Michael J. Bidart (State Bar No. 60582)
Gregory L. Bentley (State Bar No. 151147)
Clare H. Lucich (State Bar No. 287157)
SHERNOFF BIDART
ECHEVERRIA BENTLEY LLP
600 S. Indian Hill Blvd.
Claremont, California 91711
Telephone: (909) 621-4935
Facsimile: (909) 625-6915
Email: mbidart@shernoff.com
Email: gbentley@shernoff.com
Email: clucich@shernoff.com

Stuart C. Talley (State Bar No. 180374)
KERSHAW, CUTTER & RATINOFF, LLP
401 Watt Avenue
Sacramento, California 95864
Telephone: (916) 448-9800
Facsimile: (916) 669-4499
Email: stalley@kcrlegal.com

Gretchen M. Nelson (State Bar No. 112566)
Stuart R. Fraenkel (State Bar No. 173991)
KREINDLER & KREINDLER LLP
707 Wilshire Blvd., Suite 3600
Los Angeles, CA 90017
Telephone: 213-622-6469
Telecopier: 213-622-6019

Attorneys for Plaintiffs and the Class

SUPERIOR COURT FOR THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES

ELMA SANCHEZ and HOLLY WEDDING, individually and on behalf of all others similarly situated,

Plaintiffs,

v.

CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM, and DOES 1 through 100, inclusive,

Defendants

CASE NO. BC517444

CLASS ACTION

COMPLAINT AND DEMAND FOR JURY TRIAL

1. Breach of Contract
2. Breach of The Implied Covenant of Good Faith And Fair Dealing
3. Rescission
4. Declaratory and Injunctive Relief

Plaintiffs, ELMA SANCHEZ and HOLLY WEDDING individually and on behalf of all others similarly situated as defined more fully below (the "Class"), bring this action against Defendant CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM ("CalPers") seeking damages and injunctive relief arising out of CalPers' sale and renewal of long term care insurance policies ("LTC policies").

INTRODUCTION

1. In 1995 CalPers began offering and promoting the sale of LTC policies to CalPers members and their families. CalPers promised consumers that these policies would provide them with financial security and protect them against the high costs associated with nursing home or other long term facility care. They also promised consumers that the policies would be "reasonably priced" and that rates (which are based on the age of the insured at the time of enrollment) would be fixed and would never rise based on the consumer's age or health. CalPers touted that its policies were 30% cheaper than all other comparable policies and provided superior benefits. CalPers further represented that it had the requisite experience to properly underwrite the LTC policies so as to insure that the funds were carefully and prudently managed.

2. After initiating the LTC insurance program, CalPers then disseminated additional promotional materials to policyholders in order to induce them to renew their LTC policies each year. In uniform promotional materials, CalPers repeatedly touted the financial stability and strength of its LTC program.

3. However, in 2013, everything abruptly changed. CalPers suddenly and unexpectedly advised its policyholders that its LTC program was grossly underfunded and, that CalPers, unbeknownst to Plaintiffs and the other members of the Class, had stopped enrolling new members in 2009, four years before. Further, CalPers admitted that it had engaged in an improper investment strategy. For years CalPers had been pursuing an aggressive 44% investment strategy and in 2013 it abruptly shifted to a more stable and conservative 15% investment strategy. As a result, the LTC policy fund was and became even more grossly underfunded. Consequently CalPers announced that

it would increase most policyholders' premiums by 85% commencing in 2015. Now more than 125,000 Class Members, many of whom are elderly and on fixed incomes, are placed in the untenable position of either allowing their policies to lapse or paying CalPers increased premiums that they simply cannot afford.

4. Plaintiffs are informed and believe and thereon allege that at all times CalPers knew, or should have known, that its policies were grossly underpriced, the program was underfunded, and that CalPers was improperly investing the funds in an aggressive portfolio. Likewise CalPers knew, or should have known, that it would ultimately be forced to raise premiums on policyholders. Had Plaintiffs and the Class members known the truth about CalPers' LTC policies at an earlier date, they would not have purchased LTC insurance from CalPers. Instead, they would have purchased LTC insurance from an alternative carrier, avoiding the unaffordable rise in premiums and the risk of losing their insurance. This case seeks to remedy the harm caused by CalPers' wrongful conduct.

VENUE

5. Venue is proper in this Court because CalPers maintains an office in this County and received substantial compensation from the sale of LTC policies in this County. Further, many of the acts complained of occurred in this County and gave rise to the claims alleged herein.

PARTIES

6. Plaintiff, ELMA SANCHEZ ("Sanchez") was a resident of the state of California, County of Los Angeles, and city of Hacienda Heights when she applied for and received a CalPers LTC Policy. Sanchez was eligible for CalPers LTC coverage due to her employment with the Walnut Valley Unified School District in Los Angeles County. She was born on July 5, 1925. Sanchez is a member of the Class of consumers who purchased and/or renewed LTC policies from CalPers, and were similarly situated

and incurred similar damage as a result of CalPers' breach of contract and wrongful conduct.

7. Due to the fact that Sanchez is 88 years old, and many of the other Class members are advanced in age, this case warrants consideration for an early trial date.

8. Plaintiff, HOLLY WEDDING ("Wedding"), is and, at all times mentioned herein, was a resident of Sacramento, California. Wedding was born on December 29, 1949. Wedding is a member of the Class of individuals who purchased and/or renewed LTC policies from CalPers, and were similarly situated and incurred similar damage as a result of CalPers' breach of contract and wrongful conduct.

9. It is impracticable to bring all members of the Class as individual plaintiffs before the court because the members of the Class are too numerous.

10. Upon information and belief, Plaintiffs allege, that in excess of 125,000 LTC policyholders were damaged as a result of the violations and misrepresentations of CalPers as herein alleged.

11. On March 18, 2013, Plaintiff Sanchez, individually, and on behalf of other similarly situated California residents who purchased CalPers Long Term Care insurance any time from 1995 through the present, with the exception of persons whose policies lapsed before receiving notice of a premium rate increase, served CalPers with a claim pursuant to Government Code section 910. The Victim Compensation and Government Claims Board ("VCGCB") stated in a letter dated April 4, 2013 that it would act on the claim on May 16, 2013 and "rejection of your claim will allow you to initiate litigation should you wish to pursue this matter further." On May 24, 2013, the VCGCB informed Sanchez that her claim had been rejected.

12. On March 18, 2013, Plaintiff Wedding, individually, and on behalf of other similarly situated California residents who purchased CalPers Long Term Care insurance any time from 1995 through the present, with the exception of persons whose policies lapsed before receiving notice of a premium rate increase, served CalPers with a

claim pursuant to Government Code section 910. On April 26, 2013, the VCGCB informed Wedding that her claim had been rejected, allowing her to initiate litigation.

13. Defendant CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM, ("CalPers"), is a pension fund organized under the laws of the State of California. From its headquarters in Sacramento, California, throughout the Class Period (as defined below) it sold, administered and renewed the LTC policies purchased by Plaintiffs and the Class.

14. Plaintiffs are unaware of the true names and capacities of the remaining defendants sued in this action by the fictitious names DOES 1 through 100. Plaintiffs will amend their complaint when those names and/or capacities become known to Plaintiffs. Plaintiffs are informed and believe that each of the fictitiously named defendants is in some manner responsible for the events and allegations set forth in this complaint.

15. At all relevant times, defendants, and each of them, were the agents and employees of each of the remaining defendants, and were at all times acting within the purpose and scope of said agency and employment, and each defendant has ratified and approved the acts of its agents.

EXHAUSTION OF ADMINISTRATIVE REMEDIES

16. Plaintiffs and the Class lack an "adequate, available or non-futile" "clearly defined" administrative remedy. Specifically, there is no administrative remedy provided by California that would permit Plaintiffs to obtain damages and/or injunctive relief for Plaintiffs and the members of the Class for the wrongful conduct alleged herein.

FACTS

A. CalPers' Long Term Care Insurance

17. In 1995 CalPers began offering to its members and their families the LTC policies wherein CalPers promised to protect policyholders from the expenses associated with being confined to a nursing home or other long term care facility. In uniform promotional materials that were given to policyholders, CalPers promised that the

premiums for the insurance were set and that "rates do not increase simply because of age or illness." These promotional materials also utilized charts to demonstrate the advantage of locking in a lower rate at a younger age. These charts projected CalPers LTC premium costs through age 80, with no indication of a possible premium increase.

18. In uniform promotional materials, consumers were also told that the insurance was 30% cheaper than other comparable policies and that CalPers was able to keep the cost low because it is "the nation's first self-funded, not-for-profit long-term care program." Specifically, CalPers claimed that "since the program is not-for-profit, CalPers is able to pass the resulting savings on to you in lower monthly premiums. This is one of the main reasons why CalPers' plans cost on average about 30 percent less than comparable commercial plans." CalPers further represented that its LTC policies were one of the most generous policies in the long term care market. And the promotional materials identified a laundry list of benefits available under its LTC policies.

19. CalPers marketed the LTC policies through uniform promotional materials that were distributed to public employees often in meetings held in various school districts around the state. CalPers also requested that State Department Directors disseminate letters promoting its LTC policies to all department employees. In one of these letters, CalPers advertised, "[w]hen you enroll, you lock-in your premium at the same rate for as long as you pay premiums." CalPers also promised that "[b]y enrolling in the PERS long Term Care Program during the open enrollment period between now and June, 1996, you, your spouse, and your parents and parents-in-law may obtain excellent coverage at a low rate locked-in for the life of your coverage."

20. CalPers also marketed its "Inflation Protection" plan which was an elective benefit offered to policyholders. If selected by the policyholder, the Inflation Protection plan provided that CalPers would increase the policyholder's Nursing Home Daily Maximum; Residential Care Facility Daily Maximum; and Home and Community Care Monthly Maximum by 5% compounded annually each year as long as coverage remains in force. CalPers explicitly promised in the Evidence of Coverage ("EOC") that the

"premium rate will not increase as a result of these annual benefit increases." Moreover, in uniform promotional materials CalPers informed consumers that "[t]he plans with 'built-in' annual benefit increases will cost more on a monthly basis initially, but you lock in a rate now that is designed to remain level over the life of the plan and that won't rise simply with age."

21. According to CalPers' promotional materials, its LTC program was a huge success. By 1997, or within two years, CalPers had enrolled more than 119,000 members.

22. By 2000, the number of enrollees had grown to 128,000. At this time, CalPers announced that it was changing the existing policies to add even more benefits. According to promotional materials disseminated by CalPers to its insureds, the decision to add these benefits was due to the "Program's financial stability." The policy now provided a new hospice benefit, a new more affordable plan option, and a change in the program's deductible period. With the announcement of these new benefits, CalPers heavily touted the strength of the program's finances and gave each enrollee a rider to their original policy listing the new benefits.

23. Under the EOC, CalPers had the ability to add benefits to the policy without the policyholders' consent. However, changes could not be made if they would result in an "increase in premium."

24. Each year from 1995 through 2003, CalPers provided uniform written materials to its LTC policyholders, and further continued to promote the program to potential new members, advising them that the program was doing well and was financially sound. These promotional materials were intended to induce Class members to keep their insurance in place and continue paying premiums and to induce new individuals to purchase the LTC policies.

25. Commencing in 1995 and continuing through 2007, CalPers sold three categories of polices: the LTC1 which are LTC policies issued from 1995 to 2002; the LTC2 which are LTC policies issued from 2003 to 2004; and the LTC3 which are LTC policies issued from 2005 to 2008. Of the 150,330 current policyholders, more than 83%

(125,257) purchased the LTC1 category of policies. The vast majority of these policyholders are retired, living on a fixed income, and have a limited ability to earn additional funds to support the enormous premium increase demanded by CalPers. In contrast, the LTC3 policies that were sold more recently account for 10% (16,190) of the total policyholders.

