

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE
and
MEDAMERICA INSURANCE COMPANY OF NEW YORK
for
NYPERL LONG-TERM CARE INSURANCE ADMINISTRATIVE SERVICES
AGREEMENT NO. C000773

THIS NYPERL Long-Term Care Administrative Services Agreement (“Agreement” or “Contract”) is entered into by and between the NEW YORK STATE DEPARTMENT OF CIVIL SERVICE (“DCS” or “Department” or “State”), having its principal office at Empire State Plaza, Albany, NY, 12239, and MEDAMERICA INSURANCE COMPANY OF NEW YORK (“MedAmerica” or “Insurer” or “Contractor”) with a principal place of business located at 165 Court Street, Rochester, New York 14647, referred to collectively as “the Parties.”

WHEREAS, pursuant to New York State Civil Service Law Article XI-A, the Department is required to purchase a contract or contracts to provide long term care benefits under the long-term care insurance plan established in accordance with the provisions of Civil Service Law Article XI-A ; and

WHEREAS, DCS and MedAmerica were parties to that certain Agreement #C000488 (as amended from time to time, the “Prior Agreement”) concerning the long-term care insurance plan established pursuant to Section 172 of the Civil Service Law and commonly known as the New York Public Employee and Retiree Long Term Care Insurance Plan (“NYPERL”); and

WHEREAS, the Prior Agreement concluded when its term ended on or about April 30, 2016; and

WHEREAS, after expiration of the Prior Agreement, MedAmerica ceased offering new certificates of long-term care insurance under NYPERL, but continued to maintain coverage of existing certificate holders as required under New York State law; and

WHEREAS, on or about April 30, 2018, MedAmerica filed in the New York State Court of Claims and served upon the Attorney General of the State of New York a claim against DCS captioned *MedAmerica Insurance Company of New York v State of New York* (Claim No. 131373, the “Claim”); and

WHEREAS, the Parties desire to enter into this Agreement to resolve the Claim and, in accord with Civil Service Law Article XI-A, to ensure the orderly administration by MedAmerica of NYPERL for existing certificate holders of both the Partnership and Non-Partnership Plans, for the remainder of their policy terms; and

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein, the Parties, intending to be legally bound, hereby agree as follows:

ARTICLE I: SCOPE OF AGREEMENT AND ENGAGEMENT

In accordance with the terms of this Agreement, MedAmerica is hereby engaged to and shall provide administrative services in accordance with this Agreement and New York State Law, including, without limitation, the administrative services specified in Article X, required to administer the individual certificates of NYPERL long-term care insurance identified herein, together with any riders or endorsements thereto; hereinafter referred to as the “certificates.”

ARTICLE II: CONSIDERATION

In consideration of the Parties’ settlement of the Claim and MedAmerica’s obligations thereunder, including, without limitation, (a) MedAmerica’s execution, service, and filing of its Stipulation Discontinuing the Claim, on the merits and with prejudice; (b) MedAmerica’s furnishing to the Attorney General a General Release releasing the State of New York, its officers and employees from all claims, causes of action, demands, duties, and liabilities of every kind and nature, legal or equitable, that may have existed, currently exist, or may ever exist related to, arising out of, or in connection with the Prior Agreement; and (c) MedAmerica’s performance of the services specified herein and in Article X, below, the Department shall pay MedAmerica in accordance with the amounts set forth in Article XI, below.

ARTICLE III: INTEGRATION

- 3.1.0 Entire Agreement. This Agreement, including all Exhibits, copies of which are attached hereto, and incorporated by reference, constitutes the entire Agreement between the Parties. All prior agreements, representations, statements, and negotiations and undertakings are superseded hereby.
- 3.2.0 No Warranties by the Department. All statements made by the DCS shall be deemed to be representations and not warranties.

ARTICLE IV: AGREEMENT DURATION AND AMENDMENTS

- 4.1.0 Term. The Agreement will take effect upon approval of the Agreement by the New York State Office of the State Comptroller (OSC) (Effective Date). This Agreement is for the period starting January 1, 2026, through and including December 31, 2030, subject to the approval of the New York State Attorney General’s Office (“OAG”) and OSC.

Thereafter, the Parties agree to extend the term of the Contract, upon written amendment of the Contract on the same terms and conditions, subject to any statutory or regulatory

changes and/or Appendix A, Standard Clauses for New York State Contracts revisions, and subject to approval of the OAG and OSC, for up to an additional ten (10) terms of five (5) years each, unless the Agreement is terminated pursuant to the terms herein or, prior to the end of the additional term, if no certificates remain in force.

- 4.2.0 Partial Invalidity. Each Party agrees that it shall perform its obligations under the Agreement in accordance with all applicable laws, rules, and regulations now or hereinafter in effect. If any term or provision of the Agreement shall be found to be illegal or unenforceable, then, notwithstanding such term or provision, the Agreement shall remain in full force and effect, and such term or provision shall be deemed stricken.
- 4.3.0 Amendments. The Agreement is subject to modification(s) or amendment(s) only upon mutual consent of the Parties, reduced to writing and approved by OSC.
- 4.4.0 No Waiver. No term or provision of the Agreement shall be deemed waived and no breach excused, unless such waiver or consent shall be in writing and signed by the Party claimed to have waived or consented. No consent by a Party to, or waiver of, a breach under the Agreement shall constitute a consent to, a waiver of, or excuse of any other, different, or subsequent breach.

ARTICLE V: DOCUMENT INCORPORATION AND ORDER OF PRECEDENCE

- 5.1.0 The Agreement shall be composed solely of the following documents which, in the event of an inconsistency or conflicting terms, shall be given precedence in the order indicated:
 - 5.1.1 Appendix A (Standard Clauses for All New York State Contracts), dated June 2023, attached hereto, is hereby expressly made a part of this Contract as fully as if set forth at length herein;
 - 5.1.2 Any Amendments to the body of the Agreement;
 - 5.1.3 The body of the Agreement (that portion preceding signatures); and
 - 5.1.4 The following Attachments are incorporated by reference to the body of the Agreement:
 - a. Attachment A: the Group Policy(ies) and Certificate(s) of Insurance.
- 5.2.0 Only documents expressly enumerated above shall be deemed a part of the Agreement, and references contained in those documents to additional MedAmerica documents not enumerated above shall be of no force and effect.
- 5.3.0 All prior agreements, representations, statements, negotiations, and undertakings are superseded. All statements made by the Department shall be deemed to be representations and not warranties.

- 5.4.0 The terms, provisions, representations and warranties contained in the Agreement shall survive performance hereunder.

ARTICLE VI: NEW YORK STATE CONTRACTUAL REQUIREMENTS

- 6.1.0 Governing Law; Venue for Legal Proceedings by Insurer. The Parties agree that this Agreement shall be interpreted according to the laws of the State of New York. The Insurer shall be required to bring any legal proceeding against the DCS arising from this Agreement in New York State courts in Albany County.
- 6.2.0 Approval by State Comptroller. Section 112 of the State Finance Law requires that any contract made by a State department which exceeds fifty thousand (\$50,000) dollars in amount be first approved by the Comptroller of the State of New York before becoming effective. The Parties recognize that the Agreement is wholly executory until and unless approved by the Comptroller of the State of New York.
- 6.3.0 Standard Clauses for All New York State Contracts. The Insurer acknowledges that it is bound by the terms of Appendix A, Standard Clauses for All New York State Contracts, which is attached and incorporated by reference to the Agreement. In the event of any inconsistency in, or conflict among, Appendix A and the remainder of this Agreement, such inconsistency or conflict shall be resolved by giving precedence to Appendix A.
- 6.4.0 Headings or Captions. The headings or captions contained within the Agreement are intended solely for convenience and reference purposes and shall in no way be deemed to define, limit or describe the scope or intent of the Agreement or any provisions thereof.
- 6.5.0 Compliance with Laws. MedAmerica warrants and represents that, throughout the term of the Contract, in the performance of its obligations under the Contract, it will: (i) comply with all applicable State and Federal laws, ordinances, rules and regulations and policies of any governmental entity; (ii) pay, at its sole expense, all applicable permits, licenses, tariffs, tolls and fees; and (iii) give all notices required by any laws, ordinances, rules, and regulations of any governmental entity.
- 6.6.0 Notice of Substantial Change in Contractor Status. In addition to the requirements of New York State Finance Law §138 (requiring the State's approval of subcontractors and assignments and/or conveyances), the Contractor shall notify the Department of any substantial change in the ownership or financial viability of the Contractor, its Affiliates, subsidiaries or divisions, or partners, in writing immediately upon occurrence. "Substantial change" means: (i) sales, acquisitions, mergers or takeovers of the Contractor, its Affiliates, subsidiaries, divisions, or partners that result in a change in the controlling ownership or assets of such entity after the submission of the Bid or execution of Contract; (ii) entry of an order for relief under Title 11 of the United States Code; (iii) the making of a general assignment for the benefit of creditors; (iv) the appointment of a

receiver of Contractor's business or property or that of its Affiliates, subsidiaries or divisions, or partners; or action by Contractor, its Affiliates, subsidiaries or divisions, or partners under any State insolvency or similar law for the purposes of its bankruptcy, reorganization, or liquidation; or (v) court ordered liquidation of Contractor, its Affiliates, subsidiaries or divisions, or partners.

Upon the Department's receipt of such notice, the Department shall have thirty (30) business days from the date of notice to review the information. The Contractor may not transfer the Contract to or among Affiliates, subsidiaries or divisions, or partners, or to any other person or entity, without the express written consent of the Department. In addition to any other remedies available at law or equity, the Department shall have the right to terminate the Contract, in whole or in part, for cause, if it finds, in its sole judgment, that such substantial change adversely affects the delivery of Services or is otherwise not in the best interests of the State.

- 6.7.0 Notice of Circumstances Expected to Adversely Affect Contractor's Performance. The Contractor shall immediately notify Department upon learning of any situation that can reasonably be expected to adversely affect the delivery of services under the Contract. If such notification is oral, the Contractor shall follow such initial oral notice with a written notice to Department within three (3) calendar days of Contractor's becoming aware of the situation. The written notification shall include a description of the situation and a recommendation of a resolution.
- 6.8.0 No Third-Party Beneficiaries. Nothing contained in the Contract, expressed or implied, is intended to confer upon any person or corporation, other than the Parties hereto and their successors in interest and assigns, any rights or remedies under or by reason of the Contract.
- 6.9.0 Work Outside of Scope of the Contract. The Contractor must not perform work outside the scope of the Contract unless such work is authorized by a properly executed written amendment to the Contract, and if applicable, approved by the Office of the State Comptroller. Work not so authorized shall not be compensated.
- 6.10.0 Liability for Taxes.
- 6.10.1 The Department represents that the purchases on behalf of the State of New York are not subject to any state or local sales or use taxes, or to federal excise taxes.
- 6.10.2 Contractor remains liable and solely responsible without exemption from social security, unemployment insurance, workers' compensation and other taxes and obligations to which Contractor may be subject to by law.

6.11.0 Dispute Resolution. Unless otherwise agreed to in writing by the Parties, any dispute raised by the Contractor concerning any question of fact or law arising under the Contract which is not disposed of by mutual agreement of the Parties shall be decided initially by the designee of the Commissioner (“Commissioner”). A copy of the written decision shall be furnished to the Contractor. The Parties shall proceed diligently with the performance of the Contract and shall comply with the provisions of such decision and continue to comply pending further resolution of any such dispute as provided herein.

The decision of the designee of the Commissioner shall be final and conclusive unless, within ten (10) Days from the receipt of such decision, the Contractor furnishes the Commissioner a written appeal. In the event of an appeal, the Commissioner shall promptly review the initial decision, and confirm, annul, or modify it. The decision of the Commissioner shall be final and conclusive unless, as determined by a court of competent jurisdiction, it violates one of the provisions of section 7803 of the Civil Practice Law and Rules (“Article 78”). Pending final decision of any Article 78 proceeding, the Parties shall diligently perform the Contract in accordance with the Commissioner’s decision.

6.12.0 Audit Authority. The DCS and the OSC shall have the authority to conduct financial and performance audits of the Insurer’s delivery of the Post-Closure Services, as defined below, in accordance with this Agreement and any applicable State and federal statutory and regulatory authorities during normal business hours for scheduled audits. Nothing herein precludes DCS or OSC from conducting audits, upon reasonable notice to MedAmerica outside normal business hours.

6.11.1 Such audit activity may include, but not necessarily be limited to, the following activities:

- a. Review of claim certification and adjudication procedures and systems;
- b. Review of processed claims to assess the accuracy of claims certification and adjudication, including, but not limited to, tests of the following: direct billings, non-duplication of benefits, proper coordination of benefits, payment of covered-services only, and prior application and compliance with other Agreement provisions and to corroborate amounts charged under this Agreement;
- c. Review of any and all activities relating to the Insurer’s administration of the Agreement; and
- d. Review of enrollment files to corroborate amounts charged under this Agreement. The enrollment file(s) will be securely transmitted to the Department upon request.

- 6.11.2 The Insurer shall make available documentary evidence necessary to perform such reviews. Documentation made available by the Insurer may include, but is not limited to, source documents, books of account, and supporting work papers, claim documentation and pertinent contracts and correspondence.
- 6.11.3 Documentation necessary for an understanding of accounting, claim(s) payment, billing or other systems and activities shall be made available by the Insurer. Such systems and activities shall be demonstrated to the State's auditing personnel upon request by DCS or OSC. The Insurer shall provide documentation of computerized aspects of the accounting, claim(s) payment, billing and other systems to auditing personnel with full explanation of such systems.
- 6.11.4 The Insurer shall make available to the DCS's and OSC's auditors all data in its computerized files that is relevant to and subject to the Agreement. Such data may, at the DCS's or OSC's discretion, be submitted to the DCS or OSC in machine readable format, or the data may be extracted by the DCS or OSC, or by the Insurer under the direction of the DCS's or the OSC's auditors. Subject to applicable federal and state privacy laws, confidentiality of records relating to specific certificate holders and the Insurer's operations shall be appropriately respected and maintained by the DCS and the OSC.
- 6.11.5 The Insurer shall, at the DCS's or the OSC's request, search its files, retrieve information and records and provide to the DCS's or the OSC's auditors such documentary evidence as they require.
- 6.11.6 The Insurer shall comment on the contents of any audit report prepared by the Department and transmit such comments in writing to the Department within 30 days of receiving any audit report. The response will specifically address each audit recommendation. If the Insurer agrees with the recommendation, the response will include a work plan and timetable to implement the recommendation. If the Insurer disagrees with an audit recommendation, the response will give all details and reasons for such disagreement.
- 6.11.7 All records and documentation described in this Article for review and use by the DCS' and the OSC's auditors pertain to the administration of the Agreement. The DCS's and OSC's auditors may not access such records and documentation which pertain to another agreement to which DCS is not a party.
- 6.11.8 If MedAmerica has an independent audit performed of the records relating to this Agreement, a certified copy of the audit report shall be provided to the Department within 10 days after receipt of such audit report by MedAmerica.

- 6.11. 9 The audit provisions contained herein shall in no way be construed to limit the audit authority or audit scope of the Office of the State Comptroller and the Department as set forth in Appendix A of the Contract, Standards Clauses for All New York State Contracts.
- 6.11.10 Upon request by the State, the Contractor shall cooperate with the State, including the Office of the State Comptroller, in any investigation, audit, or other inquiry related to the Agreement or any related litigation, at no cost to the State. This provision shall survive the termination of the Contract.
- 6.12.0 Legal Authority to Perform Services. The Insurer represents and warrants that it is authorized under Section 1117 of the New York State Insurance Law to issue long-term care insurance contracts in New York State. The Insurer represents and warrants that it possesses the legal authority to perform NYPERL Administrative Services in accordance with the terms and conditions of this Agreement.
- 6.13.0 Requirements for Subcontracts. MedAmerica may enter into subcontracts concerning its obligations in this Agreement. All subcontracts by MedAmerica shall be in writing and shall contain provisions which are functionally identical to, and consistent with, the provisions of this Agreement. Such functionally identical and consistent provisions shall include, but not be limited to, the following provisions of this Agreement: Appendix A – Standard Clauses for All New York State Contracts; Section 6.12, related to audit authority; and Article VII,. Any subcontract shall not relieve the Insurer in any way of any responsibility, duty, and/or obligation of the Agreement.
- 6.14.0 Compliance with Federal Law. The Insurer shall ensure that its employment practices comply with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended. The Insurer shall ensure compliance with the Americans with Disabilities Act (42 U.S.C. §2101 et seq.) such that programs and services provided during the course of performance of the Agreement shall be accessible under Title II of the Americans with Disabilities Act and as otherwise applicable under the Americans with Disabilities Act.
- 6.15.0 Independent Contractor. The Parties agree that Insurer is an independent contractor, and the Insurer, its officers, employees, agents, consultants, and/or subcontractors in the performance of the Agreement shall act in an independent capacity and not as agents, officers, or employees of the State or the DCS. Neither the Insurer nor any contractor or subcontractor shall thereby be deemed an agent, officer, or employee of the State.
- 6.16.0 Force Majeure. Neither Party to the Agreement shall be liable or deemed to be in default for any delay or failure in performance under the Agreement resulting directly from any acts of God, civil or military authority, acts of public enemy, wars, riots, civil disturbances, insurrections, accident, fire, explosions, earthquakes, floods, the elements, acts or omissions of public utilities or strikes, work stoppages, slowdowns or other labor

interruptions due to labor/management disputes involving entities other than the Parties to this Agreement, or any other causes not reasonably foreseeable or beyond the control of a Party. The Parties are required to use best efforts to eliminate or minimize the effect of such events during performance of the Agreement and to resume performance of the Agreement upon termination or cessation of such events.

6.17.0 Continuing Obligation to Remain Responsible. The Contractor shall at all times during the Contract term remain responsible. The Contractor agrees, if requested by the Commissioner or the Commissioner's designee, to present evidence of its continuing legal authority to do business in New York State, integrity, experience, ability, prior performance, and organizational and financial capacity, including the submission of an updated Vendor Responsibility Questionnaire. The Contractor is required to promptly report to the Department any material changes in the information reported in its initial Vendor Responsibility Questionnaire.

6.18.0 Suspension of Work. The Department reserves the right to suspend any or all activities under the Contract, at any time, in the best interests of the State. In the event of such suspension, the Contractor will be given a formal written notice outlining the particulars of such suspension. Examples of the reasons for such suspension include but are not limited to, a budget freeze on State spending or declaration of emergency. Upon issuance of such notice, the Contractor shall comply with the suspension order. Contractor shall be paid for services performed prior to suspension in accordance with the Contract. Such suspension will be lifted upon written notice to Contractor.

ARTICLE VII: CONFIDENTIALITY, NON-DISCLOSURE AND USE, FREEDOM OF INFORMATION LAW, COMPLIANCE WITH FEDERAL AND STATE PRIVACY, SECURITY, AND CONFIDENTIALITY LAWS, DISCLOSURE OF BREACH, AND REMEDIES

7.1.0 Confidentiality.

In order to perform under this Agreement, certain confidential information relating to certificate holders, will be disclosed to or received by MedAmerica, the confidentiality of which, and its prevention from further disclosure and unauthorized use, must be protected, subject to applicable state and federal privacy laws. Accordingly, it is hereby agreed as follows:

Except as may be required by applicable law or a court of competent jurisdiction, the MedAmerica, its officers, agents, employees, and subcontractors, if any, shall maintain strict confidence with respect to any "Confidential Information" to which the MedAmerica, its officers, agents, employees, and subcontractors, if any, have access. This requirement shall survive termination of the Contract.

For purposes of the Agreement, all data from the State of which MedAmerica, its officers, agents, employees, and subcontractors, if any, becomes aware during the Contract performance shall be deemed to be Confidential Information (whether oral, visual or written) including all claims and enrollment records relating to the Agreement and shall be used by MedAmerica solely for the purpose of carrying out its obligations under the Agreement.

Notwithstanding the foregoing, data that falls into any of the following categories shall not be considered Confidential Information:

- i. Information that is previously rightfully known to the receiving party without restriction on disclosure;
- ii. Information that becomes, from no act or failure to act on the part of the receiving party, generally known in the relevant industry or is in the public domain; and
- iii. Information that is independently developed by MedAmerica without use of Confidential Information of the State.

MedAmerica shall protect the confidentiality of Confidential Information in its possession by incorporating adequate measures in all management information and claims processing systems, including but not limited to physical controls, data segregation, and password protection.

MedAmerica agrees that all officers, agents, employees and subcontractors, if any, shall be made aware of and shall agree to the terms of this Contract and shall be bound by a confidentiality/nondisclosure agreement consistent with applicable confidentiality and privacy laws, rules and regulations or policies.

In the event that it is necessary for MedAmerica to receive Confidential Information, which Federal or State statute or regulation prohibits from disclosure, MedAmerica hereby agrees it shall not retain a copy of such Confidential Information and shall either return or destroy, in accordance with the provisions of this Contract, all such Confidential Information when the purpose that necessitated its receipt by MedAmerica has been completed.

Notwithstanding the foregoing, if the return or destruction of the Confidential Information is not feasible, MedAmerica agrees to extend the contractual protection for as long as necessary to protect the Confidential Information and to limit any further use or disclosure of that Confidential Information.

MedAmerica agrees that it shall use all appropriate safeguards to prevent any unauthorized use or unauthorized disclosure of Confidential Information, which Federal or State statute or regulation prohibits from disclosure.

MedAmerica agrees that it shall immediately report to the Department the discovery of any unauthorized use or unauthorized disclosure of such Confidential Information in accordance with the Contract notification provisions.

7.2.0 Non-disclosure.

Except as otherwise required by law or allowed in this Agreement, MedAmerica shall not disclose Confidential Information to a third party. Except where expressly prohibited by law, MedAmerica shall promptly notify the Department of any subpoena, warrant, judicial, administrative or arbitral order of an executive or administrative agency or other governmental authority of competent jurisdiction (a "Demand") that it receives and which relates to or requires production of the information or data MedAmerica is processing or storing on the State's behalf where the State is the object of the underlying subpoena, warrant, judicial, administrative or arbitral order. If MedAmerica is required to produce confidential information in response to such Demand, MedAmerica will provide the Department with the confidential information in its possession that it plans to produce in response to the Demand prior to production of such information or data. Except as otherwise required by law, MedAmerica shall provide the Department with reasonable time to assert its rights with respect to the withholding of such information from production. If the State is required to produce information or data in response to a Demand, MedAmerica will, at the State's request and unless expressly prohibited by law, produce to the State any information in its possession that may be responsive to the Demand and shall provide assistance as is reasonably required for the State to respond to the Demand in a timely manner. The Department acknowledges that MedAmerica has no responsibility to interact directly with the entity making the Demand. The Parties agree that the State's execution of this Contract, does not constitute consent to the release or production of data or information.

7.3.0 Use of Confidential Information.

MedAmerica is permitted to use Confidential Information solely for the purposes set forth in the Agreement, and for no other purpose. At no time shall the MedAmerica access, use, or disclose any Confidential Information (including personal, financial, health, or criminal history record information) for any other purpose. MedAmerica is strictly prohibited from releasing or using information for any purposes other than those purposes specifically authorized by the Department. MedAmerica agrees that access to and use of sensitive and Confidential Information is limited to authorized employees and legally designated agents, for authorized purposes only. MedAmerica agrees that Confidential Information shall not be distributed, used, repurposed, transmitted, exchanged or shared across other applications, environments, or business units of the MedAmerica or otherwise passed to other contractors, agents, subcontractors or any other interested parties, except as required to fulfill the requirements of this Agreement. This provision shall survive the termination of the Contract.

DCS agrees that MedAmerica may utilize subcontractors in performing its services under this Agreement. Accordingly, MedAmerica shall (a) direct such subcontractors to use Confidential

Information solely for the purpose described in this Article; (b) inform such subcontractors of the confidential nature of such information; (c) direct and cause such subcontractors to treat such information as confidential and in accordance with the provisions contained herein.

7.4.0 Freedom of Information Law.

Disclosure of information related to this Agreement shall be permitted consistent with New York State laws, specifically the Freedom of Information Law (“FOIL”). The Department shall take reasonable steps to protect from public disclosure any records or portions thereof relating to this Agreement that are exempt from disclosure under FOIL. MedAmerica information constituting trade secrets or critical infrastructure information for purposes of FOIL must be clearly marked and identified by MedAmerica as such. If MedAmerica intends to request an exemption from disclosure under FOIL, MedAmerica shall at the time of submission, request the exemption in writing and provide an explanation of why the information should be exempted from disclosure pursuant to Public Officers Law § 87(2) of FOIL. Acceptance of the identified information by the Department does not constitute a determination that the information is exempt from disclosure under FOIL. Determinations as to whether the materials or information may be withheld from disclosure will be made in accordance with FOIL at the time a request for such information is received by the Department.

7.5.0 Return of Confidential Information.

Upon request by the Department, or in the event this Agreement is terminated, MedAmerica shall promptly return to the Department or destroy all written and electronic material containing or reflecting Confidential Information, to the extent permissible by law. Otherwise, MedAmerica may retain one copy of all Confidential Information after termination of this Agreement. In the event that return or destruction of any material containing or reflecting any Confidential Information is infeasible, the Parties will limit the further use or disclosure of that Confidential Information to those purposes that make return or destruction infeasible and will certify in writing to the other Party that: (i) such Confidential Information will only be used or disclosed for those purposes that make return or destruction infeasible; and (ii) the Party will continue to extend the protections of this Agreement to that Confidential Information for so long as such Confidential Information remains in the Party’s possession or under its control.

7.6.0 Insurer’s Compliance with Federal and State Privacy, Security, and Confidentiality Laws.

The Insurer, its officers, employees, agents, consultants and/or any sub-contractors agree to comply, during the performance of the Agreement, with all applicable federal and State privacy, security, and confidentiality statutes, including but not limited to the NYS Department of Financial Services Cybersecurity Regulations (23 NYCRR 500); and the NYS Personal Privacy Law (New York Public Officers Law article 6-A, as amended), and its implementing regulations, policies, and requirements, for all material and information obtained by the Insurer through its

performance under the Agreement, with particular emphasis on such information relating to certificate holders.

7.7.0 Disclosure of Breach.

Notwithstanding on any other provision of this Contract or requirements of law or regulation, the Contractor shall, as provided below, provide notice to the Department as soon as possible following the Contractor's discovery or reasonable belief that there has been unauthorized disclosure or loss of sensitive Confidential Information ("Security Incident").

7.7.1 As soon as possible but no more than 72 hours of the discovery or reasonable belief of a Security Incident, the Contractor shall provide a written report to the Department detailing the circumstances of the incident, which includes at a minimum:

- i. A description of the nature of the Security Incident;
- ii. The type of Department information involved including the categories of data;
- iii. Who may have obtained the Department information;
- iv. What steps the Contractor has taken or shall take to investigate the Security Incident;
- v. What steps the Contractor has taken or shall take to mitigate any negative effect of the Security Incident; and
- vi. A point of contact for additional information.

7.7.2 Each day, or as otherwise mutually agreed to in writing by the Department and Contractor, thereafter until the Contractor's investigation is complete or otherwise directed by the Department, the Contractor shall provide the Department with a written report regarding the status of the investigation and the following additional information as it becomes available:

- i. Who is known or suspected to have gained unauthorized access to the Department's information;
- ii. Whether there is any knowledge if the Department information has been used in an unauthorized fashion or compromised;
- iii. What additional steps the Contractor has taken or shall take to investigate the Security Incident;
- iv. What steps the Contractor has taken or shall take to mitigate any negative effect of the Security Incident; and
- v. What corrective action the Contractor has taken or shall take to prevent future similar unauthorized use or disclosure.

7.7.3 Contractor shall also take immediate and necessary steps needed to restore the information security system to prevent further breaches.

7.7.4 The Contractor shall confer with the Department regarding the proper course for the investigation and risk mitigation. The Department reserves the right to conduct an independent investigation of any Security Incident, and should the Department choose to do so, the Contractor shall reasonably cooperate by making resources, personnel, and systems access available to the Department and the Department's authorized representative(s) who may include the New York State Chief Information Security Office.

