Continental Casualty Company

CNA Plaza A Stock Company
Chicago, Illinois 60685

THIS CERTIFICATE IS A QUALIFIED LONG TERM CARE INSURANCE CONTRACT AS DEFINED UNDER SECTION 7702(B) (b) OF THE INTERNAL REVENUE CODE OF 1986. BE SURE TO CONSULT WITH YOUR TAX ADVISOR.

Certifies that the Insured is covered under the Policy.

"We,"Our," and "Us" are used to refer to the Continental Casualty Company. The Insured is the person named in the Certificate Identification.

This certificate is not the Policy. It is evidence of the Insured's coverage under the Policy. Coverage is subject to the Policy provisions. The Holder has the Policy. The Insured may inspect it at the Holder's office during normal business hours.

The Policy is not a Medicare Supplement policy. If the Insured is eligible for Medicare, the Medicare Supplement Buyer's Guide is available from Us for review.

NOTICE OF RIGHT TO EXAMINE CERTIFICATE

It is important to us that the Insured understands this certificate. If the Insured is not satisfied with it for any reason, the Insured may return it, within 30 days of its delivery, to the address shown below or to the agent through whom coverage was obtained. We will then refund any premium paid and consider coverage to have never been put in force.

Caution: If the Insured submitted evidence of insurability for Our approval, then issuance of coverage is based upon the Insured's responses to the questions in the individual application for coverage. If the Insured's answers are incorrect or untrue, We have the right to rescind coverage, subject to the Incontestability provision.

Any misstatement of age in the Insured's enrollment form or individual application, as applicable, will be handled as stated in the Misstatement of Age provision.

A copy of the Insured's individual application or enrollment form, as applicable, is attached to this certificate. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of the Insured's answers are incorrect, contact Us at this address:

Continental Casualty Company
PO Box 946760
Maitland, FL 32794-6760

Notice to Buyer: The Policy may not cover all the costs associated with Long Term Care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

Signed for the Continental Casualty Company at its Home Office, CNA Plaza, Chicago, Illinois 60685.

Chairman of the Board

Secretary

GROUP LONG TERM CARE INSURANCE CERTIFICATE

SCS1BA-22-TQ
SR-LTCC-22-TQ

EFFECTIVE DATE AND TERM

The Policy starts on the Policy Effective Date. The Insured's coverage starts on the Insured's Effective Date stated in the Certificate Identification. It stays in force for the period for which premium has been paid.

The Insured's coverage may be continued in force, as provided in the Continuation of Coverage Due to Termination and in the Continuation of Coverage Due to Death or Divorce of Spouse provisions, if the Policy is not renewed or the Insured is no longer in a class eligible for coverage.

SCS3AA

CERTIFICATE IDENTIFICATION

Insured:

Date of Birth:

Address:

Holder:

Policy No.: XXXXXXX (“the Policy”)

Certificate No.:

Policy Effective Date:

Insured’s Original Effective Date:

Insured’s Current Coverage Effective Date:

(PLEASE NOTE THAT THIS SCHEDULE PAGE REPLACES ANY SCHEDULE PAGE PREVIOUSLY ISSUED TO YOU.)

SCHEDULE OF BENEFITS

Certificate Examination Period:

Premium Payment Mode:

Premium Due Dates:

Premium:

Long Term Care Benefit:

Waiting Period:

Lifetime Maximum Benefit:

Hospice Care Facility Benefit:

Emergency Alert System Benefit:

Care Assist Benefit:

Caregiver Training Benefit:

Temporary Bed Holding Benefit.

Guaranteed Benefit Increase:

Refund of Premium at Death

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DEFINITIONS

The terms defined here are capitalized whenever they are used.
SGD1AA

Alternate Care Facility means a facility or other supportive residence which is engaged primarily in providing ongoing care and related services to residents in one location and meets all of the following criteria:

1. Provides 24 hour care and/or supervision and is able to provide Qualified Long Term Care Services sufficient to support needs resulting from the Insured being Chronically Ill.
2. The facility has at least one supervised, trained and ready to respond employee on duty at all times to provide care;
3. Offers 3 meals a day and accommodates special dietary needs;
4. Is licensed or accredited by the appropriate agency to provide such care, if such licensing or accreditation is required by the state in which care is received, or, if licensing is not required, has a quality of care program;
5. Maintains specific policies and procedures, consistent with state requirements, for handling medical emergencies and trains staff to follow those procedures;
6. Maintains accessible files or records for each resident which includes up to date information listing that resident's physician, dentist and other community based health care providers;
7. has appropriate methods and procedures for recording, handling and administering drugs and biologicals, as needed; and
8. If the facility provides dementia care, has a secured physical plant and specialized dementia programs.