26. The truth about CalPers' program was not as represented. From the very beginning, the premiums for the insurance were grossly underpriced and were not sufficient to provide the level of benefits promised under the program. Moreover, CalPers was woefully incapable of accurately underwriting the policies that it was actively marketing. Not only was CalPers unable to accurately assess the true projected costs of the policies it was selling, it determined it would aggressively invest the premiums paid by the policyholders. In short, CalPers, which had *no* prior experience providing long-term care coverage, over-promised and under-delivered. CalPers failed to do the necessary underwriting to ensure that premiums were sufficient to support the risks insured against, failed to invest the premiums wisely and safely, and failed to conduct the necessary actuarial analysis that would have revealed the true costs for future benefits.

27. In 2009 CalPers was forced to close the program to new enrollments. When an insurance company fails to properly price an LTC policy and fails to properly establish reserves for a block of LTC insured business, closing the block can lead to a "death spiral" that will guarantee that the premium rates on LTC policies will increase at an even greater rate. Despite this, CalPers never informed Class members about its decision to stop new enrollments nor did it explain the consequences of doing so.

28. Commencing in approximately February 2013, Class members began receiving letters from CalPers advising them that it had voted to increase premiums by another 5% immediately, 5% in 2014, and 85% in 2015. These increases applied to all policyholders who purchased LTC1 and LTC2 policies issued from 1995-2004 with

lifetime coverage and built-in inflation protection, as well as lifetime policies without inflation protection, and 3-year and 6-year policies with inflation protection.

29. The impact of the increase is extraordinary. By way of example, when she originally enrolled in the program, Plaintiff Sanchez was paying $179.00 per month in premiums. Commencing in 2015 her monthly premium will be $793.75. When Plaintiff Wedding initially enrolled in the program, she was paying $58.00 per month in premiums. Commencing in 2015 her monthly premium will be $304.41.

30. The stated reason for the increase was to "stabilize" the $3.6 billion fund. And although CalPers announced that it will re-open enrollment in the LTC program in December 2013 with a new policy entitled LTC4, it has conceded that it does not know if efforts to correct its grossly deficient policy program will succeed.

31. At all times, CalPers knew its LTC policies were grossly underpriced and that it would inevitably have to raise premiums due to poor investments. Had Class members known the truth, they would not have purchased or renewed the LTC policies. Instead, they would have been able to purchase alternative insurance while younger at a substantially reduced overall cost and avoided the significant rise in premiums that will likely force many Class members to either drop their policies or accept the reduction in benefits now mandated by CalPers.

32. Plaintiffs and the other Class members are now faced with an untenable situation; either abandon the policies they have been paying into for almost 20 years or pay premiums that many simply cannot afford. The only other alternative is for Class members to elect to reduce their lifetime benefits to either a 3, 6, or 10 year maximum and to eliminate the inflation protection that Plaintiffs and the Class members paid for.

33. CalPers' irresponsible conduct resulted in Plaintiffs and the Class renewing their policies until they were too old to purchase alternative coverage with another company. CalPers knew that future increases in premiums were inevitable, yet continued on with the misrepresentations. Plaintiffs and the Class are also in the

untenable position of having to forfeit whatever premiums have been paid to CalPers, if they choose to drop their coverage because they can no longer afford the premiums.

34. Upon information and belief, the conduct alleged herein was devised, approved of, and implemented by officers, directors, and/or agents of CalPers at its headquarters in Sacramento, California.

35. Had CalPers informed Plaintiffs and the Class of these material facts and/or omissions, Plaintiffs and the Class would not have initially purchased or renewed these policies.

B. CalPers Had a Legal Duty to Not Under-Price Its Insurance and Keep Policyholders Fully Apprised of Its Financial Condition.

36. Consumers purchase insurance with the common goal of exchanging the gamble of going at it alone -- whereby he or she could either escape all loss whatsoever or suffer a loss that might be devastating -- for the opportunity to pay a fixed and certain amount into a fund knowing that this amount is the maximum he or she will lose on account of the particular type of risk insured against. Whatever the reason one has for buying LTC insurance, a planned hidden rate increase is unacceptable.

37. A product is an insurance product only if it shifts the risk of loss from the insured to the insurer, which in turn manages its risk by creating a sufficiently large pool of insureds to spread the risk, by reinsuring all or part of the risk, and/or by carefully investing premiums now to help pay claims later.

38. This expertise is reasonably expected and relied upon in the marketplace, and combined with the use of "form contracts" explains the well-known fact that most consumers do not understand their insurance contracts.

39. The duty of care of the insurer to the insured is elevated and involves the obligation of utmost good faith. Consumers reasonably expect compliance with that obligation. The duty of care includes the requirement that the insurer communicate to the insured, in good faith, all facts within its knowledge that are material to the contract, and which the insured cannot ascertain.

40. Likewise, policy language may not be invoked to frustrate the reasonable expectations of the marketplace regarding the scope or form of coverage. Similarly, policyholders should be notified when a block of business is closed, as it affects the stability of the pool and reserves.

41. Consistent with consumers' expectations, insurers may not engage in the same kind of free-wheeling profit-motivation of other industries dealing with products less close to the core of our long-term, economic well being.

42. Thus, insurers may not engage in low-ball pricing of LTC insurance products with planned or reasonably foreseeable rate increases. Similarly, insurers may not insert self-serving, exculpatory language that interferes with or nullifies the insurance being promised. And, any ambiguity in the policy language must be construed against the drafter of the policy.

43. The LTC products offered by CalPers were targeted at individuals who could not reasonably be expected to afford rate increases. These individuals either were or would become retirees on fixed incomes, and were employed in the public sector with incomes that were modest in comparison with the private sector. LTC policies such as the subject ones are not suitable for people on fixed incomes unless they are designed and administered as level-premium policies.

44. The applications and sales brochures provided to Plaintiffs and the Class did not contain a statement that CalPers would increase premiums or that CalPers had in place planned premium increases for its LTC policies.

45. Despite CalPers' affirmative representations to Plaintiffs and the Class regarding the LTC policies being guaranteed renewable for life, CalPers had knowledge that premiums for the LTC policies would be increased to unaffordable and unexpected levels. CalPers knew this increase would require its policyholders to choose between paying additional enormous premiums to maintain their LTC coverage, forfeiting the thousands of dollars of premiums paid for these policies, and accepting a reduction in benefits.

46. When the policies were sold, CalPers knew that many of its LTC policyholders would not be able to purchase affordable long-term care insurance with other carriers should they cease paying the increased premiums, because with the passage of time, the policyholders age and/or medical history would either bar coverage or make it unaffordable.

47. CalPer's conduct alleged herein, including but not limited to, decisions regarding lapse assumptions, fund investment strategies, the design of the LTC policies, underwriting assumptions, representations regarding the LTC policies, the form and content of applications and brochures, and the decision to stop accepting new applicants in 2009, occurred at the direction, control, and supervision of officers, directors, employees and/or agents of CalPers.

C. General Allegations As To Elma Sanchez

48. In or around 1998, Sanchez became aware that CalPers was offering LTC insurance to CalPers Members. Prior to purchasing the policy, CalPers provided Sanchez with promotional materials for the policy. Those materials stated that the policy was a fixed premium policy and that premiums would never rise based on Sanchez's age or health. None of the materials provided to Sanchez disclosed that the policy being offered by CalPers was underpriced and that rate increases in the future were certain. Based on these representations and/or non-disclosures, Sanchez purchased the subject LTC policy from CalPers.

49. Sanchez received additional promotional materials from CalPers wherein CalPers touted the financial stability of its LTC program. At no time during this period did CalPers disclose to Sanchez that its LTC policies were underpriced and improperly invested. Sanchez relied on these representations and non-disclosures each year she decided to renew her LTC policy.

50. In February 2013, Sanchez was advised by CalPers that the premiums for her LTC policy would increase by 85%.

51. As a direct and proximate result of CalPers' wrongful course of conduct, Sanchez and the Class have been damaged because they are either required to pay premium increases in order to keep their LTC policies in force, reduce their coverage to keep premiums at their original rate, or risk having their coverage terminated by CalPers for nonpayment of premiums, thereby leaving Class members without the insurance coverage they contracted for with CalPers.

D. General Allegations As To Holly Wedding

52. In 1995, Wedding became aware that CalPers was offering LTC insurance to CalPers members. Prior to purchasing the policy, CalPers provided Wedding with promotional materials for the policy. Those materials stated that the policy was a fixed premium policy and that premiums would never rise based on Wedding's age or health. None of the materials provided to Wedding disclosed that the policy being offered by CalPers was underpriced and that rate increases in the future were certain. Based on these representations and/or non-disclosures, Wedding purchased the subject LTC policy from CalPers.

53. Wedding received additional promotional materials from CalPers wherein CalPers touted the financial stability of its LTC program. At no time during this period did CalPers disclose to Wedding that its LTC policies were underpriced and improperly invested. Wedding relied on these representations and non-disclosures each year she decided to renew her LTC policy.

54. In February 2013, Wedding was advised by CalPers that the premiums for her LTC policy would increase by 85%.

55. As a direct and proximate result of CalPers' wrongful course of conduct, Wedding and the Class have been damaged because they are either required to pay premium increases in order to keep their LTC policies in force, reduce their coverage to keep premiums at their original rate, or risk having their coverage terminated by

CalPers for nonpayment of premiums, thereby leaving Class members without the insurance coverage they contracted for with CalPers.

CLASS ACTION ALLEGATIONS

56. Plaintiffs bring this action as a class action pursuant to California Code of Civil Procedure section 382 and California Rules of Court 3.760, et seq.

57. Class Definition: Plaintiffs bring this action individually and on behalf of all others similarly situated who purchased LTC1 and LTC2 policies issued from 1995-2004 with lifetime coverage and built-in inflation protection, lifetime policies without inflation protection, as well as 3-year and 6-year policies with inflation protection from CalPers at any time; except that, notwithstanding the foregoing, the Class does not include any of the following: (1) persons whose policies lapsed before receiving notice of a premium rate increase in February 2013; (2) persons who received claim payments under their policies before February 2013; and (3) any officer or director of CalPers involved in the management of CalPers Long Term Care program.

58. The Class as defined above, may be further defined or amended by additional pleadings, evidentiary hearings, a class certification hearing, and orders of this Court.

59. The requirements for maintaining this action as a class action are satisfied in that:

a. It is impracticable to bring all members of the Class before the Court. Plaintiffs estimate that there are more than 125,000 members of the Class and their identities can be ascertained from CalPers' books and records. Attempting to join and name each Class member as a co-Plaintiff would be unreasonable and impracticable.

b. The prosecution of separate actions by individual Class members or the individual joinder of all Class members in this action is impracticable and would create a massive and unnecessary burden on the resources

of the courts and could result in inconsistent adjudications, while a single class action can determine with judicial economy the rights of each member of the Class.

c. Because of the disparity of resources available to CalPers versus those available to individual Class members, prosecution of separate actions would work a financial hardship on many Class members.

d. Prosecuting this case as a class action conserves the resources of the parties and the court system, protects the rights of each member of the Class, and meets all due process requirements as to fairness to CalPers. Prosecuting this case as a class action is also far superior to individual claims, all arising out of the same circumstances and course of conduct.

e. The claims or defenses of the representative Plaintiffs are typical of the claims or defenses of each member of the Class.

f. The Plaintiffs will fairly and adequately protect the interests of the Class. Each Class member's interests are consistent with, and not antagonistic to, those of Plaintiffs. Plaintiffs have engaged counsel experienced and competent in insurance and class action litigation.

g. Upon certification, notice can be efficiently and effectively accomplished since class members' identities and locations can easily be ascertained from CalPers' records. CalPers regularly provides notice of actions relating to the LTC policies by U.S. Mail or electronic mail to Class members and thus, notice can readily be accomplished through a number of methods including first class mail and/or electronic mail.

