
Group Long Term Care Benefits

AMERICAN
FOREIGN
SERVICE
**PROTECTIVE
ASSOCIATION**

**The American Foreign Service
Protective Association**

HOW TO OBTAIN PLAN BENEFITS

To obtain benefits see the Payment of Claims provision.

You may request a claim form from Mutual of Omaha or from the Plan Administrator.

Forward your completed claim form to the Plan Administrator.

American Foreign Service
Protective Association
1716 N Street NW
Washington, DC 20036
Phone (202) 833-4910

CLAIM ASSISTANCE

If you need assistance with filing your claim or an explanation of how your claim was paid, contact the:

Mutual of Omaha Insurance Company
Group LTD Claims
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Phone 1-800-877-1052

IMPORTANT NOTICE

30-DAY RIGHT TO EXAMINE CERTIFICATE

Please read your certificate. If you are not satisfied, send it back to us within 30 days after you receive it. We will send back your money and this certificate will be considered to never have been issued.

This Certificate-Booklet is part of a policy that was effective prior to 1-1-97 and therefore should be grandfathered as a tax-qualified long-term care insurance plan by the federal government.

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appear in the following order.

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CERTIFICATE OF INSURANCE

**MUTUAL OF OMAHA
INSURANCE COMPANY**

Home Office: Mutual of Omaha Plaza
Omaha, Nebraska 68175

Mutual of Omaha Insurance Company certifies that Group Policy No. GMLC-2Y67 (Policy) has been issued to American Foreign Service Protective Association (Policyholder).

You are insured as described in this Certificate-Booklet, subject to the terms and conditions of the Policy. Your insurance begins on the date shown on your Certificate Validation Form.

Attach Your Certificate Validation Form Here.

Your insurance ends as set forth in the When Your Insurance Ends section of this Certificate-Booklet.

If the provisions of this Certificate-Booklet and those of the Policy do not agree, the provisions of the Policy will apply.

This Certificate-Booklet replaces any previous Certificate issued under the policy.

DEFINITIONS

When used in the Policy or your certificate:

Our, We, Us means the Company shown on your Certificate of Insurance.

You, Your means a member who is insured under the Policy.

Member means a person who qualifies for membership in the American Foreign Service Protective Association, as defined in the Association's by laws.

Insured Person means a person who is insured under the Policy.

Sickness means a disease, disorder or condition, which requires treatment by a physician.

Injury means an accidental bodily injury which requires treatment by a physician .

Mental and Nervous Disorders means any condition or disease, regardless of its cause, listed in the most recent edition of the **International Classification of Diseases** as a Mental Disorder. Not included in this definition are conditions or diseases specifically excluded from coverage.

Physician means any of the following licensed practitioners acting within the scope of his or her license:

- (a) a doctor of medicine (MD), osteopathy (DO), surgical chiropody, podiatry, or chiropractic;
- (b) a licensed clinical psychologist; or
- (c) where group insurance law requires, any other licensed practitioner who is acting within the scope of that license.

A physician does not include a person who lives with you or is part of your family (you; your spouse; or a child, brother, sister or parent of you or your spouse).

Expense means the expense incurred for a covered service or supply. A physician has to order or prescribe the service or supply. Expense is considered incurred on the date the service or supply is received. Expense **does not include** any charge:

- (a) for a service or supply which is not medically necessary; or
- (b) which is in excess of the usual and customary charge for a service or supply.

A **Medically Necessary** service or supply means one which our medical staff and/or an Independent Medical Review believes is appropriate and consistent in accord with accepted standards of community practice.

The fact that the insured person's physician prescribes services or supplies does not automatically mean such services or supplies are medically necessary and covered by the Policy.

Usual and Customary Charge means a charge for a service or supply which is no higher than the 90th percentile of our prevailing health care charges data. This data reflects a current statistical sampling of charges for services and supplies made in the same or comparable area.

For services or supplies for which data is unavailable, usual and customary will be determined by the charges generally incurred for cases of comparable nature and severity in the particular geographical area concerned .

Skilled or Intermediate Nursing Care means care which:

- (a) is performed under the direction of a licensed physician; and
- (b) consists of nursing and rehabilitation services administered by registered nurses (RNs), licensed practical nurses (LPNs) or physical therapist.

Custodial Nursing Care means care which:

- (a) is primarily for the purpose of assisting an insured person in performing the Activities of Daily Living; and
- (b) could be rendered safely by a person without medical skills.

Nursing Care Facility means a facility that:

- (a) is licensed or certified by the state in which it is located to provide skilled, intermediate or custodial care as its main function;
- (b) provides continuous room and board for at least 3 people;
- (c) is supervised by an on-duty RN or LPN;
- (d) maintains daily medical records; and
- (e) maintains control and records for medication.

Nursing Care Facility shall not include a facility which primarily provides psychiatric treatment.

Home Health Agency means a public or private agency or organization licensed and operated in accord with state law to provide home health care.

Home Health Care Plan means a plan of continued care and treatment of an insured person:

- (a) who is under the care of a physician; and
- (b) who would need hospital or nursing care facility confinement without the home health care.

The **Home Health Care Plan** must be approved in writing by a physician.

