AMERICAN INDEPENDENT NETWORK INSURANCE COMPANY OF NEW YORK[SM]
Executive Offices: 3440 Lehigh Street, PO Box 7066
Allentown, PA 18105-7066
(800) 362-0700

NURSING HOME AND HOME CARE INSURANCE

TAX-QUALIFIED INSURANCE POLICY

NOTICE TO BUYER: This Policy may not cover all of the costs associated with nursing home and home care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

TAX-QUALIFIED STATUS

This contract for nursing home and home care insurance is intended to be a federally-tax-qualified nursing home and home care insurance contract and may qualify You for federal and state tax benefits.

GUARANTEED RENEWABLE FOR LIFE

This Policy is guaranteed renewable for Your Lifetime, subject to the Policy maximums. It may be kept in force by the timely payment of premiums. We cannot refuse to renew this Policy as long as You pay the premiums when due. (Payment of the renewal premium will not restore or replenish the benefits available under this Policy. Please refer to the Policy's **Restoration of Benefits** provision on Page 14 to learn how benefits may be restored.) We will never rider, reduce benefits or change this Policy in any way because of a change in your health or as you become older. Changes to federal or state laws or regulations, or their interpretation, could jeopardize the tax-qualified status of this Policy. In this event, the Policy will be revised to maintain tax-qualification. You will be offered the revised Policy for acceptance or rejection, and thus either accept or reject the continuance of tax-qualified status of Your coverage.

PREMIUM RATES SUBJECT TO CHANGE

We reserve the right to change the premium rates for this Policy. We will not make any such change, however, unless we: (1) first obtain the prior approval of the New York Superintendent of Insurance; (2) change the premium rates for all policies bearing form number series ALP2(NY)-TQ, regardless of where an insured lives at the time of such change; and (3) We give You a 31-day advance written notice of the change. We cannot change the renewal premium rates for this Policy during the first three (3) years that it is in force.

NOTICE OF THIRTY (30) DAY RIGHT TO EXAMINE POLICY

Carefully read this Policy as soon as You receive it. If You are not satisfied for any reason, You may return it to Us, or Our authorized agent, within thirty (30) days of Your receiving it. We will refund the entire premium paid directly to You within thirty (30) days of the Policy being returned. Upon Our receipt of the returned Policy, the Policy will be considered void from the beginning.

CAUTION: THE ISSUANCE OF THIS POLICY IS BASED UPON YOUR RESPONSES TO THE QUESTIONS ON YOUR APPLICATION. A COPY OF YOUR APPLICATION IS ATTACHED. IF YOUR ANSWERS FAIL TO INCLUDE ALL MATERIAL MEDICAL INFORMATION REQUESTED, WE MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR POLICY. THE BEST TIME TO CLEAR UP ANY QUESTIONS IS NOW, BEFORE A CLAIM ARISES! IF, FOR ANY REASON, ANY OF YOUR ANSWERS ARE INCORRECT, CONTACT US AT THIS ADDRESS: 3440 LEHIGH STREET, PO BOX 7066, ALLENTOWN, PA 18105-7066.

TABLE OF CONTENTS

		Page
1.	Notice to Buyer	1
2.	Tax-Qualified Status	1
3.	Renewability Terms	1
4.	30 Day Right to Examine Policy	1
5.	Caution Statement	1
6.	Policy Schedule Page	3
7.	Section I: Policy Benefit Provisions	4
	Assisted Living Facility Benefits	4
	Nursing Facility Benefits	6
	Adult Day Care Benefits	7
	Hospice Care Benefits	8
	Respite Care Benefits	9
8.	Section II: Conditions of Eligibility	10
9.	Section III: Additional Benefits	12
	Bed Reservation Benefits	12
	Alternative Plan of Care Benefits	12
	Restoration of Benefits	14
	Waiver of Premium Benefits	14
10.	Section IV: Benefit Limitations	15
	Maximum Daily Benefit	15
	Maximum Lifetime Benefit	15
	Elimination Period	15
	Pre-Existing Conditions Limitation	15
11.	Section V: Additional Features	16
	Third Party Notification of Lapse	16
	Reinstatement for Loss of Cognitive/Functional Capacity	16
	Our Promise – Your Right to Convert to a Non-Tax-Qualified Policy	17
	Extension of Benefits	17
12.	Section VI: Exclusions	18
13.	General Contract Provisions	19
14.	Claims Under this Policy – What to do when You have a Claim	20
15.	Application	Attached

