
Continental Casualty Company



333 S. Wabash Ave. A Stock Company
Chicago, IL 60604

"We," "Our," and "Us" are used to refer to the Continental Casualty Company.

Holder: University of Rochester
Policy Number: 9571-IS
Policy Effective Date: January 1, 2009

**THIS POLICY IS A QUALIFIED LONG TERM CARE INSURANCE CONTRACT
AS DEFINED IN SECTION 7702B UNDER THE INTERNAL REVENUE CODE.**

The Policy is issued in consideration of the statements made in the Master Application, any other required evidence of insurability for participants and the payment of premium. We agree with the Holder to insure eligible persons based on the statements made in the Master Application. We promise to pay benefits for loss covered by the Policy.

**THE POLICY IS NOT QUALIFIED UNDER THE NEW YORK STATE PARTNERSHIP FOR LONG TERM
CARE.**

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.

EFFECTIVE DATE AND TERM

The Policy starts on the Policy Effective Date. The Insured's coverage starts on the Coverage Effective Date stated in the Master Application and stays in force for the period for which premium has been paid.

The Holder may elect not to renew the Policy at any time by written notice to Us. If this occurs, the Policy will terminate on the later of: (a) The effective date of non-renewal stated in the Holder's written notice; or (b) The end of the Period for Notice of Non-Renewal stated in the Schedule of the Master Application. This period starts on the date We receive the written notice from the Holder.

The Policy's Initial Renewal Period starts on the Policy Effective Date. Each Subsequent Renewal Period starts on the day after the preceding period ends. The length of these periods is stated in the Schedule of the Master Application. If We elect not to renew the Policy, it terminates on the later of: (a) The effective date of non-renewal stated in Our written notice; or (b) The end of the Period for Notice of Non-Renewal 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 any non-renewal by written notice at least 31 days before the Policy terminates.

All insurance periods start and end at 12:01 a.m., Standard Time, at the Holder's address stated in the Master Application.

Signed for the Continental Casualty Company at its Home Office, 333 S. Wabash Ave. , Chicago, Illinois 60604.

**GROUP LONG TERM CARE INSURANCE
POLICY**

GLTC-3-P-NY-01

Irwin Kohn
Chairman of the Board

Jonathan Kauton
Secretary

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WHEN DOES MY INSURANCE BEGIN?

Your coverage starts on the Insured's Original Effective Date stated in the Certificate Identification.

HOW DO I BECOME ELIGIBLE FOR THE PAYMENT OF BENEFITS?

You must be Chronically III as defined below to become eligible for benefits.

Chronically III means You have been certified by a Licensed Health Care Practitioner as being expected to be unable to perform, without Hands-On Assistance or Stand-by Assistance from another person, at least 2 Activities of Daily Living, as listed and defined below, for a period of 90 consecutive days, or requiring Substantial Supervision to protect You from threats to health and safety due to a Severe Cognitive Impairment.

Activities of Daily Living are defined as follows:

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.

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.

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

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.

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

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

Hands-On Assistance means physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the Activity of Daily Living.

Stand-by Assistance means the presence of another person within arm's reach of You that is necessary to prevent, by physical intervention, injury to You while You are performing the Activities of Daily Living.

Severe Cognitive Impairment means a loss or deterioration in Your intellectual capacity (including Alzheimer's disease and organic brain diseases) that is measured by clinical evidence and standardized tests that reliably measures impairment in all the following areas:

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

Substantial Supervision means continual supervision, which may include cueing 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.

You will not be considered Chronically III unless within the preceding 12 months a Licensed Health Care Practitioner has certified that You meet the above requirements.

WHEN DO LONG TERM CARE BENEFITS BECOME PAYABLE?

We will pay the Long Term Care Benefits and other benefits, stated in the Schedule of Benefits, when all of the following conditions are met unless exempted for a particular benefit/provision:

- (a) Your coverage is in force;
- (b) You have been certified as Chronically III by a Licensed Health Care Practitioner;
- (c) All benefits have been included in a Plan of Care which has been provided by a Licensed Health Care Practitioner;
- (d) The Waiting Period has been completed, unless not required under a particular benefit/provision;
- (e) The Lifetime Maximum Benefit has not yet been reached.

WHAT ARE MY LONG TERM CARE BENEFITS?

Your Long Term Care Benefits consist of Facility Care, Home Based Care, and Other Benefits as follows:

Facility Care

Nursing Home Care
Bed Reservation
Hospice Facility
Assisted Living Facility

Home Based Care

Home Care
Home Hospice Care
Adult Day Care
Caregiver Training
Home Medical Technology

Other Benefits

Respite Care
Alternate Plan of Care
Waiver of Premium

FACILITY CARE

NURSING HOME CARE BENEFIT

What is Nursing Home Care?

Nursing Home Care is the care You receive if You are confined in a Nursing Home.

Nursing Home Care consists of the categories of care listed and defined below when received in a Nursing Home.

