



# Long Term Care Insurance Outline of Coverage

from Genworth Life Insurance Company  
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Genworth Life Insurance Company  
Administrative Office  
P.O. Box 64010  
St Paul MN 55164-0010  
800 416.3624

Group Policy Form No.: Series 7053  
Certificate Form No.: 7053CRT CA  
Group Policyholder: Chevron Corporation

The Group Policy is an approved Long Term Care Insurance Policy under California law and regulations. However, the benefits payable by the Group Policy will not qualify for Medi-Cal asset protection under the California Partnership for Long Term Care. For information about policies and certificates qualifying under the California Partnership for Long Term Care, call the Health Insurance Counseling and Advocacy Program at the toll-free number, 1 (800) 434-0222.

## TAX CONSEQUENCES

The group contract for long term care insurance is intended to be a federally qualified long term care insurance contract and may qualify You for federal and state tax benefits.

## NOTICE TO BUYER

This Group Policy may not cover all of the costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Group Policy limitations.

## CAUTION

The issuance of this long term care insurance Certificate is based upon Your responses to the questions on any Application You submit. A copy of Your Application(s), if any, will be provided to You. If Your answers are incorrect or untrue, Genworth Life Insurance Company (called We, Us and Our in this Outline of Coverage) has the right to deny Benefits or rescind Your Coverage. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact Us at this address: the Administrative Office address shown above.

## 1. POLICY DESIGNATION

The Policy is a Group Policy issued in the state of CALIFORNIA.

## 2. PURPOSE OF THE OUTLINE OF COVERAGE

This Outline Of Coverage provides a very brief description of the important features of the Group Policy. You should compare this Outline Of Coverage to outlines of coverage for other policies available to You. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy, and not the Outline Of Coverage, contains governing contractual provisions. This means that the individual or group policy sets forth in detail the rights and obligations of both You and Us. Therefore, if You purchase this Coverage, or any other coverage, it is important that You **READ YOUR POLICY OR CERTIFICATE CAREFULLY!**

## 3. TERMS UNDER WHICH THE CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED

**30-Day Free Look Period:** You have 30 days from the day You receive the Certificate to review and return it to Us at Our Administrative Office if You are not satisfied with it for any reason. All Premium and fees paid will be refunded directly to the payor within 30 days after: (a) return of the Certificate during this Free Look Period; or (b) Our denial of Your Application.

**Unearned Premium Refunds:** Unearned Premium will be refunded if Your Coverage ends due to death, surrender or cancellation.

## 4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Us. Neither We nor Our agents or producers represent Medicare, the federal government, or any state government.

## 5. LONG TERM CARE COVERAGE

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WE HAVE THE RIGHT TO CHANGE PREMIUM BECOMING DUE IN THE FUTURE. We can change Premium either on a Group Policy or class basis; but only if We change Premium for all similar Certificates issued under the Group Policy in the same State. Premium will not change due to a change in Your age, health, or use of Benefits. A change in Premium may occur only once in any 12 month period. We will give You at least 60 days written notice before We change Premium.

## 6. BENEFITS PROVIDED

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**(a) Covered Services:** Payment of institutional and non-institutional Benefits described below is subject to the provisions, conditions, limitations and exclusions of the Group Policy as restated in the issued Certificate. Once the Elimination Period has been satisfied, Benefits are available up to daily or monthly and annual maximums until the applicable Benefit limits are exhausted. Benefits are paid up to the applicable limits for 100% of Your Covered Expenses. You will be responsible for the payment of any expenses not reimbursed by Your Coverage. The limits and features for Your Coverage are based on Your plan choices.

**(b) Institutional Benefits:** These pay for Covered Expenses incurred while confined in a Nursing Facility, Residential Care Facility, or Hospice Care Facility.

- The Residential Care Facility Benefit pays up to 100% of the Nursing Facility Maximum.
- Bed Reservation Benefits are available for temporary absences of up to 60 days per calendar year when room charges are covered in the facility.

**(c) Non-Institutional Benefits:** These include the following:

**Privileged Care<sup>®</sup> Coordination Services** are offered to assist in identifying care needs and community resources available to deliver care while You are Chronically Ill. When You choose to use these services they will be furnished by a Privileged Care Coordination team provided by Us at no cost to You.