7.7.5 Subject to review and approval of the Department, the Contractor shall, at its own cost, without limitation, provide notice that satisfies the requirements of applicable law or regulation to individuals whose personal, confidential, or privileged data were compromised or likely compromised as a result of the Security Incident as well as notice to any regulatory authority as required under the Contract or applicable law or regulation. If the Department, in its sole discretion, elects to send its own separate notice, then all costs associated with preparing and providing notice shall be reimbursed to the Department by the Contractor. If the Contractor does not reimburse such costs within thirty (30) calendar days of the Department's written request, the Department shall have the right to collect such costs including as a set-off against moneys due the Contractor.

7.7.6 The Department reserves the right to require the Contractor to provide commercially standard credit monitoring for any and all individuals affected by the data breach at the sole expense, without limitation, of the Contractor for a period not to exceed 12 months, which shall begin 30 days following the notice of offer from the Contractor of such credit monitoring to those affected individuals, which shall be within a reasonable time following the identification of such affected individuals. The Department reserves the right to require notice by regular or electronic mail.

7.8.0 Remedies.

Each Party acknowledges that the remedies available at law for any breach of this Article may, by their nature, be inadequate. Accordingly, without prejudicing any other remedies that may be available to it, the party whose Confidential Information is subject to breach or threatened breach may seek injunctive relief or other equitable relief to restrain a breach or threatened breach or to specifically enforce the terms of this Article, without proving that any monetary damages have been sustained.

ARTICLE VIII: INDEMNIFICATION

8.1.0 General. MedAmerica shall be fully liable for the actions of its agents, employees, partners or subcontractors and shall fully indemnify, save harmless, and, upon request of the Attorney General of the State of New York, defend the DCS, the State, its officers,

agents and employees, without limitation, from suits, actions, claims, proceedings, liabilities, losses, damages, and costs (including, without limitation, attorney fees) of every description that the DCS, the State or any officers, agents or employees of the State may suffer as a result of caused by, or arising out of the claims of any person or entity for injuries or damages caused by the negligent acts or omissions of MedAmerica, its officers, employees, agents, consultants, and/or subcontractors in connection with the NYPERL program. Furthermore, MedAmerica agrees to indemnify, save harmless, and, upon the request of the Attorney General of the State of New York, defend the DCS and the State, its officers, agents, and employees, without limitation, from suits, actions, claims, proceedings, liabilities, losses, damages, and costs (including, without limitation, attorney fees) of every description that caused by, resulting from, or arising out of, caused by, resulting from, or arising out of the acts or omissions of any and all contractors, subcontractors, consultants and any other persons, firms, or corporations furnishing or supplying work, services, materials, or supplies in connection with the performance of the Agreement and from all claims and losses accruing or resulting to any person, firm, or corporation who may be injured or damaged by the Insurer in the performance of the Agreement, and against any liability, including, but not limited to, costs and expenses, for violation of proprietary rights, copyrights, patents, or rights of privacy, arising out of the publication, translation, reproduction, delivery, performance, use, or disposition of any material, information, or data furnished under the Agreement, or based on any libelous or otherwise unlawful matter contained in such material, information or data, except as otherwise provided herein. The DCS shall give the Insurer prompt written notice of such action, claim, suit, or notice of intention to sue together with full information and all reasonable cooperation in the defense of any such action, claim, or suit. Notwithstanding the foregoing provisions of this Article, the State reserves the right to join any such claim or action, at its sole expense, if and when the State determines there is an issue involving a significant public interest.

- 8.2.0 Declination of Defense and Indemnification. If, upon receipt of a request for defense under Section 8.1, or at any time thereafter, MedAmerica is of the opinion that the allegations in such action, in whole or in part, are not covered by the defense and indemnification provisions set forth herein, MedAmerica shall immediately notify the DCS and the Office of the Attorney General of the State of New York (“OAG”), by and through the OAG Office of General Counsel, 28 Liberty St., New York, New York, in writing, and shall specify to what extent MedAmerica believes it is and is not obligated to defend and indemnify under the terms and conditions of this Agreement. MedAmerica shall, in such event, to the extent reasonably practicable, protect the interests of the State of New York to appear and defend its interest in cooperation with the Insurer, as is appropriate, including any jurisdictional defenses which the State shall have.

- 8.3.0 No Defense or Indemnification by the State: The State will not defend or hold MedAmerica, its officers, employees, agents or subcontractors harmless from or indemnify them from any suits, actions, claims, proceedings, liabilities, losses, damages, and costs (including, without limitation, attorney fees) of every description arising out of, resulting from, or allegedly attributable to the negligence of the State or of its officers or employees.

ARTICLE IX: NOTICES

- 9.1.0 Transmission. All notices permitted or required hereunder shall be in writing and shall be transmitted either: a. via certified or registered United States mail, return receipt requested; b. by personal delivery; c. by expedited delivery service; or d. by e-mail.
- 9.2.0 Notice Addresses. Such notices shall be addressed as follows, or to such different addresses as the parties may from time-to-time designate:

State of New York Department of Civil Service

Name: Daniel Yanulavich
Title: Director, Employee Benefits Division
Address: Swan Street Building (Core 1), 1st Floor, Albany, New York 12239
Telephone: (518) 473-1977
Email: eugene.sarfoh@cs.ny.gov

With Additional Notice To:

Name: Eugene Sarfoh, Esq.
Title: General Counsel
Address: Empire State Plaza, Agency Building 1, Albany, New York 12239
Telephone: (518) 473-1662
Email: eugene.sarfoh@cs.ny.gov

MedAmerica Insurance Company of New York

Name: Mark Allyn
Title: President
Address: 165 Court Street, Rochester, New York 14647
Telephone: (800) 544-0327
Email: mark.allyn@medamericaltc.com

With Additional Notice To:

Name: Megan Gomez, Esq.
Title: SVP, General Counsel
Address: 165 Court Street, Rochester, New York 14647
Telephone: (800) 544-0327
Email: megan.gomez@excellus.com

ARTICLE X: STATEMENT OF SERVICES

10.1.0 MedAmerica shall perform the following administrative services (the “Post-Closure Services”) for the Department and for the benefit of individual NYPERL certificate holders of both the Partnership and Non-Partnership Plans who elected conversion or continuation pursuant to 11 NYCRR 52.25 following the termination of the NYPERL group policy(ies) issued by MedAmerica pursuant to the Prior Agreement and whose individual certificate(s) remained in force as of the date of the Post-Closure Services:

10.1.1 Policy administration and recordkeeping, policyholder and certificate holder services, to include, without limitation, maintaining the policyholder and certificate holder address, the provision of claim forms and reasonable explanatory guidance to claimants in connection therewith, responding to all written or oral claims-related communication, processing all policy changes, lapses, cancellations and reinstatements, the investigation of complaints and any suspected or actual fraud or abuse.

10.1.2 Claims adjusting, benefit eligibility determination, adjudication, and payment.

10.1.3 Providing the Department a monthly detailed invoice to substantiate services provided (“Monthly Post-Closure Services Invoice”).

10.1.4 Providing to all certificate holders any ordinary or routine written notice, disclosure, or other information required by state law or regulation, or otherwise as determined by Insurer to be appropriate or necessary for the administration of the insurance benefits under the Certificate(s) of Insurance, in accordance with applicable law and regulation.

10.2.0 Notwithstanding anything to the contrary in the Prior Agreement, during the term of this Agreement, individual certificate holders shall make direct payment of premiums to MedAmerica using the following methods, and MedAmerica may, but is not obligated to, accept direct payment via any other methods:

10.2.1 Electronic Funds Transfer on a monthly, quarterly, semi-annually or annual basis; and

10.2.2 Direct Paper Bill on a quarterly, semi-annually or annual basis.

ARTICLE XI: ADMINISTRATIVE EXPENSE

11.1.0 Compensation to MedAmerica. The Department shall compensate MedAmerica for the Post-Closure Services performed under this Agreement in accordance with the terms set forth below:

[REDACTED]

11.2.0 Invoicing.

The Contractor shall invoice the Department each month for Post-Closure Services in accordance with the provisions set forth herein, together with full supporting detail(s) to the State's satisfaction. Such invoice(s) shall be submitted on a monthly basis to accountspayable@ogs.ny.gov and InvoiceApproval@cs.ny.gov. The subject line should include the Invoice Number and the term "Department of Civil Service. The invoice must include:

- 11.2.1 Name of the NYS Agency being billed;
- 11.2.2 Name of the vendor and NYS Statewide Financial System (SFS) Vendor Number;
- 11.2.3 Contract number;
- 11.2.4 Enrollment counts to substantiate amounts charged under this Agreement; and
- 11.2.5 Annual paid claims and premiums charged to enrollees to substantiate amounts charged under of this Agreement.

After review and approval of the Contractor's invoice, the Department shall submit it to OSC for payment. OSC shall render payment for invoices under the Agreement in accordance with ordinary State procedures and practices. The Department will make best efforts to process all acceptable invoices within thirty (30) days of their receipt; however, failure to make payment within said timeframe shall not be considered a breach of contract. The Contractor acknowledges that timeliness of payment and any interest to be paid to Contractor for late payment shall be governed by Article XI-A of the State Finance Law. Submission of an invoice and payment thereof shall not preclude the Department, as applicable, from reimbursement or demanding a price adjustment in any case where Post-Closure Services as delivered are found to deviate from the terms and conditions of the Agreement.

The fees due to MedAmerica under this Article XI shall not be paid to or collected by MedAmerica from premiums or other payments collected by Insurer from certificate holders.

**[REMAINDER OF PAGE INTENTIONALLY LEFT BLANK –
SIGNATURES ON FOLLOWING PAGE]**

IN WITNESS WHEREOF, the Parties hereto have hereunder signed this Agreement on the day and year appearing opposite their respective signatures.

Agency Certification: "In addition to acceptance of this Agreement #C000773, I also certify that original copies of this signature page will be attached to all exact copies of this contract."

Contractor Certification: By signing I certify my express authority to sign on behalf of myself, my company, or other entity and full knowledge and acceptance of this Agreement and all appendices. By signing, I affirm my understanding of, and agreement to comply with the Department's procedures relative to the Procurement Lobbying Law as required by State Finance Law §139-j and §139-k.

**NEW YORK STATE
DEPARTMENT OF CIVIL
SERVICE**

Name: Rebecca A. Corso
Title: Executive Deputy Commissioner
By: Rebecca A. Corso
Date: 3/26/26

**MEDAMERICA INSURANCE
COMPANY OF NEW YORK
FEIN: 16-1310986**

Name: Mark Allyn
Title: President
By: Mark Allyn
Date: March 23, 2026

Approved as to form:

Letitia James
ATTORNEY GENERAL

By: _____

Date: _____

Approved:

Thomas P. DiNapoli
STATE COMPTROLLER

By: _____

Date: _____

APPROVED DEPT. OF AUDIT & CONTROL Jun 08 2026 Michelle Y. Ko FOR THE STATE COMPTROLLER

CORPORATION ACKNOWLEDGMENT

STATE OF NEW YORK)

) ss.

COUNTY OF Monroe)

On the 23rd day of March, 20226, before me personally came Mark Allyn, to me known, and known to me to be the person who executed the above instrument, who, being duly sworn by me, did for her/himself depose and say that (s)he is the President of MedAmerica Insurance Company of New York, the corporation or organization described in and which executed the above instrument, and that (s)he signed his/her name thereto.

Laurie A. Samponaro

NOTARY PUBLIC

My commission expires: Jan. 25, 2029



Attachment A

Policy/Certificate Forms List

NYG11-341-NY-200

NYG11-342-NY-200

NYP11-341-NY-200

NYP11-342-NY-200

NYG11-341-NY-0612

NYG11-342-NY-0612

NYP11-341-NY-0612

NYP11-342-NY-0612

NYG11-341-NY-200

CARE DIRECTIONS®
Premier

**NEW YORK STATE PUBLIC EMPLOYEE AND RETIREE
LONG-TERM CARE INSURANCE PLAN (NYPERL)
GROUP POLICY**

GROUP POLICYHOLDER: NEW YORK STATE DEPARTMENT OF CIVIL SERVICE
GROUP NUMBER: 50
EFFECTIVE DATE: 06/01/01 Revised 05/01/11

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.

This Policy is a legal contract between the Group Policyholder and MedAmerica Insurance Company of New York (herein called We, Us or Our). We agree to pay the benefits of this Policy, subject to all of its terms.

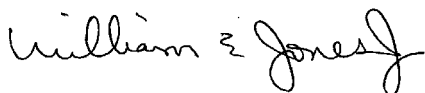
The provisions on the pages that follow are a part of this Policy. Also a part of this Policy are the provisions of the certificates of insurance (herein called the Certificate) which are issued and applicable to persons insured under this Policy (herein called Insured Persons). A copy of the Certificate that applies to each class of Insured Persons is attached to and made a part of this Policy.

This Policy is issued in consideration of the application of the Group Policyholder and payment of any required premium. It will take effect at 12:01 A.M. standard time at the Policyholder's address on the Effective Date shown above. This date is its date of issue.

Guaranteed Renewability. This Policy continues in effect as long as any required premiums are paid on time. Premiums for coverage provided under this Policy may change, but only if We change the premium rates for all Insured Persons in the same payment class, regardless of where you reside at the time of the premium change. In addition to this Guaranteed Renewable feature of the Policy, We guarantee that the Policy premiums will not increase FOR ANY REASON for a full three (3) years from the Policy effective date as listed in the Schedule.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If an Insured Person is eligible for Medicare, he or she must review the Medicare Supplement Buyer's Guide available from Us.

This Policy is delivered in the State of New York and is governed by its laws.



William E. Jones, Jr.
President

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SCHEDULE

This is an outline of the Benefits available to Insured Persons and Group Policyholder paid Benefit selections in the eligible classes. The Benefits that apply to each class are described in the Certificate for that class as shown below.

Class No.

1

2

Certificate No.

NYG11-342-NY-200

NYG11-342-NY-200

Benefits Offered to Certificateholders

LIFETIME BENEFIT AMOUNT

We will deduct from this amount all Benefits paid under the Certificate.
(This does not include services for Caregiver Training and Transition Benefit.)

\$ XXXXX

Caregiver Training Lifetime Maximum Benefit:

\$500

Transition Benefit Lifetime Maximum Benefit:

\$XXXX

LIFETIME ELIMINATION PERIOD

X 90 Days

DAILY BENEFIT AMOUNT

For a Nursing Facility, Assisted Living Facility, Respite or Hospice Program:

Actual Charges incurred up to:

\$100 Per Day

\$150 Per Day

\$180 Per Day

\$250 Per Day

For Home Care or Adult Day Care:

\$XXXX Per Day

60% of Nursing Facility Daily Benefit Amount.

Shortened Benefit Period Nonforfeiture Rider:

X

Return of Premium Rider:

X

Restoration of Benefits Rider:

X

Spousal Benefit Transfer Rider:

X

Survivorship Benefit Rider:

X

INFLATION PROTECTION OPTIONS(Must be offered to each Insured)

Compound Inflation Protection X

The Insured Person's Lifetime Benefit Amount and Daily Benefit Amount will each increase on every anniversary of the effective date of his or her Certificate. Annual increases will apply to Benefits payable for any expenses the Insured Person incurs on or after the date of the increase. This first increase will be equal to 5% of the Insured Person's original amounts. Each increase thereafter will be equal to 5% of the increased amounts that applied on the date of the prior increase.

Guaranteed Purchase Benefit Option X

Once every three years the offer to increase the Insured Person's Lifetime Benefit Amount and Daily Benefit Amount will be made without evidence of insurability. The increase will not be offered if the Insured Person is eligible to receive covered services under this Policy. The increase amount will be equal to 5%, compounded annually for three years, of the Insured Person's current Daily Benefit Amount, rounded to the nearest whole dollar. If accepted, the increase will apply to Benefits payable for any expenses the Insured Person incurs on or after the date of the increase. If the Insured Person declines two consecutive offers, any future benefit increases will require evidence of insurability. The additional premium for the increase will be based on the Insured Person's attained age at the time the increase becomes effective, at the premium rates then in effect.

PREMIUM PAYMENT TERM

Lifetime or as long as the Insured Person wishes to keep the Certificate in force X

10 Year Paid-in-Full^o X

^oIf 10 Year Paid in Full option is chosen, your policy cannot lapse after satisfaction of payment term.

PREMIUM PAYMENT MODE

Bank Account Draft OR Credit Card X
(Monthly, Quarterly, Semi-Annual, Annual)

Payroll Deduction X
(Depending on Employer Capabilities)
(Bi-Monthly, Monthly, Quarterly, Semi-Annual, Annual)

Direct Bill X
(Quarterly, Semi-Annual, Annual)

Refer to the applicable Certificate(s) for a description of these Benefits

ELIGIBILITY AND EFFECTIVE DATES

WHO IS ELIGIBLE

Group Requirements:

Group Size at Initial Open Enrollment: Number of active employees/eligibles - _____

Open Enrollment Period: Initial open enrollment period 60 days

Open Enrollment Period For New Employees/Eligibles: 60 days from date of hire

Enrollment Eligibility: These classes of persons are eligible for insurance under this Policy:

Residency Requirements: personal or work address in the State of New York.

Age Requirements: minimum age of 18

Employment Status: Employees and Retirees (including Vestees and Dependent Survivors) and their eligible Dependents including spouses, Domestic Partners, dependent children, including student dependent children the natural parents of employees, retired employees, Vestees and their spouses/domestic partners.

Underwriting Selections:

Class 1: Modified Guaranteed Issue – During Initial Open Enrollment Health Statement required.

Employees who apply for coverage during the initial open enrollment period and newly eligible Employees who apply for coverage within 60 days of their hire date or the date they first meet the following requirements:

On the day coverage is to begin, the Active Employee/Eligible must be at the employer's place of business or at a location to which the employer's business requires the Employee to travel and be able to fully perform the duties of the position for that Employee's normal workday. Including any day on which the Employee is on vacation or on authorized leave provided such absence is not due to illness or injury or Leave Without Pay. An Employee is any person in the service of the employer (State, Participating Employers or Participating Agencies) who is paid by the employer and who:

1. Is expected to work at least six biweekly pay periods; and
2. Works at least half-time on a regular schedule, and
3. Is on the payroll at the time of application, or
4. Is in one of the following categories at the time of application:
 - a. A local elected official;
 - b. A paid member of a public legislative body;
 - c. An unpaid board member of a public authority with at least six months service as a board member; or
 - d. An unpaid or paid elected member of a school board.

Class 2: Standard Issue - Long-Form Health Statement required. Standard Issue is required for the following enrollees.

1. Any Employee/Eligible who does not meet the requirements under Modified Guaranteed Issue;
2. Employees who choose to apply for coverage after the initial offering and new Employees who choose to apply for coverage more than 60 days after their hire date;
3. An Employee's eligible Dependent(s); and
4. Retirees, Spouses/Domestic Partners, Vestees, and Dependent Survivors and their eligible Dependents and Parents (including in-law).

WHEN A PERSON'S COVERAGE STARTS

The date that a person's coverage under this Policy starts depends on when he or she applies and pays premium for it. And in addition, if Special Requirements apply and are indicated below, his or her insurance will not start until that requirement is met.

A person's insurance coverage will start:

- On the date We approve his or her proof of insurability, and
- Once We are in receipt of the first premium payment.

BASIS OF INSURANCE

Persons in all classes are required to contribute toward the cost of their insurance under this Policy.

A person's contribution toward the cost of his or her insurance under this Policy may not be more than the premium charge for that insurance.

TERMINATION OF COVERAGE

WHEN THIS POLICY ENDS

This Policy ends when the first of these dates occurs:

- The date the Group Policyholder chooses to terminate this Policy; or
- The date We terminate this Policy due to fraud; or
- The date the Group Policyholder's premiums are not paid when due, subject to the Grace Period.

WHEN AN INSURED PERSON'S COVERAGE ENDS

The Certificate for each class describes when coverage ends for an Insured Person in that class.

PREMIUM PROVISIONS

The Certificate for each class sets forth the premium provisions which apply to that class.

The premium due for each Insured Person's coverage will be calculated using the approved rates.

We may change the premium rates. However, We will not change an Insured Person's premium rate unless the premium rates change for all persons in the same payment class, regardless of where you reside at the time of the premium change. We will provide at least 120 days written notice in advance of a change in premium rates. We guarantee that the Policy premiums will not increase FOR ANY REASON for a full three (3) years from the Policy effective date as listed in the Schedule.

The Group Policyholder agrees to remit to Us all applicable premiums for employees/eligibles and their spouses. All applicable premium payments due from the Group Policyholder are subject to the Grace Period provision set forth below.

All other Insured Persons will pay premiums directly to Us.

GRACE PERIOD

An initial Grace Period of 30 days will be granted for each premium payment that is unpaid on the date due. After 30 days, a notice will be sent to the Group Policyholder explaining that a payment has been missed and that this Policy is at risk of lapsing. An additional 35 days from the date We mail the notice will be granted during which any unpaid premium must be paid. Payment will allow this Policy to continue in force without interruption. Failure to pay any unpaid premium by the end of the Grace Period will result in the termination of this Policy as of the premium due date.

GENERAL PROVISIONS

ENTIRE CONTRACT

The entire contract consists of:

1. This Policy and any papers made a part of it, including the Group Master Application completed by the Group Policyholder; and
2. The Certificate that applies to each class of Insured Persons, which is attached to and made a part of this Policy; and
3. The written statements, if any, of the Insured Persons, including their enrollment forms; and
4. The signed Agreement #C000488 between the Group Policyholder and Us.

In the absence of fraud, all statements made by the Group Policyholder or by the Insured Persons will be deemed to be representations and not warranties. No statement made by an Insured Person will be used to avoid insurance, reduce the benefits, or defend a claim under this Policy unless:

1. The statement is in writing and signed by the Insured Person; and
2. A copy of that statement is given to the Insured Person or to his or her beneficiary.

POLICY CHANGES

This Policy may be changed at any time by written agreement between the Group Policyholder and Us. But the change must be approved by one of Our executive officers. We will not be bound by a promise or representation made by any other person. No agent has the authority to change this Policy, or any Certificate issued hereunder, in any way or to waive any of its terms.

CERTIFICATES

We will provide certificates of insurance for delivery to each Insured Person. They will describe: (1) the coverage the Insured Person has; (2) any limitations, reductions, and exclusions that apply to the coverage; (3) to whom the benefits will be paid; and (4) the Insured Person's continuation or conversion rights if coverage ends. We may send the certificate directly to the Insured Person or give it to the Group Policyholder for delivery to him or her.

INCONTESTABILITY

We will not contest the validity of this Policy after it has been in force for two (2) years from its date of issue.

DATA REQUIRED FROM GROUP POLICYHOLDER

We need certain data to carry out the terms of this Policy and to determine the premium. The Group Policyholder shall give us the data we need to do this whenever we need it. We also have the right to inspect any records of the Group Policyholder, if We believe they would have a bearing on this Policy. We have the right to do this at any reasonable time.

NON-PARTICIPATING

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

CONFORMITY WITH APPLICABLE LAW

Any provision of this Policy that, on its effective date is in conflict with the federal statutes pertaining to qualified long-term care insurance or the statutes of the state in which You reside on such date is hereby amended to conform to the minimum requirement of such statutes, if required.



**NEW YORK STATE PUBLIC EMPLOYEE AND RETIREE
LONG-TERM CARE INSURANCE PLAN (NYPERL)
GROUP POLICY**

GROUP POLICYHOLDER: [XXX]
GROUP NUMBER: [XXX]
EFFECTIVE DATE: [XX/XX/XXXX]

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.

This Policy is a legal contract between the Group Policyholder and MedAmerica Insurance Company of New York (herein called We, Us or Our). We agree to pay the benefits of this Policy, subject to all of its terms.

The provisions on the pages that follow are a part of this Policy. Also a part of this Policy are the provisions of the certificates of insurance (herein called the Certificate) which are issued and applicable to persons insured under this Policy (herein called Insured Persons). A copy of the Certificate that applies to each class of Insured Persons is attached to and made a part of this Policy.

This Policy is issued in consideration of the application of the Group Policyholder and payment of any required premium. It will take effect at 12:01 A.M. standard time at the Policyholder's address on the Effective Date shown above. This date is its date of issue.

Guaranteed Renewability. This Policy continues in effect as long as any required premiums are paid on time. Premiums for coverage provided under this Policy may change, but only if We change the premium rates for all Insured Persons in the same payment class, regardless of where you reside at the time of the premium change. [In addition to this Guaranteed Renewable feature of the Policy, We guarantee that the Policy premiums will not increase FOR ANY REASON for a full three (3) years from the Policy effective date as listed in the Schedule.]

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If an Insured Person is eligible for Medicare, he or she must review the Medicare Supplement Buyer's Guide available from Us.

This Policy is delivered in the State of New York and is governed by its laws.

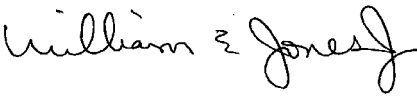

[
[William E. Jones, Jr.]
[President]

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Eligibility and Effective Dates.....	[X]
Termination of Coverage	[X]
Premium Provisions	[X]
General Provisions.....	[X]

SCHEDULE

This is an outline of the Benefits available to Insured Persons [and Group Policyholder paid Benefit selections] in the eligible classes. The Benefits that apply to each class are described in the Certificate for that class as shown below.

Class No.

[1]

[2]

Certificate No.

[123456-Ed.1]

[123456-Ed.2]

Benefits Offered to Certificateholders

LIFETIME BENEFIT AMOUNT

We will deduct from this amount all Benefits paid under the Certificate.
(This does not include services for Caregiver Training and Transition Benefit.)

[\$ XXXXX]

Caregiver Training Lifetime Maximum Benefit:

[\$500]

Transition Benefit Lifetime Maximum Benefit:

[\$XXXX]

LIFETIME ELIMINATION PERIOD

☒ 90 Days]

DAILY BENEFIT AMOUNT

For a Nursing Facility, Assisted Living Facility, Respite or Hospice Program:

Actual Charges incurred up to:

[\$100 Per Day]

[\$150 Per Day]

[\$180 Per Day]

[\$250 Per Day]

For Home Care or Adult Day Care:

[\$XXXX Per Day]

[60% of Nursing Facility Daily Benefit Amount.]

[Shortened Benefit Period Nonforfeiture Rider:]

☒

[Return of Premium Rider:]

☒

[Restoration of Benefits Rider:]

☒

[Spousal Benefit Transfer Rider:]

☒

[Survivorship Benefit Rider:]

☒

INFLATION PROTECTION OPTIONS(Must be offered to each Insured)

[Compound Inflation Protection ☒

The Insured Person's Lifetime Benefit Amount and Daily Benefit Amount will each increase on every anniversary of the effective date of his or her Certificate. Annual increases will apply to Benefits payable for any expenses the Insured Person incurs on or after the date of the increase. This first increase will be equal to 5% of the Insured Person's original amounts. Each increase thereafter will be equal to 5% of the increased amounts that applied on the date of the prior increase.]

[Guaranteed Purchase Benefit Option ☒

Once every three years the offer to increase the Insured Person's Lifetime Benefit Amount and Daily Benefit Amount will be made without evidence of insurability. The increase will not be offered if the Insured Person is eligible to receive covered services under this Policy. The increase amount will be equal to 5%, compounded annually for three years, of the Insured Person's current Daily Benefit Amount, rounded to the nearest whole dollar. If accepted, the increase will apply to Benefits payable for any expenses the Insured Person incurs on or after the date of the increase. If the Insured Person declines two consecutive offers, any future benefit increases will require evidence of insurability. The additional premium for the increase will be based on the Insured Person's attained age at the time the increase becomes effective, at the premium rates then in effect.]

[PREMIUM PAYMENT TERM]

[Lifetime or as long as the Insured Person wishes to keep the Certificate in force] ☒

[10 Year Paid-in-Full^o] ☒

^oIf 10 Year Paid in Full option is chosen, your policy cannot lapse after satisfaction of payment term.