- (a) **Nursing Care.** Nursing services which require the training and skills of a Registered Nurse (RN), Licensed Vocational Nurse (LVN) or Licensed Practical Nurse (LPN).
- (b) **Custodial Care.** Services which are above the level of room and board but do not require the continuous attention of trained medical or paramedical personnel. They may be provided by persons without professional skills or training.

What is payable under this benefit?

If You are in a Nursing Home, We will pay the Facility Care Benefit, as stated in the Schedule of Benefits.

Under what conditions are benefits paid?

Benefits are paid if the Nursing Home meets the following definition:

Nursing Home means a place which:

- (a) Is licensed by the state in which it is located;
- (b) Provides 24-hour care on an inpatient basis under the supervision of a physician;
- (c) Has nursing services provided by or under the supervision of a Registered Nurse (RN), Licensed Vocational Nurse (LVN) or Licensed Practical Nurse (LPN);
- (d) Keeps a daily medical record of each patient; and
- (e) Is either a freestanding facility or a ward, wing, unit or swing bed of a hospital or other institution.

BED RESERVATION BENEFIT

What is Bed Reservation?

If You must temporarily leave a Nursing Home, Assisted Living Facility, or Hospice Facility (Facility) due to a hospital stay or other event, You may incur a charge by the Facility to hold Your place while You are away.

What is payable under this benefit?

If You leave the Facility temporarily, We will pay a benefit equal to the benefit payable for Facility Care as shown in the Schedule of Benefits.

Under what conditions are benefits paid?

- (a) The temporary absence must start while You are receiving benefits for a stay in the Facility. It will be limited to the number of days per calendar year as shown in the Schedule of Benefits. Unused days cannot be carried over into the next calendar year;
- (b) You must incur a charge by the Facility for holding Your place, and that charge must be one that You would incur even in the absence of insurance.

HOSPICE FACILITY BENEFIT

What is Hospice Facility Care?

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

What is payable under this benefit?

If You are confined to a facility that provides Hospice Care, We will pay the Facility Care Benefit, as stated in the Schedule of Benefits.

Under what conditions are benefits paid?

- (a) 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 must be a stand-alone facility or ward/wing of a Nursing Home and is licensed by the state in which it is located;
- (b) We will not simultaneously pay benefits for Hospice Care under this benefit and any other benefit.

In no event will benefits paid under this option reduce the lifetime maximum benefit for Facility Care below the minimum level of two years as set forth in the Rules and Regulations of New York, sections 52.12 (a) of Regulation 62.

ASSISTED LIVING FACILITY BENEFIT

What is the Assisted Living Facility Benefit?

Assisted Living Facility Care is a combination of housing, personalized supportive services, and health care designed to meet the needs -- both scheduled and unscheduled -- of those who need help with Activities of Daily Living or supervision due to Severe Cognitive Impairment. Assisted Living Facility Care includes care on an intermittent basis in a facility that accepts only individuals who are impaired. These facilities may be called Adult Foster Care or Board and Care homes.

What is payable under this benefit?

If You are confined in an Assisted Living Facility, We will pay the Facility Benefit shown in the Schedule of Benefits.

Under what conditions are benefits paid?

The Assisted Living Facility must meet the definition set forth in the Definitions section. However, care or services for Assisted Living Facilities not meeting the definition may be covered by a Home Care Provider.

HOME BASED CARE

HOME CARE BENEFIT

What is Home Care?

Home Care means the following types of services:

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 or Housekeeper Services;
4. Home Delivered Meals.

What is payable under this benefit?

If You receive the care described above, We will pay the Home Based Care Benefit as shown in the Schedule of Benefits for services other than room and board.

Under what conditions are benefits paid?

- (a) Care must be received from a Home Care Provider;
- (b) Care must be provided at Your Residence.

See the Definitions section for further explanation of Personal Care Services, Housekeeper Services, Home Care Provider and Your Residence.

HOME HOSPICE CARE BENEFIT

What is Home Hospice Care?

Home Hospice Care means care, received in Your Residence, that is designed to alleviate the physical, emotional, social, and spiritual discomforts resulting from the last stages of a terminal disease. It is also designed to provide emotional support to the primary caregiver and family.

What is payable under this benefit?

If You are diagnosed as being Terminally Ill and are living in Your Residence, We will pay the Home Based Care Benefit as shown in the Schedule of Benefits for services delivered by a hospice program licensed by the state where services are provided.

Under what conditions are benefits paid?

- (a) Terminal Illness means an incurable or irreversible condition that, with or without the administration of treatment will, in the opinion of the attending physician, result in death within six months;
- (b) All care must be provided at Your Residence;
- (c) Benefits are payable for Home Hospice Care and other benefits in the Policy simultaneously; however, in no event will the total benefit payable for any combination of Home Hospice Care and other benefits exceed the Home Based Care Benefit as shown in the Schedule of Benefits.