Alternate Care Facility does not mean a Long Term Care facility, hospital or clinic, assisted living facility not meeting the above criteria or a place which operates primarily for the treatment of alcoholics or drug addicts. However, care or services for assisted living facilities not meeting the Alternate Care Facility definition may be covered subject to the conditions of the Alternate Plan of Care provision.
SGDAC1AA

Community Based Care consists of the categories of care listed and defined below.

(a) Home Health Care means the following types of care when received from a Home Health Care Provider at the Insured's Residence:

(1) Occupational, physical, respiratory or speech therapy, or nutritional services;

(2) Nursing care performed by a registered nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN);

(3) Personal Care Services provided by a home health care aide or by a medical social worker;

(4) Maintenance Services provided by a home health care aide or homemaker; or

(5) Hospice care.

A **Home Health Care Provider** is an entity which:

(1) Has an agreement as a provider of Home Health Care under Medicare; or

(2) Is certified or licensed by the state in which it is located as a provider of such care; or

(3) Is accredited as a provider of such care by the National League of Nursing, American Public Health Association or Joint Commission on Accreditation of Healthcare Organizations.

A **Home Health Care Provider** may also be an RN, LPN or LVN working within the scope of his or her license.
SGDH1CB-TQ

(b) **Adult Day Care** means a community based group program of health, social and related support services for 6 or more individuals provided during the day in a community group setting. Services must be provided for the sole purpose of supporting impaired elderly or other disabled adults who can benefit from care in a group setting outside of the home. It does not include 24-hour care. The facility providing this type of care must meet the certification or licensing requirements, if any, of the state in which it is located. If the state does not certify or license adult day care centers, the facility must be certified by a recognized accrediting agency.
SGDH2AA-22

(c) **Assisted Living Care** means Qualified Long Term Care Services provided by a living arrangement in a facility other than an Alternate Care facility for Insureds whose condition is such that it precludes total independent living, but which does not require the level of care available in a Nursing Home. The facility must charge separately for room charges and board/rent charges.
SGDH3CA

(d) **Adult Foster Care** means a facility providing 24 hour care other than a Nursing Home for Insureds whose condition is such that they cannot live alone, but whose needs can be met in a private home. The provider of this type of care must be certified or licensed by the state in which it is located.
SGDH4AA-22

Disability means any disorder resulting in the Insured being Chronically Ill.
SGD28AA-TQ

Eligible Expense means the actual expense incurred by the Insured for Long Term Care and other services covered by the Policy. For Community Based Care, it does not include the cost of transportation (except for Adult Day Care), supplies and rent or those costs which the Insured would incur regardless of whether the Insured is Chronically Ill.
SGD2AA-TQ

Hospice Care means care designed to alleviate the physical, emotional, social and spiritual discomforts resulting from the last stages of a terminal disease and to provide emotional support to the primary caregiver and family.
SGD20AB

Insured means the eligible person whose coverage is in force under the Policy.
SGD3AA

Insured's Residence means wherever the Insured lives, except a hospital or Nursing Home.
SGD4AA

Licensed Health Care Practitioner means any physician, registered professional nurse (RN) or licensed social worker, acting within the scope of his or her license.
SGD24AA-TQ

Lifetime Maximum Benefit means the most we will pay in benefits due to the Insured who has been certified to be Chronically Ill. This maximum is stated in the Schedule. All amounts paid to the Chronically Ill Insured, under any benefit provision in or attached to the Policy, including the Alternate Plan of Care Benefit, count towards the maximum.
SGD5AA-TQ

Long Term Care means Qualified Long Term Care Services providing Nursing Home or Alternate Facility Care, Hospice Care, Informal Care and/or Community Based Care.
SGD6IA-TQ

Loss of Functional Capacity means requiring the substantial assistance of another person to perform the prescribed Activities of Daily Living.
SGD34AA-22

Maintenance Services means any care which is received due to the Insured having a Disability, including the protection from threats to health and safety due to a severe Cognitive Impairment. This may include homemaker services such as cooking, cleaning, laundering, organizing bills for payment and running errands.
SGD29AA-22-TQ

Master Application means the Holder's application attached to the Policy when issued.
SGD7AA