[PREMIUM PAYMENT MODE]

[**Bank Account Draft OR Credit Card** ☒
(Monthly, Quarterly, Semi-Annual, Annual)]

[**Payroll Deduction** ☒
(Depending on Employer Capabilities)
(Bi-Monthly, Monthly, Quarterly, Semi-Annual, Annual)]

[**Direct Bill** ☒
(Quarterly, Semi-Annual, Annual)]

Refer to the applicable Certificate(s) for a description of these Benefits

ELIGIBILITY AND EFFECTIVE DATES

WHO IS ELIGIBLE

[Group Requirements:

Group Size at Initial Open Enrollment: Number of active employees/eligibles - _____

Open Enrollment Period: Initial open enrollment period- _____ days

Open Enrollment Period For New Employees/Eligibles: [60] days from date of hire]

Enrollment Eligibility: These classes of persons are eligible for insurance under this Policy:

[Residency Requirements: residents of the State of - _____]

[Age Requirements: minimum age of - 18]

[Employment Status: Employees and Retirees (including Vestees and Dependent Survivors) and their eligible Dependents including spouses, Domestic Partners, dependent children, including student dependent children the natural parents of employees, retired employees, Vestees and their spouses/domestic partners.]

Underwriting Selections:

[Class 1: Modified Guaranteed Issue – During Initial Open Enrollment Health Statement required.

Employees who apply for coverage during the initial open enrollment period and newly eligible Employees who apply for coverage within 60 days of their hire date or the date they first meet the following requirements:

On the day coverage is to begin, the Active Employee/Eligible must be at the employer's place of business or at a location to which the employer's business requires the Employee to travel and be able to fully perform the duties of the position for that Employee's normal workday. Including any day on which the Employee is on vacation or on authorized leave provided such absence is not due to illness or injury or Leave Without Pay. An Employee is any person in the service of the employer (State, Participating Employers or Participating Agencies) who is paid by the employer and who:

1. is expected to work at least six biweekly pay periods; and
2. works at least half-time on a regular schedule, and
3. is on the payroll at the time of application, or
4. is in one of the following categories at the time of application:
 - a. A local elected official;
 - b. A paid member of a public legislative body;
 - c. An unpaid board member of a public authority with at least six months service as a board member; or
 - d. An unpaid or paid elected member of a school board.]

[Class 2: Standard Issue - Long-Form Health Statement required. Standard Issue is required for the following enrollees.

1. Any Employee/Eligible who does not meet the requirements under Modified Guaranteed Issue;
2. Employees who choose to apply for coverage after the initial offering and new Employees who choose to apply for coverage more than 60 days after their hire date;
3. An Employee's eligible Dependent(s); and
4. Retirees, Spouses/Domestic Partners, Vestees, and Dependent Survivors and their eligible Dependents and Parents (including in-law).]

WHEN A PERSON'S COVERAGE STARTS

The date that a person's coverage under this Policy starts depends on when he or she applies and pays premium for it. And in addition, if Special Requirements apply and are indicated below, his or her insurance will not start until that requirement is met.

A person's insurance coverage will start:

- on the date We approve his or her proof of insurability, and
- once We are in receipt of the first premium payment.

BASIS OF INSURANCE

Persons in all classes are required to contribute toward the cost of their insurance under this Policy.

A person's contribution toward the cost of his or her insurance under this Policy may not be more than the premium charge for that insurance.

TERMINATION OF COVERAGE

WHEN THIS POLICY ENDS

This Policy ends when the first of these dates occurs:

- the date the Group Policyholder chooses to terminate this Policy; or
- the date We terminate this Policy due to fraud; or
- [the date the Group Policyholder's premiums are not paid when due, subject to the Grace Period.]

WHEN AN INSURED PERSON'S COVERAGE ENDS

The Certificate for each class describes when coverage ends for an Insured Person in that class.

PREMIUM PROVISIONS

The Certificate for each class sets forth the premium provisions which apply to that class.

The premium due for each Insured Person's coverage will be calculated using the approved rates.

We may change the premium rates. However, We will not change an Insured Person's premium rate unless the premium rates change for all persons in the same payment class, regardless of where you reside at the time of the premium change. We will provide at least 120 days written notice in advance of a change in premium rates. [We guarantee that the Policy premiums will not increase FOR ANY REASON for a full three (3) years from the Policy effective date as listed in the Schedule.]

[The Group Policyholder agrees to remit to Us all applicable premiums for employees/eligibles and their spouses. All applicable premium payments due from the Group Policyholder are subject to the Grace Period provision set forth below.]

[All other Insured Persons will pay premiums directly to Us.]

[GRACE PERIOD

An initial Grace Period of 30 days will be granted for each premium payment that is unpaid on the date due. After 30 days, a notice will be sent to the Group Policyholder explaining that a payment has been missed and that this Policy is at risk of lapsing. An additional 35 days from the date We mail the notice will be granted during which any unpaid premium must be paid. Payment will allow this Policy to continue in force without interruption. Failure to pay any unpaid premium by the end of the Grace Period will result in the termination of this Policy as of the premium due date.]

GENERAL PROVISIONS

ENTIRE CONTRACT

The entire contract consists of:

1. this Policy and any papers made a part of it, including the Group Master Application completed by the Group Policyholder; and
2. the Certificate that applies to each class of Insured Persons, which is attached to and made a part of this Policy; and
3. the written statements, if any, of the Insured Persons, including their enrollment forms; and
4. [The signed Agreement #C000488 between the Group Policyholder and Us.]

In the absence of fraud, all statements made by the Group Policyholder or by the Insured Persons will be deemed to be representations and not warranties. No statement made by an Insured Person will be used to avoid insurance, reduce the benefits, or defend a claim under this Policy unless:

1. the statement is in writing and signed by the Insured Person; and
2. a copy of that statement is given to the Insured Person or to his or her beneficiary.

POLICY CHANGES

This Policy may be changed at any time by written agreement between the Group Policyholder and Us. But the change must be approved by one of Our executive officers. We will not be bound by a promise or representation made by any other person. No agent has the authority to change this Policy, or any Certificate issued hereunder, in any way or to waive any of its terms.

CERTIFICATES

We will provide certificates of insurance for delivery to each Insured Person. They will describe: (1) the coverage the Insured Person has; (2) any limitations, reductions, and exclusions that apply to the coverage; (3) to whom the benefits will be paid; and (4) the Insured Person's [continuation or conversion] rights if coverage ends. We may send the certificate directly to the Insured Person or give it to the Group Policyholder for delivery to him or her.

INCONTESTABILITY

We will not contest the validity of this Policy after it has been in force for [two (2) years] from its date of issue.

DATA REQUIRED FROM GROUP POLICYHOLDER

We need certain data to carry out the terms of this Policy and to determine the premium. The Group Policyholder shall give us the data we need to do this whenever we need it. We also have the right to inspect any records of the Group Policyholder, if We believe they would have a bearing on this Policy. We have the right to do this at any reasonable time.

[NON-PARTICIPATING

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

CONFORMITY WITH APPLICABLE LAW

Any provision of this Policy that, on its effective date is in conflict with the federal statutes pertaining to qualified long-term care insurance or the statutes of the state in which You reside on such date is hereby amended to conform to the minimum requirement of such statutes, if required.

NYG11-342-NY-200



**NEW YORK STATE PUBLIC EMPLOYEE AND RETIREE
LONG-TERM CARE INSURANCE PLAN (NYPERL)
GROUP CERTIFICATE
Group Number 50**

This Group Policy meets the minimum requirements for long-term care insurance in the state of New York. It is intended to be a federally tax-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.

This Certificate explains the Benefits MedAmerica Insurance Company of New York (herein called "the Company," or "We" or "Us" or "Our") provides to the Certificateholder ("You" or "Your" or "Yourself") whose name and identification number are in the Schedule. These Benefits are provided under a contract (the "Group Policy") between Us and the group whose number is also shown in the Schedule. (This group is called the "Group Policyholder.")

This Certificate is issued to You. It will continue unless it is terminated for any of the reasons described in this Certificate. Your coverage under the Group Policy starts on the effective date shown in Your Schedule.

The premiums may change, but only if 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.

The Benefits of the Certificate provide coverage to persons needing assistance for care as shown in the Benefits Section of this Certificate, and are subject to its provisions, limitations and exclusions.

Your coverage under the Group Policy is not intended to replace Your present health insurance or Medicare Supplement Insurance. **THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT POLICY.** If You are eligible for Medicare, You should review the Medicare Supplement Buyer's Guide available from Us.

30 Day Free Look

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

NOTICE TO BUYER: This Certificate 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 certificate limitations.

Caution: The issuance of this long-term care insurance Certificate is based upon Your responses to the questions on Your enrollment form. A copy of Your enrollment form is enclosed. If Your answers are incorrect or untrue, or fail to include all material medical and eligibility information requested, the Company has the right to deny Benefits or rescind Your Certificate. 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 the Company at the above address.

The Group Policy determines governing contractual provisions.

A handwritten signature in black ink that reads "William E. Jones, Jr.".

William E. Jones, Jr.
President

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SCHEDULE

Certificateholder Name:	JOHN DOE
Certificate Effective Date:	XX/XX/XX
Certificateholder Issue Age:	XX
Premium Mode:	XXXXXXXXX
Certificateholder Identification No.:	L123456789-01
Group Name:	NYS Department of Civil Services
Group Number:	50

Premium Totals:

Base Premium:	\$XXXX
Spousal Benefit Transfer Rider:	\$XXXX
Total Premium:	\$XXXX

Total Benefit

LIFETIME BENEFIT AMOUNT

We will deduct from this amount all Benefits paid under this Certificate. (This does not include services for Caregiver Training and Transition Benefit.)

\$XXXX
Unlimited Dollars

Caregiver Training Lifetime Maximum Benefit: **\$500.00**

Transition Benefit Lifetime Maximum Benefit: **\$XXXX**

LIFETIME ELIMINATION PERIOD

90 Days

DAILY BENEFIT AMOUNT

For Nursing Facility, Assisted Living Facility, Bed Reservation, Respite Care, Hospice Program:

Actual Charges incurred up to: **\$X Per Day**

For Home Care or Adult Day Care:

Actual Charges Incurred up to

60% of Nursing Facility Daily Benefit Amount **\$ Per Day**

INFLATION PROTECTION OPTION

Compound Inflation Protection

Your Lifetime Benefit Amount and Daily Benefit Amount will each increase on every anniversary of the effective date of this Certificate. 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

Guaranteed Purchase Benefit Option

Once every three years the offer to increase Your Lifetime Benefit Amount and Daily Benefit Amount will be made without evidence of insurability. The increase will not be offered if You are eligible to receive covered services under this Certificate. The increase amount will be equal to 5%, compounded annually for three years, of Your current Daily Benefit Amount, rounded to the nearest whole dollar. If accepted, the increase will apply to Benefits payable for any expenses You incur on or after the date of the increase. If You decline two consecutive offers, any future benefit increases will require evidence of insurability. The additional premium for the increase will be based on Your attained age at the time the increase becomes effective, at the premium rates then in effect.

 X

PREMIUM PAYMENT TERM

Lifetime or as long as the Insured Person wishes to keep the Certificate in force.

 X

10 Year Paid-in-Full *

 X

* If the 10 Year Paid in Full option is Chosen, Your Policy cannot lapse after satisfaction of payment term.

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

DEFINITIONS

ACTIVITIES OF DAILY LIVING (ADL):

Each of the following is an Activity of Daily Living:

<u>Bathing:</u>	This means washing Yourself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
<u>Continence:</u>	This means the ability to maintain control of bowel or bladder functions; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
<u>Dressing:</u>	This means the ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.
<u>Eating:</u>	This means the ability to feed oneself by getting food into Your body from a receptacle (such as plate, cup or table) or by a feeding tube or intravenously.
<u>Toileting:</u>	This means the ability to go to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
<u>Transferring:</u>	This means the ability to move into or out of a bed, chair or wheelchair.

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 facility.

A portion, wing, ward or unit of a multi-use facility will qualify as an Assisted Living Facility only if it meets all of 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 Certificate, Your Schedule, and attached riders.

BENEFIT ELIGIBILITY:

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

CERTIFICATE:

This document which describes the Benefits provided under the group contract between Us and the Group Policyholder whose number is shown on Your Schedule. It shall also include Your enrollment form and any riders or endorsements. This Certificate is not a contract between You and Us.

CERTIFICATE HOLDER:

The person to whom this Certificate is issued and whose name appears in the Schedule.

DAILY BENEFIT AMOUNT:

This is the maximum amount We will pay for all charges You incur on any one day as stated in Your Schedule. An Inflation Protection Option will increase Your Daily Benefit Amount over time.

FAMILY, FAMILY MEMBER:

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

GROUP POLICY:

This is the contract between Us and the Group Policyholder whose name and number are shown on Your Schedule.

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 six (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 Certificate entitles You to the Lifetime Benefit Amount of coverage as shown in Your Schedule. This is the maximum amount of money You have available for Benefits. We will deduct from this amount all Benefits paid for all covered services provided under this Certificate as listed in Your Schedule. The Lifetime Benefit Amount is determined by Your selection of a Daily Benefit Amount multiplied by the number of Benefit days You select.

LIFETIME ELIMINATION PERIOD:

This is the number of days shown in Your Schedule for which We are not liable to pay expenses for any services listed in this Certificate. The Elimination Period begins on the first day You are certified as meeting Benefit Eligibility as defined in this Certificate and continues until the first such calendar day You are no longer Benefit Eligible or You reach the Lifetime Elimination Period listed in Your Schedule. Days used to satisfy Your Lifetime Elimination Period do not need to be consecutive, but must be accumulated within a period of 365 days (or 366 days in a leap year).

The Lifetime Elimination Period will be applied only once during the life of the Certificate. There is no Lifetime Elimination Period for Hospice Program, Respite Care or Transition Benefit. These Benefits may not be used to satisfy 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 Certificate.

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 institution, 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 also contain services that You need that are not covered under this Certificate. We retain the right to request periodic updated assessments.

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 Certificate; and (b) are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

SCHEDULE:

The section of Your Certificate titled Schedule. It lists Your information such as coverage amounts and Benefit options.

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:

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 Activity of Daily Living.
- 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 Activity of Daily Living (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:

This 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).

TRANSITION BENEFIT:

This means equipment that is used to provide You with Qualified Long-Term Care Services. It must be able to withstand repeated use and is designed to be used in the Home to assist You in performing Activities Of Daily Living.

Examples of supportive equipment include:

- hospital-style beds; and
- ramps to permit Your movement from one level of the residence to another; and
- grab bars to assist You in toileting; and
- pumps and other devices for intravenous injection; and
- respirators; and
- medical alert systems.

Supportive Equipment does NOT include items such as:

- artificial limbs; or
- teeth; or
- hearing aids; or
- medical supplies; or
- equipment placed in Your body, temporarily or permanently.

WE, US, OUR:

This refers to MedAmerica Insurance Company of New York.

YOU, YOUR, YOURSELF:

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

BENEFIT ACCESS

BENEFIT ELIGIBILITY

To start the Benefit access process, You must contact Us as soon as You think You might need services covered under this Certificate. Please call Our Customer Service Representative at 1-800-919-8816.

To be eligible for Benefits provided by this Certificate, 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 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 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 Certificate. This information may be gathered by Us or by 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.

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 will provide an initial on-site consultation by Our Personal Care Advisor if requested.

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

The maximum amount We will pay for all charges You incur 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.

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.

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
- Respite 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, 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.

ALTERNATIVE CARE

If You meet Benefit Eligibility, We may pay for alternative care Benefits under this provision. The Benefits must be for Qualified Long-Term Care Services that are medically acceptable, cost effective and agreed to by You and by Us. This includes medically necessary transportation to and from Adult Day Care.

The total of this alternative care Benefit will not exceed the total Benefits to which You would otherwise be entitled under this Certificate.

BED RESERVATION

If You are hospitalized temporarily while We are paying for Benefits in a Nursing Facility or Assisted Living Facility and that facility charges You a fee to reserve Your bed, We will pay to reserve Your bed for up to 21 days per calendar year.

We will pay the actual charges to reserve Your bed, up to the Daily Benefit Amount shown in Your Schedule. Payments made under this Benefit are deducted from Your Lifetime Benefit Amount.

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.

CAREGIVER TRAINING

If You meet Benefit Eligibility, and You are at Home, We will pay for training You, or a person designated by You, and agreed to by Us in:

1. The proper use and care of Supportive Equipment, provided that the training:
 - Is not included in the rental, lease or purchase agreement of Supportive Equipment; and
 - Is provided by a Registered Professional Nurse or other professionally designated person who is qualified to provide such training; and
 - Is intended to provide the knowledge and skills necessary for the proper use and care of the Supportive Equipment.
2. The proper use and care of disposable medical aids, including, but not limited to, catheters, ostomy bags, or suctioning tubes.
3. The proper way to assist You in the performance of Your Activities of Daily Living or other supportive needs.

Caregiver Training must be provided by a registered professional nurse or another professionally designated person who is qualified to provide training.

The total Caregiver Training Lifetime Maximum Benefit is \$500 (five hundred dollars). Benefits paid for Caregiver Training will not be deducted from Your Lifetime Benefit Amount.

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

TRANSITION BENEFIT

If You meet Benefit Eligibility, We will reimburse You for expenses You pay for the rental, lease or purchase of supportive equipment that is used to provide You with Qualified Long-Term Care Services. This benefit may include, but is not limited to, such items as home modifications, emergency response systems and durable medical equipment.

We will pay this Benefit up to a maximum lifetime amount of five (5) times Your Daily Benefit Amount as listed in Your Schedule. Benefits paid for under this Transition Benefit will not be deducted from Your Lifetime Benefit Amount.

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

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 and You are at Home, 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 the actual charges incurred up to the Daily Benefit Amount shown in Your Schedule for a maximum Benefit of 21 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.

REQUIRED AND ADDITIONAL BENEFITS

Certain of the benefits described above are not required for Long-Term Care Insurance coverage by state regulation. These additional benefits include:

- Services in a hospital with units or beds assigned for long-term or custodial care;
- Services in a facility other than a nursing home;
- Respite Care;
- Hospice Care;
- Alternate Care;
- Bed Reservation;
- Caregiver Training; and
- Transition Benefit.

Use of the additional benefits outlined above will reduce the Lifetime Benefit Amount of coverage available to You as described in this Certificate for those benefits required by state regulation. The required benefits are:

- Services in a nursing home; and
- Services in Your home.

It is Your choice whether to use the coverage available for the additional benefits. If You desire to use all of Your Lifetime Benefit Amount for the required benefits, then the additional benefits should not be used.

WORLDWIDE COVERAGE

This Certificate covers 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 Certificate:

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. Treatment provided in a government facility except treatment provided to a Medicaid recipient or as otherwise required by State or Federal law.
4. Services for which any Benefits are provided under Workers' Compensation, employer's liability program, occupational disease law or mandatory no-fault insurance.
5. Services provided by a member of Your Family, except for Caregiver Training Benefits included in the Benefits section of this Certificate.
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 reimbursable by Medicare but have been applied to a deductible or coinsurance amount.

PREMIUM

PREMIUM AMOUNT

The initial premium is listed in Your Schedule. If there is a change in the premium for Your coverage, We will give the Group Policyholder and You, if You pay premium to Us directly, at least 30 days written notice before the new premium goes into effect.

No change will be made to the premium amount unless the premium rates change for all persons in the same 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, if You pay premium to Us directly, or to the Group Policyholder explaining that a payment has been missed and that Your Certificate 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 or the Group Policyholder 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 Certificate to continue in force without interruption. Failure to pay any unpaid premium by the end of this sixty-five (65) day Grace Period will result in the termination of Your Certificate as of the premium due date.

REINSTATEMENT

If Your Certificate ends for non-payment of premium within the Grace Period, You may request reinstatement, within twelve (12) months, with no break in coverage subject to evidence of insurability. If We honor this request, Your Certificate will be reinstated retroactive to the date Your Certificate ended. Once reinstated, You must pay the premium due retroactive to the date Your Certificate ended.

EXTENDED REINSTATEMENT BENEFIT FOR SEVERE COGNITIVE IMPAIRMENT AND LOSS OF FUNCTIONAL CAPACITY

If You are paying premium directly to Us and You failed to pay Your premium within the Grace Period, because of a condition that would qualify You for Benefits under this Certificate, You may request reinstatement up to five (5) months after termination of Your Certificate.

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 Certificate. We will make a Benefit Eligibility assessment before deciding on reinstatement. If Your Certificate is reinstated, You must pay the premium due retroactive to the date Your Certificate terminated.

PREMIUM WAIVER

Your premium payments will be waived on a monthly basis starting:

- On the first day You are certified as meeting Benefit Eligibility and You have satisfied the Lifetime Elimination Period.

This waiver of premium payment ends when You are no longer eligible for covered services under this Policy for a period of 180 days.

UNEARNED PREMIUM

When We are notified of Your death, We will refund to the Group Policyholder or to Your estate any premium already paid for the period beyond Your death. If Your Certificate is cancelled We will refund to the Group Policyholder, or to You if You pay premium directly to Us, any premium already paid for the period beyond the cancellation.

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 Certificateholder 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 notice, You will be deemed to have met the timeliness of claim filing requirements upon submitting, within the time fixed in this Certificate 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 Certificateholder Identification Number, the Group Policyholder's name and the Group 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 Certificate. The following conditions also apply:

- Your Certificate 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 Certificate; 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, upon Your request, to the Approved Provider. 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 or Your Benefit Eligibility 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.

We will make a Benefit determination, independent of the original, using medical records and the provisions of this Certificate. We will send You Our written decision within 30 business days of Our receipt of all requested information. If You appeal that decision, an independent review of the decision will be made by an external agency.

For any claims appeal the request should be sent to Our office within three (3) years of the time of filing written notice of proof of loss for the claim being appealed.

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 three (3) years after the time written proof of loss is furnished.

COORDINATION OF BENEFITS

WHEN YOU HAVE OTHER HEALTH BENEFITS

This Benefit applies if You are covered under a Long-Term Care health insurance contract, plan or policy issued through or to a group which provides some of the same Benefits as the Group Policy.

When You receive an item of service which would be covered under both policies, We will coordinate Benefit payments with any payment made under the other policy. One company will pay its full benefit as a primary benefit. The other company will pay secondary benefits if necessary to cover Your expenses. This prevents duplicate payments and overpayments. The following are considered to be a health insurance policy:

- Any group or blanket insurance policy, including HMO and other prepaid group coverage, except that blanket school accident coverages or such coverages offered to substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance policy.
- Any self-insured or non-insured plan, or any other plan arranged through any employer; trustee; union; employer organization; or employee benefit organization.
- Any Blue Cross, Blue Shield or other service-type group plan.
- Any coverage under governmental programs or any coverage required or provided by any statute, except Medicaid.
- Medical benefits coverage in group and individual mandatory traditional automobile "fault" type contracts.

RULES TO DETERMINE PAYMENT

The first of the rules listed below which applies shall determine which policy shall be Your primary insurance:

- If the other policy does not have a provision similar to this one, then it will be primary.
- If You are covered under one policy as an employee or member of a group and You are only covered as a dependent or Family Member under this Policy, the policy which covers You as an employee or member of a group will be primary.
- If You are covered under one of the Plans as an active employee, neither laid-off nor retired, or as the dependent of such an active employee, and You are covered as a laid-off or retired employee or laid-off or retired employee's dependent under the other plan, the Plan covering You as an active employee will be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the Plans do not agree on which shall be primary, the rule below shall apply.
- If You are covered under two policies as a dependent child of different persons, then the policy of the parent whose birthday falls earlier in a year will be primary. If both parents have the same birthday, the policy which covered the parent longer is primary to the policy which covered the other parent for a shorter period of time. If the other policy does not have a provision similar to this one, but instead has a rule based on the gender of the parent, and if, as a result, the policies do not agree on the order of benefits, the rule in the other policy will determine the order of benefits.
- If none of the above applies, then the policy which has covered You for the longest time will be primary.
- The above rules apply whether or not You actually make a claim under both policies.

PAYMENT WHEN THE GROUP POLICY IS SECONDARY

When Your coverage under the Group Policy is secondary, the Benefits of the Group Policy will be reduced so that the total benefits payable under the other health insurance policy and under the Group Policy do not exceed the charge for the service. However, We will not pay more than We would have paid if it were primary.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

We have the right to release or obtain information which We believe necessary to carry out the purpose of this Coordination of Benefits section. We will not notify You or obtain Your consent before releasing or obtaining information except as required by law. We will not be legally responsible to You or anyone else for releasing or obtaining this information. You must furnish Us any information that We request. If You do not furnish the information, We have the right to deny payments.

OUR RIGHT TO RECOVER OVERPAYMENT

In some cases, We may have made payments even though You had coverage under another policy. If this happens, it will be necessary for You to refund the amount by which We should have reduced the payment We made. We also have the right to recover the overpayment from the other health benefits programs if We have not already received payment from that other program. You must sign any document that We feel is needed to help Us recover any overpayment.

RIGHT TO CONTINUATION OR CONVERSION OF COVERAGE AFTER TERMINATION

CONTINUATION

If Your relationship to the Group changes for any reason, You will be eligible to continue coverage without interruption as long as You pay all premiums when due and You have not exhausted Your Lifetime Benefit Amount. If Your premium was paid by payroll deduction, You must pay premiums directly to Us.

CONVERSION

If the Group Policy terminates, You will be provided conversion privileges as required by New York State regulations.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES

This Certificate is issued pursuant to the Group Master Policy which determines governing contractual provisions. The Group Master Policy, the Group Master Application, this Certificate, Your enrollment form, including any applicable health statements, and any Riders and attached papers establish the entire contract of insurance between the Group Policyholder and Us.

YOUR BENEFITS

Only You can receive Benefits under this Certificate.

WHEN YOUR COVERAGE STARTS

The date that Your coverage under this Certificate starts is shown in Your Schedule. All time periods start and end at 12:01 a.m. standard time at Your residence. Benefits are available only for services that You receive on or after Your effective date. They are subject to all of the conditions shown in this Certificate.

WHEN YOUR COVERAGE ENDS

You are no longer covered under the Group Policy when the first of the following occurs:

On the date Your premiums are not paid, when due, subject to the Grace Period.

When Your Maximum Benefits Available Under Your Certificate Are Exhausted: Your coverage will automatically end when You have used the maximum Benefits to which You are entitled. We will notify You when this occurs.

When You Elect to Terminate Your Coverage Under the Certificate: You may cancel Your coverage at any time by giving Us at least 30 days prior written notice. Your coverage will end on the date specified in Your written notice or on a later date as may be specified in the notice.

On Your Death: Your coverage will automatically end on the day after the date of Your death. We will refund to the Group Policyholder, or to Your estate, any premium already paid for the period between the day after the date of death until the next premium due date.

OUR OPTION TO TERMINATE

YOUR COVERAGE CANNOT BE CANCELLED BECAUSE OF YOUR AGE, A CHANGE IN YOUR RELATIONSHIP TO THE GROUP, EMPLOYMENT STATUS, HEALTH STATUS, HEALTH CARE NEEDS, OR USE OF BENEFITS.

Your coverage can be rescinded for fraud committed by You or any other person, when You applied for coverage or on the submission of any claims under the Group Policy. (See "Incontestable Period" in the General Provisions section of Your Certificate.)

EXTENSION OF BENEFITS

If Your coverage under the Group Policy ends while You are totally disabled or You are receiving Qualified Long-Term Care Services covered under the Group Policy in a Nursing Facility or an Assisted Living Facility, We will continue to pay for Your care without interruption of Benefits until the first of these dates:

- It has been determined that You are no longer eligible for Benefits under this Certificate; or
- You have used up Your Lifetime Benefit Amount;
- 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 coverage under the Group Policy had not ended.

You will not be entitled to Benefits after Your coverage ends if it ended due to You reaching Your maximum Lifetime Benefit Amount.

INCONTESTABLE PERIOD

During the first six (6) months Your Certificate is in force, We may rescind Your Certificate 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 as a Certificateholder.

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

After Your Certificate has been in force for two (2) years, We may rescind Your Certificate 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, the Group Policyholder, 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 Certificate.

MISSTATEMENT OF AGE

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

NON-PARTICIPATING

The Group Policy does not participate in Our profits or surplus earnings.

CONFORMITY WITH FEDERAL AND STATE STATUTES

Any provision of this Certificate that, on its effective date is in conflict with the federal statutes pertaining to qualified long-term care insurance or the statutes of the state in which You reside on such date is hereby amended to conform to the minimum requirement of such statutes, if required.