POLICY SCHEDULE

POLICY NUMBER **EEFFECTIVE DATE**

INSURED **FIRST RENEWAL DATE**

AGE

INITIAL PREMIUM	POLICY FEE	RENEWAL PREMIUM
$	$	$

PREMIUMS

ANNUAL	SEMI-ANNUAL	QUARTERLY
$	$	$

MONTHLY	AUTOMATIC BANK WITHDRAWAL (MONTHLY)
$	$

BENEFITS

MAXIMUM DAILY BENEFIT	**$_____**
MAXIMUM LIFETIME BENEFIT	**_____ DAYS**
ELIMINATION PERIOD	**_____ DAYS**

(THE PREMIUMS SHOWN ABOVE INCLUDE PREMIUMS FOR ANY RIDERS ISSUED ON THE SAME DATE AS THIS POLICY).

RIDERS ISSUED ON THE SAME DATE AS THIS POLICY

Independent Living Rider III

SECTION I: POLICY BENEFITS

This section tells You about the benefits available for care and assistance received in an Assisted Living Facility or in a Nursing Facility.

Important words and terms, which will help You understand the benefits available under this Policy, and the circumstances under which these benefits are payable, appear in **bold print** throughout the Policy. They appear in ***italicized bold print*** where they are defined.

Whenever "You" and "Your" appears in this Policy, it refers to the Insured listed in the Policy Schedule. "We", "Us" and "Our" refers to American Independent Network Insurance Company Of New York[SM].

ASSISTED LIVING FACILITY BENEFITS

For each day You are **confined** to an **Assisted Living Facility** and meet the **Conditions of Eligibility**, We will pay the lesser of:

1) the **Assisted Living Facility's Daily Fee**; or
2) the **Maximum Daily Benefit** listed in the Policy Schedule; or
3) the reasonable and customary charge for similar services rendered in a similar facility in the same geographic area.

(In no event will We pay less than $50 for each day of confinement in an **Assisted Living Facility**.)

(Please refer to Page 10 for the **Conditions of Eligibility**.)

Confined is assigned to a bed and physically present within the facility.

An ***Assisted Living Facility*** is a facility that is licensed by the appropriate federal or state agency to engage primarily in providing care and unscheduled services to resident inpatients, or, if not required to be licensed, a facility which:

1) provides twenty-four (24) hour a day care and services sufficient to support needs resulting from inability to perform **Activities of Daily Living** and/or **Severe Cognitive Impairment**;
2) has a trained and ready to respond employee on duty at all times to provide care and services;
3) provides three (3) meals a day and accommodates special dietary needs; and
4) has the appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications. (Please refer to Page 10 for the definitions of **Activities of Daily Living** and Page 11 for the definition of **Severe Cognitive Impairment**.)

An **Assisted Living Facility** may sometimes be called a Residential Care Facility or an Adult Congregate Living Facility. Any facility, or section thereof, known by one of these names, or any other name, will be considered eligible if it meets the Policy definition of an **Assisted Living Facility**.

If a facility or institution (such as a congregate care facility or life care community) has multiple licenses and/or multiple purposes, only the section, wing, ward or unit (including a separate room or apartment) that specifically qualifies as an **Assisted Living Facility** will be eligible for benefits.

Assisted Living Facility's Daily Fee is the facility's daily rate for room and board, assisted living care provided by the **Assisted Living Facility's** staff, and ancillary supplies and services. Incidental expenses, such as **Physician's** services, medications, pharmaceuticals, toiletries, transportation charges and beautician's services, will not be considered as part of the **Assisted Living Facility's Daily Fee**.

NURSING FACILITY BENEFITS

For each day You are **confined** to a **Nursing Facility** and meet the **Conditions of Eligibility**, We will pay the lesser of:

1) the **Nursing Facility's Daily Fee**; or
2) the **Maximum Daily Benefit** listed in the Policy Schedule; or
3) the reasonable and customary charge for similar services rendered in a similar facility in the same geographic area.

(In no event will We pay less than $50 for each day of confinement in a **Nursing Facility.)**

(Please refer to Page 4 for the definition of **confined** and Page 10 for the **Conditions of Eligibility**.)

A ***Nursing Facility*** is a facility or distinctly separate part of a hospital or other institution which is licensed by the appropriate federal or state agency to engage primarily in providing nursing care and related services to inpatients, or, if not required to be licensed, a facility or distinctly separate part of a hospital or other institution which:

1) provides twenty-four (24) hour a day nursing services;
2) has a nurse on duty or on call at all times;
3) maintains clinical records for all patients; and
4) has appropriate methods and procedures for handling and administering drugs and biologicals.