60. There are questions of law and fact common to the Class, which are substantially similar and predominate over the questions affecting the individual Class members. Among these common questions of law and fact are:

a. Whether CalPers breached its contract with the Class members by forcing Plaintiffs and the Class members to elect between paying an increased premium or accepting decreased benefits;

b. Whether CalPers induced the sale and renewal of LTC policies through misrepresentations or omissions of material information;

c. Whether CalPers wrongfully underpriced its LTC policies in order to stimulate policy sales;

d. Whether CalPers failed in its management of the LTC policies fund in a manner that rendered the fund inadequate;

e. Whether CalPers concealed from its policyholders the defects inherent in its LTC policies;

f. Whether Plaintiffs and the Class have sustained damages and the proper measure of those damages.

61. In addition or in the alternative, certification of the Class may be appropriate for purposes of obtaining declaratory or injunctive relief.

FIRST CAUSE OF ACTION

(Breach of Contract as to Defendants CalPers and DOES 1 through 100)

62. Plaintiffs repeat and re-allege the allegations contained in paragraphs 1 through 61 above, as if fully set forth herein.

63. At all times material hereto, there existed as between Plaintiffs and the members of the Class and CalPers and Does 1-100, an agreement whereby CalPers promised to provide long term care benefits in accordance with the terms of their agreement which are set forth in the EOC. Among other things, the terms of the EOC required that CalPers provide a certain level of benefits to Plaintiffs and the members of the Class in exchange for the payment of premiums. A true and correct copy of the EOC is attached hereto as Exhibit 1.

64. The EOC provided that for those policyholders who elected to purchase the Inflation Protection Benefit, CalPers would increase the Nursing Home Daily Maximum; the Residential Care Facility Daily Maximum; and the Home and Community Care Monthly Maximum by 5% compounded annually each year as long as coverage remains in force. And the EOC provided that it would increase any unused balance remaining in the policyholders Total Coverage Amount by 5% compounded annually. The EOC provided that CalPers could not increase the premium rate as a result of the annual benefit increases afforded to those who elected to purchase the Inflation Protection benefit.

65. At all times material hereto, Plaintiffs and the members of the Class performed all obligations that they were required to perform under the agreement and have faithfully and continually paid their premiums.

66. CalPers and Does 1-100 have breached their obligations under the agreement, including increasing premiums in violation of the agreement and failing to continue to provide the Inflation Protection Benefit without requiring that Plaintiffs and members of the Class pay additional premiums.

67. As a result, Plaintiffs and the members of the Class have been damaged in an amount to be established at trial.

SECOND CAUSE OF ACTION

(Breach of the Covenant of Good Faith & Fair Dealing as to Defendants CalPers and DOES 1 through 100)

68. Plaintiffs repeat and re-allege the allegations contained in paragraphs 1 through 67 above, as if set forth fully herein.

69. Plaintiffs and each member of the Class are informed and believe and thereon allege that CalPers and Does 1 - 100 breached the implied covenant of good faith and fair dealing and the special relationship contained in all insurance contracts, in at least the following respects:

a. CalPers and Does 1-100 unreasonably and without proper cause failed to properly and adequately underwrite the policies to ensure that premiums were sufficient to support the risks insured against;

b. CalPers and Does 1-100 failed to invest the premiums wisely and safely and instead engaged in a strategy of aggressive investment that resulted in enormous losses to the fund;

c. CalPers and Does 1-100 failed to conduct the necessary actuarial analysis that would have revealed the true costs for future benefits;

d. CalPers and Does 1-100 closed the program to new enrollments in 2009 without notification to Plaintiffs and to the Class knowing full well that closing enrollment would lead to a "death spiral" that would adversely affect the fund and the benefits it had guaranteed Plaintiffs and the Class;

e. CalPers and Does 1-100 made false promises of fixed premium rates in order to entice Class members to enroll in the program.

70. CalPers' announced cessation of promised benefits to Plaintiffs and other Class members in the event that Plaintiffs and the Class members fail to pay exorbitant increases in premiums was done without reasonable cause. CalPers knew that it had a duty to provide the benefits that Plaintiffs and the Class members purchased and for which Plaintiffs and the Class have been regularly and timely paying premiums; a duty to properly invest the funds in a conservative and careful manner; a duty to conduct an appropriate actuarial analysis to insure that the fund would maintain sufficient reserves to provide the promised benefits to Plaintiffs and the Class; and a duty to continue enrollments so as to insure that the fund was not adversely affected by the reduction in younger policyholders at the time when older policyholders were retiring and more likely to require the benefits provided by the LTC policies. CalPers has refused to act in accordance with those duties and in doing so has breached the covenant of good faith and fair dealing.

71. As a direct and proximate result of the unreasonable conduct of CalPers and Does 1-100, Plaintiffs and the other members of the Class have been forced into the untenable position of receiving reduced benefits in exchange for not having to pay an 85% increase in premiums and those members of the Class who purchased Inflation Protection have suffered a loss of the benefits provided under that program, and accordingly Plaintiffs and the Class members have been damaged thereby.

72. Plaintiffs and the members of the Class are informed and believe and thereon allege that CalPers and Does 1-100 engaged in a course of conduct which was intended to oppress and dissuade Plaintiffs and the Class from seeking the benefits due to them under their LTC policies.

73. CalPers and Does 1-100 have refused to fulfill their obligations under the LTC policies and their refusal has been done with a conscious disregard for the rights of Plaintiffs and the Class. These acts were done with the knowledge and approval and ratification of CalPers and its officers, directors and other managing employees.

74. As a proximate result of the aforementioned unreasonable and bad faith conduct of Defendants, Plaintiffs and members of the Class have suffered, and will continue to suffer in the future, damages, plus interest, and other economic and consequential damages, for a total amount to be shown at the time of trial.

75. As a proximate result of the unreasonable and bad faith conduct of Defendants, and each of them, Plaintiffs were compelled to retain legal counsel to obtain the benefits due under the LTC policies. Therefore, Defendants are liable to Plaintiffs for those attorneys' fees, witness fess, and cost of litigation reasonably necessary and incurred by Plaintiffs in order to obtain the benefits under the Policy, in a sum to be determined at the time of trial.

THIRD CAUSE OF ACTION

(Rescission as to Defendants CalPers and DOES 1 through 100)

76. Plaintiffs repeat and reallege the allegations in paragraphs 1 through 75 above, as if fully set forth herein.

77. Pursuant to California Insurance Code section 332, each party to an insurance contract must communicate to the other, in good faith, all facts within their knowledge which are or which they believe to be material to the contract, and to which no warranty is made, and which the other has not the means of ascertaining.

78. Pursuant to the provisions of California Insurance Code section 331, concealment, whether intentional or unintentional, entitles the injured party to rescind the insurance contract.

79. Pursuant to the provisions of California Insurance Code section 359, if a representation is false on a material point, whether affirmative or promissory, the injured party is entitled to rescind the contract from the time the representations become false.

80. Defendant CalPers and Does 1-100 made material misrepresentations and concealed material facts from Plaintiffs and members of the Class which induced them to purchase the LTC policies. If the true facts had been disclosed to Plaintiffs and other members of the Class, they would not have purchased LTC policies with Defendant CalPers.

81. Plaintiffs and the other members of the Class will suffer substantial harm and injury if the policies issued by CalPers are not rescinded, in that Plaintiffs and the other members of the Class have been deprived of the alleged benefits of the LTC policies and have remitted billions of dollars as alleged above and have not received what they were promised. Plaintiffs and the other members of the Class have also been deprived of the use of the money paid to CalPers for many years.

82. Plaintiffs and the other members of the Class are also entitled to rescind the LTC policies and are entitled to the return of the money they paid to CalPers, since

CalPers violated its implied contractual duties of good faith and fair dealing through failure to accurately state material facts, and material omissions and other failures to perform as detailed above.

83. As a proximate result of CalPers' breach of its implied duties of good faith and fair dealing, Plaintiffs and the other members of the Class have suffered damages.

84. Alternatively, Plaintiffs allege that consent to the contracts referred to above was not real, mutual or free in that it was obtained solely through mistake as herein alleged.

85. Plaintiffs and the other members of the Class entered into the above-described LTC policy contracts under a mistake of fact to the contract, in that they thought that they were buying viable insurance which could legally deliver its promised benefits. Plaintiffs and the other members of the Class would not have given their consent to the purchase of the LTC policies if the mistake had not existed.

86. CalPers was or should have been aware of the mistake by the Plaintiffs and the members of the Class as to the facts relating to the LTC policies and unfairly used this mistake to induce Plaintiffs and the other members of the Class to purchase the LTC policies described above. As a result, CalPers has been unjustly enriched and Plaintiffs and the other members of the Class have been deprived of the use of their money and are entitled to the return of their monies plus interest thereon at the maximum rate allowed by law.

87. Service of Plaintiffs' original summons and complaint constituted notice of the rescission of the LTC policies and demand that CalPers restore to Plaintiffs and the other members of the Class all of the money paid by Plaintiffs and the members of the Class, plus interest at the maximum rate allowed by law.

FOURTH CAUSE OF ACTION

(For Declaratory and Injunctive Relief as to Defendants CalPers and DOES 1 through 100)

88. Plaintiffs repeat and reallege the allegations in paragraphs 1 through 87 above, as if fully set forth herein.

89. Through the conduct described above, Defendants have refused to provide benefits under the LTC policies that they were required to provide.

90. Defendants will continue to refuse to provide benefits and or to require that Plaintiffs pay exorbitant increases in premiums to maintain those benefits unless and until this Court declares that such actions and charges are unlawful and wrong and enjoins the Defendants from continuing to pursue their course of action.

91. The wrongful acts and practices of the Defendants, as alleged herein, are suitable for injunctive relief in that the Plaintiffs and the members of the Class have no wholly adequate legal remedy. Defendants are likely to continue to pursue their scheme to wrongfully reduce benefits or extract exorbitant premiums from Plaintiffs and the members of the Class thus causing irreparable injury to them.

92. Accordingly, Plaintiffs seek a judgment against Defendants: (i) declaring that it is unlawful for Defendants to increase premiums for the LTC Policies for Plaintiffs and the Class or to reduce or terminate benefits if Plaintiffs and the Class members cannot pay the exorbitant increase in premiums; (ii) enjoining Defendants from engaging in these activities and actions in the future; and (iii) awarding attorneys' fees and costs incurred in connection with this litigation.

PRAYER FOR RELIEF

Wherefore, Plaintiffs respectfully request that the Court enter judgment in their favor and against Defendants as follows:

a. Determining that this action is a proper class action maintainable and certifying the Class; certifying Named Plaintiffs as Class representatives of the Class; and appointing Plaintiffs' counsel as counsel for the Class;

b. That Defendant be required to make restitution to each Plaintiff and each member of the Class of any and all money or property paid by that Plaintiff and Class member;

c. For a determination by the Court of the most suitable mode by which Class members are to come forward, identify themselves, and prove their entitlement to share in the total sum awarded by the Court for actual and/or statutory damages;

d. For Rescission of the LTC policies sold to Plaintiffs and the Class;

e. Awarding Plaintiffs and the Class their reasonable attorneys' fees;

f. Awarding Plaintiffs and the Class pre-judgment and post-judgment interest as provided by law;

g. For declaratory and/or injunctive relief as requested;

h. Awarding Plaintiffs and the Class their costs of suit herein incurred; and

i. Awarding Plaintiffs and the Class such other and further relief as may be just and proper.

JURY DEMAND

Plaintiffs demand a trial by jury on all issues so triable.