The **Home and Community Care Benefit** covers services received at home and in the community for:

- Adult Day Care.
- Nurse and Therapist Services.
- Home Health Care or Personal Care Services and Homemaker Services from formal and informal providers. These providers may be nurse's aides, home health aides, and other persons who provide care which is consistent with the needs addressed in Your Plan of Care. They can be independent; and do not need to be associated with an agency or provider organization.

Non-Institutional Hospice Care (as part of a separate Hospice Care Benefit).

The **Home and Community Care Benefit** pays up to 75% of the Nursing Facility Maximum.

The **Home Assistance Benefit covers:** home modifications; assistive devices; supportive equipment; emergency medical response systems; and caregiver training. It pays up to a lifetime limit equal to 90 days/3 months of full Nursing Facility Benefits.

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

The **Respite Care Benefit** provides short-term coverage to relieve the person who normally and primarily provides You with care in Your home on a regular, unpaid basis. It pays for up to 30 days per calendar year.

**Requested Alternate Benefits** may, subject to Our approval and mutual agreement, pay for Covered Expenses incurred for services, devices or treatments that are Qualified Long Term Care Services not specifically covered under another Benefit.

The **Contingent Nonforfeiture Benefit** gives You the right to reduce coverage or convert to limited paid-up Benefits in the event of a cumulative Premium increase that is considered to be substantial as stated in the Certificate.

**(d) Eligibility For The Payment Of Benefits:** For You to be eligible for the payment of Benefits:

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

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**Conditions:** Benefits will only be paid as reimbursement for expenses paid on Your behalf only if all of the following conditions have been satisfied:

- You must meet the above Eligibility For The Payment Of Benefits requirements.
- The expenses must qualify as Covered Expenses.
- The Covered Care and related Covered Expenses must be consistent with and received pursuant to Your Plan of Care as prescribed by a Licensed Health Care Practitioner.
- Your Coverage must not have ended before the date(s) the Covered Care is received.
- Any applicable Elimination Period must be satisfied.
- You must not have exhausted the Coverage Maximum or any daily, monthly, annual or lifetime limits applicable to the specific Benefits being Claimed.
- You must meet the requirements for payment in accordance with all the provisions of Your Certificate.
- The care, service, cost or item for which Benefits are payable must meet the definition of Qualified Long Term Care Services.

**Meaning of Terms:** The following definitions are being provided to assist You in understanding certain terms used in this Outline Of Coverage. The Certificate contains additional definitions not provided for in this Outline Of Coverage. The definition of any capitalized term in this Outline Of Coverage is provided for in the General Definitions section of the Certificate.

*Activities of Daily Living* means the following self-care functions: bathing (washing oneself); continence (control of bowel and bladder functions); dressing (putting on and taking off clothes and assistive devices); eating (taking nourishment); toileting (including performing associated personal hygiene tasks); and transferring (the ability to move in and out of a bed, chair or wheelchair).

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

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

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

*Substantial Assistance* is either:

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

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

*Coverage* means the Benefits You have under the Group Policy or Continuation Coverage as evidenced by Your Certificate.

*Coverage Maximum* means the maximum amount of Benefits under Your Coverage. The Coverage Maximum will change as described below and when You elect changes.

Your Coverage Maximum is \$\_\_\_\_\_.

Your Coverage Maximum and amounts based on the Nursing Facility Maximum are: (a) increased when Benefit Increases apply; and (b) exhausted only when the total of all Benefits paid equals the then applicable maximum amount. Benefit Increases that apply are not affected by any Benefits paid for Covered Expenses incurred prior to the date the applicable maximum is exhausted.

*Covered Care* means those Qualified Long Term Care Services for which Your Coverage pays Benefits or would pay Benefits in the absence of an Elimination Period or payment limits.

*Covered Expenses* means costs You incur for Covered Care. Each Benefit defines the Covered Expenses under that Benefit. An expense is considered to be incurred on the day on which the care, service or other item forming the basis for it is received by You.

## Outline of Coverage

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

*Elimination Period* means the length of time, beginning with the first day on which You incur a Covered Expense, before You are entitled to Benefits. Days used to satisfy the Elimination Period do not need to be consecutive; and can be accumulated over time. Once satisfied, You will never have to satisfy a new Elimination Period for Your Coverage.

Your Elimination Period is \_\_90\_\_ Calendar Days.