A **Nursing Facility** may sometimes be called a Skilled Nursing Facility, Intermediate Care Facility, Custodial Care Facility or Personal Care Facility. Any facility, or section thereof, known by one of these names, or any other name, will be considered eligible if it meets the policy definition of a **Nursing Facility**.

If a facility or institution (such as a congregate care facility or life care community) has multiple licenses and/or multiple purposes, only the section, wing, ward or unit (including a separate room or apartment) that specifically qualifies as a **Nursing Facility** will be eligible for benefits.

Nursing Facility's Daily Fee is the daily rate for room and board, nursing care provided by the **Nursing Facility's** staff, and ancillary supplies and services. Incidental expenses, such as **Physician's** services, medications, pharmaceuticals, toiletries, transportation charges and beautician's services, will not be considered as part of the **Nursing Facility's Daily Fee**.

ADULT DAY CARE BENEFITS

For each day You receive **Adult Day Care** and meet the **Conditions of Eligibility**, We will pay the lesser of:

1) the actual charge incurred;
2) 50% of the **Maximum Daily Benefit** listed in the Policy Schedule;
3) the reasonable and customary charge for **Adult Day Care** rendered in the same geographic area.

(In no event will We pay less than $25 for each day of **Adult Day Care** received.)

(Please refer to Page 10 for the **Conditions of Eligibility**.)

Adult Day Care is a program for two (2) or more individuals of social and health-related services provided during the day in an **Adult Day Care Center** for the purpose of supporting frail, impaired elderly or other adults with a disability who can benefit from care in a group setting outside of the home.

Adult Day Care Center is a facility that is established and operated in accordance with any applicable state or local laws that are required in order to provide **Adult Day Care**, or, if no such laws exist, a facility which:

1) operates at least five (5) days per week for a minimum of five (5) hours per day, but is not an overnight facility;
2) maintains a written record of medical services given to each client; and
3) has established procedures for obtaining appropriate aid in the event of a medical emergency.

HOSPICE CARE BENEFITS

For each day You receive **Hospice Care** and meet the **Conditions of Eligibility**, We will pay the lesser of:

1) the actual charge incurred; or
2) 50% of the **Maximum Daily Benefit** listed in the Policy Schedule; or
3) the reasonable and customary charge for **Hospice Care** rendered in the same geographic area.

(In no event will We pay less than $25 for each day of **Hospice Care** received.)

(Please refer to Page 10 for the **Conditions of Eligibility**.)

Hospice Care is an outpatient service designed to provide palliative care; alleviate the physical, emotional, social and spiritual discomforts when You are experiencing the last phase of life due to the existence of a terminal disease; and provide supportive care to Your primary care-giver and family.

RESPITE CARE BENEFITS

For each day You receive **Respite Care** and meet the **Conditions of Eligibility**, We will pay the lesser of:

1) the actual charge incurred; or
2) 50% of the **Maximum Daily Benefit** listed in the Policy Schedule; or
3) the reasonable and customary charge for similar services rendered in the same geographic area.

(In no event will We pay less than $25 for each day of **Respite Care** received.)

(Please refer to Page 10 for the **Conditions of Eligibility**.)

Respite Care may be **Adult Day Care, Hospice Care, Home Health Care** or care provided in an **Assisted Living Facility** or **Nursing Facility**, the purpose of which is to temporarily relieve a **Family Member** who has been providing care.

Home Health Care is skilled nursing services and/or assistance with the **Activities of Daily Living** provided by a nurse, certified nurse's aide, home health aide or any other caregiver, whether skilled or unskilled. (Please refer to Page 10 for the definition of **Activities of Daily Living**.)

A ***Family Member*** is You and Your spouse, and Your and Your spouse's respective parents, grandparents, siblings, children, grandchildren, aunts, uncles, cousins, nephews, nieces and in-laws.

This benefit is payable for a maximum of fifteen (15) days per calendar year and is not subject to the **Elimination Period**. Any days not used in a calendar year cannot be carried over to any subsequent years. (Please refer to Page 15 for the definition of **Elimination Period**.)

SECTION II: CONDITIONS OF ELIGIBILITY

This section explains how You become eligible for the benefits of this Policy.

The care/assistance You require must be provided pursuant to a **Plan of Care** developed by a **Licensed Health Care Practitioner** which certifies You are **Chronically Ill**. To be certified as ***Chronically Ill:***

1) You must be unable to perform at least two (2) **Activities of Daily Living** without **Substantial Assistance** for a period of at least ninety (90) days due to the loss of functional capacity;

OR

2) You must require supervision to protect You from threats to health and safety due to **Severe Cognitive Impairment**.