NYP11-341-NY-200



[Home Office:]
[One Blue Cross Place]
[165 Court Street]
[Rochester, NY 14647]
[Toll Free: 1-866-474-5824]



**NEW YORK STATE PUBLIC EMPLOYEE AND RETIREE
LONG-TERM CARE INSURANCE PLAN (NYPERL)
GROUP POLICY**

GROUP POLICYHOLDER: [XXX]
GROUP NUMBER: [XXX]
EFFECTIVE DATE: [XX/XX/XXXX]

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

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.

This Policy is a legal contract between the Group Policyholder and MedAmerica Insurance Company of New York (herein called We, Us or Our). We agree to pay the benefits of this Policy, subject to all of its terms.

The provisions on the pages that follow are a part of this Policy. Also a part of this Policy are the provisions of the certificates of insurance (herein called the Certificate) which are issued and applicable to persons insured under this Policy (herein called Insured Persons). A copy of the Certificate that applies to each class of Insured Persons is attached to and made a part of this Policy.

This Policy is issued in consideration of the application of the Group Policyholder and payment of any required premium. It will take effect at 12:01 A.M. standard time at the Policyholder's address on the Effective Date shown above. This date is its date of issue.

Guaranteed Renewability. This Policy continues in effect as long as any required premiums are paid on time. Premiums for coverage provided under this Policy may change, but only if We change the premium rates for all Insured Persons in the same payment class, regardless of where you reside at the time of the premium change. [We guarantee that Your Certificate premiums will not increase FOR ANY REASON for a full three (3) years from the Policy effective date as listed in the Schedule.] 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 and those approved by the New York State Department of Insurance.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If an Insured Person is eligible for Medicare, he or she must review the Medicare Supplement Buyer's Guide available from Us.

This Policy is delivered in the State of New York and is governed by its laws.

[Christopher D. Perna,]
[President]

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SCHEDULE

This is an outline of the Benefits available to Insured Persons in the eligible classes. The Benefits that apply to each class are described in the Certificate for that class as shown below.

Class No.

[1]

[2]

Certificate No.

[123456-Ed.1]

[123456-Ed.2]

Benefits Offered to Certificateholders

LIFETIME BENEFIT AMOUNT

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

[\$ XXXXX]

BENEFIT PERIOD

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

1,095 days (3years)

LIFETIME ELIMINATION PERIOD

[X] 90 Days]

DAILY BENEFIT AMOUNT

For Nursing Facility, Alternate Care, Hospice Care, Respite Care, Bed Reservation, Care Management
Actual Charges incurred up to:

[\$148 Per Day]

[\$180 Per Day]

[\$250 Per Day]

Home Care, Assisted Living Facility, Adult Day Care
Actual Charges incurred up to:

[\$74 Per Day]

[\$90 Per Day]

[\$125 Per Day]

[Shortened Benefit Period Nonforfeiture Rider:]

[X]

[Return of Premium Rider:]

[X]

[Survivorship Benefit Rider:]

[X]

[INFLATION PROTECTION OPTION] [(Offered to Group Policyholder only)]

[None; benefits remain level. ☒]
(Available only to Ages 80 and over)

[Compound Inflation Protection ☒
(Required for Ages 18-79)

The Insured Person's Lifetime Benefit Amount and Daily Benefit Amount will each increase on every anniversary of the effective date of his or her Certificate. Annual increases will apply to Benefits payable for any expenses the Insured Person incurs on or after the date of the increase. This first increase will be equal to 5% of the Insured Person's original amounts. Each increase thereafter will be equal to 5% of the increased amounts that applied on the date of the prior increase.]

[PREMIUM PAYMENT TERM]

[Lifetime or as long as the Insured Person wishes to keep the Certificate in force] ☒

[10 Year Paid-in-Full*] ☒

[°If 10 Year Paid in Full option is chosen, your policy cannot lapse after satisfaction of payment term.] ☒

[PREMIUM PAYMENT MODE]

[Bank Account Draft OR Credit Card ☒
(Monthly, Quarterly, Semi-Annual, Annual)]

[Payroll Deduction ☒
(Depending on Employer Capabilities)
(Bi-Monthly, Monthly, Quarterly, Semi-Annual, Annual)]

[Direct Bill ☒
(Quarterly, Semi-Annual, Annual)]

Refer to the applicable Certificate(s) for a description of these Benefits

ELIGIBILITY AND EFFECTIVE DATES

WHO IS ELIGIBLE

[Group Requirements:

Group Size at Initial Open Enrollment: Number of active employees/eligibles - _____

Open Enrollment Period: Initial open enrollment period-[_____] days

Open Enrollment Period For New Employees/Eligibles: [60] days from date of hire]

Enrollment Eligibility: These classes of persons are eligible for insurance under this Policy:

[Residency Requirements: residents of the State of -_____]

[Age Requirements: minimum of -18]

[Employment Status: Employees and Retirees (including Vestees and Dependent Survivors) and their eligible Dependents including spouses, Domestic Partners, dependent children, including student dependent children the natural parents of employees, retired employees, Vestees and their spouses/domestic partners.]

Underwriting Selections:

[Class 1: Guaranteed Issue - During Initial Open Enrollment. Health Statement not required.

Employees who apply for coverage during the initial open enrollment period and newly eligible Employees who apply for coverage within 60 days of their hire date or the date they first meet the following requirements:

On the day coverage is to begin, the Active Employee/Eligible must be at the employer's place of business or at a location to which the employer's business requires the Employee to travel and be able to fully perform the duties of the position for that Employee's normal workday. Including any day on which the Employee is on vacation or on authorized leave provided such absence is not due to illness or injury or Leave Without Pay. An Employee is any person in the service of the employer (State, Participating Employers or Participating Agencies) who is paid by the employer and who:

1. is expected to work at least six biweekly pay periods; and
2. works at least half-time on a regular schedule, and
3. is on the payroll at the time of application, or
4. is in one of the following categories at the time of application:
 - a. A local elected official;
 - b. A paid member of a public legislative body;
 - c. An unpaid board member of a public authority with at least six months service as a board member; or
 - d. An unpaid or paid elected member of a school board.]

[Class 2: Standard Issue - Long-Form Health Statement required. Standard Issue is required for the following:

1. Any Employee/Eligible who does not meet the requirements under Guaranteed Issue;
2. Employees who choose to apply for coverage after the initial offering and new Employees who choose to apply for coverage more than 60 days after their hire date;
3. An Employee's eligible Dependent(s); and
4. Retirees, Spouses/Domestic Partners, Vestees, and Dependent Survivors and their eligible Dependents and Parents (including in-law).]

WHEN A PERSON'S COVERAGE STARTS

The date that a person's coverage under this Policy starts depends on when he or she applies and pays premium for it. And in addition, if Special Requirements apply and are indicated below, his or her insurance will not start until that requirement is met.

1. If the person applies on or before his or her eligibility date, his or her insurance coverage will start:
 - on his or her eligibility date, and
 - once We are in receipt of the first premium payment.
2. If the person applies more than 60 days after his or her eligibility date, insurance coverage will start:
 - on the date We approve his or her proof of insurability, and
 - once We are in receipt of the first premium payment.

Special Requirements:

1. If the person is in class 2, he or she must give Us acceptable proof that he or she is insurable by Our standards in order for his or her insurance to start. In this case, the person's insurance will start on the date We approve his or her proof of insurability.

BASIS OF INSURANCE

Persons in all classes are required to contribute toward the cost of their insurance under this Policy.

A person's contribution toward the cost of his or her insurance under this Policy may not be more than the premium charge for that insurance.

TERMINATION OF COVERAGE

WHEN THIS POLICY ENDS

This Policy ends when the first of these dates occurs:

- the date the Group Policyholder chooses to terminate this Policy; or
- the date We terminate this Policy due to fraud; or
- [the date the Group Policyholder's premiums are not paid when due, subject to the Grace Period.]

WHEN AN INSURED PERSON'S COVERAGE ENDS

The Certificate for each class describes when coverage ends for an Insured Person in that class.

PREMIUM PROVISIONS

The Certificate for each class sets forth the premium provisions which apply to that class.

The premium due for each Insured Person's coverage will be calculated using the approved rates.

We may change the premium rates. However, We will not change an Insured Person's premium rate unless the premium rates change for all persons in the same payment class. We will provide at least 120 days written notice in advance of a change in premium rates. [We guarantee that Your Certificate premiums will not increase FOR ANY REASON for a full three (3) years from the Policy effective date as listed in the Schedule.]

[The Group Policyholder agrees to remit to Us all applicable premiums for employees/eligibles and their spouses. All applicable premium payments due from the Group Policyholder are subject to the Grace Period provision set forth below.]

[All other Insured Persons will pay premiums directly to Us.]

[GRACE PERIOD

An initial Grace Period of 30 days will be granted for each premium payment that is unpaid on the date due. After 30 days, a notice will be sent to the Group Policyholder explaining that a payment has been missed and that this Policy is at risk of lapsing. An additional 35 days from the date We mail the notice will be granted during which any unpaid premium must be paid. Payment will allow this Policy to continue in force without interruption. Failure to pay any unpaid premium by the end of the Grace Period will result in the termination of this Policy as of the premium due date.]

GENERAL PROVISIONS

ENTIRE CONTRACT

The entire contract consists of:

1. this Policy and any papers made a part of it, including the Group Master Application completed by the Group Policyholder; and
2. the Certificate that applies to each class of Insured Persons, which is attached to and made a part of this Policy; and
3. the written statements, if any, of the Insured Persons, including their enrollment forms; and
4. [The signed Agreement #C000488 between the Group Policyholder and Us.]

In the absence of fraud, all statements made by the Group Policyholder or by the Insured Persons will be deemed to be representations and not warranties. No statement made by an Insured Person will be used to avoid insurance, reduce the benefits, or defend a claim under this Policy unless:

1. the statement is in writing and signed by the Insured Person; and
2. a copy of that statement is given to the Insured Person or to his or her beneficiary.

POLICY CHANGES

This Policy may be changed at any time by written agreement between the Group Policyholder and Us. But the change must be approved by one of Our executive officers. We will not be bound by a promise or representation made by any other person. No agent has the authority to change this Policy, or any Certificate issued hereunder, in any way or to waive any of its terms.

CERTIFICATES

We will provide certificates of insurance for delivery to each Insured Person. They will describe: (1) the coverage the Insured Person has; (2) any limitations, reductions, and exclusions that apply to the coverage; (3) to whom the benefits will be paid; and (4) the Insured Person's continuation or conversion rights if coverage ends. We may send the certificate directly to the Insured Person or give it to the Group Policyholder for delivery to him or her.

INCONTESTABILITY

We will not contest the validity of this Policy after it has been in force for [two (2) years] from its date of issue.

DATA REQUIRED FROM GROUP POLICYHOLDER

We need certain data to carry out the terms of this Policy and to determine the premium. The Group Policyholder shall give us the data we need to do this whenever we need it. We also have the right to inspect any records of the Group Policyholder, if We believe they would have a bearing on this Policy. We have the right to do this at any reasonable time.

[NON-PARTICIPATING

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

CONFORMITY WITH APPLICABLE LAW

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, if required.

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 and Certificates issued under this Policy, We will implement one or a combination of the following amendments to this Policy and any Certificates, 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 and any Certificates have been duplicated by the national program.
- B. Increase benefits under this Policy and any Certificates to make up for benefits that have been duplicated by the national program.



[Home Office:]
[165 Court Street]
[Rochester, NY 14647]
[Toll Free: 1-866-474-5824]



**NEW YORK STATE PUBLIC EMPLOYEE AND RETIREE
LONG-TERM CARE INSURANCE PLAN (NYPERL)
GROUP POLICY**

GROUP POLICYHOLDER: [XXX]
GROUP NUMBER: [XXX]
EFFECTIVE DATE: [XX/XX/XXXX]

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

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.

This Policy is a legal contract between the Group Policyholder and MedAmerica Insurance Company of New York (herein called We, Us or Our). We agree to pay the benefits of this Policy, subject to all of its terms.

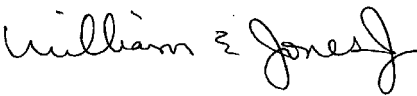
The provisions on the pages that follow are a part of this Policy. Also a part of this Policy are the provisions of the certificates of insurance (herein called the Certificate) which are issued and applicable to persons insured under this Policy (herein called Insured Persons). A copy of the Certificate that applies to each class of Insured Persons is attached to and made a part of this Policy.

This Policy is issued in consideration of the application of the Group Policyholder and payment of any required premium. It will take effect at 12:01 A.M. standard time at the Policyholder's address on the Effective Date shown above. This date is its date of issue.

Guaranteed Renewability. This Policy continues in effect as long as any required premiums are paid on time. Premiums for coverage provided under this Policy may change, but only if We change the premium rates for all Insured Persons in the same payment class, regardless of where you reside at the time of the premium change. [We guarantee that Your Certificate premiums will not increase FOR ANY REASON for a full three (3) years from the Policy effective date as listed in the Schedule.] 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 and those approved by the New York State Department of Insurance.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If an Insured Person is eligible for Medicare, he or she must review the Medicare Supplement Buyer's Guide available from Us.

This Policy is delivered in the State of New York and is governed by its laws.


[]

[William E. Jones, Jr.]
[President]

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SCHEDULE

This is an outline of the Benefits available to Insured Persons in the eligible classes. The Benefits that apply to each class are described in the Certificate for that class as shown below.

Class No.

[1]

[2]

Certificate No.

[123456-Ed.1]

[123456-Ed.2]

Benefits Offered to Certificateholders

LIFETIME BENEFIT AMOUNT

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

[\$ XXXXX]

BENEFIT PERIOD

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

1,095 days (3years)

LIFETIME ELIMINATION PERIOD

[X 90 Days]

DAILY BENEFIT AMOUNT

For Nursing Facility, Alternate Care, Hospice Care,
Respite Care, Bed Reservation, Care Management
Actual Charges incurred up to:

[\$148 Per Day]

[\$180 Per Day]

[\$250 Per Day]

Home Care, Assisted Living Facility, Adult Day Care
Actual Charges incurred up to:

[\$74 Per Day]

[\$90 Per Day]

[\$125 Per Day]

[Shortened Benefit Period Nonforfeiture Rider:]

[X]

[Return of Premium Rider:]

[X]

[Survivorship Benefit Rider:]

[X]

[INFLATION PROTECTION OPTION] [(Offered to Group Policyholder only)]

[None; benefits remain level. ☒]
(Available only to Ages 80 and over)]

[Compound Inflation Protection ☒
(Required for Ages 18-79)

The Insured Person's Lifetime Benefit Amount and Daily Benefit Amount will each increase on every anniversary of the effective date of his or her Certificate. Annual increases will apply to Benefits payable for any expenses the Insured Person incurs on or after the date of the increase. This first increase will be equal to 5% of the Insured Person's original amounts. Each increase thereafter will be equal to 5% of the increased amounts that applied on the date of the prior increase.]

[PREMIUM PAYMENT TERM]

[Lifetime or as long as the Insured Person wishes to keep the Certificate in force] ☒

[10 Year Paid-in-Full*] ☒

[°If 10 Year Paid in Full option is chosen, your policy cannot lapse after satisfaction of payment term.] ☒

[PREMIUM PAYMENT MODE]

[Bank Account Draft OR Credit Card ☒
(Monthly, Quarterly, Semi-Annual, Annual)]

[Payroll Deduction ☒
(Depending on Employer Capabilities)
(Bi-Monthly, Monthly, Quarterly, Semi-Annual, Annual)]

[Direct Bill ☒
(Quarterly, Semi-Annual, Annual)]

Refer to the applicable Certificate(s) for a description of these Benefits

ELIGIBILITY AND EFFECTIVE DATES

WHO IS ELIGIBLE

[Group Requirements:

Group Size at Initial Open Enrollment: Number of active employees/eligibles - _____

Open Enrollment Period: Initial open enrollment period-[_____] days

Open Enrollment Period For New Employees/Eligibles: [60] days from date of hire]

Enrollment Eligibility: These classes of persons are eligible for insurance under this Policy:

[Residency Requirements: residents of the State of -_____]

[Age Requirements: minimum of -18]

[Employment Status: Employees and Retirees (including Vestees and Dependent Survivors) and their eligible Dependents including spouses, Domestic Partners, dependent children, including student dependent children the natural parents of employees, retired employees, Vestees and their spouses/domestic partners.]

Underwriting Selections:

[Class 1: Modified Guaranteed Issue - During Initial Open Enrollment. Health Statement required.

Employees who apply for coverage during the initial open enrollment period and newly eligible Employees who apply for coverage within 60 days of their hire date or the date they first meet the following requirements:

On the day coverage is to begin, the Active Employee/Eligible must be at the employer's place of business or at a location to which the employer's business requires the Employee to travel and be able to fully perform the duties of the position for that Employee's normal workday. Including any day on which the Employee is on vacation or on authorized leave provided such absence is not due to illness or injury or Leave Without Pay. An Employee is any person in the service of the employer (State, Participating Employers or Participating Agencies) who is paid by the employer and who:

1. is expected to work at least six biweekly pay periods; and
2. works at least half-time on a regular schedule, and
3. is on the payroll at the time of application, or
4. is in one of the following categories at the time of application:
 - a. A local elected official;
 - b. A paid member of a public legislative body;
 - c. An unpaid board member of a public authority with at least six months service as a board member; or
 - d. An unpaid or paid elected member of a school board.]

[Class 2: Standard Issue - Long-Form Health Statement required. Standard Issue is required for the following:

1. Any Employee/Eligible who does not meet the requirements under Modified Guaranteed Issue;
2. Employees who choose to apply for coverage after the initial offering and new Employees who choose to apply for coverage more than 60 days after their hire date;
3. An Employee's eligible Dependent(s); and
4. Retirees, Spouses/Domestic Partners, Vestees, and Dependent Survivors and their eligible Dependents and Parents (including in-law).]

WHEN A PERSON'S COVERAGE STARTS

The date that a person's coverage under this Policy starts depends on when he or she applies and pays premium for it. And in addition, if Special Requirements apply and are indicated below, his or her insurance will not start until that requirement is met.

A person's insurance coverage will start:

- on the date We approve his or her proof of insurability, and
- once We are in receipt of the first premium payment.

BASIS OF INSURANCE

Persons in all classes are required to contribute toward the cost of their insurance under this Policy.

A person's contribution toward the cost of his or her insurance under this Policy may not be more than the premium charge for that insurance.

TERMINATION OF COVERAGE

WHEN THIS POLICY ENDS

This Policy ends when the first of these dates occurs:

- the date the Group Policyholder chooses to terminate this Policy; or
- the date We terminate this Policy due to fraud; or
- [the date the Group Policyholder's premiums are not paid when due, subject to the Grace Period.]

WHEN AN INSURED PERSON'S COVERAGE ENDS

The Certificate for each class describes when coverage ends for an Insured Person in that class.

PREMIUM PROVISIONS

The Certificate for each class sets forth the premium provisions which apply to that class.

The premium due for each Insured Person's coverage will be calculated using the approved rates.

We may change the premium rates. However, We will not change an Insured Person's premium rate unless the premium rates change for all persons in the same payment class. We will provide at least 120 days written notice in advance of a change in premium rates. [We guarantee that Your Certificate premiums will not increase FOR ANY REASON for a full three (3) years from the Policy effective date as listed in the Schedule.]

[The Group Policyholder agrees to remit to Us all applicable premiums for employees/eligibles and their spouses. All applicable premium payments due from the Group Policyholder are subject to the Grace Period provision set forth below.]

[All other Insured Persons will pay premiums directly to Us.]

[GRACE PERIOD

An initial Grace Period of 30 days will be granted for each premium payment that is unpaid on the date due. After 30 days, a notice will be sent to the Group Policyholder explaining that a payment has been missed and that this Policy is at risk of lapsing. An additional 35 days from the date We mail the notice will be granted during which any unpaid premium must be paid. Payment will allow this Policy to continue in force without interruption. Failure to pay any unpaid premium by the end of the Grace Period will result in the termination of this Policy as of the premium due date.]

GENERAL PROVISIONS

ENTIRE CONTRACT

The entire contract consists of:

1. this Policy and any papers made a part of it, including the Group Master Application completed by the Group Policyholder; and
2. the Certificate that applies to each class of Insured Persons, which is attached to and made a part of this Policy; and
3. the written statements, if any, of the Insured Persons, including their enrollment forms; and
4. [The signed Agreement #C000488 between the Group Policyholder and Us.]

In the absence of fraud, all statements made by the Group Policyholder or by the Insured Persons will be deemed to be representations and not warranties. No statement made by an Insured Person will be used to avoid insurance, reduce the benefits, or defend a claim under this Policy unless:

1. the statement is in writing and signed by the Insured Person; and
2. a copy of that statement is given to the Insured Person or to his or her beneficiary.

POLICY CHANGES

This Policy may be changed at any time by written agreement between the Group Policyholder and Us. But the change must be approved by one of Our executive officers. We will not be bound by a promise or representation made by any other person. No agent has the authority to change this Policy, or any Certificate issued hereunder, in any way or to waive any of its terms.

CERTIFICATES

We will provide certificates of insurance for delivery to each Insured Person. They will describe: (1) the coverage the Insured Person has; (2) any limitations, reductions, and exclusions that apply to the coverage; (3) to whom the benefits will be paid; and (4) the Insured Person's continuation or conversion rights if coverage ends. We may send the certificate directly to the Insured Person or give it to the Group Policyholder for delivery to him or her.

INCONTESTABILITY

We will not contest the validity of this Policy after it has been in force for [two (2) years] from its date of issue.

DATA REQUIRED FROM GROUP POLICYHOLDER

We need certain data to carry out the terms of this Policy and to determine the premium. The Group Policyholder shall give us the data we need to do this whenever we need it. We also have the right to inspect any records of the Group Policyholder, if We believe they would have a bearing on this Policy. We have the right to do this at any reasonable time.

[NON-PARTICIPATING

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

CONFORMITY WITH APPLICABLE LAW

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, if required.

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 and Certificates issued under this Policy, We will implement one or a combination of the following amendments to this Policy and any Certificates, 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 and any Certificates have been duplicated by the national program.
- B. Increase benefits under this Policy and any Certificates to make up for benefits that have been duplicated by the national program.

NYP11-342-NY-200



**NEW YORK STATE PUBLIC EMPLOYEE AND RETIREE LONG-TERM CARE INSURANCE PLAN (NYPERL)
GROUP PARTNERSHIP PROGRAM**

Group Number 50

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

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.

This Certificate explains the Benefits MedAmerica Insurance Company (herein called "the Company," or "We" or "Us" or "Our") provides to the Certificateholder ("You" or "Your" or "Yourself") whose name and identification number are in the Schedule. These Benefits are provided under a contract (the "Group Policy") between Us and the group whose number is also shown in the Schedule. (This group is called the "Group Policyholder.")

This Certificate is issued to You. It will continue unless it is terminated for any of the reasons described in this Certificate. Your coverage under the Group Policy starts on the effective date shown in Your Schedule. Your Certificate premiums may change, but only if 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.

The Benefits of the Certificate provide coverage to persons needing assistance for care as shown in the Benefits Section of this Certificate, and are subject to its provisions, limitations and exclusions. Your coverage under the Group Policy is not intended to replace Your present health insurance or Medicare Supplement Insurance. **THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT POLICY.** If You are eligible for Medicare, You should review the Medicare Supplement Buyer's Guide available from Us.

30 Day Free Look: If You feel this Certificate does not meet Your needs, You may return it to Us within 30 days. If You do so: (1) We will return any premium paid and (2) We will not provide You with any Benefits under the Group Policy.

NOTICE TO BUYER: THIS CERTIFICATE 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 CERTIFICATE LIMITATIONS.

Caution: The issuance of this long-term care insurance Certificate is based upon Your responses to the questions on Your enrollment form. A copy of Your enrollment form is enclosed. If Your answers are incorrect or untrue, or fail to include all material medical or eligibility information requested, the Company has the right to deny Benefits or rescind Your Certificate. 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 the Company at the above address.

This Group Policy meets the minimum requirements for long-term care insurance in the state of New York. It is intended to be a federally tax-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. 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 the Group Policyholder and the Group Policyholder may accept or reject them.

The Group Policy determines governing contractual provisions.

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 Certificate entitled General Provisions for details.

The Group Policy determines governing contractual provisions.

William E. Jones, Jr.
President

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SCHEDULE

Certificateholder Name:	JOHN DOE
Certificate Effective Date:	XX/XX/XX
Certificateholder Issue Age:	XX
Premium Mode:	XXXXXXXXX
Certificateholder Identification No.:	L123456789-01
Group Name:	NYS Department of Civil Services
Group Number:	50
Premium Totals:	
Base Premium:	\$XXXX
Total Premium:	\$XXXX

Total Benefit

LIFETIME BENEFIT AMOUNT

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

\$XXXX

BENEFIT PERIOD

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

1,095 Days (3 years)

LIFETIME ELIMINATION PERIOD

90 Days

DAILY BENEFIT AMOUNT

For Nursing Facility, Alternate Care, Respite Care, Hospice Care, Bed Reservation, Care Management:

Actual Charges incurred up to:

\$X Per Day

Home Care, Assisted Living Facility, Adult Day Care,

Actual Charges Incurred up to:

50% of above Nursing Home amount

\$Z Per Day

INFLATION PROTECTION OPTION

None, Benefits remain level.

 X

Compound Inflation Protection

 X

Your Lifetime Benefit Amount and Daily Benefit Amount will each increase on every anniversary of the effective date of this Certificate. 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.

PREMIUM PAYMENT TERM

Lifetime or as long as the Insured Person wishes to keep the Certificate in force.

 X

10 Year Paid-in-Full*

 X

*If the 10 Year Paid in Full option is chosen, Your
Certificate cannot lapse after satisfaction of payment term.

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

DEFINITIONS

ACTIVITIES OF DAILY LIVING (ADL):

Each of the following is an Activity of Daily Living:

<u>Bathing:</u>	This means washing Yourself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
<u>Continence:</u>	This means the ability to maintain control of bowel or bladder functions; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
<u>Dressing:</u>	This means the ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.
<u>Eating:</u>	This means the ability to feed oneself by getting food into Your body from a receptacle (such as plate, cup or table) or by a feeding tube or intravenously.
<u>Toileting:</u>	This means the ability to go to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
<u>Transferring:</u>	This means the ability to move into or out of a bed, chair or wheelchair.

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.

A portion, wing, ward or unit of a multi-use facility will qualify as an Assisted Living Facility only if it meets all of 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 Certificate, Your Schedule, and attached riders.

BENEFIT ELIGIBILITY:

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

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.

CERTIFICATE:

This document which describes the Benefits provided under the group contract between Us and the Group Policyholder whose number is shown on Your Schedule. It shall also include Your enrollment form and any riders or endorsements. This Certificate is not a contract between You and Us.

CERTIFICATE HOLDER:

The person to whom this Certificate is issued and whose name appears in the Schedule.

DAILY BENEFIT AMOUNT:

This is the maximum amount We will pay for all charges You incur 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 or domestic partner and anyone related to You or Your spouse or domestic partner (including adopted, in-law and step-relatives) as parent, grandparent, child, grandchild, brother, sister, aunt, uncle, first cousin, nephew or niece.

GROUP POLICY:

This is the contract between Us and the Group Policyholder whose name and number are shown on Your Schedule.

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 six (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 Certificate 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 Certificate.

- 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 We are not liable to pay expenses for any services listed in this Certificate. The Elimination Period begins on the first day You are certified as meeting Benefit Eligibility as defined in this Certificate and continues until the first such calendar day You are no longer Benefit Eligible or You reach the Lifetime Elimination Period listed in Your Schedule. Days used to satisfy Your Lifetime Elimination Period do not need to be consecutive, but must be accumulated within a period of 365 days (or 366 days in a leap year). The Lifetime Elimination Period will be applied only once during the life of the Certificate. There is no Lifetime Elimination Period for Hospice Program, Respite Care, or Transition Benefit. These Benefits may not be used to satisfy the Lifetime Elimination Period.

A Lifetime Elimination Period based on benefit eligibility minimizes premiums due to the fact that only the days in which You are certified as eligible to receive benefits are counted toward Your 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 Certificate.

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 minimum benefit period listed in Your Schedule.