Adult Day Care Center means an organization:

- (a) which provides a program of adult day care;
- (b) which is established and operated in accordance with state law;
- (c) whose staff includes:
 - (1) a full-time director;
 - (2) 1 or more RNs in attendance at least 4 hours a day during operating hours;
 - (3) a registered dietitian;
 - (4) a licensed physical therapist; and
 - (5) a licensed speech therapist;
- (d) which operates at least 5 days a week and operates a minimum of 6 hours and a maximum of 12 hours daily;
- (e) which maintains a written record of medical services given to each client; and
- (f) which has established procedures for obtaining appropriate aide in the event of a medical emergency.

Waiting Periods means those days when an insured person is confined in a nursing care facility or receiving home health care or adult day care and the Activities of Daily Living Test is met. Benefits are not payable for these days. The Waiting Periods will be applied to each new Benefit Period. Days applied toward the Waiting Period for confinement in a nursing care facility may be applied toward the Waiting Period for home health care or adult day care, or days applied toward the Waiting Period for home health care or adult day care may be applied toward the Waiting Period for confinement in a nursing care facility if within the same Benefit Period. The Waiting Periods are shown on your Certificate Validation Form.

Benefit Period is a period of time which:

- (a) begins with the first day of nursing home confinement, home health care or adult day care; and
- (b) ends when there is a continuous period of 180 days or more when the insured person is neither confined in a nursing care facility nor receiving home health care or adult day care.

Activities of Daily Living are:

- (a) transferring (able to get in or out of bed or move from bed to chair) and walking (able to use a wheelchair or walk unassisted, even with braces, a walker, a cane or other aid);
- (b) taking medication;
- (c) eating (able to consume food or other nourishment once it has been prepared and made available to the insured person);
- (d) dressing (able to put on and take off all necessary items of clothing and get clothing from drawers, closets, etc);
- (e) toileting (able to get to and from the toilet. transfer on and off the toilet and associated personal hygiene); and
- (f) bathing.

Activities of Daily Living Test is:

- (a) for nursing care facility confinement, met when the insured person's physician and our medical staff confirms that the insured person is unable to perform 3 or more of the Activities of Daily Living without the assistance of another person; and
- (b) for adult day care or home health care, met when the insured person's physician and our medical staff confirms that the insured person is unable to perform 2 or more of the Activities of Daily Living without the assistance of another person.

Respite Care means short-term care which is provided on a 24-hour basis in the insured person's home when the primary caregiver is absent. Respite care is provided as a means of giving temporary relief to a caregiver who regularly assists with home care and who resides in the insured person's home.

Caregiver means a person who resides in the home and provides nonmedical services related to the Activities of Daily Living and companionship. This may be a family member.

Rider means a provision added to the Policy or your certificate to expand or limit benefits or coverage.

GENERAL PROVISIONS

Eligible Members

You are eligible on the day you become a member.

NOTE: A member can be eligible for the insurance provided under the Policy only if such person is under age 80 on the date insurance would otherwise become effective.

If you have previously enrolled for insurance under the Policy as a spouse or parent, you are not eligible as a member.

When Your Insurance Begins

If we receive your signed written request on, before or within 31 days from the day you become eligible, you will become insured on the date shown on your Certificate Validation Form; providing you submit evidence of insurability that is acceptable to us.

This insurance may not be reinstated once it has lapsed.

EXCEPTIONS

Confinement Rule

If you are:

- (a) hospital confined;
- (b) confined in any institution or facility other than a hospital, or at home or elsewhere due to an injury or sickness; or
- (c) disabled, either physically or mentally, to the extent of being unable to perform all of the usual and customary duties and activities (the "normal activities") of a person of the same age and sex who is in good health;

the insurance will not become effective in the case of paragraphs (a) or (b) above, until such confinement ends, and is no longer medically necessary, as determined by our medical staff and/or an independent medical review, and in the case of paragraph (c) above, until the full resumption of all normal activities.

Late Request

You may enroll in the Plan when you are initially eligible and during future enrollment periods, if any, as agreed upon by us and the Policyholder.

Amount of Coverage

Your amount of coverage is shown on the Certificate Validation Form and on the Schedule.

Changes In Your Classification

Any changes in your classification will take effect on the first day of the Policy month which coincides with or follows the day of the change.

When Your Insurance Ends

Your insurance will end at midnight on the earliest of:

- (a) the day the Policyholder withdraws coverage;
- (b) the day any premium for your insurance is due and unpaid;
- (c) the day before you enter the Armed Forces on active duty (except for temporary active duty of two weeks or less); or
- (d) the last day of the Policy month in which you are no longer eligible under the Policy.

You will no longer be eligible when you are no longer a member.

If your insurance ends as shown in the above paragraph, you may continue your insurance in accordance with the following provision:

Portability (Continuation of Insurance)

If your insurance ends in accordance with the above provisions (except for nonpayment of premium) you may continue coverage under the Policy.

This continuation is available without evidence of insurability provided you make a written request and send it along with the initial premium to us at our Home Office within 31 days of insurance ending.

The following conditions apply to continued coverage:

- (a) except as modified by these conditions (a) and (b), all other provisions of the Policy will continue to apply, including our right

to terminate your insurance on the day any premium is due and unpaid; and

- (b) we may, at our sole discretion, include or exclude the premium, claims and other financial experience of your certificate in any group experience rating calculation.