The ***Plan of Care*** specifies the type of care/assistance that is necessary and certifies that You are a **Chronically Ill Individual**. This certification must be made at the time the care/assistance is received, or during the preceding twelve (12) months. (Certification of Your condition may be required periodically, but not more than once every thirty-one (31) days.)

A ***Licensed Health Care Practitioner*** is any Physician or any registered professional nurse, licensed social worker, or other individual who meets the requirements prescribed by the Secretary of Health and Human Services or is a state licensed provider acting within the scope of his/her license as appropriate to a tax-qualified policy.

Activities of Daily Living are the basic human functional abilities required for You to remain independent. They are as follows:

1) Eating is feeding oneself by getting food into the body from a receptacle, (such as a plate, cup or table), or by a feeding tube or intravenously.
2) Bathing is washing oneself by sponge bath; or in either a tub or shower, including getting into and out of the tub or shower.
3) Dressing is putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
4) Transferring is moving into or out of a bed, chair or wheelchair.
5) Toileting is getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
6) Continence is the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel and/or bladder function, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag.

Substantial Assistance may be **Hands-on Assistance** and/or **Standby Assistance**.

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

Standby Assistance is the presence of another person within arm's reach of You that is necessary to prevent, by physical intervention, injury to You while You are performing an **Activity of Daily Living**.

Severe Cognitive Impairment is confusion and/or disorientation resulting from a deterioration or loss of intellectual capacity that is not related to, or a result of, mental illness, but which can result from Alzheimer's Disease and other forms of Organic Brain Syndrome. **Severe Cognitive Impairment** must result in Your requiring supervision to maintain Your safety and/or the safety of others. This deterioration or loss of intellectual capacity may be established through the use of standardized tests that reliably measure impairment in the following areas: short-term and/or long-term memory; orientation as to person, place and time; deductive or abstract reasoning.

SECTION III: ADDITIONAL BENEFITS

This section tells You about the extra benefits available with this Policy and explains how You can receive them.

BED RESERVATION BENEFIT

We will pay a ***Bed Reservation Benefit*** when You are charged to hold Your room in an **Assisted Living Facility** or **Nursing Facility** when hospitalized during the course of an **Assisted Living Facility** or **Nursing Facility** confinement. The amount payable per day under the **Bed Reservation Benefit** shall be equal to the **Assisted Living Facility Benefit** or **Nursing Facility Benefit** payable on the day prior to the hospitalization. This benefit will not be less than $50 per day and will be limited to thirty (30) days per calendar year on a combined basis. Any days not used in a calendar year cannot be carried over to any subsequent year.

ALTERNATIVE PLAN OF CARE

If You would otherwise qualify for benefits for a confinement to an **Assisted Living Facility** or **Nursing Facility**, You may request that We consider providing benefits for an alternative to such a confinement. A written request must be submitted in advance and describe, in detail, the proposed alternative, as well as the costs of said alternative. The **Alternative Plan of Care** must be a medically acceptable option and be agreed on in advance by You, Your **Physician** and Us. We will review the proposed **Alternative Plan of Care** and, if it is acceptable, let You know specifically under what terms We will pay benefits and the amount of benefits to be paid.

The **Alternative Plan of Care** must be in lieu of a confinement to an **Assisted Living Facility** or a **Nursing Facility**. An example of an **Alternative Plan of Care** would be to equip Your home with adaptive devices, such as shower bars, a special toilet and a wheelchair ramp, which would enable You to remain at home, and without which You would need to enter an **Assisted Living Facility** or **Nursing Facility**.

Benefits extended under the **Alternative Plan of Care** will be deducted from the **Maximum Lifetime Benefit** listed in the Policy Schedule and will, correspondingly, reduce the benefits available for the other forms of care/assistance covered by this Policy by an equal amount. (Please refer to Page 15 for the definition of **Maximum Lifetime Benefit**.)

Neither **Home Health Care** nor **Homemaker Care** will be considered for benefits under the **Alternative Plan of Care**. (Please refer to Page 9 for the definition of **Home Health Care**.)