Dated: August 6, 2013

SHERNOFF BIDART ECHEVERRIA BENTLEY LLP

By: _____
Michael J. Bidart
Gregory L. Bentley
Clare H. Lucich

KERSHAW, CUTTER & RATINOFF LLP

KREINDLER & KREINDLER LLP

Counsel for Plaintiffs and the Class

EXHIBIT 1

Long-Term Care Program Evidence of Coverage

Nursing Home & Assisted Living/ Residential Care Facility Plan

CALIFORNIA
PERS

EVIDENCE OF COVERAGE
Nursing Home & Assisted Living/Residential Care Facility Plan

The California Public Employees Retirement System (CalPERS) is pleased to issue this long-term care coverage to **You**. Benefits are payable subject to the terms and conditions outlined in this Evidence of Coverage. Please read it carefully.

Qualified Long-Term Care Plan

This Long-Term Care coverage is intended to be a federally "qualified long-term care insurance contract" under Section 7702B(b) of the Internal Revenue Code and may qualify **You** for federal and state tax benefits. If in the future, it is determined that this **Agreement** does not meet these requirements, **We** will make every reasonable effort to amend **Your** coverage to gain favorable income tax treatment.

Your 30-Day Right To Cancel

You may cancel **Your** coverage for any reason within 30 days after **You** receive this Evidence of Coverage. To do so, mail or deliver the Evidence of Coverage to **Our** Administrative Office at the address on page 3. **We** will refund any premium **You** have paid. The coverage will then be treated as if it were never issued.

Your Coverage is Guaranteed Renewable

We cannot cancel or refuse to renew **Your** coverage until benefits have been exhausted as long as **You** pay premiums on time. **Your** premiums will never increase due solely to a change in **Your** age or health. CalPERS can, however, change **Your** premiums, but only if **We** change the premium schedule on an issue-age basis for all similar coverage issued in **Your** state on the same form as this coverage. **We** must give **You** at least 60 days written notice before **We** change **Your** premiums. The premium for any increases in coverage which **You** voluntarily elect will be based on **Your** age at the time **You** elect the increase.

Important Caution About Your Application

We issued this coverage based on **Your** responses to questions on **Your Application** which is made a part of this coverage. A copy of **Your Application** is enclosed; please retain it for **Your** records. If **Your** answers on the **Application** are misstated or untrue, **We** have the right to refuse benefits or rescind **Your** coverage. If, for any reason, any of **Your** answers are misstated or untrue, contact **Us** immediately at the address shown on page 3.

Notice to Buyer

This plan 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 plan limitations.

This long-term care plan has been approved by the Board of Administration of the California Public Employees' Retirement System. However, the benefits payable under this plan will not qualify for Medi-Cal asset protection under the California Partnership for Long-Term Care.

For information about plans qualifying under the California Partnership for Long-Term Care, please call the California Department of Aging's Health Insurance Counseling and Advocacy Program at 800-434-0222 or Our customer service department at 800-982-1775.

TABLE OF CONTENTS

These are the major provisions of this Evidence of Coverage in the order in which they appear.

The CalPERS Long-Term Care Program is administered by:
Long Term Care Group, Inc.
CalPERS Long-Term Care Program
Route CAL-07-P
PO Box 5708
Hopkins, Minnesota 55343-5708
1-800-982-1775

DEFINITIONS

This section provides the definitions of words used often in this **Agreement** which have a special meaning when applied to **Your Nursing Home** and **Assisted Living/Residential Care Facility** Plan. To help **You** recognize these special words and phrases used in this **Agreement**, the word will be highlighted and the first letter of each word is capitalized wherever it appears.

Activities of Daily Living means the following self care functions:

Bathing	Cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, reaching head and body parts for soaping, rinsing and drying.
Dressing	Putting on and taking off, fastening and unfastening garments and undergarments, and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.
Toileting	Getting on and off a toilet or commode and emptying a commode, managing clothes and wiping and cleaning the body after toileting, and using and emptying a bedpan and urinal.
Transferring	Moving from one sitting or lying position to another sitting or lying position (e.g., from bed to or from a wheelchair or sofa, coming to a standing position and/or repositioning to promote circulation and prevent skin breakdown).

Continence	Ability to control bowel and bladder as well as use ostomy and/or catheter receptacles, and apply diapers and disposable barrier pads.
Eating	Reaching for, picking up, grasping a utensil and cup; getting food on a utensil, bringing food, utensil, and cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meal.

Administrator means the entity or organization designated by CalPERS to administer this **Agreement** on its behalf and in accordance with the rules and procedures it specifies.

Agreement means this Evidence of Coverage and any **Application** or other paper attached to it, which outlines the terms and conditions of **Your** coverage.

Application means the written **Application** form provided by **Us** and completed by **You** when **You** apply for long-term care coverage.

Assessment means an evaluation done by **Us** or **Our** representative to determine or verify **Your** deficiencies in **Activities of Daily Living** or **Your Severe Cognitive Impairment**. The **Assessment** uses generally accepted tests and instruments that use objective measures and produce verifiable results.

Care Advisor means a person who is qualified by training and experience to assess and coordinate the overall medical, personal, and social needs of a person who suffers long-term physical or cognitive disability and who is employed by or under contract to a **Care Advisory Services Agency** designated by **Us** to provide **Care Advisory Services**.

Care Advisory Services means services that identify a person's physical, cognitive, social and medical needs for care and services and can help link the person to a full range of appropriate services. It may include but is not limited to the following:

- the performance of comprehensive individualized face-to-face **Assessments** including reassessments at least every 6 months;
- the development of **Care Advisory Services Plans**, including an initial **Care Advisory Services Plan** and subsequent **Care Advisory Services Plans** as needed for changes in **Your** condition, when services are about to end or when **You** become eligible for Medi-Cal;
- when desired by the individual and determine necessary by the **Care Advisory Services Agency**, coordination of appropriate services and ongoing monitoring of the delivery of such services;
- a discharge plan when the **Care Advisory Services** or the Plan benefits are about to be terminated and further care is required.

Care Advisory Services Agency means an agency or other entity designated by **Us** that provides **Care Advisory Services** and meets certain standards that pertain to staffing requirements, quality assurance, agency functions, and reporting and records maintenance requirements.

Care Advisory Services Plan means a written individualized plan of services approved by a **Care Advisory Services Agency** designated by **Us** which specifies **Your** long-term care needs and the type, frequency and providers of services appropriate to meet those needs, and the costs, if any, of those services. The **Care Advisory Services Plan** will be modified as required to reflect changes in **Your** medical or social situation, **Your** functional, behavioral or cognitive abilities, and **Your** service needs.

Certification Date means the earliest possible date that **You** suffered **Severe Cognitive Impairment** or a deficiency in the required number of **Activities of Daily Living** as determined by **Us**.

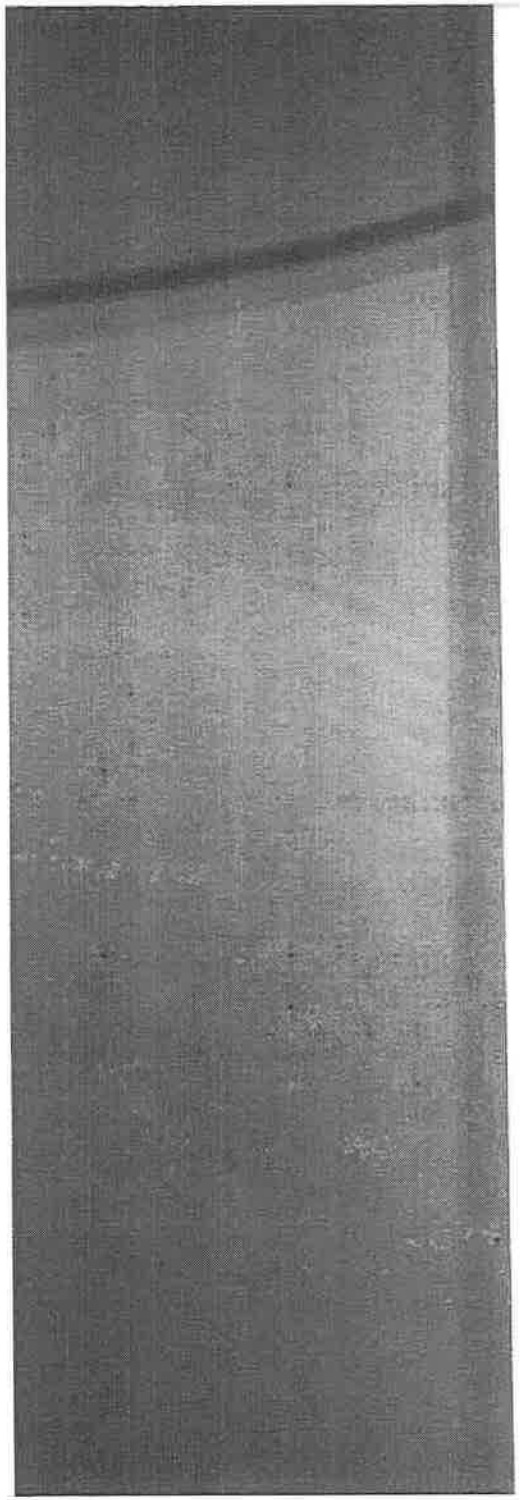
Chronically Ill Individual means **You** have been certified by a **Licensed Health Care Practitioner** within the preceding 12 months as being unable to perform (without **Substantial Assistance**) at least 2 **Activities of Daily Living** for a period of at least 90 days due to a loss of functional capacity or **You** require **Substantial Supervision** to protect **You** from threats to **Your** health or safety due to **Severe Cognitive Impairment**.

Confinement means **You** are an inpatient in a **Nursing Home** or a resident in a **Residential Care Facility** for a period for which a room and board charge is made.

Coverage Effective Date means the date **Your** coverage begins.

Deductible Period (also called an **Elimination Period**) means the total number of days that covered **Formal Long-Term Care Services** must be received after **You** have met the Conditions for Receiving Benefits and before the benefits covered by this **Agreement** are payable. The **Deductible Period** must be accumulated within a 12-month period after **You** have met the Conditions for Receiving Benefits. The number of days may be accumulated before the filing of a claim if **You** can establish that **You** met the Conditions for Receiving Benefits before filing a claim. The **Deductible Period** need only be met once during a lifetime. Any day when covered services are reimbursed by any insurance or **Medicare** may be counted toward meeting the **Deductible Period**.

Formal Long-Term Care Services means long-term care services for which the provider is paid.



Immediate Family means **Your** spouse and **Your** children, grandchildren, parents, brothers, and sisters and their spouses.

Licensed Health Care Practitioner means any **Physician** (as defined in section 1861(r)(1) of the Social Security Act), any registered professional nurse, licensed social worker, or any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Nursing Home means a facility or distinctly separate part of a hospital or other institution which is appropriately licensed to engage primarily in providing nursing care to inpatients under a planned program supervised by a **Physician**. It also:

- Provides 24-hour a day nursing care by a registered nurse (R.N.), a licensed practical nurse (L.P.N.) under the supervision of a registered nurse (R.N.) or a **Physician**;
- Maintains a daily medical record of each inpatient; and
- Provides nursing care at skilled, intermediate or custodial levels.

Nursing Home also means a facility that is licensed as a specialized Alzheimer's Unit in all states where such licensure exists. **Nursing Home** does not mean a Hospital or clinic, a community living center, or a place that provides residential or retirement care only.

Plan of Care means a written individualized plan of services prescribed by a **Licensed Health Care Practitioner**.

Physician or **Doctor** means a licensed medical doctor (M.D.) or licensed Doctor of Osteopathy (D.O.), who is legally qualified and licensed to practice medicine.

Qualified Long-Term Care Services are necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal services needed to assist with the disabling condition that cause **You** to be a **Chronically Ill Individual**. All of the services covered by the Plan are **Qualified Long-Term Care Services**.

Representative means a person or entity legally empowered to represent **You**.