Nursing Home means a place which:

(a) Is licensed as a nursing home under Chapter 144A of Minnesota Statutes Annotated ;

(b) Is licensed as a boarding care home under Sections 144.50 to 144.56 of Minnesota Statutes Annotated and certified as an intermediate care facility for purposes of the medical assistance program; and

(c) In states other than Minnesota, meets licensing and certification standards comparable to those that apply to the facilities described in clauses 1. and 2.
SGDN1AA-22

Nursing Home Care means care received in a Nursing Home.
SGDN2AA-22

Personal Care Services means assistance with Activities of Daily Living or similar personal assistance such as walking, using a wheelchair, walking with braces or walker, a cane or other walking aid device.
SGD25AA-TQ

Plan of Care means a program of care and treatment initiated by and approved in writing by a Licensed Health Care Practitioner.
SGD26AA-TQ

Qualified Long Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services and Maintenance or Personal Care Services, which:

1. are required by a Chronically Ill Insured, and
2. are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

SGD27AA-22-TQ

Schedule means the schedule of benefits.
SGD8AA

Waiting Period means the number of days of Long Term Care, stated in the Schedule, which the Insured must receive due to the same or a related condition before the Long Term Care Benefit becomes payable.
SGD9AA

Waiver of Premium Qualification Period means the number of days of Long Term Care, stated in the Schedule, which the Insured must receive before we start to waive premiums.
SGD10AA

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

SGDE1AA

Chronically Ill means an Insured who has been certified by a Licensed Health Care Practitioner as being unable to perform (without substantial assistance from another individual) at least 2 Activities of Daily Living for a period of 90 days, due to a Loss of Functional Capacity or requiring Substantial Supervision to protect the Insured from threats to health and safety due to a Severe Cognitive Impairment.

The Insured will not be considered Chronically Ill unless within the preceding 12 months a Licensed Health Care Practitioner has certified that the Insured meets the above requirements.
SGD23BA-22-TQ

Activities of Daily Living Impairment means the Insured's inability to perform without human assistance or substantial supervision from another person at least two of the Activities of Daily Living listed and defined below**.**
SGD22AA-TQ

Bathing. Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
SGDQ2CA-9

Continence. The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag.
SGDQ2BA-6

Dressing. Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
SGDQ2BA-2

Eating. Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
SGDQ2BA-1

Toileting. Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
SGDQ2BA-3

Transferring. Moving into or out of a bed, chair or wheelchair.
SGDQ2BA-8

Severe Cognitive Impairment means a loss or deterioration in the Insured's intellectual capacity that is measured by clinical evidence and standardized tests that reliably measures impairment in the following areas:

1. Short term or long term memory,
2. Orientation as to people, places or time, and
3. Deductive or abstract reasoning.

SGDQ3EA

Substantial Supervision means continual supervision, which may include cuing by verbal prompting, gestures, or other demonstrations, by another person that is necessary to protect the severely cognitively impaired Insured from threats to his or her safety.
SGD32AA

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

Exclusions - We will not pay benefits for the following:
SGL2AA

1. Loss due to or resulting from war or an act of war whether declared or undeclared.
SGL2AA-1

2. Long Term Care to the extent that benefits are payable under Workers' Compensation, the Occupational Disease Act or Law, or a group health plan. However, the days on which Long Term Care is received will count towards satisfying the Waiting Period and Waiver of Premium Qualification Period, subject to the provisions of the Policy.
SGL2AA-2-22-TQ

3. Long Term Care which would be provided without charge in the absence of insurance.
SGL2AA-3

4. Treatment for neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder which is not of organic origin. Alzheimer's Disease and similar dementias are covered, subject to the provisions of the Policy.
SGL2AA-4

5. Nursing Home Care received in a hospital or clinic or a rehabilitation hospital, except as provided in the definition of Nursing Home; or in a facility or section of a facility which operates primarily for the treatment of alcoholics or drug addicts or the mentally ill.
SGL2DB-5

6. Long Term Care to the extent that benefits are payable under Medicare or would be so reimbursable for the application of a deductible or coinsurance amount.
SGL2AA-7-22-TQ

Waiting Period - The Insured must complete the Waiting Period before the Long Term Care Benefit becomes payable. A day of Long Term Care which counts toward the Waiting Period for the benefit payable for Nursing Home Care simultaneously counts toward the Waiting Period for the benefit payable for Community Based Care and vice versa.
SGL3AA