Homemaker Care is assistance with the **Instrumental Activities of Daily Living.**

The ***Instrumental Activities of Daily Living*** are the following basic functional activities required for You to remain in Your home:

1) Meal Preparation is the preparation of food for human consumption, including cooking and cleanup.
2) Shopping/Travel is utilizing public or private transportation to get to a store and shop for groceries, pick up prescriptions and to get to medical appointments.
3) Light Housekeeping is maintaining a clean home living environment so that Your health, safety and welfare are not jeopardized. Light Housekeeping does not include any type of home construction or maintenance, work on the exterior of the home**,** heavy cleaning such as annual "spring cleaning", lawn care, snow removal, maintenance of a vehicle, or any other service provided outside the home.
4) Laundry is washing, drying and storing Your clothing, bed linens, etc.
5) Telephoning is using a telephone to make calls.
6) Handling Money/Bill Paying is depositing and/or withdrawing funds at a financial institution, writing checks to pay bills, etc.
7) Medication Management is safely controlling, dispensing and/or administering medications prescribed by a **Physician** in the proper dosages and at the proper times.

RESTORATION OF BENEFITS

We will restore the **Maximum Lifetime Benefit** of this Policy to the full original amount listed in the Policy Schedule when:

1) You have not been confined to an **Assisted Living Facility** or **Nursing Facility** and You did not receive **Adult Day Care, Hospice Care, Home Health Care** or **Homemaker Care** for a period of one hundred and eighty (180) consecutive days; and
2) Your **Physician** certifies that:
   a) You recovered sufficiently to not require confinement to, and you were not advised to be confined to, an **Assisted Living Facility** or **Nursing Facility**; and
   b) You recovered sufficiently to not receive, and You were not advised to receive, **Adult Day Care, Hospice Care, Home Health Care** or **Homemaker Care** (whether provided by a **Family Member** or any other caregiver) during that one hundred eighty (180) day period. (Please refer to Page 9 for the definition of **Home Health Care** and Page 12 for the definition of **Homemaker Care**.)

There is no limit to the number of times the **Maximum Lifetime Benefit** will restore as long as You meet the above requirements.

WAIVER OF PREMIUM BENEFITS

Once You have received benefits for ninety (90) continuous days for confinement to an **Assisted Living Facility** or **Nursing Facility** and/or for **Adult Day Care** and/or **Hospice Care** received on a regular basis, (a regular basis is five (5) days or more per week), We will waive the payment of premiums for this Policy and any riders attached to this Policy while You continue to be so eligible for benefits. Premiums that have been paid for coverage that extends beyond the date You become eligible for the **Waiver of Premium** will be held by Us and applied to any premiums payable once You are no longer eligible for the **Waiver of Premium Benefit**. If You die while eligible for this benefit, the waived premiums held by Us will be refunded to Your estate.

SECTION IV: BENEFIT LIMITATIONS

This section explains the limitations on the benefits available under this Policy.

MAXIMUM DAILY BENEFIT

The ***Maximum Daily Benefit*** is the maximum amount We will pay under any one (1) benefit, or combination of benefits, for care/assistance received during the same calendar day. The **Maximum Daily Benefit** is listed in the Policy Schedule.

MAXIMUM LIFETIME BENEFIT

The ***Maximum Lifetime Benefit*** is the maximum number of days in benefits We will pay during Your lifetime under this Policy, unless benefits are restored as described in the **Restoration of Benefits** provision on Page 14. Each day You are eligible for and receive the **Assisted Living Facility Benefits** and/or **Nursing Facility Benefits** will count as one (1) full day of the **Maximum Lifetime Benefit**. Each day You are eligible for and receive the **Adult Day Care Benefits, Hospice Care Benefits** and/or **Respite Care Benefits** will count as one-half (1/2) day of the **Maximum Lifetime Benefit**. Your Policy's **Maximum Lifetime Benefit** is listed in the Policy Schedule.

(The **Maximum Lifetime Benefit** is separate from the Rider's **Maximum Benefit Period**. Benefits paid against the **Maximum Benefit Period** for **Homemaker Care Benefits**, **Personal Care Benefits**, or **Home Health Care Benefits** will not count against the Policy's **Maximum Lifetime Benefit**. Please refer to the Rider for the definition of **Maximum Benefit Period**.)

ELIMINATION PERIOD

The ***Elimination Period*** serves as a deductible which must be satisfied before benefits will be available. Specifically, it is the number of days You must receive care/assistance before You can receive benefits. For each day of care/assistance to be applied towards the satisfaction of the **Elimination Period**, the care/assistance must be otherwise covered by the Policy and You must otherwise be eligible for benefits. When benefits do begin, they will not be retroactive to the beginning of the **Elimination Period**.