Your income remains subject to the New York State Social Services income limitations when You apply 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 also contain services that You need that are not covered under this Certificate. We retain the right to request periodic updated assessments.

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 Certificate; and (b) are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

SCHEDULE:

The section of Your Certificate titled Schedule. It lists Your information such as coverage amounts and Benefit options.

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:

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 Activity of Daily Living.
- 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 Activity of Daily Living (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:

This 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 Certificate is issued and whose name appears in the Schedule.

BENEFIT ACCESS

BENEFIT ELIGIBILITY

To start the Benefit access process, You must contact Us as soon as You think You might need services covered under this Certificate. Please call Our Customer Service Representative at 1-800-919-8816.

To be eligible for Benefits provided by this Certificate, 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 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 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 Certificate. This information may be gathered by Us or by 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.

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 will provide an initial on-site consultation by our Personal Care Advisor if requested.

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

The maximum amount We will pay for all charges You incur 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.

BED RESERVATION

If You are hospitalized temporarily while We are paying for Benefits in a Nursing Facility, Assisted Living Facility or a Hospice 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. Benefits paid for Bed Reservation will be deducted from Your Lifetime Benefit Amount.

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.

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.

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.

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.

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.

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
- Respite 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, 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.

WORLDWIDE COVERAGE

This Certificate 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 Certificate:

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. Treatment provided in a government facility except treatment provided to a Medicaid recipient or as otherwise required by State or Federal law.
4. Services for which any Benefits are provided under Workers' Compensation, employer's liability program, occupational disease law or mandatory no-fault insurance.
5. Services provided by a member of Your 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 reimbursable by Medicare but have been applied to a deductible or coinsurance amount.

PREMIUM

PREMIUM AMOUNT

The initial premium is listed in Your Schedule. If there is a change in the premium for Your coverage, We will give the Group Policyholder and You, if You pay premium to Us directly, at least 30 days written notice before the new premium goes into effect. No change will be made to the premium amount unless the premium rates change for all persons in the same 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 the Group Policyholder or to You, if You pay premium to Us directly, explaining that a payment has been missed and that Your Certificate 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 or the Group Policyholder 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 Certificate to continue in force without interruption. Failure to pay any unpaid premium by the end of this sixty five (65) day Grace Period will result in the termination of Your Certificate as of the premium due date.

REINSTATEMENT

If Your Certificate ends for non-payment of premium within the Grace Period, You may request reinstatement, within twelve (12) months, with no break in coverage subject to evidence of insurability. If We honor this request, Your Certificate will be reinstated retroactive to the date Your Certificate ended. Once reinstated, You must pay the premium due retroactive to the date Your Certificate ended.

EXTENDED REINSTATEMENT BENEFIT FOR SEVERE COGNITIVE IMPAIRMENT AND LOSS OF FUNCTIONAL CAPACITY

If You are paying premium directly to Us and You failed to pay Your premium within the Grace Period, because of a condition that would qualify You for Benefits under this Certificate, You may request reinstatement up to five (5) months after termination of Your Certificate.

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 Certificate. We will make a Benefit Eligibility assessment before deciding on reinstatement. If Your Certificate is reinstated, You must pay the premium due retroactive to the date Your Certificate terminated.

PREMIUM WAIVER

Your premium payments will be waived on a monthly basis starting:

- On the first day You are certified as meeting Benefit Eligibility and You have satisfied the Lifetime Elimination Period.

This waiver of premium payment ends when You are no longer eligible for covered services under this Policy for a period of 180 days.

UNEARNED PREMIUM

When We are notified of Your death, We will refund to the Group Policyholder, or to Your estate if You pay premium directly to Us, any premium already 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 Certificateholder 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 notice, You will be deemed to have met the timeliness of claim filing requirements upon submitting, within the time fixed in this Certificate 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 Certificateholder Identification Number, the Group Policyholder's name and the Group 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 Certificate. The following conditions also apply:

- Your Certificate 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 Certificate; 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, upon Your request, to the Approved Provider. 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 or Your Benefit Eligibility 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.

We will make a Benefit determination, independent of the original, using medical records and the provisions of this Certificate. We will send You Our written decision within 30 business days of Our receipt of all requested information. If You appeal that decision, an independent review of the decision will be made by an external agency.

For any claims appeal the request should be sent to Our office within three (3) years of the time of filing written notice of proof of loss for the claim being appealed.

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 three (3) years after the time written proof of loss is furnished.

COORDINATION OF BENEFITS

WHEN YOU HAVE OTHER HEALTH BENEFITS

This Benefit applies if You are covered under a Long-Term Care or health insurance contract, plan or policy issued through or to a group which provides some of the same Benefits as the Group Policy.

When You receive an item of service which would be covered under both policies, We will coordinate Benefit payments with any payment made under the other policy. One company will pay its full benefit as a primary benefit. The other company will pay secondary benefits if necessary to cover Your expenses. This prevents duplicate payments and overpayments. The following are considered to be a health insurance policy:

- Any group or blanket insurance policy, including HMO and other prepaid group coverage, except that blanket school accident coverages or such coverages offered to substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance policy.
- Any self-insured or non-insured plan, or any other plan arranged through any employer; trustee; union; employer organization; or employee benefit organization.
- Any Blue Cross, Blue Shield or other service-type group plan.
- Any coverage under governmental programs or any coverage required or provided by any statute, except Medicaid.
- Medical benefits coverage in group and individual mandatory traditional automobile "fault" type contracts.

RULES TO DETERMINE PAYMENT

The first of the rules listed below which applies shall determine which policy shall be Your primary insurance:

- If the other policy does not have a provision similar to this one, then it will be primary.
- If You are covered under one policy as an employee or member of a group and You are only covered as a dependent or Family Member under this Policy, the policy which covers You as an employee or member of a group will be primary.
- If You are covered under one of the Plans as an active employee, neither laid-off nor retired, or as the dependent of such an active employee, and You are covered as a laid-off or retired employee or laid-off or retired employee's dependent under the other plan, the Plan covering You as an active employee will be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the Plans do not agree on which shall be primary, the rule below shall apply.
- If You are covered under two policies as a dependent child of different persons, then the policy of the parent whose birthday falls earlier in a year will be primary. If both parents have the same birthday, the policy which covered the parent longer is primary to the policy which covered the other parent for a shorter period of time. If the other policy does not have a provision similar to this one, but instead has a rule based on the gender of the parent, and if, as a result, the policies do not agree on the order of benefits, the rule in the other policy will determine the order of benefits.
- If none of the above applies, then the policy which has covered You for the longest time will be primary.

The above rules apply whether or not You actually make a claim under both policies.

PAYMENT WHEN THE GROUP POLICY IS SECONDARY

When Your coverage under the Group Policy is secondary, the Benefits of the Group Policy will be reduced so that the total benefits payable under the other health insurance policy and under the Group Policy do not exceed the charge for the service. However, We will not pay more than We would have paid if it were primary.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

We have the right to release or obtain information which We believe necessary to carry out the purpose of this Coordination of Benefits section. We will not notify You or obtain Your consent before releasing or obtaining information except as required by law. We will not be legally responsible to You or anyone else for releasing or obtaining this information. You must furnish Us any information that We request. If You do not furnish the information, We have the right to deny payments.

OUR RIGHT TO RECOVER OVERPAYMENT

In some cases, We may have made payments even though You had coverage under another policy. If this happens, it will be necessary for You to refund the amount by which We should have reduced the payment We made. We also have the right to recover the overpayment from the other health benefits programs if We have not already received payment from that other program. You must sign any document that We feel is needed to help Us recover any overpayment.

RIGHT TO CONTINUATION OR CONVERSION OF COVERAGE AFTER TERMINATION

CONTINUATION

If Your relationship to the Group changes for any reason, You will be eligible to continue coverage without interruption as long as You pay all premiums when due and You have not exhausted Your Lifetime Benefit Amount. If Your premium was paid by payroll deduction, You must pay premiums directly to Us.

CONVERSION

If the Group Policy terminates, You will be provided conversion privileges as required by New York State regulations.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES

This Certificate is issued pursuant to the Group Master Policy which determines governing contractual provisions. The Group Master Policy, the Group Master Application, Your enrollment form, including any applicable health statements, any Riders and attached papers establish the entire contract of insurance between the Group Policyholder and Us.

YOUR BENEFITS

Only You can receive Benefits under this Certificate.

WHEN YOUR COVERAGE STARTS

The date that Your coverage under this Certificate starts is shown in Your Schedule. All time periods start and end at 12:01 a.m. standard time at Your residence. Benefits are available only for services that You receive on or after Your effective date. They are subject to all of the conditions shown in this Certificate.

WHEN YOUR COVERAGE ENDS

You are no longer covered under the Group Policy when the first of the following occurs:

On the date Your premiums are not paid, when due, subject to the Grace Period.

When Your Maximum Benefits Available Under Your Certificate Are Exhausted: Your coverage will automatically end when You have used the maximum Benefits to which You are entitled. We will notify You when this occurs.

When You Elect to Terminate Your Coverage Under the Certificate: You may cancel Your coverage at any time by giving Us at least 30 days prior written notice. Your coverage will end on the date specified in Your written notice or on a later date as may be specified in the notice.

On Your Death: Your coverage will automatically end on the day after the date of Your death. We will refund to the Group Policyholder, or to Your estate, any premium already paid for the period between the day after the date of death until the next premium due date.

OUR OPTION TO TERMINATE

YOUR COVERAGE CANNOT BE CANCELLED BECAUSE OF YOUR AGE, A CHANGE IN YOUR RELATIONSHIP TO THE GROUP, EMPLOYMENT STATUS, HEALTH STATUS, HEALTH CARE NEEDS, OR USE OF BENEFITS.

Your coverage can be cancelled for fraud committed by You or any other person, when You applied for coverage or on the submission of any claims under the Group Policy. (See "Incontestable Period" in the General Provisions section of Your Certificate.)

EXTENSION OF BENEFITS

If Your coverage under the Group Policy ends while You are totally disabled or while You are receiving Qualified Long-Term Care Services covered under the Group Policy, We will continue to pay for Your care without interruption of Benefits until the first of these dates:

- It has been determined that You are no longer eligible for Benefits under this Certificate; 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 coverage under the Group Policy had not ended.

You will not be entitled to Benefits after Your coverage ends if it ended due to You reaching Your maximum Lifetime Benefit Amount.

INCONTESTABLE PERIOD

During the first six (6) months Your Certificate is in force, We may rescind Your Certificate 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 as a Certificateholder.

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

After Your Certificate has been in force for two (2) years, We may rescind Your Certificate 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, the Group Policyholder, 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 Certificate.

MISSTATEMENT OF AGE

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

NON-PARTICIPATING

The Group Policy does not participate in Our profits or surplus earnings.

CONFORMITY WITH FEDERAL AND STATE STATUTES

Any provision of this Certificate that, on its effective date is in conflict with the statutes of the state in which You reside on such date is hereby amended to conform to the minimum requirement of such statutes if required.

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 Certificate, We will implement one or a combination of the following amendments to this Certificate, 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 Certificate have been duplicated by the national program.
- B. Increase benefits under this Certificate to make up for benefits that have been duplicated by the national program.



**NEW YORK STATE PUBLIC EMPLOYEE AND RETIREE LONG-TERM CARE INSURANCE PLAN (NYPERL)
GROUP PARTNERSHIP PROGRAM**

Group Number 50

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

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.

This Certificate explains the Benefits MedAmerica Insurance Company (herein called "the Company," or "We" or "Us" or "Our") provides to the Certificateholder ("You" or "Your" or "Yourself") whose name and identification number are in the Schedule. These Benefits are provided under a contract (the "Group Policy") between Us and the group whose number is also shown in the Schedule. (This group is called the "Group Policyholder.")

This Certificate is issued to You. It will continue unless it is terminated for any of the reasons described in this Certificate. Your coverage under the Group Policy starts on the effective date shown in Your Schedule. Your Certificate premiums may change, but only if 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.

The Benefits of the Certificate provide coverage to persons needing assistance for care as shown in the Benefits Section of this Certificate, and are subject to its provisions, limitations and exclusions. Your coverage under the Group Policy is not intended to replace Your present health insurance or Medicare Supplement Insurance. **THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT POLICY.** If You are eligible for Medicare, You should review the Medicare Supplement Buyer's Guide available from Us.

30 Day Free Look: If You feel this Certificate does not meet Your needs, You may return it to Us within 30 days. If You do so: (1) We will return any premium paid and (2) We will not provide You with any Benefits under the Group Policy.

NOTICE TO BUYER: THIS CERTIFICATE 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 CERTIFICATE LIMITATIONS.

Caution: The issuance of this long-term care insurance Certificate is based upon Your responses to the questions on Your enrollment form. A copy of Your enrollment form is enclosed. If Your answers are incorrect or untrue, or fail to include all material medical or eligibility information requested, the Company has the right to deny Benefits or rescind Your Certificate. 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 the Company at the above address.

This Group Policy meets the minimum requirements for long-term care insurance in the state of New York. It is intended to be a federally tax-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. 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 the Group Policyholder and the Group Policyholder may accept or reject them.

The Group Policy determines governing contractual provisions.

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 Certificate entitled General Provisions for details.

The Group Policy determines governing contractual provisions.

William E. Jones, Jr.
President

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SCHEDULE

Certificateholder Name:	JOHN DOE
Certificate Effective Date:	XX/XX/XX
Certificateholder Issue Age:	XX
Premium Mode:	XXXXXXXXXX
Certificateholder Identification No.:	L123456789-01
Group Name:	NYS Department of Civil Services
Group Number:	50
Premium Totals:	
Base Premium:	\$XXXX
Total Premium:	\$XXXX

Total Benefit

LIFETIME BENEFIT AMOUNT

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

\$XXXX

BENEFIT PERIOD

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

1,095 Days (3 years)

LIFETIME ELIMINATION PERIOD

90 Days

DAILY BENEFIT AMOUNT

For Nursing Facility, Alternate Care, Respite Care, Hospice Care, Bed Reservation, Care Management:

Actual Charges incurred up to:

\$X Per Day

Home Care, Assisted Living Facility, Adult Day Care,

Actual Charges Incurred up to:

50% of above Nursing Home amount

\$Z Per Day

INFLATION PROTECTION OPTION

None, Benefits remain level.

X

Compound Inflation Protection

X

Your Lifetime Benefit Amount and Daily Benefit Amount will each increase on every anniversary of the effective date of this Certificate. 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.

PREMIUM PAYMENT TERM

Lifetime or as long as the Insured Person wishes to keep the Certificate in force.

X

10 Year Paid-in-Full*

X

*If the 10 Year Paid in Full option is chosen, Your
Certificate cannot lapse after satisfaction of payment term.

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

DEFINITIONS

ACTIVITIES OF DAILY LIVING (ADL):

Each of the following is an Activity of Daily Living:

<u>Bathing:</u>	This means washing Yourself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
<u>Continence:</u>	This means the ability to maintain control of bowel or bladder functions; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
<u>Dressing:</u>	This means the ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.
<u>Eating:</u>	This means the ability to feed oneself by getting food into Your body from a receptacle (such as plate, cup or table) or by a feeding tube or intravenously.
<u>Toileting:</u>	This means the ability to go to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
<u>Transferring:</u>	This means the ability to move into or out of a bed, chair or wheelchair.

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.

A portion, wing, ward or unit of a multi-use facility will qualify as an Assisted Living Facility only if it meets all of 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 Certificate, Your Schedule, and attached riders.

BENEFIT ELIGIBILITY:

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

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.

CERTIFICATE:

This document which describes the Benefits provided under the group contract between Us and the Group Policyholder whose number is shown on Your Schedule. It shall also include Your enrollment form and any riders or endorsements. This Certificate is not a contract between You and Us.

CERTIFICATE HOLDER:

The person to whom this Certificate is issued and whose name appears in the Schedule.

DAILY BENEFIT AMOUNT:

This is the maximum amount We will pay for all charges You incur 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 or domestic partner and anyone related to You or Your spouse or domestic partner (including adopted, in-law and step-relatives) as parent, grandparent, child, grandchild, brother, sister, aunt, uncle, first cousin, nephew or niece.

GROUP POLICY:

This is the contract between Us and the Group Policyholder whose name and number are shown on Your Schedule.

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 six (6) months or less to live.

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

INDEPENDENT PROVIDER:

A Licensed Health Care Practitioner, or A certified or officially-trained home health care provider, without being affiliated with an entity licensed and/or certified by the New York State Department of Health, or agency exempt from licensure or certification under New York State Law.

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 Certificate 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 Certificate.

- 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 We are not liable to pay expenses for any services listed in this Certificate. The Elimination Period begins on the first day You are certified as meeting Benefit Eligibility as defined in this Certificate and continues until the first such calendar day You are no longer Benefit Eligible or You reach the Lifetime Elimination Period listed in Your Schedule. Days used to satisfy Your Lifetime Elimination Period do not need to be consecutive, but must be accumulated within a period of 365 days (or 366 days in a leap year). The Lifetime Elimination Period will be applied only once during the life of the Certificate. There is no Lifetime Elimination Period for Hospice Program, Respite Care, or Transition Benefit. These Benefits may not be used to satisfy the Lifetime Elimination Period.

A Lifetime Elimination Period based on benefit eligibility minimizes premiums due to the fact that only the days in which You are certified as eligible to receive benefits are counted toward Your 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 Certificate.

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 minimum benefit period listed in Your Schedule.

Your income remains subject to the New York State Social Services income limitations when You apply 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 also contain services that You need that are not covered under this Certificate. We retain the right to request periodic updated assessments.

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 Certificate; and (b) are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

SCHEDULE:

The section of Your Certificate titled Schedule. It lists Your information such as coverage amounts and Benefit options.

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:

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 Activity of Daily Living.
- 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 Activity of Daily Living (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:

This 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 Certificate is issued and whose name appears in the Schedule.

BENEFIT ACCESS

BENEFIT ELIGIBILITY

To start the Benefit access process, You must contact Us as soon as You think You might need services covered under this Certificate. Please call Our Customer Service Representative at 1-800-919-8816.

To be eligible for Benefits provided by this Certificate, 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 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 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 Certificate. This information may be gathered by Us or by 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.

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 will provide an initial on-site consultation by our Personal Care Advisor if requested.

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
- Independent Provider; or
- Home Health Care Agency; or
- Adult Day Care Center.

BENEFITS

The maximum amount We will pay for all charges You incur 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.

BED RESERVATION

If You are hospitalized temporarily while We are paying for Benefits in a Nursing Facility, Assisted Living Facility or a Hospice 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. Benefits paid for Bed Reservation will be deducted from Your Lifetime Benefit Amount.

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.

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.

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.

RESPIRE 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.

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.

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
- Respite 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, 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.

WORLDWIDE COVERAGE

This Certificate 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 Certificate:

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. Treatment provided in a government facility except treatment provided to a Medicaid recipient or as otherwise required by State or Federal law.
4. Services for which any Benefits are provided under Workers' Compensation, employer's liability program, occupational disease law or mandatory no-fault insurance.
5. Services provided by a member of Your 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 reimbursable by Medicare but have been applied to a deductible or coinsurance amount.

PREMIUM

PREMIUM AMOUNT

The initial premium is listed in Your Schedule. If there is a change in the premium for Your coverage, We will give the Group Policyholder and You, if You pay premium to Us directly, at least 30 days written notice before the new premium goes into effect. No change will be made to the premium amount unless the premium rates change for all persons in the same 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 the Group Policyholder or to You, if You pay premium to Us directly, explaining that a payment has been missed and that Your Certificate 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 or the Group Policyholder 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 Certificate to continue in force without interruption. Failure to pay any unpaid premium by the end of this sixty five (65) day Grace Period will result in the termination of Your Certificate as of the premium due date.

REINSTATEMENT

If Your Certificate ends for non-payment of premium within the Grace Period, You may request reinstatement, within twelve (12) months, with no break in coverage subject to evidence of insurability. If We honor this request, Your Certificate will be reinstated retroactive to the date Your Certificate ended. Once reinstated, You must pay the premium due retroactive to the date Your Certificate ended.

EXTENDED REINSTATEMENT BENEFIT FOR SEVERE COGNITIVE IMPAIRMENT AND LOSS OF FUNCTIONAL CAPACITY

If You are paying premium directly to Us and You failed to pay Your premium within the Grace Period, because of a condition that would qualify You for Benefits under this Certificate, You may request reinstatement up to five (5) months after termination of Your Certificate.

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 Certificate. We will make a Benefit Eligibility assessment before deciding on reinstatement. If Your Certificate is reinstated, You must pay the premium due retroactive to the date Your Certificate terminated.

PREMIUM WAIVER

Your premium payments will be waived on a monthly basis starting:

- On the first day You are certified as meeting Benefit Eligibility and You have satisfied the Lifetime Elimination Period.

This waiver of premium payment ends when You are no longer eligible for covered services under this Policy for a period of 180 days.

UNEARNED PREMIUM

When We are notified of Your death, We will refund to the Group Policyholder, or to Your estate if You pay premium directly to Us, any premium already 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 Certificateholder 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 notice, You will be deemed to have met the timeliness of claim filing requirements upon submitting, within the time fixed in this Certificate 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 Certificateholder Identification Number, the Group Policyholder's name and the Group 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 Certificate. The following conditions also apply:

- Your Certificate 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 Certificate; 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, upon Your request, to the Approved Provider. 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 or Your Benefit Eligibility 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.

We will make a Benefit determination, independent of the original, using medical records and the provisions of this Certificate. We will send You Our written decision within 30 business days of Our receipt of all requested information. If You appeal that decision, an independent review of the decision will be made by an external agency.

For any claims appeal the request should be sent to Our office within three (3) years of the time of filing written notice of proof of loss for the claim being appealed.

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 three (3) years after the time written proof of loss is furnished.

COORDINATION OF BENEFITS

WHEN YOU HAVE OTHER HEALTH BENEFITS

This Benefit applies if You are covered under a Long-Term Care or health insurance contract, plan or policy issued through or to a group which provides some of the same Benefits as the Group Policy.

When You receive an item of service which would be covered under both policies, We will coordinate Benefit payments with any payment made under the other policy. One company will pay its full benefit as a primary benefit. The other company will pay secondary benefits if necessary to cover Your expenses. This prevents duplicate payments and overpayments. The following are considered to be a health insurance policy:

- Any group or blanket insurance policy, including HMO and other prepaid group coverage, except that blanket school accident coverages or such coverages offered to substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance policy.
- Any self-insured or non-insured plan, or any other plan arranged through any employer; trustee; union; employer organization; or employee benefit organization.
- Any Blue Cross, Blue Shield or other service-type group plan.
- Any coverage under governmental programs or any coverage required or provided by any statute, except Medicaid.
- Medical benefits coverage in group and individual mandatory traditional automobile "fault" type contracts.

RULES TO DETERMINE PAYMENT

The first of the rules listed below which applies shall determine which policy shall be Your primary insurance:

- If the other policy does not have a provision similar to this one, then it will be primary.
- If You are covered under one policy as an employee or member of a group and You are only covered as a dependent or Family Member under this Policy, the policy which covers You as an employee or member of a group will be primary.
- If You are covered under one of the Plans as an active employee, neither laid-off nor retired, or as the dependent of such an active employee, and You are covered as a laid-off or retired employee or laid-off or retired employee's dependent under the other plan, the Plan covering You as an active employee will be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the Plans do not agree on which shall be primary, the rule below shall apply.
- If You are covered under two policies as a dependent child of different persons, then the policy of the parent whose birthday falls earlier in a year will be primary. If both parents have the same birthday, the policy which covered the parent longer is primary to the policy which covered the other parent for a shorter period of time. If the other policy does not have a provision similar to this one, but instead has a rule based on the gender of the parent, and if, as a result, the policies do not agree on the order of benefits, the rule in the other policy will determine the order of benefits.
- If none of the above applies, then the policy which has covered You for the longest time will be primary.

The above rules apply whether or not You actually make a claim under both policies.

PAYMENT WHEN THE GROUP POLICY IS SECONDARY

When Your coverage under the Group Policy is secondary, the Benefits of the Group Policy will be reduced so that the total benefits payable under the other health insurance policy and under the Group Policy do not exceed the charge for the service. However, We will not pay more than We would have paid if it were primary.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

We have the right to release or obtain information which We believe necessary to carry out the purpose of this Coordination of Benefits section. We will not notify You or obtain Your consent before releasing or obtaining information except as required by law. We will not be legally responsible to You or anyone else for releasing or obtaining this information. You must furnish Us any information that We request. If You do not furnish the information, We have the right to deny payments.

OUR RIGHT TO RECOVER OVERPAYMENT

In some cases, We may have made payments even though You had coverage under another policy. If this happens, it will be necessary for You to refund the amount by which We should have reduced the payment We made. We also have the right to recover the overpayment from the other health benefits programs if We have not already received payment from that other program. You must sign any document that We feel is needed to help Us recover any overpayment.

RIGHT TO CONTINUATION OR CONVERSION OF COVERAGE AFTER TERMINATION

CONTINUATION

If Your relationship to the Group changes for any reason, You will be eligible to continue coverage without interruption as long as You pay all premiums when due and You have not exhausted Your Lifetime Benefit Amount. If Your premium was paid by payroll deduction, You must pay premiums directly to Us.

CONVERSION

If the Group Policy terminates, You will be provided conversion privileges as required by New York State regulations.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES

This Certificate is issued pursuant to the Group Master Policy which determines governing contractual provisions. The Group Master Policy, the Group Master Application, Your enrollment form, including any applicable health statements, any Riders and attached papers establish the entire contract of insurance between the Group Policyholder and Us.

YOUR BENEFITS

Only You can receive Benefits under this Certificate.

WHEN YOUR COVERAGE STARTS

The date that Your coverage under this Certificate starts is shown in Your Schedule. All time periods start and end at 12:01 a.m. standard time at Your residence. Benefits are available only for services that You receive on or after Your effective date. They are subject to all of the conditions shown in this Certificate.

WHEN YOUR COVERAGE ENDS

You are no longer covered under the Group Policy when the first of the following occurs:

On the date Your premiums are not paid, when due, subject to the Grace Period.

When Your Maximum Benefits Available Under Your Certificate Are Exhausted: Your coverage will automatically end when You have used the maximum Benefits to which You are entitled. We will notify You when this occurs.

When You Elect to Terminate Your Coverage Under the Certificate: You may cancel Your coverage at any time by giving Us at least 30 days prior written notice. Your coverage will end on the date specified in Your written notice or on a later date as may be specified in the notice.

On Your Death: Your coverage will automatically end on the day after the date of Your death. We will refund to the Group Policyholder, or to Your estate, any premium already paid for the period between the day after the date of death until the next premium due date.

OUR OPTION TO TERMINATE

YOUR COVERAGE CANNOT BE CANCELLED BECAUSE OF YOUR AGE, A CHANGE IN YOUR RELATIONSHIP TO THE GROUP, EMPLOYMENT STATUS, HEALTH STATUS, HEALTH CARE NEEDS, OR USE OF BENEFITS.

Your coverage can be cancelled for fraud committed by You or any other person, when You applied for coverage or on the submission of any claims under the Group Policy. (See "Incontestable Period" in the General Provisions section of Your Certificate.)

EXTENSION OF BENEFITS

If Your coverage under the Group Policy ends while You are totally disabled or while You are receiving Qualified Long-Term Care Services covered under the Group Policy, We will continue to pay for Your care without interruption of Benefits until the first of these dates:

- It has been determined that You are no longer eligible for Benefits under this Certificate; 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 coverage under the Group Policy had not ended.

You will not be entitled to Benefits after Your coverage ends if it ended due to You reaching Your maximum Lifetime Benefit Amount.

INCONTESTABLE PERIOD

During the first six (6) months Your Certificate is in force, We may rescind Your Certificate 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 as a Certificateholder.

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

After Your Certificate has been in force for two (2) years, We may rescind Your Certificate 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, the Group Policyholder, 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 Certificate.

MISSTATEMENT OF AGE

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

NON-PARTICIPATING

The Group Policy does not participate in Our profits or surplus earnings.

CONFORMITY WITH FEDERAL AND STATE STATUTES

Any provision of this Certificate that, on its effective date is in conflict with the statutes of the state in which You reside on such date is hereby amended to conform to the minimum requirement of such statutes if required.