ADULT DAY CARE

What is Adult Day Care?

Adult Day Care is care in a group setting outside Your Residence. It normally does not include 24-hour care, but may do so on occasion as an incidental service. Adult Day Care means a program for six (6) or more individuals which provides social and health-related services during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

What is payable under this benefit?

We will pay the Home Based Care benefit as stated in the Schedule of Benefits, including costs of transportation from Your Residence to the location where services are provided.

Under what conditions are benefits paid?

Benefits are payable for Adult Day Care and other benefits in the Policy simultaneously; however, in no event will the total benefit payable for any combination of Adult Day Care and other benefits exceed the Home Based Care Benefit as shown in the Schedule of Benefits.

CAREGIVER TRAINING BENEFIT

What is Caregiver Training?

Caregiver Training is the training of an Informal Caregiver, or independent provider not previously qualified, to such an extent that he or she is able to care for You in Your Residence.

What is payable under this benefit?

We will pay the Caregiver Training Benefit, as stated in the Schedule of Benefits. If necessary, We will also pay for the training of the Informal Caregiver, or independent provider not previously qualified, to such an extent that any required licensure or certification, for the services he or she provides, may be obtained.

Under what conditions are benefits paid?

- (a) The Policy's Waiting Period will not apply to this benefit, but all other conditions as described under "When do Long Term Care Benefits Become Payable" must be met;
- (b) The Caregiver Training must be provided by a Home Care Provider, Care Coordinator, Nursing Home, or hospital while You are receiving Long Term Care Benefits under this Policy. If You are in a Nursing Home or in a hospital, the Caregiver Training Benefit will only be payable if the training will make it possible for You to return to Your Residence where You can be cared for by the Informal Caregiver;
- (c) The Informal Caregiver to be trained must be the person who has the primary responsibility of caring for You in Your Residence, or who will have the primary responsibility after he or she has been trained;
- (d) If changes in Your condition warrant it, this benefit will pay for additional training of the Informal Caregiver to such an extent that he or she will be able to provide additional care or will pay for training of another Informal Caregiver to replace the one currently providing care.

HOME MEDICAL TECHNOLOGY BENEFIT

What is Home Medical Technology?

Home Medical Technology means the following types of systems and/or equipment used in Your Residence: assistive devices, medical monitoring or communications, medication compliance, and emergency response. Home Medical Technology also means, for purposes of this benefit, home modifications which may be necessary to accommodate such equipment or which is necessary to allow You to remain at home.

What is payable under this benefit?

We will pay the Home Medical Technology Benefit, as stated in the Schedule of Benefits.

Under what conditions are benefits paid?

- (a) We will not pay for charges for normal telephone service, home security system(s), or other household improvements unless those charges relate directly to the services payable under this benefit;
- (b) The Policy's Waiting Period shall not apply to this benefit;
- (c) All other conditions as described under "When do Long Term Care Benefits Payable" must be met.

OTHER BENEFITS

RESPIRE CARE BENEFIT

What is Respite Care?

Respite Care is the temporary use of the long term care services in this Policy to relieve Informal Caregivers of their duties so that they may have time off. Any of the Facility Care or Home Based Care benefits may be used to care for You while the Informal Caregiver is temporarily relieved.

What is payable under this benefit?

For any benefit used for Respite Care, We will pay up to the maximum amount for that benefit as shown in the Schedule of Benefits.

Under what conditions are benefits paid?

- (a) The Policy's Waiting Period shall not apply to this benefit, but the Respite Care benefit cannot be used to satisfy the Waiting Period;
- (b) You cannot receive Respite Care for more than the number of days stated in the Schedule of Benefits. You may not carry over unused Respite Care benefits into the next calendar year;
- (c) You may not receive Respite Care benefits and other benefits in this Policy at the same time.

ALTERNATE PLAN OF CARE BENEFIT

What is an Alternate Plan of Care?

An Alternate Plan of Care is a plan that may include Long Term Care not otherwise covered. Care received under this benefit may be received in an alternate facility or setting, or at Your Residence. This benefit may specify special treatments or different sites or levels of care or a benefit payable in a different manner than specified in the Policy.

What is payable under this benefit?

We will pay for alternate services, devices, or types of care pursuant to a written Alternate Plan of Care developed by or with a Licensed Health Care Practitioner, agreed to by You, and approved by Your physician and Us. Benefits will be paid at the levels specified and agreed to in the Alternate Plan of Care.

Under what conditions are benefits paid?

- (a) No benefits are payable under this benefit until an agreement is reached between You and Us and approved by Your personal physician;
- (b) Agreement to participate in an Alternate Plan of Care will waive neither Your nor Our rights under the Policy;
- (c) The Alternate Plan of Care must only include Qualified Long Term Care as defined by the Federal Tax Code;
- (d) We are not obligated to provide benefits for services received prior to agreement on an Alternate Plan of Care unless those services are covered elsewhere under the Policy;
- (e) Benefits will not be paid under the Alternate Plan of Care and under other benefits simultaneously unless specified in the Alternate Plan of Care.