Each day You are otherwise eligible for the **Assisted Living Facility Benefits** or the **Nursing Facility Benefits** will count as one (1) full day towards the satisfaction of Your **Elimination Period**. Each day You are otherwise eligible for the **Adult Day Care Benefits** or **Hospice Care Benefits** will count as one-half (1/2) day towards the satisfaction of Your **Elimination Period**. (The **Respite Care Benefits** are not subject to the **Elimination Period**.)

The **Elimination Period** must be satisfied only once during the lifetime of this Policy and applies to all of the benefits available under this Policy on a combined basis. (For example, if You satisfy the **Elimination Period** for **Adult Day Care** and would then require admission to an **Assisted Living Facility**, it will not be necessary for You to satisfy the **Elimination Period** again.) The **Elimination Period** is listed in the Policy Schedule.

PRE-EXISTING CONDITIONS LIMITATION

Pre-Existing Condition is a condition for which medical advice or treatment was recommended by or received from a **Physician** within six (6) months preceding the Policy's Effective Date as shown in the Policy Schedule.

Pre-Existing Conditions listed on the application are covered immediately. Pre-Existing Conditions which are not listed on the application are not covered until six (6) months after the Effective Date shown in the Policy Schedule.

SECTION V: ADDITIONAL FEATURES

This section explains 4 additional Policy Features designed to protect You.

THIRD PARTY NOTIFICATION OF LAPSE

You have the right to designate at least one (1) person who will be notified in the event Your Policy is about to lapse because the renewal premium has not been paid. This is to protect You from losing this valuable coverage in the event You become mentally incompetent or physically incapable of paying the renewal premium when due.

If You elect to designate such a person, Your Policy cannot be canceled for nonpayment of premium unless We have notified the designated person at least thirty (30) days in advance of the cancellation date. Notice shall be given by first class United States mail, postage prepaid, and will be sent thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given five (5) days after the date We have mailed it to the third party.

Your written designation shall include the person's full name and home address and shall become a part of Our records. We shall notify You of the right to change this written designation at least once every two (2) years. If You do not elect to designate a Third Party to receive notice of cancellation for nonpayment of premium, a written waiver dated and signed by You will become part of Our records. You may elect to designate a Third Party or change the Third Party previously designated, at any time, by submitting a written request to Our Home Office.

(Designation of this Third Party does not constitute acceptance of any liability by this person for the cost of any care/assistance You receive.)

REINSTATEMENT FOR ALZHEIMER'S DISEASE, OTHER FORMS OF SEVERE COGNITIVE IMPAIRMENT AND/OR LOSS OF FUNCTIONAL CAPACITY

If Your Policy lapses, We will provide a retroactive continuation of coverage if We receive the following within five (5) months of the date it lapses:

1) Satisfactory proof You had **Severe Cognitive Impairment** (including, but not limited to Alzheimer's Disease) and/or a loss of functional capacity (the inability to perform two (2) or more of the **Activities of Daily Living**) on the renewal date; and
2) Payment of all past-due premiums for this Policy and any riders attached to the Policy that were in force on the date of lapse.
   (Please refer to Page 10 for the definitions of **Activities of Daily Living** and Page 11 for the definition of **Severe Cognitive Impairment**.)

This reinstatement will provide uninterrupted coverage to the same extent that the Policy would have provided had it not lapsed.

OUR PROMISE – Your Right to Convert to a Non-Tax-Qualified Policy

In the event the U.S. Congress or the Treasury Department rules the premiums and/or benefits of a non-tax-qualified policy will receive preferential treatment, as is the case with this Policy, You may convert this Policy to a non-tax-qualified policy at any time prior to its first anniversary. All You have to do is submit a written request to Our Home Office. The premiums of the new policy will be based on Your original issue age and You will not have to submit additional evidence of insurability for any benefit amounts not exceeding those elected with the original policy. (The premiums for the non-tax-qualified policy may be higher because of the additional coverage it provides.) You may also convert this Policy to a non-tax-qualified policy after its first anniversary if You provide evidence of insurability acceptable to Us. The premiums of the new policy will be based on Your original issue age.

EXTENSION OF BENEFITS

Termination of Your Policy and Rider shall be without prejudice to any benefits payable for care/services if eligibility for such benefits or Your **Total Disability** began while the Policy and Rider were in force and continue without interruption after termination. The extension of benefits beyond the period the Policy is in force is limited to the benefits remaining in the **Maximum Lifetime Benefit**. (Please refer to the definition of **Maximum Lifetime Benefit** on Page 15.) The extension of benefits beyond the period the Rider is in force is limited to the benefits remaining in the **Maximum Benefit Period**. (Please refer to the definition of **Maximum Benefit Period** on Page 11of the Rider.)