In no event will an increase in any coverage be allowed during continued coverage.

SPOUSE ELIGIBILITY
(Long-Term Care Insurance)

Eligible Spouse

Only your lawful spouse is eligible for this Long Term Care insurance.

In addition, the member must have applied for this long-term care coverage for the spouse to be eligible to apply.

Not Eligible

The following are not eligible for spouse insurance:

- (a) your divorced spouse;
- (b) a spouse who is covered for long-term care insurance under the Policy as a member or parent; or
- (c) a spouse who is age 80 or older on the date insurance would otherwise become effective.

When Spouse Insurance Begins

If you want to insure your eligible spouse, you must furnish evidence acceptable to us that your spouse is in good health. If the evidence is acceptable to us, we will determine the date your spouse's insurance begins. We will furnish a Certificate Validation Form to your spouse.

EXCEPTIONS

Confinement Rule

If your spouse is:

- (a) hospital confined;
- (b) confined in any institution or facility other than a hospital, or at home or elsewhere due to an injury or sickness; or
- (c) disabled, either physically or mentally, to the extent of being unable to perform all of the usual and customary duties and activities (the "normal activities") of a person of the same age and sex who is in good health;

the insurance will not become effective in the case of paragraphs (a) or (b) above, until such confinement ends, and is no longer medically necessary, as determined by our medical staff and/or an independent medical review, and in the case of paragraph (c) above, until the full resumption of all normal activities.

This insurance may not be reinstated once it has lapsed.

Late Request

A spouse may enroll in the Plan when initially eligible and during future enrollment periods, if any, as agreed upon by us and the Policyholder.

Amount of Coverage

A spouse's amount of coverage is shown on the Certificate Validation Form and on the Schedule.

Changes In A Spouse's Classification

Any changes in a spouse's classification will take effect on the first day of the Policy month which coincides with or follows the day of the change.

When Insurance Ends

A spouse's insurance will end at midnight on the earliest of:

- (a) the day the Policyholder withdraws coverage;
- (b) the day the spouse is no longer eligible;
- (c) the day any premium is due and unpaid;
- (d) the day your eligibility ends;
- (e) the day your insurance ends; or
- (f) the day before a spouse enters the Armed Forces on active duty (except for temporary active duty of two weeks or less).

When a spouse's insurance ends, insurance may be continued in accordance with the following continuation provision.

Portability (Continuation of Insurance)

If insurance ends in accordance with the above provisions (except for nonpayment of premium) a spouse's insurance may be continued under the Policy.

This continuation is available without evidence of insurability provided a written request along with the initial premium is sent to us at our Home Office within 31 days of insurance ending.

The following conditions apply to continued coverage:

- (a) except as modified by these conditions (a) and (b), all other provisions of the Policy will continue to apply, including our right to terminate your insurance when the premiums is due and unpaid; and
- (b) we may, at our sole discretion, include or exclude the premium, claims and other financial experience of your certificate in any group experience rating calculation.

In no event will an increase in any coverage be allowed during continued coverage.

PARENTS ELIGIBILITY
(Long-Term Care Insurance)

Eligible Parents

Only the following are eligible for this Long Term Care insurance:

- (a) Your parents; and
- (b) Your lawful spouse's parents.

In addition, the member must have applied for this long-term care coverage for the member's parents to be eligible to apply. The member's spouse must have applied for this long-term care coverage for the spouse's parents to be eligible to apply.

Parents shall include one male and one female person for the member and one male and one female person for the member's spouse and shall include:

- (a) the natural parent of the member or his or her spouse;
- (b) the person who legally adopted the member or his or her spouse; or
- (c) any other person who at one time was married to the natural or adoptive parent of the member or his or her spouse.

You or your spouse may not change the designation of a parent once made. In addition, no more than 2 parents may be designated by the member and no more than 2 parents may be designated by the member's spouse while insured under this Policy.

Not Eligible

The following are not eligible for parents' insurance:

- (a) a parent who is covered for long-term care insurance under the Policy as a member or spouse;
- (b) a parent who is age 80 or older on the date insurance would otherwise become effective;
- (c) a parent of a member or spouse who resides in Texas; or
- (d) a parent who resides in Texas.

When Parents Insurance Begins

If you want to insure parents, you must furnish evidence acceptable to us that the parents are in good health. If the evidence is acceptable to us, we will determine the date insurance begins. We will furnish a Certificate Validation Form to each parent.

EXCEPTIONS

Confinement Rule

If a parent is:

- (a) hospital confined;
- (b) confined in any institution or facility other than a hospital or at home or elsewhere due to an injury or sickness; or
- (c) disabled, either physically or mentally, to the extent of being unable to perform all of the usual and customary duties and activities (the "normal activities") of a person of the same age and sex who is in good health:

the insurance will not become effective in the case of paragraphs (a) or (b) above, until such confinement ends, and is no longer medically necessary, as determined by our medical staff and/or an independent medical review, and in the case of paragraph (c) above, until the full resumption of all normal activities.

This insurance may not be reinstated once it has lapsed.