Residential Care Facility (also called **Assisted Living Facility**) means a licensed facility engaged primarily in providing on-going care and related services that meets all of the following criteria:

- it provides twenty-four (24) hour a day care and services sufficient to support needs resulting from inability to perform **Activities of Daily Living** or **Severe Cognitive Impairment**; and
- it has an awake, trained and ready-to-respond employee on duty in the facility at all times to provide care; and
- it provides three meals a day and accommodates special dietary needs; and
- it has written contractual arrangements or otherwise ensures that residents receive the medical care services of a **Physician** or nurse in case of emergency; and
- it has appropriate methods and procedures to assist residents in self-administration of prescribed medications.

Respite Care means the supervision and care of persons with deficiencies in **Activities of Daily Living** or a **Severe Cognitive Impairment** while the family or other individuals who normally provide care on a daily basis take short-term leave or rest that provides them with temporary relief from the responsibilities of caregiving.

Severe Cognitive Impairment means confusion 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, or similar forms of senility or irreversible dementia. This deterioration or loss of intellectual capacity is measured through use of standardized tests or instruments.

Substantial Assistance means either Hands-on Assistance or Standby Assistance. Hands-on Assistance is the physical assistance of another person without which **You** would be unable to perform the **Activities of Daily Living**. Standby Assistance means the presence of another person, within **Your** arm's reach, that is necessary to prevent, by physical intervention, **Your** injury while **You** are performing the Activities of Daily Living.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures or other demonstrations) by another person that is necessary to protect **You** from threats to **Your** health or safety (including but not limited to such threats as may result from wandering).

Total Coverage Amount means the maximum amount **We** will pay for expenses covered by this **Agreement**. The **Total Coverage Amount** is shown in the Schedule of Benefits. The **Total Coverage Amount** is reduced by the amount of claims paid, except that covered expenses **We** incur for the Care Advisory Services Benefit do not count against **Your Total Coverage Amount**. The **Total Coverage Amount** will increase on each anniversary of the **Coverage Effective Date** if **You** have elected the Inflation Protection provision described on page 23.

We, **Us**, or **Our** means the CalPERS Long-Term Care Program, self-funded by the California Public Employees' Retirement System (CalPERS).

You or **Your** means the person named in the Schedule of Benefits and covered under this Evidence of Coverage.

CONDITIONS FOR RECEIVING BENEFITS

This section describes important features of **Your** coverage and how **You** become eligible to receive benefits. **You** will be eligible to receive **Qualified Long-Term Care Services** covered by this plan if **You** become a **Chronically Ill Individual** and meet all of the Conditions for Receiving Benefits as described in this section.

Benefits Covered by this Agreement

The benefits included in this coverage are:

- Nursing Home Benefit
- Residential Care Facility Benefit
- Respite Care Benefit
- Care Advisory Services Benefit
- Inflation Protection Option, if **You** have elected it
- Benefit Increase Option, if **You** have elected it
- Return of Premium Death Benefit
- Nonforfeiture Benefit Option, if **You** have elected it

How You Become Eligible for Benefits

We will pay all Benefits when **We** determine that **You**:

- Cannot perform three (3) or more of the **Activities of Daily Living** without **Substantial Assistance**; or
- Require **Substantial Supervision** due to **Severe Cognitive Impairment**; and
- Meet the Additional Requirements for Receiving Benefits outlined below.

Additional Requirements for Receiving Benefits

We will pay the benefits described in this **Agreement** when the following requirements are met:

- the coverage is in force on the date(s) the care is approved and received;
- the service is a Qualified Long-Term Care Service covered under this **Agreement** and provided pursuant to a **Plan of Care**;
- **You** Incur Covered Expenses; and
- **You** have completed the **Deductible Period** that applies; and
- **You** have not exhausted the **Total Coverage Amount.**

Deductible Period

You must complete a **Deductible Period** before **We** will pay benefits. Once **You** meet the **Deductible Period**, **You** will never have to satisfy the **Deductible Period** again to be eligible to receive benefits. The Schedule of Benefits shows the number of days in the **Deductible Period**.

You do not need to satisfy the **Deductible Period** to receive the Respite Care Benefit or the Care Advisory Services Benefit. However, days on which **You** receive only these benefits cannot be used to meet the **Deductible Period**.

Days on which **You** are temporarily hospitalized while eligible for either **Nursing Home** or Residential Care Facility Benefits can be used to meet the **Deductible Period** if the **Nursing Home** or **Residential Care Facility** charges **You** a fee to reserve **Your** bed. Any day when covered services are reimbursed by any insurance or **Medicare** may be counted toward meeting the **Deductible Period**.

Only One Daily Benefit is Payable for a Single Day

If **You** are eligible for more than one of the following benefits, **We** will pay only one benefit for covered expenses for care on a single day:

- Respite Care Benefit; or
- Nursing Home Benefit; or
- Residential Care Facility Benefit

We will pay only the maximum benefit for which **You** are eligible.

Total Coverage Amount

This is the maximum amount that **We** will pay for all benefits covered under this **Agreement**. All benefits paid, except for the Care Advisory Services Benefit, count against the **Total Coverage Amount**. The **Total Coverage Amount** is shown in the Schedule of Benefits.

Timely Notification

It is important that **You** notify **Us** as soon as possible if it appears that **You** will need benefits covered by this **Agreement**. This lets **Us** better help **You** and **Your** family plan for the financial obligations of **Your** care. The Care Advisory Services Benefit can help identify the services **You** might need. This benefit is more useful to **You** if it is provided as soon as **You** need care. Even if **You** have not completed the **Deductible Period**, **We** urge **You** to contact **Us**.

Certain Exclusions May Apply

There are certain conditions under which benefits will not be paid under this **Agreement** even if **You** otherwise qualify for benefits. These Exclusions are outlined on page 32.

BENEFIT: NURSING HOME BENEFIT

You are eligible to receive a benefit for Covered Expenses **You** incur for **Nursing Home** care. The amount of the benefit **We** will pay and the conditions **You** must meet to receive the benefit are described below.

Covered Expenses

Covered Expenses for **Nursing Home** care means expenses **You** incur while **You** are an inpatient in a **Nursing Home**, for:

- room and board;
- ancillary services; and/or
- patient supplies provided by the **Nursing Home** for care of their residents.

We will not pay for any charges for **Your** comfort and convenience such as televisions, telephones, beauty care and entertainment.

Bed Reservation

If **You** become temporarily hospitalized while eligible for benefits under this provision, and the **Nursing Home** charges **You** a fee to reserve **Your** bed, **We** will pay expenses for the bed reservation up to the Nursing Home Daily Maximum for each day **You** are charged. **We** will pay these expenses for up to 14 days per hospitalization.

How Much Will We Pay?

Once **You** have satisfied the **Deductible Period**, **We** will pay 100% of **Your** Covered Expenses up to the Nursing Home Daily Maximum at the time the expenses are incurred for each day of **Confinement**. The Nursing Home Daily Maximum is shown in the Schedule of Benefits.

When Will Benefits End?

This benefit will be paid as long as:

- the Conditions for Receiving Benefits are met; and
- the **Total Coverage Amount** has not been reached. The **Total Coverage Amount** is shown in the Schedule of Benefits.

This benefit will not be paid on any day **You** are receiving Residential Care Facility Benefits or Respite Care Benefits.

BENEFIT: RESIDENTIAL CARE FACILITY BENEFIT

You are eligible to receive a benefit for Covered Expenses **You** incur while **You** are a resident in a **Residential Care Facility**. The amount of the benefit **We** will pay and the conditions **You** must meet to receive the benefit are described below.

Covered Expenses

Covered Expenses for Residential Facility Care means expenses **You** incur while **You** are a resident in a **Residential Care Facility**, for:

- room and board;
- ancillary services; and/or
- patient supplies provided by the Residential Care Facility for care of their residents.

We will not pay for any charges for **Your** comfort and convenience such as televisions, telephones, beauty care and entertainment.

Eligible Providers

In California, eligible **Residential Care Facility** providers are a subset of those facilities licensed as Residential Care Facilities for the Elderly and Residential Care Facilities (Health and Safety Code Section 1569). In other states, these facilities must be licensed by the appropriate federal or state agency to provide residential and personal care for at least 6 resident inpatients in one location.

A **Residential Care Facility** is not: a hospital or clinic, a place which operates primarily for the treatment of alcoholism, drug addiction or mental illness, a **Nursing Home**, **Your** primary place of residence in an area used principally for independent residential living, or a similar establishment.

Bed Reservation Feature

If **You** become temporarily hospitalized while eligible fo benefits under this provision, and the **Residential Car Facility** charges **You** a fee to reserve **Your** bed, **We** will pa expenses for the bed reservation up to the Residential Car Facility Daily Maximum for each day **You** are charged. **We** w pay these expenses for up to 14 days per hospitalization.

How Much Will We Pay?

Once **You** have satisfied the **Deductible Period**, **We** will pa 100% of **Your** Covered Expenses up to the Residential Car Facility Daily Maximum at the time the expenses are incurre for each day of **Confinement**. The Residential Care Facilit Daily Maximum is shown in the Schedule of Benefits.

When Will Benefits End?

This benefit will be paid as long as:

- the Conditions for Receiving Benefits are met; and
- the **Total Coverage Amount** has not been reached The **Total Coverage Amount** is shown in the Schedul of Benefits.

This benefit will not be paid on any day **You** are receivin Nursing Home Benefits or Respite Care Benefits.

BENEFIT: RESPITE CARE BENEFIT

Respite Care is temporary care provided to **You** to allow time off for those persons who ordinarily care for **You** on a regular basis. The amount of the benefit **We** will pay and the conditions **You** must meet to receive the benefit are described below.

What is Respite Care?

Respite Care is the supervision and care of persons with deficiencies in **Activities of Daily Living** or a **Severe Cognitive Impairment**, while the family or other individuals who normally provide care on a daily basis take short-term leave or rest that provides them with temporary relief from the responsibilities of caregiving.

Covered Expenses

Covered Expenses for **Respite Care** means:

- Covered Expenses for **Nursing Home** care; or
- Covered Expenses in a **Residential Care Facility**

Eligible Providers of Respite Care

Respite Care may be provided by a **Nursing Home** or a **Residential Care Facility**.

How Much Will We Pay?

We will pay 100% of **Your** Covered Expenses, for up to 15 days per calendar year when **You** receive **Respite Care**. **We** will pay this benefit only once per calendar year. Days on which **You** receive **Respite Care** do not need to be consecutive days.

Deductible Period Does Not Apply

You are not required to complete a **Deductible Period** before **We** will pay benefits for **Respite Care**. However, any day that **You** receive Respite Care Benefits may not be used to meet the **Deductible Period** for any other benefits under this coverage. Once **You** have met a **Deductible Period** and begin to receive covered services under this **Agreement**, no Respite Care Benefits are payable until **You** are no longer receiving other covered services. Expenses paid under this benefit reduce **Your Total Coverage Amount**.

When Will Benefits End?

This benefit will be paid as long as:

- the Conditions for Receiving Benefits are met; and
- the **Total Coverage Amount** has not been reached.

The **Total Coverage Amount** is shown in the Schedule of Benefits.

BENEFIT: CARE ADVISORY SERVICES BENEFIT

We will pay for **Care Advisory Services** that **You** receive when **You** are eligible for other benefits covered under this **Agreement**. **Care Advisory Services** help **You** identify **Your** specific care needs and the long-term care services and programs in **Your** area which can best meet those needs. The amount of the benefit **We** will pay and the conditions **You** must meet to receive the benefit are described below.

About the Care Advisory Services

Care Advisory Services provide **You** with the knowledge and training of a **Care Advisor** who will review **Your** unique situation and develop **Care Advisory Services Plans** to meet **Your** needs. The **Care Advisor** will:

- assess **Your** physical, cognitive, social and medical needs for care and services on an on-going basis;
- work with **You** to determine the specific services **You** require;
- develop and suggest initial and subsequent **Care Advisory Services Plans** to assist **You** in meeting **Your** needs;
- coordinate and monitor **Your** care needs on an on-going basis to help **You** receive appropriate care; and
- help **You** arrange for care, if **You** desire.