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 Certificate, We will implement one or a combination of the following amendments to this Certificate, 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 Certificate have been duplicated by the national program.
- B. Increase benefits under this Certificate to make up for benefits that have been duplicated by the national program.



**NEW YORK STATE PUBLIC EMPLOYEE AND RETIREE
LONG-TERM CARE INSURANCE PLAN (NYPERL)
GROUP PARTNERSHIP PROGRAM**

Group Number [XXXX]

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

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.

This Certificate explains the Benefits MedAmerica Insurance Company of New York (herein called "the Company," or "We" or "Us" or "Our") provides to the Certificateholder ("You" or "Your" or "Yourself") whose name and identification number are in the Schedule. These Benefits are provided under a contract (the "Group Policy") between Us and the group whose number is also shown in the Schedule. (This group is called the "Group Policyholder.")

This Certificate is issued to You. It will continue unless it is terminated for any of the reasons described in this Certificate. Your coverage under the Group Policy starts on the effective date shown in Your Schedule. Your Certificate premiums may change, but only if 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.

The Benefits of the Certificate provide coverage to persons needing assistance for care as shown in the Benefits Section of this Certificate, and are subject to its provisions, limitations and exclusions. Your coverage under the Group Policy is not intended to replace Your present health insurance or Medicare Supplement Insurance. **THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT POLICY.** If You are eligible for Medicare, You should review the Medicare Supplement Buyer's Guide available from Us.

30 Day Free Look: If You feel this Certificate does not meet Your needs, You may return it to Us within 30 days. If You do so: (1) We will return any premium paid; and (2) We will not provide You with any Benefits under the Group Policy.

NOTICE TO BUYER: THIS CERTIFICATE 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 CERTIFICATE LIMITATIONS.

Caution: The issuance of this long-term care insurance Certificate is based upon Your responses to the questions on Your enrollment form. A copy of Your enrollment form is enclosed. If Your answers are incorrect or untrue, or fail to include all material medical [or eligibility] information requested, the Company has the right to deny Benefits or rescind Your Certificate. 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 the Company at the above address. **This Group Policy meets the minimum requirements for long-term care insurance in the state of New York. It is intended to be a federally tax-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. 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 the Group Policyholder and the Group Policyholder may accept or reject them.** The Group Policy determines governing contractual provisions.

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 Certificate entitled General Provisions for details.

William E. Jones, Jr.
President

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Home Office:
[165 Court Street]
[Rochester, NY 14647]
[1-800-919-8816]

SCHEDULE

Certificateholder Name:	JOHN DOE
Certificate Effective Date:	XX/XX/XXXX
Certificateholder Issue Age:	XX
Premium Mode <u>[YOUR CONTRIBUTION]</u> :	[XXXXXXXXXX]
Certificateholder Identification No.:	[L123456789-01]
Group Name:	[Group ABC]
Group Number:	[XXXX]

PREMIUM [TOTALS / YOUR CONTRIBUTION]

Base Premium: [\$XXXX]

Total Premium: \$XXXX

Total Initial Benefit

LIFETIME BENEFIT AMOUNT

We will deduct from this amount all Benefits paid for covered services received as outlined in this Certificate. [\$ XXXXX]

BENEFIT PERIOD

We will deduct from this amount the days in which Benefits are paid for covered services received as outlined in this Certificate. 1,095 days (3years)

LIFETIME ELIMINATION PERIOD

[X] 90 Days]

DAILY BENEFIT AMOUNTS

Nursing Facility, Alternate Care, Respite Care, Hospice Care, Bed Reservation, Care Management
Actual Charges incurred up to:

[\$XX Per Day]

Home Care, Assisted Living Facility, Adult Day Care,
Actual Charges incurred up to:

[\$XX Per Day]

[INFLATION PROTECTION]

[None- Benefits remain level.] [X]

[Compound Inflation Protection] [X]

Your Lifetime Benefit Amount and Daily Benefit Amount will each increase on every anniversary of the effective date of Your Certificate. 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.]

PREMIUM PAYMENT TERM

[Lifetime or as long as the Insured Person wishes to keep the Certificate in force] [X]

[10 Year Paid-in-Full*] [X]

[*If the 10 Year Paid in Full option is chosen, your policy cannot lapse after satisfaction of payment term.]

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

DEFINITIONS

ACTIVITIES OF DAILY LIVING (ADL): Each of the following is an Activity of Daily Living:

- Bathing: This means washing Yourself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- Continence: This means the ability to maintain control of bowel or bladder functions; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- Dressing: This means the ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.
- Eating: This means the ability to feed oneself by getting 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, getting on and off the toilet, and performing associated personal hygiene.
- Transferring: This means the ability to move into or out of a bed, chair or wheelchair.

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.

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 Certificate, Your Schedule, and attached riders.

BENEFIT ELIGIBILITY: The section of this Certificate that describes the conditions You must meet to qualify for payments under this Certificate.

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.

CERTIFICATE: This document which describes the Benefits provided under the group contract between Us and the Group Policyholder whose name and number is shown on Your Schedule. It shall also include Your enrollment form and any riders or endorsements. This Certificate is not a contract between You and Us.

CERTIFICATE HOLDER: The person to whom this Certificate is issued and whose name appears in the Schedule.

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

GROUP POLICY: This is the contract between Us and the Group Policyholder whose name and number are shown on Your Schedule.

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 six (6) months or less to live.

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

INDEPENDENT PROVIDER: A Licensed Health Care Practitioner, or A certified or officially-trained home health care provider, without being affiliated with an entity licensed and/or certified by the New York State Department of Health, or agency exempt from licensure or certification under New York State Law.

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 Certificate 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 Certificate.

- 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 We are not liable to pay expenses for any services listed in this Certificate. The Elimination Period begins on the first day You are certified as meeting Benefit Eligibility as defined in this Certificate and continues until the first such calendar day you are no longer Benefit Eligible or you reach the Lifetime Elimination Period listed in Your Schedule. Days used to satisfy Your Lifetime Elimination Period do not need to be consecutive, but must be accumulated within a period of 365 days (or 366 days in a leap year). The Lifetime Elimination Period will be applied only once during the life of the Certificate. There is no Lifetime Elimination Period for Hospice Program, Respite Care or Transition Benefit. These Benefits may not be used to satisfy the Lifetime Elimination Period.

A Lifetime Elimination Period based on benefit eligibility minimizes premium's due to the fact that only the days in which you are certified as eligible to receive benefits are counted toward Your 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 Certificate.

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 minimum benefit period listed in Your Schedule.

Your income remains subject to the New York State Social Services income limitations when you apply 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 also contain services that You need that are not covered under this Certificate. We retain the right to request periodic updated assessments.

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 Certificate; and (b) are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

SCHEDULE: The section of Your Certificate titled Schedule. It lists Your information such as coverage amounts and Benefit options.

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: 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 Activity of Daily Living.
- 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 Activity of Daily Living (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: This 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 Certificate is issued and whose name appears in the Schedule.

BENEFIT ACCESS

BENEFIT ELIGIBILITY

To start the Benefit access process, You must contact Us as soon as You think You might need services covered under this Certificate. Please call Our Customer Service Representative at [1-800-919-8816.]

To be eligible for Benefits provided by this Certificate, 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 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 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 Certificate. This information may be gathered by Us or by 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.

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 will provide an initial on-site consultation by our Personal Care Advisor if requested.

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
- Independent Provider; or
- Home Health Care Agency; or
- Adult Day Care Center.

BENEFITS

The maximum amount We will pay for all covered Benefits 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.

BED RESERVATION

If You are hospitalized temporarily while We are paying for Benefits in a Nursing Facility, Assisted Living Facility or a Hospice 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. Benefits paid for Bed Reservation will be deducted from your Lifetime Benefit Amount

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.

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.

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.

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.

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.

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
- respite 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, 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.

WORLDWIDE COVERAGE

This Certificate 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 Certificate:

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. Treatment provided in a government facility except treatment provided to a Medicaid recipient or as otherwise required by State or Federal law.
4. Services for which any Benefits are provided under Workers' Compensation, employer's liability program, occupational disease law or mandatory no-fault insurance.
5. Services provided by a member of Your 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 listed in Your Schedule. If there is a change in the premium for Your coverage, We will give the Group Policyholder and You, if You pay premium to Us directly, at least 30 days written notice before the new premium goes into effect. No change will be made to the premium amount unless the premium rates change for all persons in the same 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 the Group Policyholder or to You, if You pay premium to Us directly, explaining that a payment has been missed and that Your Certificate 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 or the Group Policyholder 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 Certificate to continue in force without interruption. Failure to pay any unpaid premium by the end of this sixty five (65) day Grace Period will result in the termination of Your Certificate as of the premium due date.

REINSTATEMENT

If Your Certificate ends for non-payment of premium within the Grace Period, You may request reinstatement, within twelve (12) months, with no break in coverage subject to evidence of insurability. If We honor this request, Your Certificate will be reinstated retroactive to the date Your Certificate ended. Once reinstated, You must pay the premium due retroactive to the date Your Certificate ended.

EXTENDED REINSTATEMENT BENEFIT FOR SEVERE COGNITIVE IMPAIRMENT AND LOSS OF FUNCTIONAL CAPACITY

If You are paying premium directly to Us and You failed to pay Your premium within the Grace Period, because of a condition that would qualify You for Benefits under this Certificate, You may request reinstatement up to five (5) months after termination of Your Certificate.

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 Certificate. We will make a Benefit Eligibility assessment before deciding on reinstatement. If Your Certificate is reinstated, You must pay the premium due retroactive to the date Your Certificate terminated.

PREMIUM WAIVER

Your premium payments will be waived on a monthly basis starting:

- On the first day You are certified as meeting Benefit Eligibility and you have satisfied the Lifetime Elimination Period.

This waiver of premium payment ends when You are no longer eligible for covered services under this Policy for a period of 180 days.

UNEARNED PREMIUM

When We are notified of Your death, We will refund to the Group Policyholder, or to Your estate any premium already 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 Certificateholder 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 notice, You will be deemed to have met the timeliness of claim filing requirements upon submitting, within the time fixed in this Certificate 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 Certificateholder Identification Number, the Group Policyholder's name and the Group 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 Certificate. The following conditions also apply:

- Your Certificate 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 Certificate; 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, upon Your request, to the Approved Provider. 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 or Your Benefit Eligibility 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.

We will make a Benefit determination, independent of the original, using medical records and the provisions of this Certificate. We will send You Our written decision within 30 business days of Our receipt of all requested information. If you appeal that decision, an independent review of the decision will be made by an external agency.

For any claims appeal the request should be sent to Our office within three (3) years of the time of filing written notice of proof of loss for the claim being appealed.

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 three (3) years after the time written proof of loss is furnished.

COORDINATION OF BENEFITS

WHEN YOU HAVE OTHER HEALTH BENEFITS

This Benefit applies if You are covered under a Long-Term Care or health insurance contract, plan or policy issued through or to a group which provides some of the same Benefits as the Group Policy.

When You receive an item of service which would be covered under both policies, We will coordinate Benefit payments with any payment made under the other policy. One company will pay its full benefit as a primary benefit. The other company will pay secondary benefits if necessary to cover Your expenses. This prevents duplicate payments and overpayments. The following are considered to be a health insurance policy:

- Any group or blanket insurance policy, including HMO and other prepaid group coverage, except that blanket school accident coverages or such coverages offered to substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance policy.
- Any self-insured or non-insured plan, or any other plan arranged through any employer; trustee; union; employer organization; or employee benefit organization.
- Any Blue Cross, Blue Shield or other service-type group plan.
- Any coverage under governmental programs or any coverage required or provided by any statute, except Medicaid.
- Medical benefits coverage in group and individual mandatory traditional automobile “fault” type contracts.

RULES TO DETERMINE PAYMENT

The first of the rules listed below which applies shall determine which policy shall be Your primary insurance:

- If the other policy does not have a provision similar to this one, then it will be primary.
- If You are covered under one policy as an employee or member of a group and You are only covered as a dependent or Family Member under this Policy, the policy which covers You as an employee or member of a group will be primary.
- If you are covered under one of the Plans as an active employee, neither laid-off nor retired, or as the dependent of such an active employee, and you are covered as a laid-off or retired employee or laid-off or retired employee's dependent under the other plan, the Plan covering you as an active employee will be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the Plans do not agree on which shall be primary, the rule below shall apply.
- If you are covered under two policies as a dependent child of different persons, then the policy of the parent whose birthday falls earlier in a year will be primary. If both parents have the same birthday, the policy which covered the parent longer is primary to the policy which covered the other parent for a shorter period of time. If the other policy does not have a provision similar to this one, but instead has a rule based on the gender of the parent, and if, as a result, the policies do not agree on the order of benefits, the rule in the other policy will determine the order of benefits.
- If none of the above applies, then the policy which has covered You for the longest time will be primary.

The above rules apply whether or not You actually make a claim under both policies.

PAYMENT WHEN THE GROUP POLICY IS SECONDARY

When Your coverage under the Group Policy is secondary, the Benefits of the Group Policy will be reduced so that the total benefits payable under the other health insurance policy and under the Group Policy do not exceed the charge for the service. However, We will not pay more than We would have paid if it were primary.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION.

We have the right to release or obtain information which We believe necessary to carry out the purpose of this Coordination of Benefits section. We will not notify You or obtain Your consent before releasing or obtaining information except as required by law. We will not be legally responsible to You or anyone else for releasing or obtaining this information. You must furnish Us any information that We request. If You do not furnish the information, We have the right to deny payments.

OUR RIGHT TO RECOVER OVERPAYMENT

In some cases, We may have made payments even though You had coverage under another policy. If this happens, it will be necessary for You to refund the amount by which We should have reduced the payment We made. We also have the right to recover the overpayment from the other health benefits programs if We have not already received payment from that other program. You must sign any document that We feel is needed to help Us recover any overpayment.

RIGHT TO CONTINUATION OF COVERAGE AFTER TERMINATION

CONTINUATION

If Your relationship to the Group changes for any reason, You will be eligible to continue coverage without interruption as long as You pay all premiums when due and you have not exhausted your Lifetime Benefit Amount. If Your premium was paid by payroll deduction, You must pay premiums directly to Us.

CONVERSION

If the Group Policy terminates, You will be provided conversion privileges as required by New York State regulations.

[WHEN TO NOTIFY US YOU WISH TO CONTINUE [OR APPLY FOR THE NEW CONTRACT]

[If you elect to continue coverage under the Group Policy [or to purchase a new contract,] You will receive a notice from the Group Policyholder or from Us. You must notify Us that You wish to continue coverage [or convert to individual coverage] and make the first premium payment within 45 days of receiving the notice from the Group Policyholder or from Us.]

[THE NEW CONTRACT]

[The new contract will be guaranteed renewable. This means that the new contract will remain in force over Your lifetime, as long as You pay premiums on time. The premiums for the new contract may change in the future, but only if We change the premium rates for all persons in the same premium payment class.]

[Any Lifetime Benefit Amount used under the Group Policy will be counted in determining Your Lifetime Benefit Amount available under the continuing [or converted] coverage.]

[If You selected the 10-year paid-in-full option under the Group Policy, then the payments for Your coverage under the Group Policy will be credited towards the satisfaction of the same period under the continuing [or converted] coverage. If you have questions on how the 10-year paid-in-full option works with the continuation provision, please contact us.]

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES

This Certificate is issued pursuant to the Group Master Policy which determines governing contractual provisions. The Group Master Policy, the Group Master Application, Your Enrollment form and any applicable Health Statements, any Riders and attached papers establish the entire contract of insurance between the Group Policyholder and Us.

YOUR BENEFITS

Only You can receive Benefits under this Certificate.

WHEN YOUR COVERAGE STARTS

The date that Your coverage under this Certificate starts is shown in Your Schedule. All time periods start and end at 12:01 a.m. standard time at Your residence. Benefits are available only for services that You receive on or after Your effective date. They are subject to all of the conditions shown in this Certificate.

WHEN YOUR COVERAGE ENDS

You are no longer covered under the Group Policy when the first of the following occurs:

On the date Your premiums are not paid, when due, subject to the Grace Period.

When Your Maximum Benefits Available Under Your Certificate Are Exhausted: Your coverage will automatically end when You have used the maximum Benefits to which You are entitled. We will notify You when this occurs.

When You Elect to Terminate Your Coverage Under the Certificate: You may cancel Your coverage at any time by giving Us at least 30 days prior written notice. Your coverage will end on the date specified in Your written notice or on a later date as may be specified in the notice.

On Your Death: Your coverage will automatically end on the day after the date of Your death. We will refund to the Group Policyholder, or to Your estate, any premium already paid for the period between the day after the date of death until the next premium due date.

OUR OPTION TO TERMINATE

YOUR COVERAGE CANNOT BE CANCELLED BECAUSE OF YOUR AGE, [A CHANGE IN YOUR RELATIONSHIP TO THE GROUP], [EMPLOYMENT STATUS,] HEALTH STATUS, HEALTH CARE NEEDS, OR USE OF BENEFITS.

Your coverage can be cancelled for fraud committed by You or any other person, when You applied for coverage or on the submission of any claims under the Group Policy. (See "Incontestable Period" in the General Provisions section of Your Certificate.)

EXTENSION OF BENEFITS

If Your coverage under the Group Policy ends while You are totally disabled or while You are receiving Qualified Long-Term Care Services covered under the Group Policy, We will continue to pay for Your care without interruption of Benefits until the first of these dates:

- It has been determined that You are no longer eligible for Benefits under this Certificate; 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 coverage under the Group Policy had not ended.

You will not be entitled to Benefits after Your coverage ends if it ended due to You reaching Your maximum Lifetime Benefit Amount.

INCONTESTABLE PERIOD

During the first six (6) months Your Certificate is in force, We may rescind Your Certificate 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 as a Certificateholder.

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

After Your Certificate has been in force for two (2) years, We may rescind Your Certificate 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, the Group Policyholder, 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 Certificate.

MISSTATEMENT OF AGE

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

[NON-PARTICIPATING

The Group Policy does not participate in Our profits or surplus earnings.]

CONFORMITY WITH FEDERAL AND STATE STATUTES

Any provision of this Certificate that, on its effective date is in conflict with the statutes of the state in which You reside on such date is hereby amended to conform to the minimum requirement of such statutes if required.

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 Certificate, We will implement one or a combination of the following amendments to this Certificate, 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 Certificate have been duplicated by the national program.
- B. Increase benefits under this Certificate to make up for benefits that have been duplicated by the national program.

NYG11-341-NY-0612



**NEW YORK STATE PUBLIC EMPLOYEE AND RETIREE
LONG-TERM CARE INSURANCE PLAN (NYPERL)
GROUP POLICY**

GROUP POLICYHOLDER: [XXX]
GROUP NUMBER: [XXX]
EFFECTIVE DATE: [XX/XX/XXXX]

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 State Insurance Law.

This Policy is a legal contract between the Group Policyholder and MedAmerica Insurance Company of New York (herein called We, Us or Our). We agree to pay the benefits of this Policy, subject to all of its terms.

The provisions on the pages that follow are a part of this Policy. Also a part of this Policy are the provisions of the certificates of insurance (herein called the Certificate) which are issued and applicable to persons insured under this Policy (herein called Insured Persons). A copy of the Certificate that applies to each class of Insured Persons is attached to and made a part of this Policy.

This Policy is issued in consideration of the application of the Group Policyholder and payment of any required premium. It will take effect at 12:01 A.M. standard time at the Policyholder's address on the Effective Date shown above. This date is its date of issue.

Guaranteed Renewability. This Policy continues in effect as long as any required premiums are paid on time. Premiums for coverage provided under this Policy may change, but only if We change the premium rates for all Insured Persons in the same payment class, regardless of where you reside at the time of the premium change. In addition to this Guaranteed Renewable feature of the Policy, We guarantee that the Policy premiums will not increase FOR ANY REASON for a full three (3) years from the Policy effective date as listed in the Schedule.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If an Insured Person is eligible for Medicare, he or she must review the Medicare Supplement Buyer's Guide available from Us.

This Policy is delivered in the State of New York and is governed by its laws.

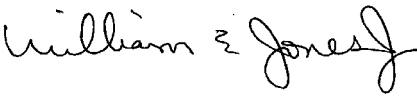

[
[William E. Jones, Jr]
[President]

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SCHEDULE

This is an outline of the Benefits available to Insured Persons in the eligible classes. The Benefits that apply to each class are described in the Certificate for that class as shown below.

Class No.

[1]

[2]

Certificate No.

[123456-Ed.1]

[123456-Ed.2]

Benefits Offered to Certificateholders

LIFETIME BENEFIT AMOUNT

We will deduct from this amount all Benefits paid under the Certificate.
(This does not include services for Caregiver Training and Transition Benefit.)

\$ XXXXX

Caregiver Training Lifetime Maximum Benefit:

\$500

Transition Benefit Lifetime Maximum Benefit:

\$XXXX

LIFETIME ELIMINATION PERIOD

90 Days

DAILY BENEFIT AMOUNT

For a Nursing Facility, Assisted Living Facility, Respite or Hospice Program:

Actual Charges incurred up to:

[\$100 Per Day]

[\$150 Per Day]

[\$180 Per Day]

[\$250 Per Day]

[\$300 Per Day]

For Home Care or Adult Day Care:

\$XXXX Per Day

[Spousal Benefit Transfer Rider:]

[X]

INFLATION PROTECTION OPTIONS(Must be offered to each Insured)

5% Compound Inflation Protection

X

The Insured Person's Lifetime Benefit Amount and Daily Benefit Amount will each increase on every anniversary of the effective date of his or her Certificate. Annual increases will apply to Benefits payable for any expenses the Insured Person incurs on or after the date of the increase. This first increase will be equal to 5% of the Insured Person's original amounts. Each increase thereafter will be equal to 5% of the increased amounts that applied on the date of the prior increase.

3.5% Compound Inflation Protection

X

The Insured Person's Lifetime Benefit Amount and Daily Benefit Amount will each increase on every anniversary of the effective date of his or her Certificate. Annual increases will apply to Benefits payable for any expenses the Insured Person incurs on or after the date of the increase. This first increase will be equal to 3.5% of the Insured Person's original amounts. Each increase thereafter will be equal to 3.5% of the increased amounts that applied on the date of the prior increase.

[Guaranteed Purchase Benefit Option

[X]

Once every three years the offer to increase the Insured Person's Lifetime Benefit Amount and Daily Benefit Amount will be made without evidence of insurability. The increase will not be offered if the Insured Person is eligible to receive covered services under this Policy. The increase amount will be equal to 5%, compounded annually for three years, of the Insured Person's current Daily Benefit Amount, rounded to the nearest whole dollar. If accepted, the increase will apply to Benefits payable for any expenses the Insured Person incurs on or after the date of the increase. If the Insured Person declines two consecutive offers, any future benefit increases will require evidence of insurability. The additional premium for the increase will be based on the Insured Person's attained age at the time the increase becomes effective, at the premium rates then in effect.]

PREMIUM PAYMENT TERM

[Lifetime or as long as the Insured Person wishes to keep the Certificate in force]

[X][10 Year Paid-in-Full^o][X]

^oIf 10 Year Paid in Full option is chosen, your policy cannot lapse after satisfaction of payment term.

PREMIUM PAYMENT MODE**[Bank Account Draft OR Credit Card**[X]

(Monthly, Quarterly, Semi-Annual, Annual)]

[Payroll Deduction[X]

(Depending on Employer Capabilities)

(Bi-Monthly, Monthly, Quarterly, Semi-Annual, Annual)]

[Direct Bill[X]

(Quarterly, Semi-Annual, Annual)]

Refer to the applicable Certificate(s) for a description of these Benefits

ELIGIBILITY AND EFFECTIVE DATES

WHO IS ELIGIBLE

[Group Requirements:

Group Size at Initial Open Enrollment: Number of active employees/eligibles - _____

Open Enrollment Period: Initial open enrollment period- _____ days

Open Enrollment Period For New Employees/Eligibles: [60] days from date of hire]

Enrollment Eligibility: These classes of persons are eligible for insurance under this Policy:

[Residency Requirements: residents of the State of - _____]

[Age Requirements: minimum age of -_18_]

[Employment Status: Employees and Retirees (including Vestees and Dependent Survivors) and their eligible Dependents including spouses, Domestic Partners, dependent children, including student dependent children the natural parents of employees, retired employees, Vestees and their spouses/domestic partners.]

Underwriting Selections:

[Class 1: Modified Guaranteed Issue – During Initial Open Enrollment Health Statement required.

Employees who apply for coverage during the initial open enrollment period and newly eligible Employees who apply for coverage within 60 days of their hire date or the date they first meet the following requirements:

On the day coverage is to begin, the Active Employee/Eligible must be at the employer's place of business or at a location to which the employer's business requires the Employee to travel and be able to fully perform the duties of the position for that Employee's normal workday. Including any day on which the Employee is on vacation or on authorized leave provided such absence is not due to illness or injury or Leave Without Pay. An Employee is any person in the service of the employer (State, Participating Employers or Participating Agencies) who is paid by the employer and who:

1. is expected to work at least six biweekly pay periods; and
2. works at least half-time on a regular schedule, and
3. is on the payroll at the time of application, or
4. is in one of the following categories at the time of application:
 - a. A local elected official;
 - b. A paid member of a public legislative body;
 - c. An unpaid board member of a public authority with at least six months service as a board member; or
 - d. An unpaid or paid elected member of a school board.]

[Class 2: Standard Issue - Long-Form Health Statement required. Standard Issue is required for the following enrollees.

1. Any Employee/Eligible who does not meet the requirements under Modified Guaranteed Issue;
2. Employees who choose to apply for coverage after the initial offering and new Employees who choose to apply for coverage more than 60 days after their hire date;
3. An Employee's eligible Dependent(s); and
4. Retirees, Spouses/Domestic Partners, Vestees, and Dependent Survivors and their eligible Dependents and Parents (including in-law).]

WHEN A PERSON'S COVERAGE STARTS

The date that a person's coverage under this Policy starts depends on when he or she applies and pays premium for it.

A person's insurance coverage will start:

- on the date We approve his or her proof of insurability, and
- once We are in receipt of the first premium payment.

BASIS OF INSURANCE

Persons in all classes are required to contribute toward the cost of their insurance under this Policy.

A person's contribution toward the cost of his or her insurance under this Policy may not be more than the premium charge for that insurance.

TERMINATION OF COVERAGE

WHEN THIS POLICY ENDS

This Policy ends when the first of these dates occurs:

- the date the Group Policyholder chooses to terminate this Policy; or
- the date We terminate this Policy due to fraud; or
- [the date the Group Policyholder's premiums are not paid when due, subject to the Grace Period.]

WHEN AN INSURED PERSON'S COVERAGE ENDS

The Certificate for each class describes when coverage ends for an Insured Person in that class.

PREMIUM PROVISIONS

The Certificate for each class sets forth the premium provisions which apply to that class.

The premium due for each Insured Person's coverage will be calculated using the approved rates.

We may change the premium rates. However, We will not change an Insured Person's premium rate unless the premium rates change for all persons in the same payment class, regardless of where you reside at the time of the premium change. We will provide at least 120 days written notice in advance of a change in premium rates. We guarantee that the Policy premiums will not increase FOR ANY REASON for a full three (3) years from the Policy effective date as listed in the Schedule.

The Group Policyholder agrees to remit to Us all applicable premiums for employees/eligibles and their spouses. All applicable premium payments due from the Group Policyholder are subject to the Grace Period provision set forth below.

All other Insured Persons will pay premiums directly to Us.

GRACE PERIOD

An initial Grace Period of 30 days will be granted for each premium payment that is unpaid on the date due. After 30 days, a notice will be sent to the Group Policyholder explaining that a payment has been missed and that this Policy is at risk of lapsing. An additional 35 days from the date We mail the notice will be granted during which any unpaid premium must be paid. Payment will allow this Policy to continue in force without interruption. Failure to pay any unpaid premium by the end of the Grace Period will result in the termination of this Policy as of the premium due date.

GENERAL PROVISIONS

ENTIRE CONTRACT

The entire contract consists of:

1. this Policy and any papers made a part of it, including the Group Master Application completed by the Group Policyholder; and
2. the Certificate that applies to each class of Insured Persons, which is attached to and made a part of this Policy; and
3. the written statements, if any, of the Insured Persons, including their enrollment forms; and
4. The signed Agreement [#C000488] between the Group Policyholder and Us.