SOME BENEFITS PAID UNDER THE ALTERNATE PLAN OF CARE MAY NOT MEET THE FEDERAL TAX LAW REQUIREMENTS FOR TAX FAVORED BENEFITS. ASSISTANCE SHOULD BE SOUGHT FROM YOUR PERSONAL TAX ADVISOR.

WAIVER OF PREMIUM

We will waive premiums starting with the first premium due after You complete the Waiting Period. We will continue to waive premiums until the first of the month following the end of the Plan of Care.

If premiums are being paid other than monthly, You 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, Your coverage may be continued in force by payment of the first modal premium due after the date it stops. The modal premium will be quarterly unless otherwise agreed to, subject to any change in the premium rates which may have occurred as provided in the Payment of Premium provision.

ARE THERE LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS?

Yes, benefits under this Policy may be delayed, limited, or excluded under certain circumstances as follows:

Waiting Period - You must complete the Waiting Period shown in the Schedule of Benefits before Long Term Care Benefits become payable. The Waiting Period starts on the date the Licensed Health Care Practitioner certifies that You became Chronically III; however, in no event will the Waiting Period start later than the date We receive notice of claim if You are Chronically III at that time. For benefits to become payable after the Waiting Period, You must have been certified as Chronically III during the entire Waiting Period.

Once the Waiting Period is satisfied, no additional Waiting Period is required during Your lifetime.

Exclusions:

We will not pay benefits for the following:

- (a) Long Term Care resulting from war or an act of war whether declared or undeclared;
- (b) Long Term Care for which benefits are provided under Workers' Compensation, the Occupational Disease Act or Law, or to the extent that benefits are payable under a group medical plan, or a group long term care plan. However, the days on which Long Term Care is received will count towards satisfying the Waiting Period;
- (c) Long Term Care which would be provided without charge in the absence of insurance;
- (d) 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;
- (e) Alcoholism and drug addiction;
- (f) Long Term Care to the extent that benefits are payable under Medicare or would be so reimbursable but for the application of a deductible or coinsurance amount.

CONVERSION OF YOUR COVERAGE

You may convert Your coverage to an individual policy if any of the following situations occur:

- 1. You are the employee and You are no longer a member of a class eligible for insurance according to the Master Application;
- 2. You are the spouse of the employee and become divorced;
- 3. You are the spouse of the employee and the employee dies or is no longer a member of a class eligible for insurance according to the Master Application;
- 4. The group Policy ends.

Under what conditions is coverage continued?

- (a) You must notify Us within 60 days following the applicable above occurrence to assure that Your coverage remains in force;
- (b) You 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. You must remit the first quarterly premium to Us regardless of whether a bill has been sent by Us or received by You. Your not receiving a bill for conversion of coverage is not to be considered a clerical error made by Us or the Holder;
- (c) The first quarterly premium for the converted coverage is three times Your 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 Your Certificate Number and Social Security Number. The remittance should be sent to Continental Casualty Company, Group Long Term Care, 333 S. Wabash Ave. , Chicago, IL 60604;

- (d) Upon receipt of Your remittance of the first quarterly premium for the converted coverage, We will verify that You are eligible for conversion and provide ongoing billings. All future premiums are due quarterly. You must remit them directly to Us. We will consider requests for payment modes other than quarterly;
- (e) Coverage will be converted with the same benefits and provisions as the Policy, such that You are left in the same position as if coverage had not terminated under the group plan.

Under the above conditions, Your Certificate becomes Your individual policy with the modifications described in the Conversion Rider.

Notwithstanding the foregoing, this provision shall not apply if:

- (a) Following non-renewal of the Policy, it is replaced by Us on its date of termination by a new policy; and
- (b) You are covered under the new policy on the same basis as You were covered under the Policy.

WHEN DOES MY LONG TERM CARE INSURANCE END?

Your coverage ends on the earliest of the following dates:

- (a) 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;
- (b) The first of the month following the later of (1) the date We receive Your written request to cancel Your insurance or (2) the date You request, in writing, that We cancel Your insurance;
- (c) The date the Lifetime Maximum Benefit is reached.

CAN COVERAGE BE CONTINUED AFTER TERMINATION?

Yes. If Your coverage terminates due to non-payment of premium Your Long Term Care coverage may be continued even after termination. The provisions that allow for continuation are as follows:

EXTENSION OF BENEFITS

If Your insurance terminates, except as provided in (c) of "When Does My Long Term Care Insurance End?," while You are receiving benefits under this plan, We will recognize those expenses incurred after termination in the same manner as if Your coverage were still in force. This Extension of Benefits stops on the earlier of:

- (a) The date on which You no longer incur charges under this plan; or
- (b) The date the Lifetime Maximum Benefit is reached.