LONG TERM CARE BENEFIT

We will pay the Long Term Care Benefit stated in the Schedule, subject to the conditions below.

a) The Insured must be certified as Chronically Ill by a Licensed Healthcare Practitioner.

b) The Long Term Care Benefit will be paid pursuant to a Plan of Care provided by a Licensed Healthcare Practitioner.

c) The Long Term Care must start while the Insured's coverage is in force.

d) The Lifetime Maximum Benefit must not yet have been reached.

e) The terms of the Limitations or Conditions on Eligibility for Benefits provision must be met.
SGNH1AA-22-TQ

INTERRUPTION IN CARE

If the Insured has completed the Waiting Period, We will consider the Long Term Care for the same or for a related condition to be continuing without interruption until 6 months pass during which the Insured receives no Long Term Care due to such condition. When Long Term Care due to the same or a related condition recurs, the Insured must complete the full Waiting Period before benefits again become payable and premiums are again waived for Long Term Care due to such condition.
SGNH2BA

WAIVER OF PREMIUM

We will waive premiums starting with the first premium due after the Insured completes the Waiver of Premium Qualification Period. We will continue to waive premiums until no benefits have been paid for 6 months.

If premiums are being paid other than monthly, the Insured will be placed on the monthly premium payment mode when we start to waive premiums. We will then refund any unearned monthly premiums, starting with the premium of the first full month for which premiums are waived.

When waiver of premium stops, the Insured's coverage may be continued in force by payment of the first modal premium due after the date it stops. The modal premium will be the same as in effect prior to the date waiver of premium started, subject to any change in the premium rates which may have occurred as provided in the Payment of Premium provision.
SGS3AA

ALTERNATE PLAN OF CARE BENEFIT

If the Insured requires Long Term Care, we may pay for alternate services, devices or types of care, pursuant to a written Alternate Plan of Care, developed by or with a Licensed Healthcare Practitioner.

Any alternate care, including the benefits to be paid, may be adopted, as long as it is mutually agreeable to the Insured, the Insured's physician and us. No benefits will be payable under this provision until an agreement is reached. Agreement to participate in an alternate Plan of Care will waive neither the Insured's nor our rights.

The Alternate Plan of Care may specify special treatments or different sites or levels of care. Some of the care the Insured may receive may be different from that otherwise covered by the Policy. In this case, benefits will be paid at the levels specified and agreed to in the alternate Plan of Care.
SGA1AB-TQ

INDIVIDUAL TERMINATIONS

The Insured's coverage under the Policy terminates on the earliest of the dates below. Unless termination occurs under Paragraphs (c) or (d) of this provision, the Insured's coverage may be continued in force as provided in the Continuation of Coverage Due to Termination provision.

(a) Except as stated in the Continuation of Coverage Due to Death or Divorce of Spouse provision, the date the Insured is no longer eligible for coverage, as provided in the Master Application.

(b) On the date the Policy terminates.

(c) The end of the grace period of an unpaid premium, unless non-payment is due to a clerical error made by Us or the Holder.

(d) The date the Lifetime Maximum Benefit is reached.
SGS4AA

CONTINUATION OF COVERAGE DUE TO TERMINATION

The Insured becomes eligible for continuation of coverage on the date his or her coverage under the Policy terminates as provided in Paragraphs (a) and (b) of the Individual Terminations provision. Coverage will be continued under a new group policy (the "continuation policy") subject to the conditions below

(a) The Insured must remit the first quarterly premium to us for the continued coverage and We must receive it within 60 days from the date coverage terminates under the Policy or, if a claim started before termination, when waiver of premium stops. The Insured must remit the first quarterly premium to us regardless whether a bill has been sent by us or received by the Insured. The Insured not receiving a bill for continuation of coverage is not to be considered a clerical error made by us or the Holder.

The first quarterly premium for the continued coverage is three times the Insured's monthly premium and is due on the date coverage terminates under the Policy. The first quarterly premium should be paid by check, made out to 'Continental Casualty Company' and identify the Insured's Certificate Number and Social Security Number. The remittance should be sent to CNA-GLTC, P.O. Box 946760, Maitland, FL 32794-6760.

(b) Upon receipt of the Insured's remittance of the first quarterly premium for continuation coverage, We will verify that the Insured is eligible for continuation and provide ongoing billings. All future premiums under the continuation policy are due quarterly. The Insured must remit them directly to us. We will consider requests for payment modes other than quarterly.