You or **Your** family should contact **Us** to arrange for the services of a **Care Advisor** as soon as **You** need to receive services.

Care Advisory Services Benefits are Voluntary

You are not required to use the Care Advisory Services Benefit, to follow the recommendations of the **Care Advisory Services Plan**, or to use the services or providers identified in the **Care Advisory Services Plan**. This benefit is advisory only.

However, all benefits paid under this coverage must be provided pursuant to a **Plan of Care** prescribed by a **Licensed Health Care Practitioner**.

Deductible Period Does Not Apply

You are not required to complete a **Deductible Period** before **We** will pay for **Your** Care Advisory Services Benefit.

Covered Expenses

Covered Expenses for **Care Advisory Services** means fees charged for **Care Advisory Services** provided by a **Care Advisory Services Agency** designated by **Us**.

How Much We Pay

We will pay 100% of Covered Expenses. Expenses **You** incur for **Care Advisory Services** will be billed directly to **Us**.

Expenses Will Not Reduce Your Total Coverage Amount

Expenses paid under the Care Advisory Services Benefit will not reduce **Your Total Coverage Amount** or **Your** Daily or Monthly Benefit Maximums.

When Will Benefits End?

This benefit will be provided as long as:

- the Conditions for Receiving Benefits are met; and
- the **Total Coverage Amount** has not been reached.

However, if **You** desire, **We** will provide a transition plan which specifies how **Your** care needs can best be addressed once the **Total Coverage Amount** has been reached. The **Total Coverage Amount** is shown in the Schedule of Benefits.

BENEFIT: INFLATION PROTECTION

The Schedule of Benefits shows whether **You** have elected to be covered by this benefit. If it does not appear on **Your** Schedule of Benefits page, then **You** do not have this provision. If **You** have elected the Inflation Protection Option, then this section describes how **Your** benefits will increase each year **Your** coverage is in force to help keep pace with inflation.

How Does this Benefit Work?

We will increase each of the following by 5% compounded annually each year as long as coverage remains in force:

- **Your** Nursing Home Daily Maximum; and
- **Your** Residential Care Facility Daily Maximum;

We will also increase any unused balance remaining in **Your Total Coverage Amount** by 5% compounded annually each year as long as coverage remains in force. The unused balance of **Your Total Coverage Amount** is the initial **Total Coverage Amount** reduced by the amount of any claims paid and increased by the coverage increases made since the **Coverage Effective Date**.

The increased amounts will be rounded to the nearest whole dollar.

When Will the Increases Become Effective?

The increase will be effective on each anniversary of **Your Coverage Effective Date** even if **You** are receiving benefits.

Your Premium Will Not Increase

Your premium rate will not increase as a result of these annual benefit increases.

BENEFIT: BENEFIT INCREASE OPTION

The Schedule of Benefits shows whether **You** have elected to be covered by this benefit. If it does not appear on **Your** Schedule of Benefits page, then **You** do not have this provision. If **You** have not elected the Inflation Protection Option, then this benefit lets **You** periodically increase **Your** coverage amounts to help offset the effects of inflation.

How Does This Option Work?

You will periodically be offered an option to increase:

- **Your** Nursing Home Daily Maximum;
- **Your** Residential Care Facility Daily Maximum; and
- Any unused balance remaining in **Your Total Coverage Amount** by an amount determined by **Us**.

This offer will be made every 36 months as long as **Your** coverage remains in force and **You** are not currently receiving benefits. The increased amounts will be rounded to the nearest whole dollar.

No Proof of Insurability is required

No proof of good health is required. As long as **You** are not currently receiving benefits, **You** may elect to increase **Your** coverage amounts by the amount offered.

Additional Premium for the Increased Coverage

The premium for the amount of increased coverage will be based on **Your** age at the time the option is offered.

How do You Put the Increase into Effect?

You must file a written request on the form **We** supply, indicating that **You** have accepted the option to increase coverage. This must be received by **Us** within 31 days after **We** send **You** notification of the option.

You May Decline the Offer

If **We** do not receive a written response from **You** within 31 days, **We** will deem this to be a declination of the Offer. **You** may decline the offer to increase coverage any time it is made, however, once **You** have refused this option twice, it will no longer be offered by **Us**. After that, if **You** want to increase **Your** coverage, **You** may apply to do so on **Your** own initiative. However, **You** must submit proof of **Your** insurability. The process for requesting an increase in coverage is described in the section on Coverage Provisions on page 51.

BENEFIT: RETURN OF PREMIUM DEATH BENEFIT

This benefit provides a full or partial return of premiums paid in the event of **Your** death if it occurs prior to age 75. The terms and conditions of this benefit are described below.

When Might this Benefit be Paid?

Upon receiving proof of **Your** death while this coverage is in force, **We** will return a percentage of the total amount of premiums paid for coverage until the date of **Your** death less any benefits **We** have paid under this coverage.

How Much Will We Pay?

The percentage of the total premium returned depends on **Your** age on the Coverage Anniversary on or before the date of **Your** death.

Age	Percentage of Premiums Paid
65 or less	100%
66	90%
67	80%
68	70%
69	60%
70	50%
71	40%
72	30%
73	20%
74	10%
75 or older	0%

To Whom is this Benefit Paid?

We will pay the Death Benefit to **Your** spouse if living. Otherwise, **We** will pay the Death Benefit to **Your** estate.

When Does this Benefit End?

No Death Benefit will be paid if **Your** death occurs at age 75 or later.

NONFORFEITURE BENEFIT

The Schedule of Benefits shows whether **You** have elected to be covered by this benefit. If it does not appear on **Your** Schedule of Benefits page, then **You** do not have this provision.

This optional benefit is only available at the time **You** submitted **Your Application**. It is not available as a coverage increase on **Your** anniversary.

This optional benefit provides a continuation of **Your** coverage up to a specified dollar amount if **Your** coverage lapses due to nonpayment of premium before the **Total Coverage Amount** has been reached. The conditions under which **We** will pay this benefit are described below.

How Does This Optional Benefit Work?

We will provide a reduced **Total Coverage Amount** if **Your** coverage lapses due to non-payment of premium after the Nonforfeiture Benefit under **Your** current **Agreement** has been in force for at least 10 years. This reduced **Total Coverage Amount** is called the Nonforfeiture Benefit Amount.

Nonforfeiture Benefit Amount

The Nonforfeiture Benefit Amount **We** will pay will be an amount equal to 90 times the applicable Nursing Home Daily Maximum at the time coverage lapses. **We** will pay up to the applicable **Nursing Home** and Residential Care Facility Daily Maximums for covered services **You** receive under this optional benefit, up to the Nonforfeiture Benefit Amount.

Will Inflation Protection Increases Apply to This Optional Benefit?

If **You** have elected the Inflation Protection Option, and it has been in force for at least 10 years at the time coverage lapses, **We** will calculate a Nonforfeiture Benefit Amount equal to 90 times the Nursing Home Daily Maximum in force at the time coverage lapses for non-payment of premium. In addition, the unused balance of **Your** Nonforfeiture Benefit Amount, the Nursing Home Daily Maximum, and the Residential Care Facility Daily Maximum will increase by 5% compounded annually on each anniversary of **Your Coverage Effective Date** following the date coverage lapses until the Nonforfeiture Benefit Amount is exhausted.

If the Inflation Protection Option has not been in force for at least 10 years, **We** will calculate a Nonforfeiture Benefit Amount equal to 90 times the highest Nursing Home Daily Maximum which has been in force at least 10 years. Payment for covered services will be made up to the highest Daily Maximums in force for at least 10 years.

Will Benefit Increases Apply to This Optional Benefit?

If the Daily Maximums in force at the time coverage lapses have been increased by the Benefit Increase Option, these increased amounts will only be included in the Nonforfeiture Benefit Amount **We** will pay if they have been in force for at least 10 years. If the Daily Maximums have been in force for less than 10 years, **We** will calculate a Nonforfeiture Benefit Amount equal to 90 times the highest Nursing Home Daily Maximum which has been in force for at least 10 years. Payment for covered services will be made up to the highest Daily Maximums in force for at least 10 years.

What if My Coverage Amounts Have Not Increased?

If **You** did not select a plan which included the Inflation Protection Option or if **You** did not accept any coverage increases under the Benefit Increase Option, then the Daily Maximums will remain at the same levels as when coverage lapsed due to non-payment of premium.

Will Plan Changes I Elect Apply to This Optional Benefit?

Any other coverage increases **You** elect to make under this **Agreement** must be in force for at least 10 years prior to the time coverage lapses before **We** will apply the coverage increases in determining the Nonforfeiture Benefit Amount, the applicable Daily Benefit Amount, and the services covered upon lapse. If the coverage increases have not been in force for at least 10 years, **We** will calculate a Nonforfeiture Benefit Amount equal to 90 times the highest Nursing Home Daily Maximum which has been in force for at least 10 years. Payment for covered services will be made up to the highest Daily Maximums in force for at least 10 years.

If the coverage in force at the time coverage lapses represents a decrease in coverage from what was initially issued, **We** will calculate a Nonforfeiture Benefit Amount equal to 90 times the Nursing Home Daily Maximum in force at the time coverage lapses and **We** will pay up to the Daily Maximums consistent with the type and amount of coverage in force at the time coverage lapses.

When Will Benefits End?

This optional benefit will be paid as long as:

- the Conditions for Receiving Benefits are met; and
- the Nonforfeiture Benefit Amount has not been reached.

ADDITIONAL BENEFITS

This section explains how **You** may receive a premium credit if a non-Medicaid government long-term care program is created and how **You** may obtain new benefits if **You** so desire.

Public Long-Term Care Program

In the event that the national government or the state government for the state in which **You** reside creates a Non-Medicaid long-term care program through public funding that substantially duplicates benefits covered by this **Agreement**, **You** will be entitled to a reduction in future premiums or an increase in future benefits. The amount of the premium reductions or increase in future benefits to be made by **Us** will be based on the extent of the duplication of covered benefits, the amount of past premium payments and **Our** claims experience. **Our** premium reduction or increase in future benefits plan must be approved by the CalPERS Board prior to implementation.

Right to Acquire New Benefits/Provisions

We will notify **You** of any new benefits or provisions that become available in the future that are not included in **Your** original **Agreement**, provided that **You** are not currently receiving benefits. **You** will be given the opportunity to acquire the new benefits and/or provisions that become available within twelve months of their availability. If **You** elect to acquire the new benefits and/or provisions, **You** will be required to provide an **Application** and proof of insurability in a form and manner specified by **Us**. If **We** approve **Your Application**, **We** will recognize **Your** past covered status by granting a premium credit that reflects the value of **Your** original coverage and that will apply toward all subsequent premium payments for the new coverage.

ALTERNATIVE CARE PAYMENT PROVISION

We Reserve the Right to Authorize Alternative Benefits and Services

Subject to all exclusions outlined in the Evidence of Coverage, **We** reserve the right to authorize benefits for providers, treatments, or services not otherwise specified in the Evidence of Coverage, or when conditions specified in this **Agreement** are not otherwise met, if **We** determine that it:

- is cost-effective;
- is appropriate to **Your** needs;
- is consistent with general standards of care;
- provides **You** with an equal or greater standard of care; and
- meets all requirements for **Qualified Long-Term Care Services** under federal law.

Any alternative benefits, treatments or services **We** authorize must also be agreed to by **You** or **Your Representative** and **Your Physician**, if appropriate.

Expenses paid under the Alternative Care Payment Provision will reduce **Your Total Coverage Amount**. **We** also reserve the right to decline to authorize alternative benefits and services.

EXCLUSIONS

This part explains the conditions under which benefits will not be paid even if **You** otherwise qualify for benefits.

What Expenses are Not Covered?