*Nursing Facility Maximum* means the maximum amount We will pay when You are Confined in a Nursing Facility. This may be a daily maximum or a monthly maximum, based on Your plan choice. This amount is also used to determine other Benefit maximums. The Nursing Facility Maximum is the maximum total amount payable for all Covered Expenses incurred (a) on a day when it is a daily maximum; or (b) in a calendar month when it is a monthly maximum. This limitation does not apply to Benefits that are not subject to a daily or monthly maximum.

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

## **OTHER FEATURES AND OPTIONS**

**(Optional items available for added Premium)**

**Automatically Included International Nursing Facility Benefit:** This Benefit will pay for Covered Expenses You receive while You are outside the United States. Subject to the Coverage Maximum, it pays up to 75% of the Nursing Facility Maximum for confinement in an Out-of-Country Nursing Facility. This Benefit terminates four years after the date for which it first makes payment.

**Optional Nonforfeiture Benefit:** This Benefit provides a continuation if Your Coverage ends due to non-payment of Premium after it has been in force for at least three years. Any Benefit Increases will cease; and the Coverage Maximum will be reduced to the greater of: (a) the sum of all Premium paid (and not waived under the Waiver of Premium Benefit) for Your Coverage; or (b) the amount equal to one month (30 days) of Benefits under the Nursing Facility Benefit in effect at the time Your Coverage ends. In no event will this amount exceed the unused Coverage Maximum at the time Your Coverage ends

**Automatically Included Informal Care Benefit:** This Benefit provides for the payment of Covered Expenses incurred for health and personal care assistance another person provides to You in Your Home in accordance with Your Plan of Care. That person can be a member of Your Immediate Family or someone else provided he or she: (a) did not reside with You in Your Home at the time Your first satisfied the Eligibility For The Payment Of Benefits provisions; and (b) is not compensated, as an employee, by any organization that is paid to provide such assistance. Payment is subject to a calendar year total of 30 days with a daily maximum of: 25% of the Nursing Facility Maximum per day when daily Benefits apply; or 1% of the Nursing Facility Maximum per day when Benefits are payable on a calendar month basis. This Benefit will not be paid for any day for which payment is made under the Home and Community Care Benefit. Payment of this Benefit is subject to the Elimination Period unless the Waiver of Home Care Elimination Period also applies.

## **7. EXCLUSIONS AND LIMITATIONS**

**Pre-Existing Conditions Limitation:** We will not pay for Covered Expenses incurred for any care or confinement that is a result of a Pre-Existing Condition when the care or Confinement begins within six (6) months following Your initial Certificate Effective Date.

A *Pre-Existing Condition* means a condition (illness, disease, injury or symptom) for which medical advice or treatment was recommended by, or received from, a provider of health care services within six (6) months prior to Your initial Certificate Effective Date. A Health Care Professional includes anyone who is: a Physician; a Nurse; a physician assistant; a physical, occupational, speech or respiratory therapist; a chiropractor; an acupuncturist; a homeopathic doctor; or a Licensed Health Care Practitioner.

If You were required to answer questions about Your health as part of Your Application, this Pre-Existing Conditions Limitation will not apply to You.

**Non-eligible Facilities/Providers:** A Nursing Facility, Assisted Living Facility or Hospice Care Facility must meet the applicable definition stated in Your Certificate in order to qualify for Coverage.

**Non-eligible Levels of Care:** Coverage is not based on the specific level of care; but is for care furnished for a specific covered reason, by or through the covered facilities and providers. Care from Immediate Family members is covered only when specifically indicated.

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**Exclusions/Exceptions and Limitations:** We will not pay Benefits for any Covered Care:

- for which no charge is normally made in the absence of insurance;
- provided outside the fifty (50) United States, the District of Columbia, and any territory of the United States of America; unless specifically provided for by a Benefit;
- provided by Your Immediate Family, unless: specifically covered by a Benefit; or he or she is paid as a regular employee of the organization that provides the services to You;
- provided by, or in, a Veteran's Administration or Federal government facility, unless a valid charge is made to You or Your estate;
- resulting from illness, treatment or medical condition arising out of any of the following:
  - war or any act of war, whether declared or not;
  - attempted suicide or an intentionally self-inflicted injury;
  - participation in a felony, riot, or insurrection;
  - service in the armed forces or units auxiliary thereto;
- for alcoholism or addiction to drugs or narcotics (except for an addiction to a prescription medication when administered in accordance with the advice of a physician).

**Non-Duplication:** Benefits will be paid only for Covered Expenses that are in excess of the amount paid or payable under:

- Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount); and
- Any State or Federal workers' compensation, employer's liability or occupational disease law;
- Any other Federal, state or other government health or long term care program or law except Medicaid.

