments or increase future benefits.

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 **[**Calendar Month**]**	$_____	$_____
Residential Care Facility Maximum As a % of the Nursing Facility Maximum	**[O**100% **O**75%]	**[O**100% **O**75%]
Home and Community Care Maximum As a % of the Nursing Facility Maximum	**[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**]**	**[O**1Year **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 Benefits paid for Covered Expenses incurred prior to the date the applicable maximum is exhausted.	**O**5% Compound **[O**3% Compound**]** **[O**5% Simple**]** **[O**5% **O**3% Future Purchase Options**]** **[O** None**]**	**O**5% Compound **[O**3% Compound**]** **[O**5% Simple**]** **[O**5% **O**3% Future Purchase Options**]** **[O** None**]**

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)	**[**XX% of the**] [**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)	**[**XX% of the**] [**The selected % of the**]** Nursing Facility Maximum per **[**day**][**calendar month**]**
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:	As stated in the Benefit
Respite Care Benefit:	Up to 30 days per calendar year
Your Right to Request Payment For Alternate Care Benefit:	Payment subject to mutual agreement
The Waiver of Premium Benefit applies only when Benefits are payable under the: Nursing Facility Benefit; Assisted Living Facility Benefit; Bed Reservation Benefit; Home and Community Care Benefit; or Hospice Care Benefit.	

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 **[**day**][**calendar month**]** is limited to the Nursing Facility Maximum. This does not apply to the Home Assistance Benefit and Benefits paid for requested alternative care.