We will not pay benefits under this Evidence of Coverage for:

- Care for which no charge is normally made in the absence of insurance;
- Care provided by a government facility, unless **You** are legally obligated to pay for the treatment;
- Care **You** receive while **You** are outside the United States of America or its possessions;
- Care provided by **Your Immediate Family** unless the family member is a regular employee of an organization providing the care, the organization receives payment for care and the family member receives no compensation other than the normal compensation as an employee; or
- Expenses which result while attempting or committing a felony following conviction, engaging in an illegal occupation or participating in a riot or insurrection.

COORDINATION OF BENEFITS

We will not pay benefits which duplicate benefit payments from any insurance coverage or any other source to which **You** are entitled or which are payable under **Medicare** or would be payable under **Medicare** except for the application of a deductible or coinsurance or other government programs except Medicaid (Medi-Cal in California). **We** will pay the difference between **Your** actual expenses and the benefits payable by all other sources (except for the deductible and coinsurance amounts under **Medicare**), but **Our** payments will not exceed the amount **We** would have paid in the absence of other coverage. However, if **Your** other coverage denies payment to **You** for a service that **We** cover, **We** will pay the benefit as outlined in this **Agreement**.

CLAIMS INFORMATION AND HOW BENEFITS ARE PAID

This section tells **You** how **We** evaluate and pay claims. It also tells **You** when to notify **Us** and what information to send **Us** so that **We** can process **Your** claims.

How Do You File a Claim?

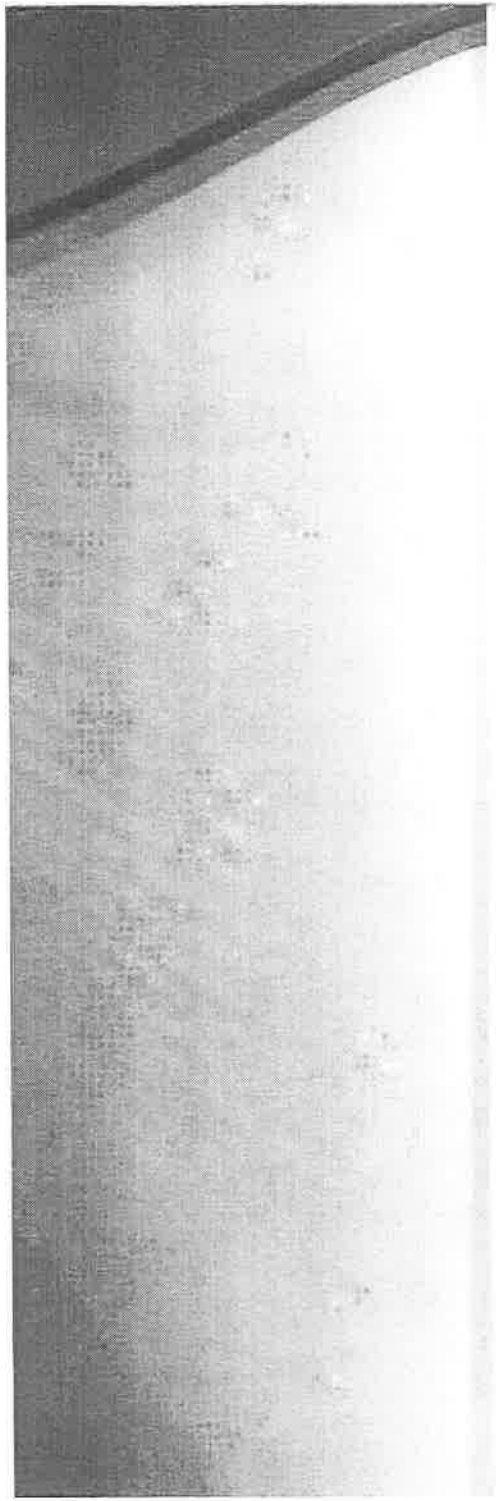
To file a claim, **You** or **Your Representative** may call **Us**, notify **Us** in writing or submit a completed claim form **We** provide.

Notify Us as Soon as Possible

We can handle **Your** claim request more efficiently if **We** are notified as soon as possible. **We** prefer that **You** notify **Us** as soon as **You** first become disabled to the extent that **You** may soon need care covered by this **Agreement**. Notify **Us** even if **You** are unsure, and **We** can help **You** determine whether or not **You** are eligible for benefits.

How are Claims Evaluated?

When notice of claim is received, **We** will collect the information **We** need to determine whether **You** meet the Conditions For Receiving Benefits. **We** may arrange for an **Assessment**, which will be performed at no cost to **You**. The **Assessment** verifies the degree of loss of **Your** functional and/or cognitive ability. The **Assessment** will be performed by a trained health care professional designated by **Us**. **We** will also request permission to contact **Your Physician** or other care provider and to review **Your** medical records. Based on the evaluation of all the information, **We** will determine **Your** eligibility for benefits.



We will not pay benefits until **Your** eligibility for benefits is determined. If **You** are determined to be eligible for benefits, **We** will arrange for a **Care Advisory Services Plan** to be developed. The **Care Advisory Services Plan** must be developed, performed and monitored by a **Care Advisory Services Agency** designated by **Us**.

Written Notification

You will be notified in writing whether or not You are eligible for benefits. We will notify You within 10 days of receiving all the information We need to make the determination. If We certify that You are eligible for benefits, Our written notice will state:

- the benefits **You** are authorized to receive and, if appropriate,
- when **We** will again require an **Assessment** to determine whether **You** continue to be eligible for benefits.

Information We Need From You To Process Your Claim

You or **Your Representative** should provide written documentation regarding **Your** condition, **Your** needs for benefits under this coverage, and costs **You** may have incurred. This information should be provided to **Us** within 90 days of the occurrence, or as soon thereafter as possible. The additional time allowed cannot exceed one year unless **You** are legally incapacitated. If **You** desire, the **Care Advisor** can assist **You** in providing written documentation, as specified above.

When Will Benefit Payments be Made?

Once **You** have completed the **Deductible Period**, benefit payments will be made on a monthly basis after receipt of **Your** claim as long as the loss and **Our** liability continue.

Direct Payment of Benefits to Care Provider (Assignmen of Benefits)

You may instruct **Us** to pay any **Nursing Home** or **Residenti Care Facility** Benefits due **You** under this coverage directly t a person or organization that provided the care for which W are reimbursing Covered Expenses. However, **You** must notif **Us** in writing. No assignment under this **Agreement** shall b binding upon **Us** unless a copy is on file at **Our** Office. **We** d not assume any responsibility for the validity or effect of a assignment.

To Whom Will We Pay Benefits?

If **You** are living, **We** will pay benefits to **You**. If **You** qualify fo a benefit while **You** are not competent, **We** will pay the benefi to **Your** guardian or other legally appointed **Representative**.

Any benefits unpaid at **Your** death will be paid to **Your** estate.

In the event of **Your** death, or if **You** qualify for benefits while **You** are not competent and **You** do not have a guardian o legally appointed **Representative**, **We** may pay up to $1,000 to any relative of Yours who **We** find is entitled to it. Any payment made in good faith will fully discharge **Us** to the extent of the payment.

Can We Ever Deny a Claim or Void Coverage Due to Misstatement?

All statements made by **You** on the **Application** Form will be deemed representations and not warranties. No statement made to effect this coverage will void the coverage or reduce benefits unless it is in writing and signed by **You**.

Material misstatements in **Your Application** can be used to void the coverage or deny any claim for up to two years after the **Coverage Effective Date**. Thereafter, only fraudulent misstatements in the **Application** may be used to void coverage or deny any claim for loss incurred after the two year period. Material misstatements are those that would have caused coverage not to have been issued based on the eligibility and underwriting standards in effect at the time.

You Have the Right to Appeal

While **You** are covered under this **Agreement**, if **You** disagree with **Our** decision regarding **Your** eligibility for benefits or other aspects of **Your** claim, **You** may request that **We** reconsider **Your** claim. **You** should submit any further written information or material **You** feel may have a bearing on the claim. **You** should include the names, addresses and phone numbers of any care providers who **You** think **We** should contact to learn more about **Your** claim. Once **We** complete **Our** review, **You** will be notified in writing of **Our** decision.

Upon request by **You**, **We** will release the information used to determine benefit eligibility. Medical information will be released to a **Physician** or an attorney designated by **You**. **We** will release any other information directly to **You** or **Your Representative**.

Reconsiderations and Appeals

The procedures for any reconsiderations or appeals are described on page 47.

PREMIUM PAYMENT PROVISIONS

You must pay the premiums for **Your** coverage either by direc billing or payroll/pension deductions. **Your** first premium is du on the **Coverage Effective Date**. The premium mode in th Schedule of Benefits shows how **You** have elected to pa premiums.

Waiver of Premium While You Receive Benefits

We will waive the payment of premium which becomes du when the coverage is in force and **You** are receiving an benefits, except for Respite Care Benefits. **We** will waiv premiums beginning the first day **You** receive benefits. W will refund the unearned premium amount paid for period beyond that for which the waiver begins.

As long as **You** continue to receive benefits, additiona premiums will not be required.

At the end of the period for which the last premium has been waived, **You** will be required to pay the pro-rata premium needed to return the coverage to its previous premium payment mode. **You** must pay future premiums as they become due, either through direct billing or through payroll/pension deductions.

Refund of Premiums Paid Beyond Your Death

If **You** die while covered under the **Agreement**, **We** will refund the pro rata part of any premium paid or deducted for a period after **Your** death. The refund will be made within 30 days of **Our** receipt of written notice of **Your** death. It will be paid to **Your** estate.

Can Premium Rates Ever Change?

The premium rates shown in the Schedule of Benefits may be changed on the anniversary of **Your Coverage Effective Date** and on any premium due date thereafter. Any changes made will be on an issue age basis for all similar coverage issued in **Your** state on the same form as this coverage, and made by action of the CalPERS Board of Administration, according to the criteria they establish.

What are Your Options if Premium Rates Change?

If premium rates are increased on a class basis, **You** will have the option of:

- maintaining **Your** current benefits at the increased premium rate; or
- electing a decrease in coverage to a coverage amount **We** offer that maintains or reduces **Your** current premium. The procedure for decreasing coverage is described in the section on Coverage Provisions on page 51.

Written Notice of Premium/Automatic Election

We will give **You** written notice of any proposed change in **Your** premium rates at least 60 days in advance of such change. Unless **You** notify **Us** within 28 days after receiving **Our** notice, **You** will be considered to have elected to maintain **Your** current benefit amount at the increased premium rate.

Payment Adjustments

Adjustments that result in overpayment of premiums will be refunded to **You**.

Changes to Your Premium Payment Frequency or Method

If **Your** premiums are paid by payroll or pension deduction an withholding cannot be accomplished due to inadequate funds **We** reserve the right to convert **You** to direct-billing. In thi situation, **You** are entitled to request to change back to payro or pension deduction once per year. Changes exceeding th one-time change may only occur at the discretion of th **Administrator**. **We** require a written request for change to b received in **Our** offices 30 days prior to the next payroll/pensio deduction of premium.

You are responsible for notifying **Us** if **Your** employment o retirement status changes so that payroll or pension deductio is not possible, or if **You** wish to change **Your** direct billing frequency. **Your** written request to change must be received i **Our** offices 30 days prior to the requested effective date for the change. **We** will change **Your** billing frequency as of the first o the month following receipt of the request.

GRACE PERIOD, COVERAGE LAPSE, AND REINSTATEMENT PROVISIONS

What Happens When Premiums Are Not Paid? (Grace Period)

This **Agreement** has a 65-day Grace Period. This means that if a premium is not paid on or before the date it is due, it may be paid during the following 65 days. **We** will continue coverage during the Grace Period.