This provision does not apply if the Policy is replaced by Us on its date of termination as provided in "Keeping Your Coverage."

REINSTATEMENT OF COVERAGE

If Your coverage terminates for non-payment of premium We may reinstate Your coverage as follows:

1. If Your coverage terminates for non-payment of premium and if You are Chronically III 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 past-due premiums must be paid in order for coverage to be reinstated. Once We reinstate coverage, subsequent reinstatements may require evidence of insurability.
2. In all other situations, if Your coverage terminates for non-payment of premium, coverage may be reinstated at Our option.
 - (a) We may require that You submit evidence of insurability. If We require that You submit evidence of insurability, We may require a reinstatement fee equal to 60 days premium. If We approve the evidence of insurability, Your coverage will be reinstated as of the first day of the month following Our approval. If We have accepted premium, Your coverage will be reinstated no later than 45 days after the date of receipt, unless We notify You by written notice prior to that date that the evidence of insurability is not approved. The reinstated coverage will cover only Long Term Care that starts after the date of reinstatement. We will not pay benefits for Long Term Care received between the date coverage lapsed and the date coverage was reinstated.
 - (b) If We do not require that You submit evidence of insurability, coverage will be reinstated back to the date that coverage ended. All past-due premiums must be paid.

In all other aspects, Your rights and Ours will be the same as before the coverage terminated, unless there are new provisions added due to the reinstatement.

CLAIMS

HOW DO I INITIATE A CLAIM? If You become Chronically III, You must notify Us at the address below. The notice will be sufficient if it identifies You and Your Certificate. You must provide Us with the information required to determine eligibility to receive benefits and develop a Plan of Care.

HOW DO I SUBMIT A CLAIM FOR SERVICES? Notice of a receipt of covered service and any additional information needed must be given to Us within 90 days of the date of the service. If this is not reasonably possible, the claim is not affected if the notice is given to Us as soon as possible. It must be sent to Us at the following address:

Continental Casualty Company
Group Long Term Care
333 S. Wabash Ave.
Chicago, IL 60604

ARE THERE ANY FORMS REQUIRED? After We receive the notice of claim, We will furnish required forms, if any, within 15 days. If We do not, We will consider You to have met the requirements for proof of receipt of covered services if We are given proof of the extent and nature of the service.

WHO ARE CLAIM PAYMENTS PAID TO? After We receive proper written notice of receipt of covered services, We will pay all benefits that are due under the Policy within 45 days. All benefits are paid to You or Your estate, unless You have assigned them elsewhere. You may choose to have benefits paid directly to You, Your legal representative, or a licensed service provider. If benefits are payable to the estate, We may pay up to \$1,000 to any of Your relatives who We feel is entitled to them. Any payment We make in good faith discharges Us to the extent of the payment.

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.

DO I HAVE TO TAKE A PHYSICAL EXAM OR BE ASSESSED? At Our expense and discretion, We may, as often as reasonably necessary during the duration of the claim, have a physician examine You or obtain an assessment of Your impairment.

WHAT CARE COORDINATION SERVICES WILL I RECEIVE? If You are not certified as Chronically III, We will pay to have a Licensed Health Care Practitioner certify that You are Chronically III and develop a Plan of Care. In addition, at Our expense and sole discretion, We may provide a Care Coordinator to assist You with other aspects of Your claim.

WHAT IF MY AGE IS MISSTATED? If Your age has been misstated, the benefit will be in an amount that the premiums paid would have purchased at Your true age. If coverage would not have been issued, We will refund the premium paid and Your Certificate will become null and void.

WHAT IF MY CLAIM IS DENIED? If a claim is denied, We will make available to You or Your 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.

HOW DO I APPEAL A DENIED CLAIM? If You contest the denial, We will request, in writing from You, the nature of the dispute and (if applicable) the amount of money involved. We will then compile all relevant information including evaluations by qualified individuals independent of Us, if appropriate. The accumulated data will be reviewed by Us. The decision is sent to You in writing within 60 days of Our receipt of all accumulated data.

PREMIUM

PAYMENT OF PREMIUM: Premium is shown on the Schedule of Benefits. Premiums are payable in United States currency to Us on the Premium Due Dates stated in the Schedule of Benefits. If the frequency and amount of premium changes, We will send You a premium notice with the changes.

IS THERE A GRACE PERIOD FOR PAYMENT OF PREMIUMS? Yes, We allow a grace period of 60 days for each premium due after the first premium. Your coverage stays in force during the grace period if You pay the premium due.

WHAT HAPPENS IF PREMIUM IS NOT PAID?