(c) Coverage will be continued under the continuation policy with the same benefits and provisions as the Policy, such that the Insured is left in the same position as if coverage had not terminated.

(d) The Insured's coverage under the continuation policy is effective as of the date coverage terminates under the Policy. The Insured will not be covered or receive benefits simultaneously under the Policy and the continuation policy.

(e) There is no continuation of coverage if Extension of Benefits stops due to the Lifetime Maximum Benefit having been reached.

SGS5DA

CONTINUATION OF COVERAGE DUE TO DEATH OR DIVORCE OF SPOUSE

If the Insured is no longer eligible for coverage due to the death of, or divorce from, the spouse, the Insured's coverage will continue in force under the Policy, subject to its provisions. If the Insured's premiums are being deducted from a payroll account, the Insured must remit the first monthly premium for the continued coverage at the end of the period for which premium has already been paid or, if later, on the first Premium Due Date after we stop waiving premiums. All future premiums are due monthly. The Insured must remit them directly to us. We will consider requests for payment modes other than monthly.

SGS6AA-22

EXTENSION OF BENEFITS

If the Insured's coverage under the Policy terminates, except as provided in (d) of the Individual Terminations provision, we will recognize the Insured's basis for a claim which started before the date of termination in the same manner as if the Insured's coverage were still in force. Extension of benefits stops on the earlier of:

(a) The end of a benefit period; or

(b) The date the Lifetime Maximum Benefit is reached.

SGS7AA-22

REINSTATEMENT OF COVERAGE

If the Insured's coverage terminates for non-payment of premium and if the Insured provides proof of a Cognitive Impairment or the loss of functional capacity at the time of termination, We will reinstate coverage up to 5 months after the coverage terminated without requiring evidence of insurability. The reinstated coverage will cover losses from the date coverage terminates. All premium must be paid in order for coverage to be reinstated. Subsequent reinstatements may require evidence of insurability.

In all other situations, if the Insured's coverage terminates for non-payment of premium, coverage may be reinstated at Our option. We may require the Insured to submit an application for reinstatement. If We approve the application, coverage will be reinstated as of the date of Our approval. If We have accepted premium and issued a conditional premium receipt, the Insured's coverage will be reinstated no later than 45 days after the date of that receipt, unless We notify the Insured by written notice prior to that date that the application for reinstatement is not approved. If We do not require an application for reinstatement, coverage will be reinstated as of the date We accept the Insured's premium.

The reinstated coverage will cover only losses for conditions that start after the date of reinstatement. In all other aspects, the Insured's rights and Ours will be the same as before the coverage terminated, unless there are new provisions added due to the reinstatement. The premium We accept for reinstatement may be used for the period for which premiums were not paid. We can apply the premium back for as many as 60 days before the date of reinstatement.
SGS8EA-22-TQ

CLAIMS

Notice of Claim. Notice must be given to Us within 90 days after a loss. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice will be sufficient if it identifies the Insured and the Policy. It must be sent to Us at the following address:

Continental Casualty Company
PO Box 946760
Maitland, FL 32794-6760

SGC1BA

Claim Forms: After We receive the notice of claim, We will furnish any required forms within 15 days. If We do not, We will consider the Insured to have met the requirements for written proof of loss if We are given written proof of the extent and nature of the loss.
SGC2BA

Written Proof of Loss: Written or electronic proof of Eligible Expenses must be given to Us within 90 days after the date of such loss. If this is not reasonably possible, the claim is not affected if the proof is given to Us as soon as possible. Unless the Insured is legally incapacitated, written proof must be given within 1 year of the time it is otherwise due.
SGC3DA

Time of Payment of Claim: Benefits for a loss which requires periodic payment will be paid monthly subject to receipt of due written proof of loss. Any balance unpaid when liability terminates will be paid when We receive due written proof.
SGC4AA

Payment of Claim: All benefits are paid to the Insured or the Insured's estate, unless the Insured has assigned them elsewhere.