Late Request

A parent may enroll in the Plan when initially eligible and during future enrollment periods, if any, as agreed upon by us and the Policyholder.

Amount of Coverage

A parent's amount of coverage is shown on the Certificate Validation Form and on the Schedule.

Changes In A Parent's Classification

Any changes in a parent's classification will take effect on the first day of the Policy month which coincides with or follows the day of the change.

When Insurance Ends

A parent's insurance will end at midnight on the earliest of:

- (a) the day the Policyholder withdraws participation;
- (b) the day the parent is no longer eligible;
- (c) the day any premium is due and unpaid;
- (d) the day your eligibility ends;
- (e) the day your insurance ends; or
- (f) the day before a parent enters the Armed Forces on active duty (except for temporary active duty of two weeks or less).

When insurance ends, insurance may be continued in accordance with the following continuation provision.

Portability (Continuation of Insurance)

If insurance ends in accordance with the above provisions (except for nonpayment of premium) insurance may be continued under the Policy.

This continuation is available without evidence of insurability provided a written request along with the initial premium is sent to us at our Home Office within 31 days of insurance ending.

The following conditions apply to continued coverage:

- (a) except as modified by these conditions (a) and (b), all other provisions of the Policy will continue to apply, including our right to terminate your insurance when the premium is due and unpaid; and
- (b) we may, at our sole discretion, include or exclude the premium, claims and other financial experience of your certificate in any group experience rating calculation.

In no event will an increase in any coverage be allowed during continued coverage.

THE DEFINITIONS, GENERAL EXCLUSIONS AND LIMITATIONS AND RIDERS ARE VERY IMPORTANT PARTS OF YOUR POLICY. PLEASE READ THOSE PAGES CAREFULLY.

SCHEDULE

The amount of insurance for you, your spouse and your parents will be in accord with the insured person's classification in this Schedule

Classifications

All eligible members
All eligible members' spouses
All eligible parents

For You, Your Spouse and Your Parents (All Classes)

NOTE: The Maximum Benefit is expressed as units of service. For your Maximum Benefit please refer to your Certificate Validation Form.

Maximum benefits payable for all Covered Services received on any 1 calendar day will not exceed the Maximum Daily Benefit.

CONFINEMENT SERVICES

Skilled or Intermediate Nursing Care Services After the Waiting Period is met, we will pay 100% of the expense incurred but not to exceed the Maximum Daily Benefit shown on your Certificate Validation Form

Each day shall be considered 1 unit of service.

Custodial Nursing Care Services

After the Waiting Period is met, we will pay 100% of the expense incurred but not to exceed the Maximum Daily Benefit shown on your Certificate Validation Form.

Each day shall be considered 1 unit of service.

NON CONFINEMENT SERVICES

Home Health Care and Respite Care Services

Home Health Care Services

After the Waiting Period is met, for each call we will pay 100% of the expense incurred but not to exceed $\frac{1}{2}$ of the Maximum Daily Benefit shown on your Certificate Validation Form.

Each call shall be considered 1 unit of service.

Respite Care Services

After the Waiting Period is met, for each 12-hour period we will pay 100% of the expense incurred but not to exceed $\frac{1}{2}$ of the Maximum Daily Benefit shown on your Certificate Validation Form, or in the aggregate 30 days in any 90-day consecutive period.

Each 12-hour period shall be considered 1 unit of service.

Adult Day Care Services

After the Waiting Period is met, we will pay 100% of the expense incurred but not to exceed $\frac{1}{2}$ of the Maximum Daily Benefit shown on your Certificate Validation Form.

Each day shall be considered 1 unit of service.

LONG-TERM CARE BENEFITS

Benefits

If an insured person, while insured under this provision, incurs expense for Covered Services we will pay benefits as shown in the Schedule, provided the Activities of Daily Living Test is met. Benefits will be payable only for expense incurred after the Waiting Period. We will pay up to the Maximum Benefit for each insured person while insured under the Policy. The **Waiting Period**, **Maximum Daily Benefit** and **Maximum Benefit** are shown on the **Certificate Validation Form**.

Covered Services

1. **Skilled or Intermediate Nursing Care Services**

Skilled or Intermediate Nursing Care Services received while confined as a resident patient in a nursing care facility.

2. **Custodial Nursing Care Services**

Custodial Nursing Care Services received while confined as a resident patient in a nursing care facility.

3. **Home Health Care and Respite Care Services**

Home Health Care Services are the services and supplies listed below which are ordered and directed by a physician and are furnished:

- (a) in the insured person's home;
- (b) by a Home Health Agency; and
- (c) in accord with a Home Health Care Plan.
 - 1. Nursing Care provided on a part-time basis (less than an eight-hour shift) by:
 - (a) a registered nurse (RN); or
 - (b) a licensed practical nurse (LPN).
 - 2. Physical, occupational or speech therapy provided by a licensed therapist.
 - 3. Part-time or intermittent home health aide services provided:
 - (a) by a home health aide; and
 - (b) under the supervision of a registered nurse.