- If You pay premium directly to Us and We do not receive it within the grace period, We will give You a lapse warning notice no earlier than 30 days after the Premium Due Date. This notice will be given by first class United States Mail, postage prepaid, and We will consider it to have been given on the sixth day after mailing. The date of lapse specified in the lapse warning notice will be at least 30 days from the date this notice is given to You.
- If We do not receive Your premium within 60 days of the Premium Due Date, Your coverage will terminate as of the last date for which premium was paid, and You will receive a notice that Your coverage has lapsed.
- If premium is paid through a payroll or pension deduction plan and We receive notice that You no longer qualify for payroll or pension deductions (or if We simply do not receive premiums for You), You must send premium as described in Keeping Your Coverage. If You do not, We will send a lapse warning notice and notification of lapse to You at Your last known address.

You may, at any time, designate another individual to receive lapse notices issued to You. In this case, We will send any such notices to both You and the designated individual. Either You or the designated individual must send premium within 60 days of the Premium Due Date or Your coverage will terminate as of the last date for which premium was paid. We will inform You of the right to change the designated individual at least once every 2 years.

WHAT HAPPENS TO ANY PRE-PAID (UNEARNED) PREMIUM IF I CANCEL? If You cancel coverage, We will make a pro-rata refund of premiums received by Us for the period beyond the date of cancellation.

WHAT HAPPENS TO ANY PRE-PAID (UNEARNED) PREMIUM IF I DIE? If You die, We will make a pro-rata refund of premium paid for the period beyond the date of death.

CAN MY PREMIUM BE CHANGED? We cannot change Your premiums because of age or health. We can, however, change Your premiums based on Your premium class, 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 or a renewal date. The length of this period is stated in the Schedule of the Master Application.

If We elect to change premium rates, Your premiums change on Your first Premium Due Date following the later of: (a) The effective date of the change stated in Our written notice to the Holder or You if the Certificate has become Your individual policy; 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 You are paying premiums directly to Us, We will notify You of the change at least 31 days before the Premium Due Date on which Your premiums change.

WHAT ARE THE CONTRACT RULES?

Entire Contract; Changes: The Policy; the Master Application; Your individual application, Certificate, and Riders; and any attached papers make up the entire contract between the parties. No change is valid unless approved in writing signed by one of Our officers. No agent may change the Policy or waive any of its provisions. The contract may be amended, at any time, without the consent of the insured person(s) or of anyone else with a beneficial interest in it. But an amendment or a reduction in benefits will not affect a claim incurred before the date of change.

Certificates. We will issue an individual certificate for the Insured. The certificate describes the benefits, to whom they are payable, the limits and where the Policy may be inspected.

Incontestability: Statements of the Holder regarding Your eligibility for coverage or statements You make on the application or enrollment form 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 You, whoever made the statement.

If Your coverage has been in force for less than 6 months when You begin needing assistance with Activities of Daily Living or supervision due to Severe Cognitive Impairment, any misstatements You make may be used to void Your coverage in the event that We would not have issued coverage if the correct information was known.

If Your coverage has been in force for at least 6 months but less than 2 years when You begin needing assistance with Activities of Daily Living or supervision due to Severe Cognitive Impairment, only misstatements You make on the application or enrollment form and which pertains to the condition for which benefits are sought may void Your coverage.

After Your coverage has been in force for 2 years, only fraudulent misstatements You make may be used to void Your coverage.

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.

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.

DEFINITIONS

The terms defined here are capitalized throughout to indicate that they have a specific meaning for purposes of this document and any attached Riders.

Assisted Living 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:

- (a) Provides 24 hour care and/or supervision and is able to provide Qualified Long Term Care Services sufficient to support needs resulting from Your being Chronically III.

- (b) The facility has at least one supervised, trained and ready to respond employee on duty at all times to provide care;
- (c) Offers 3 meals a day and accommodates special dietary needs;
- (d) 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;
- (e) Maintains specific policies and procedures, consistent with state requirements, for handling medical emergencies and trains staff to follow those procedures;
- (f) Maintains a Plan of Care that (1) includes, but is not limited to, assistance with Activities of Daily Living or supervision due to Severe Cognitive Impairment, and medical needs, and (2) is updated at least every 90 days;
- (g) Maintains at least weekly documentation of specific care provided along with Your needs and responses;
- (h) Administers drugs and biologicals with appropriate methods and procedures for recording and handling;
- (i) If the facility provides dementia care, has a secured physical plant and specialized dementia programs.

Assisted Living Facility does not mean (a) a Nursing Home, (b) a hospital or clinic, (c) a facility not meeting the above criteria or (d) a place which operates primarily for the treatment of Substance Abuse or mental illness. However, care or services for Assisted Living Facilities not meeting the definition may be covered by a Home Care Provider.

Care Coordinator means a registered nurse (RN), licensed practical nurse (LPN), licensed vocational nurse (LVN), occupational therapist, vocational therapist, or masters prepared social worker qualified, through experience or certification, to provide care coordination services.

Eligible Expense means the actual expense incurred by You for Long Term Care Services covered by the Policy. For Home Based Care, it does not include the cost of transportation (transportation for Adult Day Care is covered), supplies, and rent or those costs which You would incur regardless of whether You are Chronically III.