If benefits are payable to the estate, We may pay up to $1,000 to any relative of the Insured who We feel is entitled to them. Any payment We make in good faith discharges Us to the extent of the payment.
SGC5AA

Misstatement of Age: If the Insured's age has been misstated, the benefit will be in an amount that the premiums paid would have purchased at the Insured's true age. If coverage would not have been issued, We will refund the premium paid within 90 days of discovering the misstatement.
SGC6AA-22

Physical Examination and Assessment: At our expense, we may, as often as reasonably necessary while the claim is pending, have the Insured examined or obtain an assessment of the Insured's impairment.
SGC7AA-15-TQ

Claim Denial: If a claim is denied, We will make available to the Insured or the Insured’s personal physician, all information directly related to such denial. We will release such information within 60 days of Our receipt of the written request unless such disclosure is prohibited under state or federal law.
SGC9AA

Claim Appeal: If the Insured contests the denial, We will request from the Insured, the nature of the dispute in writing and (if applicable) the amount of money involved. We will then compile all relevant data including evaluations by qualified individuals independent of Us, if appropriate. The accumulated data will be reviewed by Us. The decision is sent to the Insured in writing within 60 days**.**
SGC10AA

PREMIUM

Payment of Premium: Premium is computed as stated in the Master Application. Premiums are payable in United States currency to us on the Premium Due Dates stated in the Schedule.

We cannot change the Insured's premiums because of age or health. We can, however, change the Insured's premiums based on his or her premium class on the Policy anniversary date, but only if we change the premiums for all other Insureds in the same premium class. A change may be made, as provided in the following paragraph, on any Premium Due Date after the end of the Premium Rate Guarantee Period. The Premium Rate Guarantee Period starts on the Policy Effective Date. The length of this period is stated in the Schedule of the Master Application.

If we elect to change premium rates, the Insured's premiums change on his or her first Premium Due Date following the later of: (a) The effective date of the change stated in our written notice to the Holder; or (b) the end of the Period for Notice of Premium Rate Changes stated in the Schedule of the Master Application. This period starts on the date the Holder receives the written notice from us. If the Insured is paying premiums directly to us, we will notify him or her of the change at least 31 days before the Premium Due Date on which his or her premiums change.

The Premium Rate Guarantee Period does not limit our right not to renew the Policy, as stated in the Effective Date and Term provision.
SGP1AA-15

Refund of Unearned Premium at Death: If the Insured dies, We will make a pro-rata refund of premium paid for the period beyond the date of death.
SGP3AA

Unintentional Lapse. The Insured has the right to designate another individual to receive notification of lapse. Upon notice of nonpayment of premium, We will inform both the Insured and, if chosen, the designated individual at least 30 days before the effective date of lapse. If payment is through a payroll or pension deduction plan, We will inform both the Insured and, if chosen, the designated individual 60 days after the Insured is no longer on a payroll or pension deduction plan. The notice will be given by first class United States mail, postage prepaid, to the designated individual no earlier than 30 days after the premium due date. Notice is considered to have been given as of 5 days after the date of mailing. The Insured will be notified of the right to change the designated person at least once every 2 years.
SGP6AB

THE CONTRACT

Entire Contract; Changes: The Policy, the Master Application, the individual applications of the Insureds and any attached papers make up the entire contract between the parties. No change is valid unless approved in writing on the Policy by one of Our officers. No agent may change the Policy or waive any of its provisions.
SGX1AA

Incontestability: Statements the Holder or the Insured makes are, in the absence of fraud, representations and not warranties. No statement voids the insurance, reduces the benefits or may be used in defense to a claim unless it is in writing and a copy of it has been furnished to the Holder or the Insured, whoever made the statement.

If the Insured’s coverage has been in force for less than 6 months, We may rescind or deny an otherwise valid claim for any misstatements made by the insured that is material to the acceptance of coverage. After the Insured’s coverage has been in force for at least 6 months but less than 2 years, we may rescind or deny an otherwise valid claim for fraudulent misstatements made on the application and which pertains to the condition for which benefits are sought. After the Insured’s coverage has been in force for 2 years, only fraudulent misstatements of the Insured who knowingly and intentionally misrepresented relevant facts relating to his health may be used to void the Insured’s coverage. If benefits have been paid under the Policy, the benefits cannot be recovered by Us in the event coverage is rescinded.

After the Policy has been in force for 2 years, only fraudulent misstatements of the Holder may be used to void the Policy.
SGX2AB-22-TQ

Legal Actions: No action at law or in equity may be brought until 60 days after the date written proof of loss was given. No action may be brought after 3 years from the date written proof is required.
SGX3AA

Conformity with Statutes: If a provision conflicts with the statutes of the jurisdiction in which the Policy was delivered or issued, it is automatically changed to meet the minimum requirements of the statute.
SGX4AA

EMERGENCY ALERT SYSTEM BENEFIT

Emergency Alert System is a communication system located in the Insured's Residence which is used to summon medical attention in case of a medical emergency.