In the absence of fraud, all statements made by the Group Policyholder or by the Insured Persons will be deemed to be representations and not warranties. No statement made by an Insured Person will be used to avoid insurance, reduce the benefits, or defend a claim under this Policy unless:

1. the statement is in writing and signed by the Insured Person; and
2. a copy of that statement is given to the Insured Person or to his or her beneficiary.

POLICY CHANGES

This Policy may be changed at any time by written agreement between the Group Policyholder and Us. But the change must be approved by one of Our executive officers. We will not be bound by a promise or representation made by any other person. No agent has the authority to change this Policy, or any Certificate issued hereunder, in any way or to waive any of its terms.

CERTIFICATES

We will provide certificates of insurance for delivery to each Insured Person. They will describe: (1) the coverage the Insured Person has; (2) any limitations, reductions, and exclusions that apply to the coverage; (3) to whom the benefits will be paid; and (4) the Insured Person's continuation or conversion rights if coverage ends. We may send the certificate directly to the Insured Person or give it to the Group Policyholder for delivery to him or her.

INCONTESTABILITY

We will not contest the validity of this Policy after it has been in force for two (2) years from its date of issue.

DATA REQUIRED FROM GROUP POLICYHOLDER

We need certain data to carry out the terms of this Policy and to determine the premium. The Group Policyholder shall give us the data we need to do this whenever we need it. We also have the right to inspect any records of the Group Policyholder, if We believe they would have a bearing on this Policy. We have the right to do this at any reasonable time.

NON-PARTICIPATING

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

CONFORMITY WITH APPLICABLE LAW

Any provision of this Policy that, on its effective date is in conflict with the federal statutes pertaining to qualified long-term care insurance or the statutes of the state in which You reside on such date is hereby amended to conform to the minimum requirement of such statutes, if required.

NYG11-342-NY-0612



**NEW YORK STATE PUBLIC EMPLOYEE AND RETIREE
LONG-TERM CARE INSURANCE PLAN (NYPERL)
GROUP CERTIFICATE**

Group Number [xxxx]

This Group Policy meets the minimum requirements for long-term care insurance in the state of New York. It is intended to be a federally tax-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 State Insurance Law.

This Certificate explains the Benefits MedAmerica Insurance Company of New York (herein called "the Company," or "We" or "Us" or "Our") provides to the Certificateholder ("You" or "Your" or "Yourself") whose name and identification number are in the Schedule. These Benefits are provided under a contract (the "Group Policy") between Us and the group whose number is also shown in the Schedule. (This group is called the "Group Policyholder.")

This Certificate is issued to You. It will continue unless it is terminated for any of the reasons described in this Certificate. Your coverage under the Group Policy starts on the effective date shown in Your Schedule.

The premiums may change, but only if 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. The Benefits of the Certificate provide coverage to persons needing assistance for care as shown in the Benefits Section of this Certificate, and are subject to its provisions, limitations and exclusions.

Your coverage under the Group Policy is not intended to replace Your present health insurance or Medicare Supplement Insurance. **THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT POLICY.** If You are eligible for Medicare, You should review the Medicare Supplement Buyer's Guide available from Us.

30 Day Free Look

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

NOTICE TO BUYER: This certificate 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 certificate limitations.

Caution: The issuance of this long-term care insurance Certificate is based upon Your responses to the questions on Your enrollment form. A copy of Your enrollment form is enclosed. If Your answers are incorrect or untrue, or fail to include all material medical and eligibility information requested, the Company has the right to deny Benefits or rescind Your Certificate. 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 the Company at the above address.

The Group Policy determines governing contractual provisions.

A handwritten signature in black ink that reads "William E. Jones, Jr." followed by a closing bracket "]".

[
[William E. Jones, Jr]
[President]

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SCHEDULE

Certificateholder Name:	JOHN DOE
Certificate Effective Date:	XX/XX/XXXX
Certificateholder Issue Age:	XX
Premium Mode:	XXXXXXXXX
Certificateholder Identification No.:	[L123456789-01]
Group Name:	[Group ABC]
Group Number:	XXXX
<u>PREMIUM TOTALS</u>	
Base Premium:	\$XXXX
[Spousal Benefit Transfer Rider:]	[\$XXXX]
Total Premium:	\$XXXX

Total Benefit

LIFETIME BENEFIT AMOUNT

We will deduct from this amount all Benefits paid under this Certificate. (This does not include services for Caregiver Training and Transition Benefit.)

\$ XXXXX

Caregiver Training Lifetime Maximum Benefit:

\$500

Transition Benefit Lifetime Maximum Benefit:

\$XXXX

LIFETIME ELIMINATION PERIOD

90 Days

DAILY BENEFIT AMOUNT

For Nursing Facility, Assisted Living Facility, Respite or Hospice Program,:

Actual Charges incurred up to: ☐ [\$100 Per Day]
☐ [\$150 Per Day]
☐ [\$180 Per Day]
☐ [\$250 Per Day]
☐ [\$300 Per Day]

For Home Care or Adult Day Care: \$XXXX Per Day
Actual Charges incurred up to:

INFLATION PROTECTION:

☐ [5% Compound Inflation Protection] ☐ [X]
Your Lifetime Benefit Amount and Daily Benefit Amount will each increase on every anniversary of the effective date of Your Certificate. 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.]

☐ [3.5% Compound Inflation Protection] ☐ [X]
Your Lifetime Benefit Amount and Daily Benefit Amount will each increase on every anniversary of the effective date of Your Certificate. 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 3.5% of Your original amounts. Each increase thereafter will be equal to 3.5% of the increased amounts that applied on the date of the prior increase.]

☐ [Guaranteed Purchase Benefit Option] ☐ [X]
Once every three years the offer to increase Your Lifetime Benefit Amount and Daily Benefit Amount will be made without evidence of insurability. The increase will not be offered if You are eligible to receive covered services under this Certificate. The increase amount will be equal to 5%, compounded annually for three years, of Your current Daily Benefit Amount, rounded to the nearest whole dollar. If accepted, the increase will apply to Benefits payable for any expenses You incur on or after the date of the increase. If You decline two consecutive offers, any future benefit increases will require evidence of insurability. The additional premium for the increase will be based on Your attained age at the time the increase becomes effective, at the premium rates then in effect.]

PREMIUM PAYMENT TERM

☐ [Lifetime or as long as the Insured Person wishes to keep the Certificate in force] ☐ [X]

☐ [10 Year Paid-in-Full°] ☐ [X]

°If the 10 Year Paid in Full option is chosen, your policy cannot lapse after satisfaction of payment term.]

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

DEFINITIONS

ACTIVITIES OF DAILY LIVING (ADL): Each of the following is an Activity of Daily Living:

- Bathing: This means washing Yourself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- Continence: This means the ability to maintain control of bowel or bladder functions; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- Dressing: This means the ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.
- Eating: This means the ability to feed oneself by getting 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, getting on and off the toilet, and performing associated personal hygiene.
- Transferring: This means the ability to move into or out of a bed, chair or wheelchair.

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 facility.

A portion, wing, ward or unit of a multi-use facility will qualify as an Assisted Living Facility only if it meets all of 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 Certificate, Your Schedule, and attached riders.

BENEFIT ELIGIBILITY: The section of this Certificate that describes the conditions You must meet to qualify for payments under this Certificate.

CERTIFICATE: This document which describes the Benefits provided under the group contract between Us and the Group Policyholder whose number is shown on Your Schedule. It shall also include Your enrollment form and any riders or endorsements. This Certificate is not a contract between You and Us.

CERTIFICATE HOLDER: The person to whom this Certificate is issued and whose name appears in the Schedule.

DAILY BENEFIT AMOUNT: This is the maximum amount We will pay for all charges You incur on any one day as stated in Your Schedule. An Inflation Protection Option will increase Your Daily Benefit Amount over time.

FAMILY, FAMILY MEMBER: Your spouse/domestic partner and anyone related to You or Your spouse/domestic partner (including adopted, in-law and step-relatives) as parent, grandparent, child, grandchild, brother, sister, aunt, uncle, first cousin, nephew or niece.

GROUP POLICY: This is the contract between Us and the Group Policyholder whose name and number are shown on Your Schedule.

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. If the program is not a state or federally licensed, accredited or certified program, it 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 six (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 Certificate entitles You to the Lifetime Benefit Amount of coverage as shown in Your Schedule. This is the maximum amount of money You have available for Benefits. We will deduct from this amount all Benefits paid for covered services provided under this Certificate as listed in Your Schedule. The Lifetime Benefit Amount is determined by Your selection of a Daily Benefit Amount multiplied by the number of Benefit days You select.

LIFETIME ELIMINATION PERIOD: This is the number of days shown in Your Schedule for which We are not liable to pay expenses for any services listed in this Certificate. The Elimination Period begins on the first day You are certified as meeting Benefit Eligibility as defined in this Certificate and continues until the first such calendar day you are no longer Benefit Eligible or you reach the Lifetime Elimination Period listed in Your Schedule. Days used to satisfy Your Lifetime Elimination Period do not need to be consecutive, but must be accumulated within a period of 365 days (or 366 days in a leap year).

The Lifetime Elimination Period will be applied only once during the life of the Certificate

There is no Lifetime Elimination Period for Hospice Program, Respite Care or Transition Benefit. These Benefits may not be used to satisfy 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 Certificate.

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 institution, 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 also contain services that You need that are not covered under this Certificate. We retain the right to request periodic updated assessments.

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 Certificate; and (b) are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

SCHEDULE: The section of Your Certificate titled Schedule. It lists Your information such as coverage amounts and Benefit options.

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: 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 Activity of Daily Living.
- 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 Activity of Daily Living (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: This 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).

TRANSITION BENEFIT: This means equipment that is used to provide You with Qualified Long-Term Care Services. It must be able to withstand repeated use and is designed to be used in the Home to assist You in performing Activities Of Daily Living.

Examples of supportive equipment include:

- hospital-style beds; and
- ramps to permit Your movement from one level of the residence to another; and
- grab bars to assist You in toileting; and
- pumps and other devices for intravenous injection; and
- respirators; and
- medical alert systems.

Supportive equipment does NOT include items such as:

- artificial limbs; or
- teeth; or
- hearing aids; or
- medical supplies; or
- equipment placed in Your body, temporarily or permanently.

WE, US, OUR: This refers to MedAmerica Insurance Company of New York

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YOU, YOUR, YOURSELF: This refers to the person to whom this Certificate is issued and whose name appears in the Schedule.

BENEFIT ACCESS

BENEFIT ELIGIBILITY

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

To be eligible for Benefits provided by this Certificate, 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 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 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 Certificate. This information may be gathered by Us or by 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.

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 will provide an initial on-site consultation by Our Personal Care Advisor if requested.

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

The maximum amount We will pay for all charges You incur 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.

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.

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
- respite 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, 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 may pay for alternate care Benefits under this provision. The Benefits must be for Qualified Long-Term Care Services that are medically acceptable, cost effective and agreed to by You and by Us. This includes medically necessary transportation to and from Adult Day Care.

The total of this alternative care Benefit will not exceed the total Benefits to which You would otherwise be entitled under this Certificate.

BED RESERVATION

If You are hospitalized temporarily while We are paying for Benefits in a Nursing Facility, Hospice Care Facility or Assisted Living Facility and that facility charges You a fee to reserve Your bed, We will pay to reserve Your bed for up to 21 days per calendar year.

We will pay the actual charges to reserve Your bed, up to the Daily Benefit Amount shown in Your Schedule. Payments made under this Benefit are deducted from Your Lifetime Benefit Amount.

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.

CAREGIVER TRAINING

If You meet Benefit Eligibility, and You are at Home, We will pay for training You, or a person designated by You, and agreed to by Us in:

1. The proper use and care of Supportive Equipment, provided that the training:
 - Is not included in the rental, lease or purchase agreement of Supportive Equipment; and
 - Is provided by a Registered Professional Nurse or other professionally designated person who is qualified to provide such training; and
 - Is intended to provide the knowledge and skills necessary for the proper use and care of the Supportive Equipment.
2. The proper use and care of disposable medical aids, including, but not limited to, catheters, ostomy bags, or suctioning tubes.
3. The proper way to assist You in the performance of Your Activities of Daily Living or other supportive needs.

Caregiver Training must be provided by a registered professional nurse or another professionally designated person who is qualified to provide training.

The total Caregiver Training Lifetime Maximum Benefit is listed in Your Schedule. Benefits paid for Caregiver Training will not be deducted from Your Lifetime Benefit Amount.

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

TRANSITION BENEFIT

If You meet Benefit Eligibility, We will reimburse You for expenses You pay for the rental, lease or purchase of supportive equipment that is used to provide You with Qualified Long-Term Care Services. This benefit may include, but is not limited to, such items as home modifications, emergency response systems and durable medical equipment.

We will pay this Benefit up to a maximum lifetime amount of five (5) times Your Daily Benefit Amount as listed in Your Schedule. Benefits paid for under this Transition Benefit will not be deducted from Your Lifetime Benefit Amount.

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

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 and You are at Home, 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 the actual charges incurred up to the Daily Benefit Amount shown in Your Schedule for a maximum Benefit of 21 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.

REQUIRED AND ADDITIONAL BENEFITS

Certain of the benefits described above are not required for Long-Term Care Insurance coverage by state regulation. These additional benefits include:

- Services in a hospital with units or beds assigned for long-term or custodial care.
- Services in a facility other than a nursing home.
- Respite Care
- Hospice Care
- Alternate Care
- Bed Reservation
- Caregiver Training
- Transition Benefit

Use of the additional benefits outlined above will reduce the Lifetime Benefit Amount of coverage available to You as described in this Certificate for those benefits required by state regulation. The required benefits are:

- Services in a nursing home, and
- Services in Your home.

It is Your choice whether to use the coverage available for the additional benefits. If You desire to use all of Your Lifetime Benefit Amount for the required benefits, then the additional benefits should not be used.

WORLDWIDE COVERAGE

This Certificate covers 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 Certificate:

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. Treatment provided in a government facility except treatment provided to a Medicaid recipient or as otherwise required by State or Federal law.
4. Services for which any Benefits are provided under Workers' Compensation, employer's liability program, occupational disease law or mandatory no-fault insurance.
5. Services provided by a member of Your Family, except for Caregiver Training Benefits included in the Benefits section of this Certificate.
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 listed in Your Schedule. If there is a change in the premium for Your coverage, We will give the Group Policyholder and You, if You pay premium to Us directly, at least 30 days written notice before the new premium goes into effect.

No change will be made to the premium amount unless the premium rates change for all persons in the same 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, if You pay premium to Us directly, or to the Group Policyholder explaining that a payment has been missed and that Your Certificate 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 or the Group Policyholder 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 Certificate to continue in force without interruption. Failure to pay any unpaid premium by the end of this sixty-five (65) day Grace Period will result in the termination of Your Certificate as of the premium due date.

REINSTATEMENT

If Your Certificate ends for non-payment of premium within the Grace Period, You may request reinstatement, within twelve (12) months, with no break in coverage subject to evidence of insurability. If We honor this request, Your Certificate will be reinstated retroactive to the date Your Certificate ended. Once reinstated, You must pay the premium due retroactive to the date Your Certificate ended.

EXTENDED REINSTATEMENT BENEFIT FOR SEVERE COGNITIVE IMPAIRMENT AND LOSS OF FUNCTIONAL CAPACITY

If You are paying premium directly to Us and You failed to pay Your premium within the Grace Period, because of a condition that would qualify You for Benefits under this Certificate, You may request reinstatement up to five (5) months after termination of Your Certificate.

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 Certificate. We will make a Benefit Eligibility assessment before deciding on reinstatement. If Your Certificate is reinstated, You must pay the premium due retroactive to the date Your Certificate terminated.

PREMIUM WAIVER

Your premium payments will be waived on a monthly basis starting:

- On the first day You are certified as meeting Benefit Eligibility and You have satisfied the Lifetime Elimination Period.

This waiver of premium payment ends when You are no longer eligible for covered services under this Policy for a period of 180 days.

UNEARNED PREMIUM

When We are notified of Your death, We will refund to the Group Policyholder or to Your estate any premium already 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 Certificateholder 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 notice, You will be deemed to have met the timeliness of claim filing requirements upon submitting, within the time fixed in this Certificate 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 Certificateholder Identification Number, the Group Policyholder's name and the Group 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 in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 90 days after the end of each month for which Benefits may be paid and in case of claim for any other loss within 120 days after the date of such loss. 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 Certificate. The following conditions also apply:

- Your Certificate must be in force when the care is approved and received or you must be receiving Benefits pursuant to the Extension of Benefits provision; and
- You have completed the Elimination Period, if it applies; and
- The service is covered under this Certificate; 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, upon Your request, to the Approved Provider. 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. **Excess payments may be only be recovered from You if the overpayment was made to You. If an overpayment was made to a provider or facility, recovery must come from the provider/facility.**

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 We contest a claim or a portion of a claim, You or Your legal representative will be notified in writing that the claim is contested or denied.

You have a right to appeal Our claims decision. The appeal must be filed in writing with Our office at [165 Court Street, Rochester, NY 14647] within 3 years of the time the denied claim being appealed was filed. Include the reason for the appeal and any documents You feel are pertinent to the situation. We will consider any new or modified information or explanations You send to Us. We will also accept the names, addresses and phone numbers of persons who may facilitate Our effective handling of Your appeal. You are entitled to all documents, records and other information relevant to the claim.

We will send You a written acknowledgement of Your appeal. If no additional information is needed, the acknowledgement will include an explanation of the denial. If additional information is required, We will explain within 15 business days of receipt of Your appeal what is needed. If We do not receive the requested information within 45 days, We will notify You in writing that the claim continues to be contested or denied. The internal appeal determination shall be made by a person not involved in the initial adverse claim determination and the person shall have the ability and expertise to reasonably evaluate and decide the internal appeal.

Within 60 days of the receipt of required information, We will notify You in writing of the outcome of the reconsideration of Your claim, and the contested claim or portion thereof that will be paid or denied. If the additional information is not received within 120 days from receipt of the appeal, We shall immediately issue an internal appeal determination based on the information available to Us at that time. You are entitled to copies of all documents, records or other relevant information regarding the claim and the appeal.

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 three (3) years after the time written proof of loss is furnished.

COORDINATION OF BENEFITS

WHEN YOU HAVE OTHER HEALTH BENEFITS

This Benefit applies if You are covered under a Long-Term Care or health insurance contract, plan or policy issued through or to a group which provides some of the same Benefits as the Group Policy.

When You receive an item of service which would be covered under both policies, We will coordinate Benefit payments with any payment made under the other policy. One company will pay its full benefit as a primary benefit. The other company will pay secondary benefits if necessary to cover Your expenses. This prevents duplicate payments and overpayments. The following are considered to be a health insurance policy:

- Any group or blanket insurance policy, including HMO and other prepaid group coverage, except that blanket school accident coverages or such coverages offered to substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance policy.
- Any self-insured or non-insured plan, or any other plan arranged through any employer; trustee; union; employer organization; or employee benefit organization.
- Any Blue Cross, Blue Shield or other service-type group plan.
- Any coverage under governmental programs or any coverage required or provided by any statute, except Medicaid.
- Medical benefits coverage in group and individual mandatory traditional automobile "fault" type contracts.

RULES TO DETERMINE PAYMENT

The first of the rules listed below which applies shall determine which policy shall be Your primary insurance:

- If the other policy does not have a provision similar to this one, then it will be primary.
- If You are covered under one policy as an employee or member of a group and You are only covered as a dependent or Family Member under this Policy, the policy which covers You as an employee or member of a group will be primary.
- If you are covered under one of the Plans as an active employee, neither laid-off nor retired, or as the dependent of such an active employee, and you are covered as a laid-off or retired employee or laid-off or retired employee's dependent under the other plan, the Plan covering you as an active employee will be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the Plans do not agree on which shall be primary, the rule below shall apply.
- If you are covered under two policies as a dependent child of different persons, then the policy of the parent whose birthday falls earlier in a year will be primary. If both parents have the same birthday, the policy which covered the parent longer is primary to the policy which covered the other parent for a shorter period of time. If the other policy does not have a provision similar to this one, but instead has a rule based on the gender of the parent, and if, as a result, the policies do not agree on the order of benefits, the rule in the other policy will determine the order of benefits.
- If neither of the above applies, then the policy which has covered You for the longest time will be primary.
- The above rules apply whether or not You actually make a claim under both policies.

PAYMENT WHEN THE GROUP POLICY IS SECONDARY

When Your coverage under the Group Policy is secondary, the Benefits of the Group Policy will be reduced so that the total benefits payable under the other health insurance policy and under the Group Policy do not exceed the charge for the service. However, We will not pay more than We would have paid if it were primary.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION.

We have the right to release or obtain information which We believe necessary to carry out the purpose of this Coordination of Benefits section. We will not notify You or obtain Your consent before releasing or obtaining information except as required by law. We will not be legally responsible to You or anyone else for releasing or obtaining this information. You must furnish Us any information that We request. If You do not furnish the information, We have the right to deny payments.

OUR RIGHT TO RECOVER OVERPAYMENT

In some cases, We may have made payments even though You had coverage under another group policy. If this happens, it will be necessary for You to refund the amount by which We should have reduced the payment We made. We also have the right to recover the overpayment from the other health benefits programs due to a Coordination of Benefits error if We have not already received payment from that other program. You must sign any document that We feel is needed to help Us recover any overpayment. Excess payments may be only be recovered from You if the overpayment was made to You. If an overpayment was made to a provider or facility, recovery must come from the provider/facility.

RIGHT TO CONTINUATION OR CONVERSION OF COVERAGE AFTER TERMINATION

CONTINUATION

If Your relationship to the Group changes for any reason, You will be eligible to continue coverage without interruption as long as You pay all premiums when due and you have not exhausted your Lifetime Benefit Amount. If Your premium was paid by payroll deduction, You must pay premiums directly to Us.

CONVERSION

If the Group Policy terminates, You will be provided conversion privileges as required by New York State regulations.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES

This Certificate is issued pursuant to the Group Master Policy which determines governing contractual provisions. The Group Master Policy, the Group Master Application, this Certificate, Your enrollment form including any applicable health statements, and any Riders and attached papers establish the entire contract of insurance between the Group Policyholder and Us.

YOUR BENEFITS

Only You can receive Benefits under this Certificate.

WHEN YOUR COVERAGE STARTS

The date that Your coverage under this Certificate starts is shown in Your Schedule. All time periods start and end at 12:01 a.m. standard time at Your residence. Benefits are available only for services that You receive on or after Your effective date. They are subject to all of the conditions shown in this Certificate.

WHEN YOUR COVERAGE ENDS

You are no longer covered under the Group Policy when the first of the following occurs:

On the date Your premiums are not paid, when due, subject to the Grace Period.

When Your Maximum Benefits Available Under Your Certificate Are Exhausted: Your coverage will automatically end when You have used the maximum Benefits to which You are entitled. We will notify You when this occurs.

When You Elect to Terminate Your Coverage Under the Certificate: You may cancel Your coverage at any time by giving Us at least 30 days prior written notice. Your coverage will end on the date specified in Your written notice or on a later date as may be specified in the notice.

On Your Death: Your coverage will automatically end on the day after the date of Your death. We will refund to the Group Policyholder, or to Your estate, any premium already paid for the period between the day after the date of death until the next premium due date.

OUR OPTION TO TERMINATE

YOUR COVERAGE CANNOT BE CANCELLED BECAUSE OF YOUR AGE, A CHANGE IN YOUR RELATIONSHIP TO THE GROUP, EMPLOYMENT STATUS, HEALTH STATUS, HEALTH CARE NEEDS, OR USE OF BENEFITS.

Your coverage can be rescinded for fraud committed by You, when You applied for coverage or on the submission of any claims under the Group Policy. (See "Incontestable Period" in the General Provisions section of Your Certificate.)

EXTENSION OF BENEFITS

If Your coverage under the Group Policy ends while You are totally disabled or You are receiving Qualified Long-Term Care Services covered under the Group Policy in a Nursing Facility or an Assisted Living Facility, We will continue to pay for Your care without interruption of Benefits until the first of these dates:

- It has been determined that You are no longer eligible for Benefits under this Certificate; or
- You have used up Your Lifetime Benefit Amount.
- 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 coverage under the Group Policy had not ended.

You will not be entitled to Benefits after Your coverage ends if it ended due to You reaching Your maximum Lifetime Benefit Amount.

INCONTESTABLE PERIOD

During the first six (6) months Your Certificate is in force, We may rescind Your Certificate 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 as a Certificateholder.

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

After Your Certificate has been in force for two (2) years, We may rescind Your Certificate 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, the Group Policyholder, 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 Certificate.

MISSTATEMENT OF AGE

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

NON-PARTICIPATING

The Group Policy does not participate in Our profits or surplus earnings.

CONFORMITY WITH FEDERAL AND STATE STATUTES

Any provision of this Certificate that, on its effective date is in conflict with the federal statutes pertaining to qualified long-term care insurance or the statutes of the state in which You reside on such date is hereby amended to conform to the minimum requirement of such statutes, if required.

NYP11-341-NY-0612



[Home Office:]
[165 Court Street]
[Rochester, NY 14647]
[Toll Free: 1-866-474-5824]



**NEW YORK STATE PUBLIC EMPLOYEE AND RETIREE
LONG-TERM CARE INSURANCE PLAN (NYPERL)
GROUP POLICY**

GROUP POLICYHOLDER: [XXX]
GROUP NUMBER: [XXX]
EFFECTIVE DATE: [XX/XX/XXXX]

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

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 State Insurance Law.

This Policy is a legal contract between the Group Policyholder and MedAmerica Insurance Company of New York (herein called We, Us or Our). We agree to pay the benefits of this Policy, subject to all of its terms.

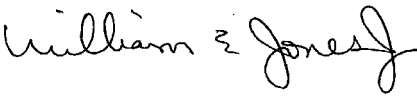
The provisions on the pages that follow are a part of this Policy. Also a part of this Policy are the provisions of the certificates of insurance (herein called the Certificate) which are issued and applicable to persons insured under this Policy (herein called Insured Persons). A copy of the Certificate that applies to each class of Insured Persons is attached to and made a part of this Policy.

This Policy is issued in consideration of the application of the Group Policyholder and payment of any required premium. It will take effect at 12:01 A.M. standard time at the Policyholder's address on the Effective Date shown above. This date is its date of issue.

Guaranteed Renewability. This Policy continues in effect as long as any required premiums are paid on time. Premiums for coverage provided under this Policy may change, but only if We change the premium rates for all Insured Persons in the same payment class, regardless of where you reside at the time of the premium change. We guarantee that Your Certificate premiums will not increase FOR ANY REASON for a full three (3) years from the Policy effective date as listed in the Schedule. 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 and those approved by the New York State Department of Financial Services.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If an Insured Person is eligible for Medicare, he or she must review the Medicare Supplement Buyer's Guide available from Us.

This Policy is delivered in the State of New York and is governed by its laws.

[]

[William E. Jones, Jr]
[President]

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SCHEDULE

This is an outline of the Benefits available to Insured Persons in the eligible classes. The Benefits that apply to each class are described in the Certificate for that class as shown below.

Class No.

[1]

[2]

Certificate No.

[123456-Ed.1]

[123456-Ed.2]

Benefits Offered to Certificateholders

LIFETIME BENEFIT AMOUNT

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

\$ XXXXXX

BENEFIT PERIOD

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

[730 days (2 years)]

[1,095 days (3 years)]

LIFETIME ELIMINATION PERIOD

90 Days

DAILY BENEFIT AMOUNT

For Nursing Facility, Alternate Care, Hospice Care in a Nursing Home, Respite Care, Bed Reservation, Care Management
Actual Charges incurred up to:

[\$____ Per Day [*Partnership Minimum]]
[\$300_ Per Day]

Home Care, Assisted Living Facility, Adult Day Care, Hospice Care at home or in a community based facility
Actual Charges incurred up to:

[\$__ Per Day]
[\$150_ Per Day]

INFLATION PROTECTION OPTION (Offered to Group Policyholder only)

None; benefits remain level. X
(Available only for Ages 80 and over)]

5% Compound Inflation Protection X
(Some Level of Inflation Required for Ages 18-79)

The Insured Person's Lifetime Benefit Amount and Daily Benefit Amount will each increase on every anniversary of the effective date of his or her Certificate. Annual increases will apply to Benefits payable for any expenses the Insured Person incurs on or after the date of the increase. This first increase will be equal to 5% of the Insured Person's original amounts. Each increase thereafter will be equal to 5% of the increased amounts that applied on the date of the prior increase.