Home Care Provider means an entity which:

- (1) Has an agreement as a provider of Home 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 Health care Organizations.

A **Home Care Provider** may also be an Registered Nurse (RN), Licensed Vocational Nurse (LVN), Licensed Practical Nurse (LPN), licensed therapist, or Independent Provider working within the scope of his or her license.

A **Home Care Provider** also includes an organization that provides care given in apartment-like settings and that accepts residents who have no initial long-term care needs. In these apartments, care is given as needed while the person is living in the apartment.

A Home Care Provider cannot be a member of Your immediate family living in Your Residence.

Home Delivered Meals means meals, delivered to Your Residence, that meet normal dietary requirements or any specific dietary requirements You may have.

Housekeeper Services are services such as cooking, cleaning, laundering, organizing bills for payment and running errands.

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.

Hands-On Assistance means physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the Activity of Daily Living.

Independent Provider means an individual who

- (a) Works independently of a licensed home health agency;
- (b) Provides services to Chronically III individuals as a business;

- (c) Provides daily records (including daily charges) of the care or services provided, as described in the Plan of Care; and
- (d) Either (a) holds an active state license or certification or (b) is included in a government-sponsored nurse aide registry; in the state where care is provided and which is appropriate to the level of care being provided. If the state in which You live does not require licensure or certification for Independent Providers nor does it have a nurse aide registry, We will approve benefits if We can determine the individual is qualified by training and experience to provide services. (The Caregiver Training Benefit may also be utilized to train an individual to perform these services.)

Informal Care means Housekeeper Services or Personal Care Services provided by an Informal Caregiver in Your Residence. Such care or services must be greater than care or services the Informal Caregiver provides for other members of the household residing in Your Residence.

Informal Caregiver means a person who:

- (1) Is approved by Us as being experienced in or trained to provide Informal Care;
- (2) Is physically capable of providing Informal Care to You; and
- (3) Is not paid as a Home Care Provider under the Policy.

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

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

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

Long Term Care means Long Term Care Services provided by a covered service provider.

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

Nursing Home means a place which:

- (a) Is licensed by the state in which it is located;
- (b) Provides 24-hour care on an inpatient basis under the supervision of a physician;
- (c) Has nursing services provided by or under the supervision of a registered nurse (RN), licensed vocational nurse (LVN), or licensed practical nurse (LPN);
- (d) Keeps a daily medical record of each patient; and
- (e) Is either a freestanding facility or a ward, wing, unit or swing bed of a hospital or other institution.

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.

Plan of Care is a written, individualized plan for care and support services for You that:

- (a) Has been developed as a result of an assessment and incorporates any information provided by Your personal physician; and
- (b) Has been prescribed by a Licensed Health Care Practitioner; and
- (c) Fairly, accurately and appropriately addresses Your long term care and support service needs; and
- (d) Specifies (1) the type, frequency, and duration of all services required to meet those needs; (2) the providers appropriate to furnish those services; and (3) an estimate of the cost of such services.

The Plan of Care must be updated as Your needs change. We must have a copy of the Plan of Care upon its completion and each time it is updated. We retain the right to obtain periodic updates at least every 90 days but not

more frequently than once every 30 days. We will make copies of the current Plan of Care available to Your personal physician.

Long Term Care Services means services that:

1. Are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner;
2. Are provided by a covered service provider;
3. Are intended to provide support for assistance with Activities of Daily Living or supervision due to Severe Cognitive Impairment.

Severe Cognitive Impairment means a loss or deterioration in Your 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.

Stand-by Assistance means the presence of another person within arm's reach of You that is necessary to prevent, by physical intervention, injury to the individual while he or she is performing the Activities of Daily Living.

Substance Abuse means abuse of alcohol or drugs or other substance abuse or dependency.

Substantial Supervision means continual supervision, which may include cueing 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.

You/Your means the Insured.

Your Residence means wherever You live except a hospital, Nursing Home, Assisted Living Facility, or Hospice facility.

CONVERSION OF COVERAGE RIDER

CONVERSION OF COVERAGE

If Your insurance under the group Policy terminates due to the conditions described in the provision entitled "Conversion of Your Coverage," the Certificate becomes the individual policy. Only the following provisions of the Certificate are changed:

1. The term "Holder," wherever it may appear, is deleted.
2. The term "Policy," wherever it may appear, means Your Certificate and any attached Riders.
3. The "When Does My Insurance Begin?" provision is changed to read as follows:

WHEN DOES MY INSURANCE BEGIN?

Your individual policy starts on the date You are no longer eligible under the group Policy.

4. The provision entitled "Can My Premium Be Changed?" is amended to read as follows:

CAN MY PREMIUM BE CHANGED? We cannot change Your premiums because of age or health. We can, however, change Your premiums based on Your premium class, but only if We change the premiums for all other Insureds in the same premium class in Your state. A change may be made on any Premium Due Date.