We will pay the Emergency Alert System Benefit stated in the Schedule for the rental or lease of an Emergency Alert System for the Insured's Residence while the Insured is living in that residence, subject to the conditions below.

(a) We will start paying the Emergency Alert System Benefit when benefits for Community Based Care start. The Emergency Alert System Benefit will continue to be paid until 6 months pass during which the Insured receives no Community Based Care, or, if earlier, until Nursing Home Care starts.

(b) The Insured's condition must be such that he or she could not be left alone were it not for the presence of the Emergency Alert System.

(c) We will not pay for any charges for normal telephone service while the system is installed or for a home security system.

(d) The Lifetime Maximum Benefit must not yet have been reached.

SGM1AA

CARE ASSIST BENEFIT

The Care Assist Benefit is designed to temporarily relieve an Informal Caregiver of the duties of caring for the Insured. We will pay the Care Assist Benefit stated in the Schedule, subject to the conditions below:

(a) The Care Assist Benefit will either be paid for care furnished at the Insured’s residence for up to 24 hours per day by a Home Health Care Provider or another Informal Caregiver or care received in a Nursing Home.

(b) During the 6 months prior to receipt of care, the Insured must have been Chronically Ill and receiving care from the Informal Caregiver being relieved of duties. A period during which the Insured is confined in a hospital will count towards satisfying the 6 month requirement.

(c) The Waiting Period does not apply to the Care Assist Benefit.

(d) The maximum amount payable per calendar year is stated in the Schedule. Unused amounts cannot be carried over into the next calendar year.

SGCA1AA

CAREGIVER TRAINING BENEFIT

Caregiver Training means training received by the Informal Caregiver to care for the Insured in the Insured's Residence.

Informal Care means Informal Care provided by an Informal Caregiver, making it unnecessary for the Insured to be in a Nursing Home, or to receive such care in the Insured's Residence from a paid provider.

Informal Caregiver means the person who has the primary responsibility of caring for the Insured in the Insured's Residence. A person who is paid for caring for the Insured cannot be an Informal Caregiver.

BENEFIT

We will pay the Caregiver Training Benefit stated in the Schedule, subject to the conditions below:

(a) The conditions which must be met for the Long Term Care Benefit to become payable, stated in the Long Term Care Benefit provision, must also be met for benefits to become payable under this provision. However, there is no Waiting Period.

(b) The Caregiver Training must be provided by a Home Health Care Provider, Nursing Home or hospital while the Insured is receiving Long Term Care or Informal Care. If the Insured is in a Nursing Home or in a hospital, the Caregiver Training Benefit will only be payable if the training will make it possible for the Insured to return to the Insured's Residence where he or she can be cared for by the Informal Caregiver.

(c) If Long Term Care or Informal Care due to the same or a related condition stops, the Caregiver Training Benefit will again become payable subject to the preceding conditions if Long Term Care or Informal Care resumes due to a new or unrelated condition. We will consider Long Term Care or Informal Care due to the same or a related condition to have stopped when 6 months have passed during which the Insured has received no Long Term Care or Informal Care due to such condition.

SGT1AA

HOSPICE CARE FACILITY BENEFIT

We will pay the Hospice Care Facility Benefit stated in the Schedule, subject to the conditions below:

(a) The conditions which must be met for the Long Term Care Benefit to become payable, stated in the Long Term Care Benefit provision, must also be met for benefits to become payable under this provision;

(b) Care must be received in a facility that specializes in Hospice Care for patients who are expected to live less than six months. This facility is a stand-alone facility or ward/wing of a Nursing Home and is licensed by the state in which it is located;

(c) The benefit payable for Hospice Care in a Hospice Care Facility will equal the Long Term Care Benefit payable for Nursing Home Care. However, benefits will not be paid for Hospice Care in a Hospice Care Facility, Community Based Care and Nursing Home Care simultaneously; and,

(d) The Lifetime Maximum Benefit must not yet have been met.

SGHC1AA

TEMPORARY BED HOLDING BENEFIT

When the Insured is receiving benefit payments for Nursing Home Care, We will pay the Temporary Bed Holding Benefit, subject to the conditions below, if the Insured is temporarily absent from the Nursing Home due to a hospital stay or other event. The Temporary Bed Holding Benefit will be paid only if the Insured continues to incur a charge for a bed in the Nursing Home and that charge would have been assessed even in the absence of insurance.