Home Health Aide Services include (but are not limited to) helping the insured person with:

- (a) bathing and care of mouth, skin and hair;
- (b) bowel and bladder care;
- (c) getting in and out of bed and walking;
- (d) exercises prescribed and taught by appropriate professionals;
- (e) medication ordered by a physician;
- (f) household services essential to the home health care (if the services would be performed if the insured person was in a hospital or skilled nursing facility); and
- (g) reporting changes in the insured person's condition to the supervising nurse.

One home health care call will consist of:

- (a) one visit for the services listed under Parts 1 and 2; or
- (b) up to four consecutive hours for the home health aide services shown under Part 3.

4. Respite Care Services

Respite Care Services provided on a 12-hour basis and with the advance approval of our Long-Term Care Utilization Review Coordinator (Call 1-800-877-1052).

4. **Adult Day Care Services**

Adult Day Care Services received in an Adult Day Care Center.

Grace Period

After the first premium has been paid, the insured person has a grace period of 31 days from each premium due date to pay the premium. Coverage will remain in force during the grace period; except, if advance written notice has been given to us that coverage will terminate prior to the end of the grace period, coverage will remain in force only until the termination date.

Exceptions

We will not pay for:

- (a) alcohol or drug abuse;
- (b) nervous or mental disorders, **except** organic brain disorders as listed in the most recent edition of the International Classification of Diseases including Alzheimer's disease;

- (c) any expense incurred after insurance ends (except termination of insurance will not affect a confinement which began prior to termination of insurance and which continues without interruption; subject to the Maximum Benefit and all other applicable Policy provisions); or
- (d) anything excluded under the General Exclusions and Limitations.

BENEFIT INCREASE OPTION

While insured under this provision, each insured person may elect to increase the Maximum Daily Benefit amount by \$20 on June 1, 1995 and every 5th anniversary of such date thereafter.

Conditions

1. The increase in coverage may not cause the Maximum Daily Benefit to exceed two times the initial Maximum Daily Benefit.
2. An insured person may not elect an increase in coverage if the Benefit Increase Option falls during a Benefit Period for that insured person.
3. A benefit increase may not be elected after the Portability Option under this Policy has been selected.
4. A benefit increase may not be elected after the insured person reaches age 80. After the insured person reaches age 66, evidence of good health is required. We will determine the effective date of the benefit increase.
5. Written request for the Increase Option must be made on or within the 60 days prior to the date the increase would become effective.
6. The benefit increase will become effective on the premium due date coinciding with or next following the option date(s), as described above, unless you are confined as described below.

Confinement Rule

If you are:

- (a) hospital confined;
- (b) confined in any institution or facility other than a hospital or at home or elsewhere due to an injury or sickness; or
- (c) disabled, either physically or mentally, to the extent of being unable to perform all of the usual and customary duties and activities (the "normal activities") of a person of the same age and sex who is in good health;

the benefit increase will not take effect in the case of paragraphs (a) or (b) above, until such confinement ends, and is no longer medically necessary, as determined by our medical staff and/or an independent medical review, and in the case of paragraph (c) above, until the full resumption of all normal activities.

PREEXISTING CONDITIONS

If an insured person received treatment or service for an injury or sickness in the 6-month period prior to that person becoming insured under the policy, we will not pay benefits for that injury or sickness until the day after a 6 month period has passed from the time that person was insured.

WAIVER OF PREMIUM

After an insured person has been confined in a nursing care facility for 90 continuous days, and those days have either been applied to the Waiting Period or benefits have been paid for them under the Policy, insurance will continue without payment of premium which comes due for that insured person as long as the insured person remains continuously confined and those days are applied to the Waiting Period or benefits are payable under the Policy. After confinement ends, or benefits are not payable, premium will again become due on the next following premium due date for that insured person.

RETURN OF PREMIUM OPTION

If an insured person, while insured under this provision:

- (a) lapses coverage for any reason; or
- (b) dies;

upon written request we will refund a percentage of the premium actually paid for the insured person based upon the following table, less the following amounts

- (a) any benefits paid;
- (b) any benefits pending or due; and
- (c) any dividends or experience rating credits paid or due.

RETURN OF PREMIUM TABLE

Full Number Of Years Coverage In	% of Premium To Be Refunded Force For Insured Person
0-4 Years	0%
5-9 Years	25%
10-14 Years	50%
15-19 Years	75%
20+ Years	100%

If the coverage for an insured person has been increased under the Benefit Increase Option, the above provision will be applied separately to each such increase selected and the applicable premiums and benefits.

If a claim is made under the Policy after a return of premium has been made, any benefits payable will be reduced by the amount of premium that was returned for the insured person.

ASSISTED LIVING FACILITY BENEFITS

Assisted Living Facility Benefit

If an insured person, while insured under this provision, incurs expense for services received in an Assisted Living Facility, benefits will be payable at 100% after the Waiting Period is satisfied; however, benefits will not exceed ½ of the Maximum Daily Benefit.

Each day paid under this provision will be considered one day of service.

Conditions

1. Benefits will be payable only for expense incurred after the Waiting Period.
2. Benefits will be payable only if the insured person is unable to perform two (2) or more Activities of Daily Living.