If **You** pay through direct billing and **Your** premium is not paid during the Grace Period, **Your** coverage will terminate at the end of the Grace Period back to the last date through which premiums were paid. This is called a lapse. A lapse will not affect any claim for care received before **Your** coverage terminates.

If a third party (an employer payroll or a pension administrator) who is responsible for remitting premiums on **Your** behalf fails to remit premiums withheld from **Your** payroll or pension check within the Grace period, **Your** coverage will not lapse. However, **We** will reserve the right to convert **Your** premium payments to direct billing. **We** will notify **You** if this happens.

Notification of Nonpayment

If **Your** premium is paid through direct billing and if **Your** premium is not paid within 30 days of the premium due date, **We** will provide written notice of nonpayment to **You** and a third-party **You** have designated to receive this notice (if applicable) at the address **You** provided for purposes of receiving notice of nonpayment. **You** have 35 days after **We** mail this notice to pay the premium. **Your** coverage will stay in force during this time unless **We** receive a written request from **You** to cancel it. If **We** do not receive the premium payment within these 35 days, **Your** coverage under this **Agreement** will lapse.

How Can the Agreement be Reinstated?

You may apply for reinstatement by writing to **Us**. **You** will be asked to complete an application for reinstatement. Completed reinstatement applications must be received by **Us** within 1 year after the end of the Grace Period. **We** have the right to require evidence of insurability. If approved, coverage will be reinstated retroactive to the date of termination of coverage if the required premium is paid. **We** have the right to decline a request for reinstatement of coverage.

Any premium accepted in connection with a reinstatement will be applied to the period for which premium was not previously paid. In all other respects, **You** will have the same rights under the **Agreement** as **You** had prior to the premium due date of the defaulted premium.

Protection Against Lapse

If **Your** coverage terminates before **Your** benefits have been exhausted, **We** will provide a continuation of coverage as specified below:

To be eligible for this continuation, **You** must provide **Us** with proof that, beginning on or before the date of termination and continuing without interruption, **You** have had either:

- A **Severe Cognitive Impairment**; or
- A functional impairment to the extent that **You** cannot perform three (3) or more of the **Activities of Daily Living** without **Substantial Assistance**.

The proof must be in the form of a certification and **Assessment** from a **Physician** (or other proof approved by **Us**) which demonstrates the existence of **Your Severe Cognitive Impairment** or the functional impairment. The proof must be provided to **Us** within 5 months of the termination date. **You** must pay all past due premiums for the coverage that was in force immediately prior to the date of lapse.

This continuation will provide uninterrupted coverage to the same extent that the **Agreement** in force immediately prior to the termination date would have provided if it had not terminated. If **You** become eligible for benefits during the continuation period, they will be payable, subject to terms and conditions of the **Agreement**.

BASIC CONTRACT PROVISIONS

The Contract

This **Agreement** with **Your Application** and the attached papers, if any, is the entire contract between **You** and **Us**. No change in this **Agreement** will be effective until approved in writing by **Us**. This approval must be noted on or attached to this **Agreement**.

Can This Agreement Be Changed?

This **Agreement** can only be changed without **Your** consent if the change does not reduce or eliminate benefits or coverage. **We** cannot change this **Agreement** without **Your** consent if the change results in an increase in benefits or coverage with a concomitant increase in premium, except if the increased benefits or coverage are required by law. Any change will be without prejudice to any claim incurred for benefits prior to the date of the change.

Contesting Coverage

Time Limit on Certain Defenses. After 2 years from the **Coverage Effective Date**, only fraudulent misstatements in **Your Application** may be used to void this coverage or deny any claim for loss incurred or disability that starts after the 2-year period.

What Happens if Your Age is Incorrectly Stated?

If **Your** age has been incorrectly stated, **Your** coverage will be adjusted to a coverage amount offered by CalPERS which **Your** premium would have purchased at the correct age. This could result in a reduction of coverage. Or You may elect to maintain **Your** existing coverage by paying the amount of additional premium due based on **Your** true age on the original **Coverage Effective Date**.

Time Periods

All time periods begin and end at 12:01 a.m. where the **Agreement** is delivered.

Conformity with State Statutes

Any provision of this **Agreement** which, on the **Coverage Effective Date**, is contrary to the applicable laws of the jurisdiction in which **You** live on that date, is amended to conform to the minimum requirements of such laws.

Clerical Error

Clerical error by **Us** or **Our** designees in keeping the records having to do with the **Agreement**, or delays in making entries on the records, will not void **Your** coverage if **Your** coverage would otherwise have been in effect. Such clerical error will not extend **Your** coverage if **Your** coverage would otherwise have ended or been reduced as provided by the **Agreement**. If a clerical error is found, premiums and benefits will be adjusted based on the true facts and the provisions of the **Agreement**.

Your Right to Cancel the Agreement at Any Time

You may cancel the **Agreement** at any time by sending **Us** written notice. If **You** are paying **Your** premiums by payroll or pension deduction, **We** require a written request for termination to be received in **Our** offices 30 days prior to the next payroll/pension deduction of premium. **We** will terminate the **Agreement** as of the end of the next available payroll/pension end date.

If **You** are paying premiums by direct bill, **We** must receive **Your** request for termination 30 days prior to **Your** requested termination date. **We** will terminate direct bill **Agreements** the last day of the month for which notice is received.

We will promptly return the unearned portion of any premium paid. The cancellation will not prejudice any claim for care received before the effective date of the cancellation.

RECONSIDERATIONS AND APPEALS

This section describes how **You** can request reconsideration or appeal decisions **We** make under this **Agreement**.

What Procedures Will be Followed?

Any issue related to the terms and conditions of this **Agreement**, including requests for review of denied claims, shall be resolved in accordance with the procedures outlined below.

Reconsideration Process

You may request in writing that **We** reconsider **Our** decision. **You** should submit **Your** request within 60 days of the event which gave rise to the issue. A detailed, written description supporting **Your** position should be sent to **Us** including **Your** name, Coverage ID number, claim number (if applicable), and any further information or material **You** feel may have a bearing on the decision made. If **You** are requesting reconsideration on a claim, please submit the names, addresses and phone numbers of any care providers with information regarding **Your** loss. **You** are responsible for the expense of securing additional information, if applicable, for each instance of reconsideration.

Release of Information

Upon request by **You**, **We** will release the information used to determine benefit eligibility. Medical information will be released to a **Physician** or an attorney designated by **You**. **We** will release any other information directly to **You**.

Appeals Process

If **You** disagree with the decision based on the reconsideration process, **You** may present information and arguments in writing and accompanied by documentation to support **Your** position to **Us** within 60 days of the reconsideration decision. **We** will submit **Your** position to a special Long-Term Care Appeals Unit.

Timeframe for Responding to Reconsiderations or Appeals

All decisions regarding reconsiderations or appeals handled by **Us** or by the Long-Term Care Appeals Unit will be made within 60 days after receipt of complete information from **You** or **Your Representative**. However, if special circumstances require an extension of time to reach a final decision, written notice of the final decision will be sent to **You** as soon as possible following the expiration of the initial 60 day period, but no later than 120 days following receipt of the request for review. If special circumstances require an extension of time, written notice of the extension will be furnished to **You** prior to the expiration of the initial 60-day period. **You** will be notified in writing of **Our** decision.

You May Request an Administrative Hearing

If the issue remains unresolved and **You** wish to appeal for further review, **You** shall submit the facts and the law upon which the appeal is based to **Us** within 60 days. Within 30 days of receipt of an appeal, **We** will forward the appeal, claim file (if applicable) and all pertinent information to the CalPERS Legal Office to initiate and handle the administrative hearing. CalPERS Legal Office will prepare and file a Statement of Issues and set the matter for hearing before an administrative law judge employed by the Office of Administrative Hearings. These hearings are conducted in accordance with the Administrative Procedure Act (Government Code Section 11500 et seq). If **You** are unrepresented by an attorney, **You** should become familiar with this law and its requirements if **You** choose to appeal at this level.

After the administrative hearing, the Administrative Law Judge will issue a proposed decision which the CalPERS Board of Administration must adopt before it can be effective. The Board may either adopt or reject the proposed decision. If it adopts a proposed decision which is unfavorable to **You**, **You** may request that the Board reconsider its decision. **You** must make a request for reconsideration to the Board within 30 days of the date of the Board's decision which **You** contest.

If the Board rejects a Proposed Decision, a hearing before the Board is required, and automatic. The Board will set a date for such hearing and notify **You** or **Your Representative** of the date.

If **You** disagree with a final decision of the Board, **You** have a right to seek court review. **You** must file with the court, generally, within 30 days after the date that the Board makes its final decision.

You May Request Arbitration

As an alternative to court action, **You** may seek review of the Board's action through binding arbitration. The matter must be submitted to binding arbitration within 1 year of the date the final decision was furnished to **You** or within 1 year of the date the claim, complaint or dispute was deemed denied on review. The arbitrators shall have no power to award any punitive or exemplary damages or to vary or ignore provisions of this **Agreement** and shall be bound by controlling law.

COVERAGE PROVISIONS

Who is Eligible to Apply for Coverage?

Active and retired members and annuitants of all California Public Retirement Systems, their spouses, parents, and parents-in-law are eligible to apply for coverage.

Coverage Continues Even if Your Eligibility Status Changes

If **You** terminate **Your** employment or make a change in **Your** eligibility status after **Your** coverage has been issued, this **Agreement** will not terminate as a result of this change. **Your** coverage will continue. However, **You** may need to change **Your** mode of premium payment from payroll/pension deduction to direct bill, if payroll/pension deduction is no longer available. **You** are responsible for notifying **Us** of any changes to **Your** status.

Evidence of Insurability Will Be Required

Individuals eligible to apply for coverage under this **Agreement** are required to provide evidence of insurability in a form and manner specified by **Us**.

The Agreement Taking Effect

You will become covered by this **Agreement** on the **Coverage Effective Date** shown on the Schedule of Benefits, subject to the payment of the required premium. If **Your** premium is payroll or pension deducted, **Your Coverage Effective Date** will be the next available payroll/pension start date after the first premium deduction has been withheld. If **You** are directly billed for **Your** premiums, **Your Coverage Effective Date** will be the first of the month following the date **Your Application** is approved by **Us**.

You May Elect to Increase Your Coverage

You have the right to increase **Your** coverage on each anniversary of **Your Coverage Effective Date** to a coverage amount that CalPERS is then currently offering. **You** will be required to provide an **Application** and proof of insurability in a form and manner specified by **Us**. The premium for the increased coverage will be based on **Your** age on the new **Coverage Effective Date**. The premium for the previously purchased coverage as of the original **Coverage Effective Date** will not be affected.

When Increases in Coverage Become Effective

If **You** make a written application to increase coverage and the request is approved, the increase will become effective on the first day of the billing period following the date **We** approve the request if the required premium is paid.

You May Elect to Decrease Coverage

After one year from the **Coverage Effective Date**, **You** have the right at any time to reduce **Your** premiums by changing to a coverage amount currently offered by CalPERS that represents a decrease in coverage. The premium for the reduced coverage will be based on **Your** original issue age for the reduced coverage.

We will notify **You** of this right to reduce coverage if **Your** coverage is about to lapse and in the event that premiums are increased.

If **You** request a change in coverage to a plan that represents a decrease in coverage, **You** will not be required to provide proof of insurability.

When Does Your Coverage End?

Your coverage terminates on the first to occur of:

- the date of **Your** death;
- the date **You** have received the maximum benefits allowed under this **Agreement**; or
- the last date through which premiums have been paid if the amount due is not received within the Grace Period.

Termination of long-term care coverage shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care coverage was in force and continues without interruption after termination.

In all instances, premium paid for periods after coverage has terminated will be returned.

The CalPERS Long-Term Care Program is administered by:
Long Term Care Group, Inc.
CalPERS Long-Term Care Program
Route CAL-07-P
PO Box 5708
Hopkins, Minnesota 55343-5708
1-800-982-1775