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

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

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

## **8. RELATIONSHIP OF COST OF CARE AND BENEFITS**

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

**Benefit Increases cease when:** (a) the applicable maximum has been exhausted; (b) they are terminated by You; (c) Your Coverage ends; or (d) Your Coverage is continued under any Nonforfeiture Benefit, if applicable.

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

**AVAILABLE BENEFIT INCREASE OPTIONS**

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5% Future Purchase Options will apply if no other Option is selected.

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

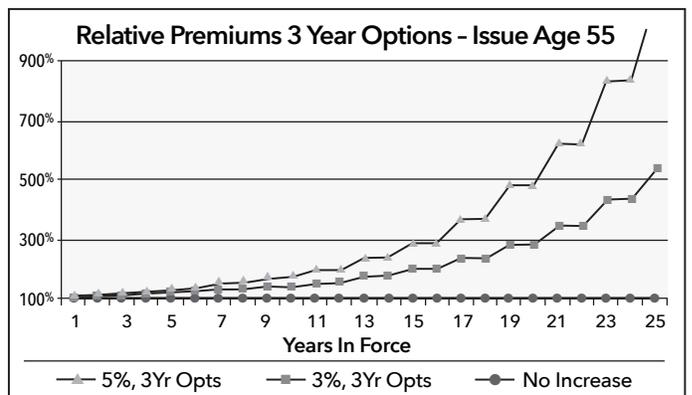
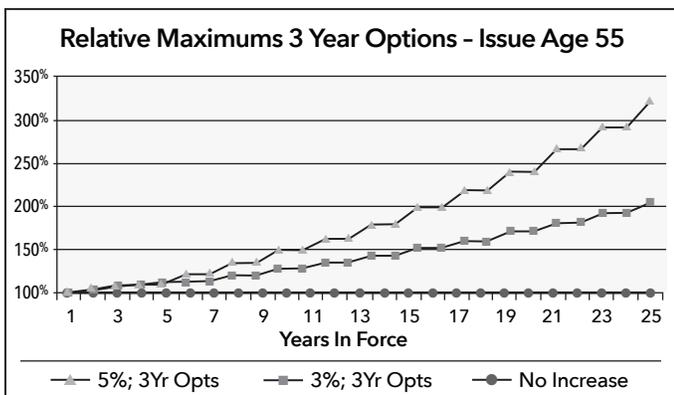
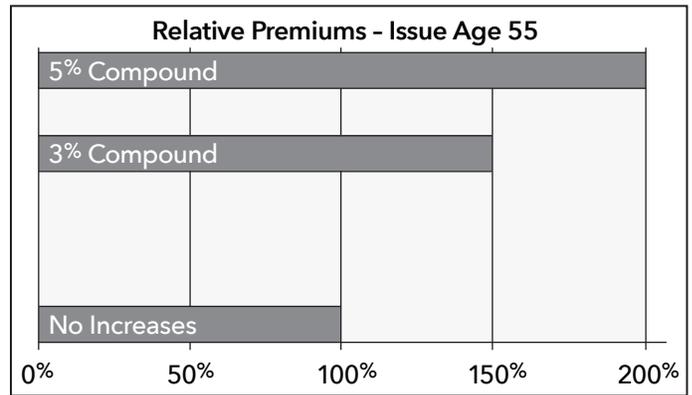
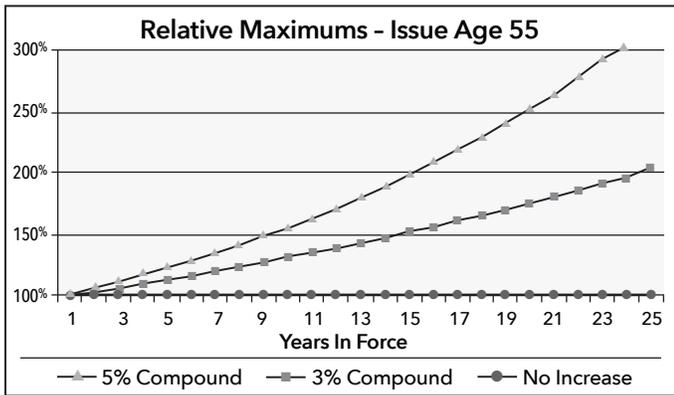
**5% Compound Benefit Increases:** On each anniversary of Your Certificate Effective Date Your then current Nursing Facility Maximum and the current amounts of other dollar maximums will each increase by 5%.