Definition

Assisted Living Facility means a facility which:

- (a) is licensed or certified by the state in which it is located to provide custodial or personal care as its main function;
- (b) provides 24-hour a day room and board for at least 5 people;
- (c) provides three full meals a day and accommodates special dietary needs;
- (d) has established procedures for obtaining appropriate services of a physician or nurse to provide medical care in case of emergency;
- (e) provides care and service sufficient to support needs resulting from the inability to perform activities of daily living or cognitive impairment; and
- (f) has a qualified person trained for the duties he/she is required to perform as specified by the facility while awake and on the premises at all times.

Exception

We will not pay for anything excluded under the General Exclusions and Limitations.

BED RESERVATION BENEFITS

Bed Reservation Benefit

If an insured person, while insured under this provision, is hospitalized and incurs expense for charges necessary to reserve his/her accommodations in a Nursing Care Facility or an Assisted Living Facility, we will pay 100% of the expense incurred after the Waiting Period is satisfied, but not to exceed:

- (a) the Maximum Daily Benefit shown on the Schedule of Benefit for accommodations in a Nursing Care Facility; or
- (b) ½ the Maximum Daily Benefit shown on the Schedule of Benefits for accommodations in an Assisted Living Facility; and
- (c) the first 21 days of accommodations (continuous or non-continuous) each calendar year. Unused days will expire on December 31 of each calendar year.

Each day paid under this provision will be considered one day of service.

Conditions

1. An insured person must have satisfied the Waiting Period and be receiving benefits for confinement in order to receive this bed reservation benefit.
2. Benefits under this provision will only be payable if an insured person returns to the Nursing Care Facility or Assisted Living Facility in which they resided prior to hospital confinement.

Exception

Benefits will not be payable when:

- (a) an insured person no longer needs care in a Nursing Care Facility or an Assisted Living Care Facility after the hospital confinement; or
- (b) the insured person dies while in the hospital.

AUTOMATIC INFLATION PROTECTION BENEFIT

NOTE: THE FOLLOWING PROVISION APPLIES ONLY IF ELECTED BY THE INSURED PERSON. PLEASE REFER TO THE CURRENT CERTIFICATE VALIDATION FORM OF THIS CERTIFICATE FOR VERIFICATION OF COVERAGE.

While insured under this provision, an insured person's Maximum Daily Benefit will automatically increase by 5% of the original Maximum Daily Benefit on the annual anniversary date. This increase will be accumulated each year for 20 years up to a maximum increase equal to the original Maximum Daily Benefit.

This benefit shall be in addition to, and independent of, any other increase of the Maximum Daily Benefit.

If an insured person is currently receiving benefits when this increase becomes effective, eligible benefits will be increased accordingly beginning on the effective date of the increase.

In no event will benefits be paid beyond the date the Maximum Benefit has been paid.

GENERAL EXCLUSIONS AND LIMITATIONS

We do not pay for:

- (a) any injury or sickness for which the insured person is entitled to benefits under a workers' compensation or occupational disease law;
- (b) any expense which is in excess of the usual and customary charges;
- (c) any expense or charge for services or supplies not medically necessary or not recommended by a physician;
- (d) any loss, expense or charge which results, whether the insured person is sane or insane, from:
 - (1) an intentionally self-inflicted injury or sickness; or
 - (2) suicide or attempted suicide;
- (e) any loss, expense or charge resulting from the insured person's participation in a riot or in the commission of a felony;
- (f) any expense or charge which the insured person does not have to pay;
- (g) any expense or charge for services or supplies which are:
 - (1) not provided in accord with generally accepted professional medical standards;
 - (2) for experimental treatment; or
 - (3) investigative, and not proven safe and effective;
- (h) any expense or charge for services or supplies which are provided or paid for by federal government or its agencies; except for:
 - (1) the Veterans Administration, when services are provided to a veteran for a disability which is not service-connected;
 - (2) a military hospital or facility, when services are provided to a retiree (or dependent of a retiree) from the armed services; or
 - (3) a group health plan established by a government for its own civilian employees and their dependents
- (i) any loss, expense or charge which results from an act of declared or undeclared war or armed aggression; or

- (j) any loss, expense or charge:
 - (1) which is incurred while the insured person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country; and
 - (2) for which any governmental body or its agencies are liable.

COORDINATION OF BENEFITS (COB)

Definitions Plan means any of the following coverages, including Policy coverage and any coverage which is declared to be “excess” to all other coverages, which provide benefit payments or services to an insured person for hospital, medical, surgical, dental, prescription drug or vision care:

- (a) Group, blanket or franchise insurance (except student accident insurance);
- (b) Group Blue Cross and/or Blue Shield and other prepayment coverage on a group basis, including HMOs (Health Maintenance Organizations);
- (c) Coverage under a labor-management trustee plan, a union welfare plan, an employer organization plan or an employee benefits plan;
- (d) Coverage under government programs, other than Medicare or Medicaid, and any other coverage required or provided by law;
- (e) Group or individual automobile “no fault” coverage;
- (f) Other arrangements of insured or self-insured group coverage.

If any of the above coverages include group and group-type hospital indemnity coverage, Plan also means that amount of indemnity benefits which exceeds \$100 a day.

Claimant means the insured person for whom the claim is made.

Claim Period means part or all of a calendar year during which the claimant is insured under the Policy.