> ***Total Disability*** is the inability to perform two (2) or more of the **Activities of Daily Living** and/or the presence of **Severe Cognitive Impairment**. (Please refer to Page 10 for the definitions of **Activities of Daily Living** and Page 11 for the definition of **Severe Cognitive Impairment**.)

Benefits may be reduced by the amount of premium payable for the duration of the **Maximum Lifetime Benefit** in accordance with the Unpaid Premium provision, which can be found on Page 21.

SECTION VI: EXCLUSIONS

This section explains the circumstances under which benefits will not be payable even if You have satisfied all of the other terms of the Policy.

Exclusions: The Policy will not pay benefits for:

1) Care/assistance provided by a **Family Member**, unless pre-approved by Us, or in a facility owned or operated by a **Family Member**.
2) Care/assistance You would not be legally obligated to pay for in the absence of this insurance.
3) Care/assistance provided outside of the United States of its possessions.
4) Care/assistance provided under any Worker's Compensation or Occupational Disease Law.
5) Care/assistance for mental, nervous or emotional disorders without demonstrable organic origin. **(NOTE: ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN SYNDROMES ARE COVERED BY THE POLICY AS ANY OTHER SICKNESS.)**
6) Care/assistance required as a result of war, or an act of war, whether declared or not.
7) Care/assistance required as a result of attempted suicide or intentionally self-inflicted injury.
8) Care/assistance required as a result of alcoholism and/or drug addiction.
9) Care/assistance required as a result of Your participation in an act of felony, riot or insurrection.
10) Care/assistance paid by Medicare. Any portion of the charges not paid by Medicare, will be covered, subject to the terms of this Policy.
11) Care/assistance required as a result of cosmetic surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part.

"Care/assistance" refers to confinement in an **Assisted Living Facility** and/or **Nursing Facility, Adult Day Care, Hospice Care,** and **Respite Care**, **Home Health Care**, and **Homemaker Care.**

Disclosure: This Policy offers a minimum of twelve (12) months' worth of benefits, in total, for confinement to a **Nursing Facility** and for **Home Health Care** required by New York Insurance Regulation. This Policy also includes benefits that are not required by New York Insurance Regulation, such as benefits for **Assisted Living Facilities, Adult Day Care, Hospice, Respite Care, Homemaker Care, and Personal Care**. You should be aware that the use of these non-required benefits may reduce the amount available for required benefits below the twelve (12) month minimum and, if You would like to retain twelve (12) months' worth of coverage for **Nursing Facilities** or **Home Health Care**, You should manage Your other benefits accordingly.

SECTION VII: GENERAL CONTRACT PROVISIONS

Your Nursing Home and Home Care Insurance Policy is a contract between You and Us. This section explains the general contract provisions that govern this Policy.

Consideration Clause: This Policy is issued to the person named in the Policy Schedule as the Insured in consideration of the answers to the questions contained in the application (a copy of which is attached to and made a part of this Policy) and the payment of the Initial Term Premium sent in with such application. The person named is the primary Insured and Policy owner and will be referred to as "You" or "Your" in this Policy.

Cancellation: We cannot cancel this policy at any time. Once this Policy's thirty (30) day examination period has expired, you may only cancel this Policy on its renewal date. To cancel this policy You must submit a written request to Our Home Office. If You request We cancel this Policy, the termination of this Policy will take effect on the first renewal date following Our Receipt of Your request.

Insuring Clause/Effective Date: This Policy is evidence of an agreement between you and the American Independent Network Insurance Company of New York℠ (hereafter referred to as "we," "our" or "us"). This agreement is a contract of insurance whereby we agree to pay you the benefits provided by this Policy for a covered loss incurred on or after the Effective Date and while this Policy is in force.
This Policy takes effect as of 12:01 A.M., standard time, at your residence on the Effective Date shown in the Policy Schedule.

Entire Contract; Changes*:* This Policy, including any attached papers, constitutes the entire contract. No change is valid until:

1) approved by one of Our executive officers; and
2) endorsed hereon or attached hereto.

No agent has authority to change this Policy or to waive any of its provisions.

Grace Period*:* A grace period of thirty-one (31) days is granted for the payment of each premium due after the first premium, during which time Your Policy continues in force.