(a) The benefit will equal the Long Term Care Benefit payable for Nursing Home Care. It will be limited to 21 days per calendar year. Unused days cannot be carried over into the next calendar year.

(b) The temporary absence must start while the Insured is receiving benefits for Nursing Home Care.

(c) The Lifetime Maximum Benefit must not yet have been reached.

SGB1AA

GUARANTEED BENEFIT INCREASE

On the third anniversary of the Policy Effective Date and no less than every three years thereafter, the Insured may elect to increase each benefit amount then in effect by the amount stated in the Schedule.

If the Insured elects to increase coverage, the premium for the increase in coverage will be based on the Insured's attained age at the time of the increase. The premium for the increase in coverage will be added to the premium being charged for the Insured's previous amount of coverage.

The Insured has the right to accept the benefit increase offers without showing evidence of insurability as long as the Insured increased his benefit amount at the most recent previous benefit increase offer. When an offer is declined, the Insured must submit evidence of insurability in order to exercise the next benefit increase offer. Once We accept the Insured's evidence of insurability, We will not require further evidence of insurability for future benefit increase offers until another offer is declined.

SGI1GC

REFUND OF PREMIUM AT DEATH

At the Insured's death, we will refund a portion of the premiums paid less any benefits paid or payable. The amount of the refund is determined by multiplying (a) by (c) and then subtracting (b). (a), (b) and (c) are defined as follows:

(a) = The Insured's total premiums paid, not including any premiums which were waived, less any unearned premiums refunded at the Insured's death.

(b) = The Insured's total benefits paid or payable.

(c) = The applicable factor from the Schedule of Factors shown below. It is determined based on the Insured's age on the birthday preceding the date of death.

Schedule of Factors

Age of Insured at Death	**Factors**
65 or younger	100%
66	90
67	80
68	70
69	60
70	50
71	40
72	30
73	20
74	10
75 or older	No refund is made

This benefit will not be payable if the Insured has exercised the Reduced Lifetime Maximum Benefit, the Benefit Account option or any other paid up benefit option in the Policy, as applicable.
SGF1AB

Continental Casualty Company

CNA Plaza A Stock Company
Chicago, Illinois 60685

ADMINISTRATIVE RIDER

It is understood and agreed that in the event the Group Long Term Care certificate to which this rider is attached replaces another Long Term Care policy or certificate, the Continental Casualty Company will waive any time periods applicable to pre-existing conditions, waiting periods and waiver of premium qualification periods to the extent such time was spent under the policy or certificate being replaced.

Signed for the Continental Casualty Company at its Home Office, CNA Plaza, Chicago, Illinois 60685.

Chairman of the Board

SRAR-11

Continental Casualty Company

CNA Plaza A Stock Company
Chicago, Illinois 60685

WORLD WIDE COVERAGE RIDER

WORLD WIDE COVERAGE

What is World Wide Coverage?

If You become eligible to receive benefits under this Policy while You are traveling or living outside the United States, benefits will be payable according to the terms of the Policy except that reimbursement will be based on a cash payment instead of actual charges.

What is payable under this benefit?
We will pay a cash benefit as shown in Your Schedule of Benefits under "World Wide Coverage" for Long Term Care services received outside the United States regardless of the provider, but subject to the conditions below. This payment is in lieu of all benefit payment descriptions otherwise shown in Your Schedule.

What are the conditions of this benefit?

(a) Expenses must have been incurred outside the United States;

(b) As a condition for receiving all benefits under this Policy, You must have been certified by a Licensed Health Care Practitioner as being Chronically Ill. For purposes of benefits paid under this Rider, We will recognize a foreign country's determination of who may be a Licensed Health Care Practitioner, and certification or licensing of this individual must comply with regulations of the jurisdiction in which care is received;

(c) All providers of care must meet licensing or certification requirements, if any, of the jurisdiction in which care is received;

(d) We may do periodic reassessments of Your condition or require a physical exam by a physician as often as once per month;

(e) Benefits will be payable in United States Currency.

This rider takes effect at 12:01 a. m. standard time at the address of the Holder on the Effective Date indicated in the Schedule of Benefits of the Certificate to which it is attached; it expires concurrently with the Policy and is subject to all the provisions, limitations, exclusions, and conditions of the Policy to the extent they are not inconsistent herewith.

Signed for the Continental Casualty Company at its Home Office, CNA Plaza, Chicago, Illinois 60685.

Continental Casualty Company

Chairman of the Board