A **Covered Expense** means any expense which is covered by at least one Plan during a Claim Period; however, any expense which is not payable by the Primary Plan because of the claimant’s failure to comply with cost containment requirements (such as second surgical opinions, pre-admission testing, pre-admission review of hospital confinement, mandatory outpatient surgery, etc.) will not be considered a Covered Expense by the Secondary Plan. Where a Plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service during a Claim Period will also be considered a Covered Expense.

Coordination of Benefits (COB)

If the claimant is covered by another Plan or Plans, the benefits under the Policy and the other Plan(s) will be coordinated. This means one Plan pays its full benefits first, then the other Plan(s) pay(s).

1. The Primary Plan (which is the Plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.
2. The Secondary Plan (which is the Plan that pays benefits after the Primary Plan) will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the Primary Plan will not exceed the greater of: (a) 100% of total Covered Expense; or (b) the amount of benefits it would have paid had it been the Primary Plan .

The Order of Benefit Determination paragraph below explains the order in which Plans must pay.

This COB provision will not apply to a claim when the Covered Expense for a Claim Period is \$50 or less; but if:

- (a) additional expense is incurred during the Claim Period; and
- (b) the total Covered Expense exceeds \$50;

then this COB provision will apply to the total amount of the claim.

Order of Benefit Determination

When another Plan **does not** have a COB provision, that Plan must determine benefits first.

When another Plan **does** have a COB provision, the first of the following rules which applies governs:

- (a) If a Plan covers the claimant as an employee, member or nondependent, then that Plan will pay its benefits first.
- (b) If the above rule does not apply, the Plan which has covered the claimant for the longer period of time will pay its benefits first; except when:
 - (1) one Plan covers the claimant as a laid-off or retired employee (or a dependent of such an employee); and
 - (2) the other Plan includes this COB rule for laid-off or retired employees (or is issued in a state which requires this COB rule by law);

then the Plan which covers the claimant as **other than** a laid-off or retired employee (or a dependent of such an employee) will pay first.

Where part of a Plan coordinates benefits and a part does not, each part will be treated like a separate Plan.

Credit Savings

Where the Policy does not have to pay its full benefits because of COB, the savings will be credited to the claimant for the Claim Period. These savings would be applied to any unpaid Covered Expense during the Claim Period.

How COB Affects Policy Benefit Limits

If COB reduces the benefits payable under more than one Policy provision, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefit limit in those Policy provisions.

Right To Collect and Release Needed Information

In order to receive benefits, the claimant must give the insurer any information which is needed to coordinate benefits. With the claimant's consent, the insurer may release to or collect from any person or organization any needed information about the claimant.

Facility of Payment

If benefits which this Plan should have paid are instead paid by another Plan, this Plan may reimburse the other Plan. Amounts reimbursed are Policy benefits and are treated like other Policy benefits in satisfying Policy liability.

Right of Recovery

If this Plan pays more for a Covered Expense than is required by this provision, the excess payment may be recovered from:

- (a) the claimant;
- (b) any person to whom the payment was made; or
- (c) any insurance company, service plan or any other organization which should have made payment.

MEDICARE COORDINATION OF BENEFITS

Medicare COB

This Medicare COB provision applies when you:

- (a) have health insurance under the policy; and
- (b) are eligible for insurance under Medicare, Parts A and B, (whether or not you have applied or are enrolled in Medicare).

It applies before any other COB provision of the policy.

Effect on Benefits

1. If, in accord with the following rules, we have primary responsibility for your claims, then we pay policy benefits first.
2. If, in accord with the following rules, we have secondary responsibility for your claims:
 - (a) first Medicare Benefits are determined or paid; and
 - (b) then policy benefits are paid;but, for services payable under both plans, the combined Medicare Benefits and policy benefits will not exceed 100% of the expense incurred.

Rules for Determining Order of Benefits

1. **For You.** We have primary responsibility for your claims if:
 - (a) you are insured under the policy because of your current active employment status with an ADEA employer, and you are eligible for Medicare benefits because of age; or
 - (b) the policy is part of a large group plan, and you are insured under the policy because of your current active employment status, and you are eligible for Medicare benefits because of disability.

We have secondary responsibility for your claims if you are eligible for Medicare benefits and the above conditions do not apply.

2. **Exception for End Stage Renal Disease.** If Medicare does not already have primary responsibility when you become eligible for Medicare benefits because of end stage renal disease:
- (a) we have primary responsibility for your claims for up to 18 months beginning with the month in which you are first eligible for Medicare benefits because of end stage renal disease; and
 - (b) we have secondary responsibility after the end of this 18-month period.

Definitions

Medicare benefits means service and supplies which you receive or are eligible for under Medicare Part A or B, (whether or not you have applied for or are enrolled in Medicare).

ADEA employer means an employer which:

- (a) is subject to the federal Age Discrimination in Employment Act (ADEA); and
- (b) has 20 or more employees each working day in 20 or more calendar weeks during the current or preceding calendar year.

Large group plan means a plan which covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year.

Important Information About Medicare

Medicare may affect policy benefits; therefore, you may want to contact your local Social Security office for information about Medicare. This should be done before your 65th birthday.

THIRD PARTY REIMBURSEMENT AND/OR SUBROGATION

This provision applies if you are injured or sick as a result of the act or omission of a third party.