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

You will be given the option to purchase additional coverage equal to 5% compounded annually for the 3 year period (an approximate increase of 15.8%). The increases will apply to Your then current Nursing Facility Maximum and the current amounts of other dollar maximums. The additional Premium for an increase will be based on: (1) the amount of the increase; and (2) Your age and the Premium in effect for the Group Policy on the date the increase takes effect.

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

**INFLATION PROTECTION – GRAPHIC COMPARISONS**



**9. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED**

- (a) **RENEWABILITY: THE CERTIFICATE IS GUARANTEED RENEWABLE.** This means You have the right, subject to the terms of the Group Policy, to continue the Certificate until Benefits are exhausted, by paying Your Premium on time. We cannot change any of the terms of the Certificate on Our own, except that, in the future, WE MAY INCREASE THE PREMIUM YOU PAY.
- (b) **CONTINUATION COVERAGE:** Your Coverage will be continued in accordance with the terms of Your Certificate even if the Policyholder ceases to sponsor the Group Policy or discontinues coverage for the group of eligible persons to which You belong. You must pay Us all Premium required for the continuation of Your Coverage.
- (c) **WAIVER OF PREMIUM:** Premium will be waived for each coverage month while You are receiving Nursing Facility Residential Care Facility, Bed Reservation, Home and Community Care or Hospice Care Benefits.
- (d) **TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUM:** We have the right to change Premium becoming due in the future. We can change Premium either on a Group Policy or class basis; subject to the approval of the California Department of Insurance. Premium will not change due to a change in Your age, health, or use of Benefits. A change in Premium may occur only once in any 12 month period. We will give You at least 60 days written notice before We change Premium.

**10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS**

Coverage is provided for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses subject to the same exclusions, limitations and provisions applicable to other Covered Care.

## 11. PREMIUM

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The initial Premium for Your Coverage will be determined from the Premium rate schedule contained in Your enrollment material based on the options selected, Your age and the Premium Payment Mode.

**(Complete to show Premium and Options Selected)**

Premium Payment Mode

Applicant A

Monthly  Quarterly

Semi-Annual  Annual

Modal Premium for Selected Coverage

Certificate with any Benefit Increases

\$ \_\_\_\_\_

Nonforfeiture Benefit

\$ \_\_\_\_\_

Annual Total Modal Premium

\$ \_\_\_\_\_

**You may have the right to choose one of the following Premium Payment Modes:** Annual in one payment that provides Coverage for 12 Coverage Months; Semi-Annual in two payments that each provide Coverage for 6 Coverage Months; Quarterly in four payments that each provide Coverage for 3 Coverage Months; or Monthly in twelve payments that each provide Coverage for 1 Coverage Month.

If You have a Premium Payment Mode other than Annual, You may pay additional charges for that Premium Payment Mode. Refer to the Modal Premium Disclosure provided in Your Certificate.

## 12. ADDITIONAL FEATURES AND REMINDERS

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**Underwriting:** We will underwrite an Application by reviewing the information submitted on the Application and any other information You authorize Us to obtain.

**Continuation for Lapse Due to Cognitive or Functional Impairment:** If Your Coverage terminates due to non-payment of Premium, We will provide a retroactive continuation if, within seven (7) months of the termination date, You provide Us with proof that You were Chronically Ill, beginning on or before the end of the Grace Period. All past due Premium must be paid within such seven (7) month period. In that event, any Benefits for which You qualified during the continuation period will be paid to the same extent they would have been paid if Your Coverage had not ended.

**Reminder:** This Outline Of Coverage is not a contract; and the only Coverage to be provided will be as stated in the issued and effective Certificate . The Certificate will set forth in detail the Benefits and Services provided and the Premium and conditions required to continue Your Coverage until it ends.

## 13. INFORMATION AND COUNSELING.

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The California Department of Insurance has prepared a Consumer Guide to Long Term Care Insurance. This guide can be obtained by calling the Department of Insurance toll-free telephone number. This number is 1-800-927-HELP. Additionally, the Health Insurance Counseling and Advocacy Program (HICAP) administered by the California Department of Aging, provides long term care insurance counseling to California senior citizens. Call the HICAP toll-free telephone number 1-800-434-0222 for a referral to your local HICAP office.