3.5% Compound Inflation Protection X
(Some Level of Inflation Required for Ages 18-79)

The Insured Person's Lifetime Benefit Amount and Daily Benefit Amount will each increase on every anniversary of the effective date of his or her Certificate. Annual increases will apply to Benefits payable for any expenses the Insured Person incurs on or after the date of the increase. This first increase will be equal to 3.5% of the Insured Person's original amounts. Each increase thereafter will be equal to 3.5% of the increased amounts that applied on the date of the prior increase.

PREMIUM PAYMENT TERM

[Lifetime or as long as the Insured Person wishes to keep the Certificate in force] [X]

[10 Year Paid-in-Full*] [X]

[°If 10 Year Paid in Full option is chosen, your policy cannot lapse after satisfaction of payment term.] [X]

PREMIUM PAYMENT MODE

[Bank Account Draft OR Credit Card] [X]
(Monthly, Quarterly, Semi-Annual, Annual)]

[Payroll Deduction] [X]
(Depending on Employer Capabilities)
(Bi-Monthly, Monthly, Quarterly, Semi-Annual, Annual)]

[Direct Bill] [X]
(Quarterly, Semi-Annual, Annual)]

Refer to the applicable Certificate(s) for a description of these Benefits

ELIGIBILITY AND EFFECTIVE DATES

WHO IS ELIGIBLE

[Group Requirements:

Group Size at Initial Open Enrollment: Number of active employees/eligibles - _____

Open Enrollment Period: Initial open enrollment period-[_____] days

Open Enrollment Period For New Employees/Eligibles: [60] days from date of hire]

Enrollment Eligibility: These classes of persons are eligible for insurance under this Policy:

[Residency Requirements: residents of the State of -_____]

[Age Requirements: minimum of -18]

[Employment Status: Employees and Retirees (including Vestees and Dependent Survivors) and their eligible Dependents including spouses, Domestic Partners, dependent children, including student dependent children the natural parents of employees, retired employees, Vestees and their spouses/domestic partners.]

Underwriting Selections:

[Class 1: Modified Guaranteed Issue - During Initial Open Enrollment. Health Statement required.

Employees who apply for coverage during the initial open enrollment period and newly eligible Employees who apply for coverage within 60 days of their hire date or the date they first meet the following requirements:

On the day coverage is to begin, the Active Employee/Eligible must be at the employer's place of business or at a location to which the employer's business requires the Employee to travel and be able to fully perform the duties of the position for that Employee's normal workday. Including any day on which the Employee is on vacation or on authorized leave provided such absence is not due to illness or injury or Leave Without Pay. An Employee is any person in the service of the employer (State, Participating Employers or Participating Agencies) who is paid by the employer and who:

1. is expected to work at least six biweekly pay periods; and
2. works at least half-time on a regular schedule, and
3. is on the payroll at the time of application, or
4. is in one of the following categories at the time of application:
 - a. A local elected official;
 - b. A paid member of a public legislative body;
 - c. An unpaid board member of a public authority with at least six months service as a board member; or
 - d. An unpaid or paid elected member of a school board.]

[Class 2: Standard Issue - Long-Form Health Statement required. Standard Issue is required for the following:

1. Any Employee/Eligible who does not meet the requirements under Modified Guaranteed Issue;
2. Employees who choose to apply for coverage after the initial offering and new Employees who choose to apply for coverage more than 60 days after their hire date;
3. An Employee's eligible Dependent(s); and
4. Retirees, Spouses/Domestic Partners, Vestees, and Dependent Survivors and their eligible Dependents and Parents (including in-law).]

WHEN A PERSON'S COVERAGE STARTS

The date that a person's coverage under this Policy starts depends on when he or she applies and pays premium for it.

A person's insurance coverage will start:

- on the date We approve his or her proof of insurability, and
- once We are in receipt of the first premium payment.

BASIS OF INSURANCE

Persons in all classes are required to contribute toward the cost of their insurance under this Policy.

A person's contribution toward the cost of his or her insurance under this Policy may not be more than the premium charge for that insurance.

TERMINATION OF COVERAGE

WHEN THIS POLICY ENDS

This Policy ends when the first of these dates occurs:

- the date the Group Policyholder chooses to terminate this Policy; or
- the date We terminate this Policy due to fraud; or
- [the date the Group Policyholder's premiums are not paid when due, subject to the Grace Period.]

WHEN AN INSURED PERSON'S COVERAGE ENDS

The Certificate for each class describes when coverage ends for an Insured Person in that class.

PREMIUM PROVISIONS

The Certificate for each class sets forth the premium provisions which apply to that class.

The premium due for each Insured Person's coverage will be calculated using the approved rates.

We may change the premium rates. However, We will not change an Insured Person's premium rate unless the premium rates change for all persons in the same payment class. We will provide at least 120 days written notice in advance of a change in premium rates. We guarantee that Your Certificate premiums will not increase FOR ANY REASON for a full three (3) years from the Policy effective date as listed in the Schedule.

The Group Policyholder agrees to remit to Us all applicable premiums for employees/eligibles and their spouses. All applicable premium payments due from the Group Policyholder are subject to the Grace Period provision set forth below.

All other Insured Persons will pay premiums directly to Us.

GRACE PERIOD

An initial Grace Period of 30 days will be granted for each premium payment that is unpaid on the date due. After 30 days, a notice will be sent to the Group Policyholder explaining that a payment has been missed and that this Policy is at risk of lapsing. An additional 35 days from the date We mail the notice will be granted during which any unpaid premium must be paid. Payment will allow this Policy to continue in force without interruption. Failure to pay any unpaid premium by the end of the Grace Period will result in the termination of this Policy as of the premium due date.

GENERAL PROVISIONS

ENTIRE CONTRACT

The entire contract consists of:

1. this Policy and any papers made a part of it, including the Group Master Application completed by the Group Policyholder; and
2. the Certificate that applies to each class of Insured Persons, which is attached to and made a part of this Policy; and
3. the written statements, if any, of the Insured Persons, including their enrollment forms; and
4. The signed Agreement [#C000488] between the Group Policyholder and Us.

In the absence of fraud, all statements made by the Group Policyholder or by the Insured Persons will be deemed to be representations and not warranties. No statement made by an Insured Person will be used to avoid insurance, reduce the benefits, or defend a claim under this Policy unless:

1. the statement is in writing and signed by the Insured Person; and
2. a copy of that statement is given to the Insured Person or to his or her beneficiary.

POLICY CHANGES

This Policy may be changed at any time by written agreement between the Group Policyholder and Us. But the change must be approved by one of Our executive officers. We will not be bound by a promise or representation made by any other person. No agent has the authority to change this Policy, or any Certificate issued hereunder, in any way or to waive any of its terms. Changes may not be made that would bring the benefits below the minimum required under the New York State Partnership Program.

CERTIFICATES

We will provide certificates of insurance for delivery to each Insured Person. They will describe: (1) the coverage the Insured Person has; (2) any limitations, reductions, and exclusions that apply to the coverage; (3) to whom the benefits will be paid; and (4) the Insured Person's continuation or conversion rights if coverage ends. We may send the certificate directly to the Insured Person or give it to the Group Policyholder for delivery to him or her.

INCONTESTABILITY

We will not contest the validity of this Policy after it has been in force for two (2) years from its date of issue.

DATA REQUIRED FROM GROUP POLICYHOLDER

We need certain data to carry out the terms of this Policy and to determine the premium. The Group Policyholder shall give us the data we need to do this whenever we need it. We also have the right to inspect any records of the Group Policyholder, if We believe they would have a bearing on this Policy. We have the right to do this at any reasonable time.

NON-PARTICIPATING

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

CONFORMITY WITH APPLICABLE LAW

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, if required.

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 and Certificates issued under this Policy, We will implement one or a combination of the following amendments to this Policy and any Certificates, 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 and any Certificates have been duplicated by the national program.
- B. Increase benefits under this Policy and any Certificates to make up for benefits that have been duplicated by the national program.

NYP11-342-NY-0612



CARE DIRECTIONS[®] *Premier*

**NEW YORK STATE PUBLIC EMPLOYEE AND RETIREE
LONG-TERM CARE INSURANCE PLAN (NYPERL)
GROUP PARTNERSHIP PROGRAM**

Group Number [XXXX]

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

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.

This Certificate explains the Benefits MedAmerica Insurance Company of New York (herein called "the Company," or "We" or "Us" or "Our") provides to the Certificateholder ("You" or "Your" or "Yourself") whose name and identification number are in the Schedule. These Benefits are provided under a contract (the "Group Policy") between Us and the group whose number is also shown in the Schedule. (This group is called the "Group Policyholder.")

This Certificate is issued to You. It will continue unless it is terminated for any of the reasons described in this Certificate. Your coverage under the Group Policy starts on the effective date shown in Your Schedule. Your Certificate premiums may change, but only if 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.

The Benefits of the Certificate provide coverage to persons needing assistance for care as shown in the Benefits Section of this Certificate, and are subject to its provisions, limitations and exclusions. Your coverage under the Group Policy is not intended to replace Your present health insurance or Medicare Supplement Insurance. **THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT POLICY.** If You are eligible for Medicare, You should review the Medicare Supplement Buyer's Guide available from Us.

30 Day Free Look: If You feel this Certificate does not meet Your needs, You may return it to Us within 30 days. If You do so: (1) We will return any premium paid; and (2) We will not provide You with any Benefits under the Group Policy.

NOTICE TO BUYER: THIS CERTIFICATE 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 CERTIFICATE LIMITATIONS.

Caution: The issuance of this long-term care insurance Certificate is based upon Your responses to the questions on Your enrollment form. A copy of Your enrollment form is enclosed. If Your answers are incorrect or untrue, or fail to include all material medical or eligibility information requested, the Company has the right to deny Benefits or rescind Your Certificate. 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 the Company at the above address. **This Group Policy meets the minimum requirements for long-term care insurance in the state of New York. It is intended to be a federally tax-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 State Insurance Law. 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 the Group Policyholder and the Group Policyholder may accept or reject them.** The Group Policy determines governing contractual provisions.

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 Certificate entitled General Provisions for details.

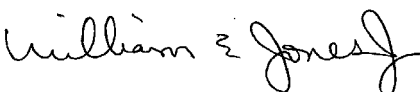

[
[William E. Jones, Jr]
[President]

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Home Office:
[165 Court Street]
[Rochester, NY 14647]
[1-800-919-8816]

SCHEDULE

Certificateholder Name:	JOHN DOE
Certificate Effective Date:	XX/XX/XXXX
Certificateholder Issue Age:	XX
Premium Mode:	XXXXXXXXXX
Certificateholder Identification No.:	[L123456789-01]
Group Name:	[Group ABC]
Group Number:	XXXX

PREMIUM TOTALS

Base Premium:	\$XXXX
---------------	--------

Total Premium:	\$XXXX
-----------------------	--------

Total Initial Benefit

LIFETIME BENEFIT AMOUNT

We will deduct from this amount all Benefits paid for covered services received as outlined in this Certificate.	\$ <u>XXXXXX</u>
--	------------------

BENEFIT PERIOD

We will deduct from this amount the days in which Benefits are paid for covered services received as outlined in this Certificate.	[730 days (2 years)] [1,095 days (3 years)]
--	--

LIFETIME ELIMINATION PERIOD

90 Days

DAILY BENEFIT AMOUNTS

Nursing Facility, Alternate Care, Respite Care, Hospice Care in a Nursing Home, Bed Reservation, Care Management

Actual Charges incurred up to:	[\$____ Per Day] [\$300 Per Day]
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Home Care, Assisted Living Facility, Adult Day Care, Hospice Care at home or in a community based facility

Actual Charges incurred up to:	[\$____ Per Day] [\$150 Per Day]
--------------------------------	-------------------------------------

INFLATION PROTECTION

[None- Benefits remain level.] [X]

[5% Compound Inflation Protection] [X]

Your Lifetime Benefit Amount and Daily Benefit Amount will each increase on every anniversary of the effective date of Your Certificate. 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.]

[3.5% Compound Inflation Protection] [X]

Your Lifetime Benefit Amount and Daily Benefit Amount will each increase on every anniversary of the effective date of Your Certificate. 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 3.5% of Your original amounts. Each increase thereafter will be equal to 3.5% of the increased amounts that applied on the date of the prior increase.]

PREMIUM PAYMENT TERM

[Lifetime or as long as the Insured Person wishes to keep the Certificate in force] [X]

[10 Year Paid-in-Full*] [X]

[*If the 10 Year Paid in Full option is chosen, your policy cannot lapse after satisfaction of payment term.]

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

DEFINITIONS

ACTIVITIES OF DAILY LIVING (ADL): Each of the following is an Activity of Daily Living:

- Bathing: This means washing Yourself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- Continence: This means the ability to maintain control of bowel or bladder functions; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- Dressing: This means the ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.
- Eating: This means the ability to feed oneself by getting 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, getting on and off the toilet, and performing associated personal hygiene.
- Transferring: This means the ability to move into or out of a bed, chair or wheelchair.

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.

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 Certificate, Your Schedule, and attached riders.

BENEFIT ELIGIBILITY: The section of this Certificate that describes the conditions You must meet to qualify for payments under this Certificate.

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.

CERTIFICATE: This document which describes the Benefits provided under the group contract between Us and the Group Policyholder whose name and number is shown on Your Schedule. It shall also include Your enrollment form and any riders or endorsements. This Certificate is not a contract between You and Us.

CERTIFICATE HOLDER: The person to whom this Certificate is issued and whose name appears in the Schedule.

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

GROUP POLICY: This is the contract between Us and the Group Policyholder whose name and number are shown on Your Schedule.

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. If the program is not a state or federally licensed, accredited or certified program, it 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 six (6) months or less to live.

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

INDEPENDENT PROVIDER: A Licensed Health Care Practitioner, or A certified or officially-trained home health care provider, without being affiliated with an entity licensed and/or certified by the New York State Department of Health, or agency exempt from licensure or certification under New York State Insurance Law.

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 Certificate 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 Certificate.

- 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 We are not liable to pay expenses for any services listed in this Certificate. The Elimination Period begins on the first day You are certified as meeting Benefit Eligibility as defined in this Certificate and continues until the first such calendar day you are no longer Benefit Eligible or you reach the Lifetime Elimination Period listed in Your Schedule. Days used to satisfy Your Lifetime

Elimination Period do not need to be consecutive, but must be accumulated within a period of 365 days (or 366 days in a leap year). The Lifetime Elimination Period will be applied only once during the life of the Certificate. There is no Lifetime Elimination Period for Hospice Program, or Respite Care. These Benefits may not be used to satisfy the Lifetime Elimination Period.

A Lifetime Elimination Period based on benefit eligibility minimizes premium's due to the fact that only the days in which you are certified as eligible to receive benefits are counted toward Your 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 Certificate.

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 minimum benefit period listed in Your Schedule.

Your income remains subject to the New York State Social Services income limitations when you apply 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 also contain services that You need that are not covered under this Certificate. We retain the right to request periodic updated assessments.

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 Certificate; and (b) are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

SCHEDULE: The section of Your Certificate titled Schedule. It lists Your information such as coverage amounts and Benefit options.

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: 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 Activity of Daily Living.
- 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 Activity of Daily Living (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: This 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 Certificate is issued and whose name appears in the Schedule.

BENEFIT ACCESS

BENEFIT ELIGIBILITY

To start the Benefit access process, You must contact Us as soon as You think You might need services covered under this Certificate. Please call Our Customer Service Representative at [1-800-919-8816.]

To be eligible for Benefits provided by this Certificate, 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 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 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 Certificate. This information may be gathered by Us or by 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.

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 will provide an initial on-site consultation by our Personal Care Advisor if requested.

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
- Independent Provider; or
- Home Health Care Agency; or
- Adult Day Care Center.

BENEFITS

The maximum amount We will pay for all covered Benefits 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.

BED RESERVATION

If You are hospitalized temporarily while We are paying for Benefits in a Nursing Facility, Assisted Living Facility or a Hospice 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. Benefits paid for Bed Reservation will be deducted from your Lifetime Benefit Amount

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.

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.

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.

RESPIRE 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.

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.

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
- respite 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, 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.

WORLDWIDE COVERAGE

This Certificate 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 Certificate:

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. Treatment provided in a government facility except treatment provided to a Medicaid recipient or as otherwise required by State or Federal law.
4. Services for which any Benefits are provided under Workers' Compensation, employer's liability program, occupational disease law or mandatory no-fault insurance.
5. Services provided by a member of Your 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 listed in Your Schedule. If there is a change in the premium for Your coverage, We will give the Group Policyholder and You, if You pay premium to Us directly, at least 30 days written notice before the new premium goes into effect. No change will be made to the premium amount unless the premium rates change for all persons in the same 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 the Group Policyholder or to You, if You pay premium to Us directly, explaining that a payment has been missed and that Your Certificate 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 or the Group Policyholder 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 Certificate to continue in force without interruption. Failure to pay any unpaid premium by the end of this sixty five (65) day Grace Period will result in the termination of Your Certificate as of the premium due date.

REINSTATEMENT

If Your Certificate ends for non-payment of premium within the Grace Period, You may request reinstatement, within twelve (12) months, with no break in coverage subject to evidence of insurability. If We honor this request, Your Certificate will be reinstated retroactive to the date Your Certificate ended. Once reinstated, You must pay the premium due retroactive to the date Your Certificate ended.

EXTENDED REINSTATEMENT BENEFIT FOR SEVERE COGNITIVE IMPAIRMENT AND LOSS OF FUNCTIONAL CAPACITY

If You are paying premium directly to Us and You failed to pay Your premium within the Grace Period, because of a condition that would qualify You for Benefits under this Certificate, You may request reinstatement up to five (5) months after termination of Your Certificate.

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 Certificate. We will make a Benefit Eligibility assessment before deciding on reinstatement. If Your Certificate is reinstated, You must pay the premium due retroactive to the date Your Certificate terminated.

PREMIUM WAIVER

Your premium payments will be waived on a monthly basis starting:

- On the first day You are certified as meeting Benefit Eligibility and you have satisfied the Lifetime Elimination Period.

This waiver of premium payment ends when You are no longer eligible for covered services under this Policy for a period of 180 days.

UNEARNED PREMIUM

When We are notified of Your death, We will refund to the Group Policyholder, or to Your estate any premium already 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 Certificateholder 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 notice, You will be deemed to have met the timeliness of claim filing requirements upon submitting, within the time fixed in this Certificate 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 Certificateholder Identification Number, the Group Policyholder's name and the Group 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 in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 90 days after the end of each month for which Benefits may be paid and in case of claim for any other loss within 120 days after the date of such loss. 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 Certificate. The following conditions also apply:

- Your Certificate must be in force when the care is approved and received or you must be receiving Benefits pursuant to the Extension of Benefits provision; and
- You have completed the Elimination Period, if it applies; and
- The service is covered under this Certificate; 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, upon Your request, to the Approved Provider. 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. **Excess payments may be only be recovered from You if the overpayment was made to You. If an overpayment was made to a provider or facility, recovery must come from the provider/facility.**

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 We contest a claim or a portion of a claim, You or Your legal representative will be notified in writing that the claim is contested or denied.

You have a right to appeal Our claims decision. The appeal must be filed in writing with Our office at [165 Court Street, Rochester, NY 14647] within 3 years of the time the denied claim being appealed was filed. Include the reason for the appeal and any documents You feel are pertinent to the situation. We will consider any new or modified information or explanations You send to Us. We will also accept the names, addresses and phone numbers of persons who may facilitate Our effective handling of Your appeal. You are entitled to all documents, records and other information relevant to the claim.

We will send You a written acknowledgement of Your appeal. If no additional information is needed, the acknowledgement will include an explanation of the denial. If additional information is required, We will explain within 15 business days of receipt of Your appeal what is needed. If We do not receive the requested information within 45 days, We will notify You in writing that the claim continues to be contested or denied. The internal appeal determination shall be made by a person not involved in the initial adverse claim determination and the person shall have the ability and expertise to reasonably evaluate and decide the internal appeal.

Within 60 days of the receipt of required information, We will notify You in writing of the outcome of the reconsideration of Your claim, and the contested claim or portion thereof that will be paid or denied. If the additional information is not received within 120 days from receipt of the appeal, We shall immediately issue an internal appeal determination based on the information available to Us at that time. You are entitled to copies of all documents, records or other relevant information regarding the claim and the appeal.

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 three (3) years after the time written proof of loss is furnished.

COORDINATION OF BENEFITS

WHEN YOU HAVE OTHER HEALTH BENEFITS

This Benefit applies if You are covered under a Long-Term Care or health insurance contract, plan or policy issued through or to a group which provides some of the same Benefits as the Group Policy.

When You receive an item of service which would be covered under both policies, We will coordinate Benefit payments with any payment made under the other policy. One company will pay its full benefit as a primary benefit. The other company will pay secondary benefits if necessary to cover Your expenses. This prevents duplicate payments and overpayments. The following are considered to be a health insurance policy:

- Any group or blanket insurance policy, including HMO and other prepaid group coverage, except that blanket school accident coverages or such coverages offered to substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance policy.
- Any self-insured or non-insured plan, or any other plan arranged through any employer; trustee; union; employer organization; or employee benefit organization.
- Any Blue Cross, Blue Shield or other service-type group plan.
- Any coverage under governmental programs or any coverage required or provided by any statute, except Medicaid.
- Medical benefits coverage in group and individual mandatory traditional automobile “fault” type contracts.

RULES TO DETERMINE PAYMENT

The first of the rules listed below which applies shall determine which policy shall be Your primary insurance:

- If the other policy does not have a provision similar to this one, then it will be primary.
- If You are covered under one policy as an employee or member of a group and You are only covered as a dependent or Family Member under this Policy, the policy which covers You as an employee or member of a group will be primary.
- If you are covered under one of the Plans as an active employee, neither laid-off nor retired, or as the dependent of such an active employee, and you are covered as a laid-off or retired employee or laid-off or retired employee's dependent under the other plan, the Plan covering you as an active employee will be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the Plans do not agree on which shall be primary, the rule below shall apply.
- If you are covered under two policies as a dependent child of different persons, then the policy of the parent whose birthday falls earlier in a year will be primary. If both parents have the same birthday, the policy which covered the parent longer is primary to the policy which covered the other parent for a shorter period of time. If the other policy does not have a provision similar to this one, but instead has a rule based on the gender of the parent, and if, as a result, the policies do not agree on the order of benefits, the rule in the other policy will determine the order of benefits.
- If none of the above applies, then the policy which has covered You for the longest time will be primary.

The above rules apply whether or not You actually make a claim under both policies.

PAYMENT WHEN THE GROUP POLICY IS SECONDARY

When Your coverage under the Group Policy is secondary, the Benefits of the Group Policy will be reduced so that the total benefits payable under the other health insurance policy and under the Group Policy do not exceed the charge for the service. However, We will not pay more than We would have paid if it were primary.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION.

We have the right to release or obtain information which We believe necessary to carry out the purpose of this Coordination of Benefits section. We will not notify You or obtain Your consent before releasing or obtaining information except as required by law. We will not be legally responsible to You or anyone else for releasing or obtaining this information. You must furnish Us any information that We request. If You do not furnish the information, We have the right to deny payments.

OUR RIGHT TO RECOVER OVERPAYMENT

In some cases, We may have made payments even though You had coverage under another group policy. If this happens, it will be necessary for You to refund the amount by which We should have reduced the payment We made. We also have the right to recover the overpayment from the other health benefits programs due to a Coordination of Benefits error if We have not already received payment from that other program. You must sign any document that We feel is needed to help Us recover any overpayment. Excess payments may be only be recovered from You if the overpayment was made to You. If an overpayment was made to a provider or facility, recovery must come from the provider/facility.

RIGHT TO CONTINUATION OF COVERAGE AFTER TERMINATION

CONTINUATION

If Your relationship to the Group changes for any reason, You will be eligible to continue coverage without interruption as long as You pay all premiums when due and you have not exhausted your Lifetime Benefit Amount. If Your premium was paid by payroll deduction, You must pay premiums directly to Us.

CONVERSION

If the Group Policy terminates, You will be provided conversion privileges as required by New York State regulations.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES

This Certificate is issued pursuant to the Group Master Policy which determines governing contractual provisions. The Group Master Policy, the Group Master Application, Your Enrollment form and any applicable Health Statements, any Riders and attached papers establish the entire contract of insurance between the Group Policyholder and Us. Changes may not be made that would bring the benefits below the minimum required under the New York State Partnership Program.

YOUR BENEFITS

Only You can receive Benefits under this Certificate.

WHEN YOUR COVERAGE STARTS

The date that Your coverage under this Certificate starts is shown in Your Schedule. All time periods start and end at 12:01 a.m. standard time at Your residence. Benefits are available only for services that You receive on or after Your effective date. They are subject to all of the conditions shown in this Certificate.

WHEN YOUR COVERAGE ENDS

You are no longer covered under the Group Policy when the first of the following occurs:

On the date Your premiums are not paid, when due, subject to the Grace Period.

When Your Maximum Benefits Available Under Your Certificate Are Exhausted: Your coverage will automatically end when You have used the maximum Benefits to which You are entitled. We will notify You when this occurs.

When You Elect to Terminate Your Coverage Under the Certificate: You may cancel Your coverage at any time by giving Us at least 30 days prior written notice. Your coverage will end on the date specified in Your written notice or on a later date as may be specified in the notice.

On Your Death: Your coverage will automatically end on the day after the date of Your death. We will refund to the Group Policyholder, or to Your estate, any premium already paid for the period between the day after the date of death until the next premium due date.

OUR OPTION TO TERMINATE

YOUR COVERAGE CANNOT BE CANCELLED BECAUSE OF YOUR AGE, A CHANGE IN YOUR RELATIONSHIP TO THE GROUP, EMPLOYMENT STATUS, HEALTH STATUS, HEALTH CARE NEEDS, OR USE OF BENEFITS.

Your coverage can be cancelled for fraud committed by You when You applied for coverage or on the submission of any claims under the Group Policy. (See "Incontestable Period" in the General Provisions section of Your Certificate.)

EXTENSION OF BENEFITS

If Your coverage under the Group Policy ends while You are totally disabled or while You are receiving Qualified Long-Term Care Services covered under the Group Policy, We will continue to pay for Your care without interruption of Benefits until the first of these dates:

- It has been determined that You are no longer eligible for Benefits under this Certificate; 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 coverage under the Group Policy had not ended.

You will not be entitled to Benefits after Your coverage ends if it ended due to You reaching Your maximum Lifetime Benefit Amount.

BENEFIT EXHAUSTION PRIOR TO MEETING DURATIONAL REQUIREMENTS

If You are faced with a gap in coverage or benefits between the time benefits are exhausted under the terms of a Partnership insurance certificate and the time that You can apply for Medicaid Extended Coverage, and if this gap is caused by the receipt of any benefits under such policy/certificate other than those specified in this agreement and in New York State Insurance Department Regulation 144, coverage during this interim gap period will be the responsibility of the Participating Insurer.

INCONTESTABLE PERIOD

During the first six (6) months Your Certificate is in force, We may rescind Your Certificate 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 as a Certificateholder.

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

After Your Certificate has been in force for two (2) years, We may rescind Your Certificate 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, the Group Policyholder, 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 Certificate.

MISSTATEMENT OF AGE

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

NON-PARTICIPATING

The Group Policy does not participate in Our profits or surplus earnings.

CONFORMITY WITH FEDERAL AND STATE STATUTES

Any provision of this Certificate that, on its effective date is in conflict with the statutes of the state in which You reside on such date is hereby amended to conform to the minimum requirement of such statutes if required.

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 Certificate, We will implement one or a combination of the following amendments to this Certificate, 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 Certificate have been duplicated by the national program.
- B. Increase benefits under this Certificate to make up for benefits that have been duplicated by the national program.