Reinstatement: If the renewal premium is not paid before the Grace Period ends, Your Policy will lapse. Later acceptance of the premium by Us, or by Our agent authorized to accept payment, without requiring an application for reinstatement will reinstate Your Policy. If We require a reinstatement application, You will be issued a conditional receipt for the premium. If We approve Your reinstatement application, Your Policy will be reinstated as of the date of Our approval. If We disapprove Your application, We must do so in writing within forty-five (45) days of the conditional receipt. Otherwise Your Policy will be reinstated forty-five (45) days after the date of the conditional receipt. The reinstated Policy will cover only loss resulting from accidental injury as may occur after the date of reinstatement and loss due to sickness as may begin more than ten (10) days after the date of reinstatement. In all other respects, both Your and Our rights under the policy will be the same as before the policy lapsed. Any premiums We accept for a reinstatement will be applied to the period for which premiums have not been paid. No premium will be applied to any period more than sixty (60) days before the date of reinstatement.

Conformity with State Statutes: Any provision of the Policy, which, on its Effective Date, conflicts with the statutes of Your state on such date, is amended to conform to its minimum requirements.

CLAIMS UNDER THIS POLICY:

What You Should Do When You Have A Claim for Assisted Living Facility, Nursing Facility, Adult Day Care, Hospice Care or Respite Care:

When You need to enter an **Assisted Living Facility** or **Nursing Facility**, or You need **Adult Day Care, Hospice Care** or **Respite Care**, the Claim Forms You will need to complete are enclosed. Please follow the instructions on these forms as they will tell You precisely what You have to do. Following these instructions and submitting the information required will help Us expedite the processing of Your claim. If You have any questions, or if You need Claim Forms, please call Us at (800) 865-8722.

What You Should Do When You Have A Claim for Homemaker Care, Personal Care, or Home Health Care:

When You need **Homemaker Care, Personal Care**, or **Home Health Care** that may be covered by the Home Health Care Rider, You should immediately call Our Claims Department at (800) 865-8722 if You would like to be eligible for up to 100% of Your Rider's Maximum Daily Benefit. Please refer to the **Early Notification of Claim** provision listed in the Rider.

When You call Us, We will give You further instructions on what forms/information You need to submit. If You elect not to notify Us of Your claim within fifteen (15) calendar days of the care/assistance beginning in accordance with the **Early Notification of Claim** provision, the Claim Forms You will need to complete are enclosed. Please follow the instructions on these forms as they will tell You precisely what You have to do. Following these instructions and submitting the information required will help Us expedite the processing of Your claim. If You have any questions, or if You need Claim Forms, please call Us at (800) 865-8722.

Claim Forms/Proof of Loss: You must submit the required claim forms or other written proof of loss within ninety (90) days from the occurrence of the loss. If You have a good reason for not doing so, We will not contest the claim. However, You must give Us proof no later than one (1) year from the time normally required unless legally incapable. We may request other proof of loss, such as proof of the expenses incurred.

Payment of Claims: All benefits will be payable to You, unless You, or someone legally authorized to act in Your behalf, assigns these benefits by providing us written instructions to pay another party. Any accrued benefits unpaid at Your death will be paid to Your estate, unless said benefits were so assigned to another party.

Time of Payment of Claims: Benefits payable under the policy for any loss incurred will be paid within thirty (30) days after receipt of written proof of loss. Any balance remaining unpaid at the end of Our liability will be paid immediately upon receipt of written proof.

Appealing a Denial of Benefits: You, or someone authorized to act in Your behalf, shall have the right to appeal any denial of a claim, or portion of a claim, made under this Policy. Such appeal should be submitted in writing and should include any information and/or documentation which supports Your position. We will send you a written explanation of the results of Our review within thirty (30) days of Our completion thereof.

Contestability/Time Limit on Certain Defenses: If this policy has been in force for less than six (6) months, We may rescind it upon a showing of misrepresentation that is material to the acceptance of coverage. If this policy has been in force for at least six (6) months, but less than two (2) years, We may rescind it upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to a condition for which benefits are sought. If this policy has been in force for two (2) years or more, We may rescind coverage only upon a showing of fraudulent misrepresentation.

Legal Actions: No legal action may be brought to recover on the policy within sixty (60) days after written proof of loss has been given as required by this policy. No action shall be brought after three (3) years from the time written proof of loss is required to be given.

Misstatement of Age: If Your age has been misstated at the time You applied for this Policy, all amounts payable shall be such as the premium paid would have purchased given the correct age.

Physical Examination: At Our expense, We shall have the right and opportunity to have You examined and/or obtain an independent assessment of your functional and/or cognitive abilities when and as often as We may reasonably require while a claim is pending.

Unpaid Premium: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

IN WITNESS WHEROF, We have caused this Policy to be signed by Our President and Secretary.

President

Secretary