Definitions

Reimbursement Rights means our right to be reimbursed if:

- (a) we pay policy benefits for you because of an injury or sickness caused by a third party's act or omission; and
- (b) you or the legal representative recovers an amount from the third party, the third party's insurer, an uninsured motorist insurer or anyone else by reason of the third party's act or omission. This recovery may be the result of a lawsuit, a settlement or some other act. We are entitled to be paid first out of any recovery, up to the amount of policy benefits we pay.

Subrogation Rights, as used in this provision, means our right to enforce our recovery of any policy benefits paid for you because of an injury or sickness caused by a third party's act or omission. We are entitled to be paid first out of any recovery, up to the amount of policy benefits we pay.

Third Party means another person or organization.

Reimbursement and Subrogation Rights

If you have an injury or sickness caused by a third party's act or omission:

1. We will pay policy benefits for that injury or sickness subject to our reimbursement and subrogation rights and on condition that you (or your legal representative):
 - (a) will not take any action which would prejudice our reimbursement or subrogation rights; and
 - (b) will cooperate in doing what is reasonably necessary to assist us in enforcing our reimbursement or subrogation rights (including signing an assignment, a reimbursement agreement or other document upon our written request).

2. Our reimbursement or subrogation rights will not be reduced because:
 - (a) the recovery does not fully compensate you for all losses sustained or alleged; or
 - (b) the recovery is not described as being related to medical costs or loss of income.
3. We may enforce our reimbursement or subrogation rights by filing a lien with the third party, the third party's insurer or another insurer, a court having jurisdiction in this matter or any other appropriate party.
4. The amount of our reimbursement will not be reduced by legal fees or court costs incurred in seeking the recovery, unless we agree otherwise in writing.
5. We may elect to charge any reimbursement due us under this provision against any further benefit payments for you under this policy. This will not reduce our right to be paid first out of any recovery up to the amount of policy benefits not yet reimbursed.

PAYMENT OF CLAIMS

How to File Claims

Before benefits are paid, we must be given a written proof of loss, as described below. In the event of your death or incapacity, your beneficiary or someone else may give us the proof.

Proof of Loss Requirements

1. First, request a claim form from the Plan Administrator or from us.

This request should be made:

- (a) within 20 days after a loss occurs; or
- (b) as soon as reasonably possible.

When we receive the request, we will send a claim form for filing proof of loss. If we do not send it within 15 days, you can meet the proof of loss requirement by giving us a written statement of what happened. We must receive a written statement within the time shown in 3 below.

2. Next, complete and sign the claim form. If a physician must complete part of the claim form, have the physician complete and sign that part.
3. Finally, return the claim form (with any bills) to the Plan Administrator or to us. The claim form is due:
 - (a) within 90 days after the loss occurs; or
 - (b) as soon as reasonably possible, but not later than one year after (a) above, unless the claimant is not legally capable.

When Claims are Paid

All Policy benefits will be paid as soon as we receive acceptable proof of loss, but in no event later than 60 days.

Direct Payments

Any benefits for hospital, medical, surgical, dental or vision services which you have assigned will be paid to the hospital or the provider of the services. If you have not assigned the benefits, we, at our option, will pay you or the hospital or the provider of the services.

Any other benefits will be paid to you except that benefits unpaid at your death may be paid, at our option, to:

- (a) your beneficiary; or
- (b) your estate.

If your beneficiary is unable to give a valid release or if benefits unpaid at your death are not more than \$1,000.00, we may pay up to \$1,000.00 to any relative of yours who we find is entitled to the benefit.

Any payment made in good faith will fully discharge us to the extent of the payment.

Examination and Autopsy

We sometimes require that a claimant be examined by a physician of our choice. We will pay for these examinations. We will not require more than a reasonable number of examinations. Where not prohibited by law, we may also require an autopsy. We will pay for this autopsy.

STANDARD PROVISIONS

Insurance Contract

The insurance contract consists of:

- (a) the Policy;
- (b) the Policyholder's application attached to the Policy; and
- (c) any application for you or any insured person.

Changes in the Insurance Contract

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time we and the Policyholder both agree to a change. No one else has the authority to change the insurance contract. A change in the insurance contract:

- (a) does not require the consent of any insured person or beneficiary; and
- (b) must be:
 - (1) in writing;
 - (2) made a part of the Policy; and
 - (3) signed by one of our officers.

A change may affect any class of insured persons, including retirees if retired coverage is included in the Policy.

Applications

We may use misstatements or omissions in the application of an insured person to contest the validity of insurance, reduce coverage or deny a claim; but we must first furnish you or your beneficiary with a copy of that application. We will not use a person's application to contest or reduce insurance which has been in force for two years or more during that person's lifetime. However, if you or any insured person is not eligible for insurance, there is no time limit on our right to contest insurance or deny a claim.

Statements in an application are treated as representations not as warranties.

Legal Actions

No legal action can be brought until at least 60 days after we have been given written proof of loss. No legal action can be brought more than three years after the date written proof of loss is required.

Group Policy Number GMLC-2Y67



**Mutual of Omaha
Companies**

Mutual of Omaha Insurance Company
Home Office: Omaha, Nebraska

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