If We elect to change premium rates, Your premiums change on Your first Premium Due Date following the effective date of the change stated in Our written notice to You.

5. The provision entitled "Entire Contract; Changes" is changed to read as follows:

Entire Contract; Changes: This Policy, the Group Policy's Master Application for purposes of incontestability, Riders, Your individual application(s); 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.

Nothing herein contained will alter, vary, or affect any of the terms, provisions, or conditions of Your Certificate other than what is stated above in this Rider.

This Rider takes effect on the date Your coverage under the group Policy terminates in consideration of the provisions and conditions set forth in the provision entitled "Keeping Your Coverage." It expires concurrently with the Certificate to which it is attached.

Signed for the Continental Casualty Company at its Home Office, 333 S. Wabash Ave., Chicago, Illinois 60604.

Continental Casualty Company



Chairman of the Board

Continental Casualty Company



333 S. Wabash Ave. A Stock Company
Chicago, IL 60604

ADMINISTRATIVE RIDER

It is understood and agreed that in the event the Group Long Term Care policy or 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, and waiting periods to the extent such time was spent under the policy being replaced.

Signed for the Continental Casualty Company at its Home Office, 333 S. Wabash Ave., Chicago, Illinois 60604.

Continental Casualty Company

Chairman of the Board

ADMINISTRATIVE RIDER

It is understood and agreed that if any premium payable by the Holder is not paid by the end of the grace period, the Group Policy will end when that period ends. But the Holder may write to Us, in advance, to ask that the Policy be terminated at the end of the period for which premiums have been paid or at any time during the grace period. In this case, the Policy will terminate on the date requested.

Signed for the Continental Casualty Company at its Home Office, 333 S. Wabash Ave., Chicago, Illinois 60604.

Continental Casualty Company



Chairman of the Board

333 S. Wabash Ave.
Chicago, IL 60604

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NONFORFEITURE RIDER

FUTURE BENEFIT GUARANTEE

What is the Future Benefit Guarantee?

This provision ensures that You won't forfeit past paid premiums if Your Long Term Care insurance ends due to non-payment of premium. At the end of the grace period of an unpaid premium, Your insurance will continue at the same benefits, but at a reduced lifetime maximum. In effect, this means the full benefit will continue to be available, but for a shorter period of time. No further premiums will be required.

What will be the Reduced Lifetime Maximum amount?

This amount will equal the total premiums You paid toward a plan that included this benefit. However, the Reduced Lifetime Maximum will never be less than 30 times Your current daily benefit for Facility Care.

What are the conditions of this benefit?

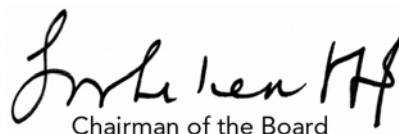
- (a) You must have had at least three years of continuous coverage under the Policy with this benefit being in effect;
- (b) The Reduced Lifetime Maximum will not be reduced due to prior benefits paid under the Policy, but in no event will the total benefits paid exceed what would have been paid had You continued to pay premiums;
- (c) No benefit increases will be offered after the effective date of the Reduced Lifetime Maximum;
- (d) If You have the Automatic Benefit Increase provision, no further increases under that provision will take effect after the effective date of the Reduced Lifetime Maximum;
- (e) The Reduced Lifetime Maximum will take effect on the Premium Due Date of the unpaid premium or, if later, on the date Extension of Benefits provision stops;
- (f) All other provisions, maximums, limitations, and conditions of the Policy will remain unchanged after the Reduced Lifetime Maximum takes effect.

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, 333 S. Wabash Ave., Chicago, Illinois 60604.

GLTC-3-R18-XX-01

Continental Casualty Company



Chairman of the Board

INFLATION PROTECTION RIDER

GUARANTEED BENEFIT INCREASE

What is the Guaranteed Benefit Increase?

This benefit offers You the opportunity to increase Your coverage.

By what amount may I increase my coverage?

You may increase each benefit amount by the percentage shown in the Schedule of Benefits.

What are the conditions of this benefit?

- (a) The offer to increase Your benefits is made not before the third anniversary of Your Original Effective date, shown in Your Certificate of Insurance, and no less than every three years thereafter;
- (b) If You elect to increase Your coverage, the premium for the increase will be based on Your age at the time of the increase. Premiums for existing benefits remain unchanged. Premium for the increase will be added to the premium for Your existing amount of coverage;
- (c) You have the right to accept the benefit increase offer without showing evidence of insurability; however, if You decline an offer You must submit evidence of insurability in order to increase benefits when the next offer is made. Once We accept Your evidence of insurability, We will not require further evidence of insurability until another offer is declined;
- (d) You will receive an offer while You are on claim if You have the right to accept an offer without evidence of insurability. If Your premiums are waived, You will be billed for the increase when the claim is completed and billing is resumed;
- (e) You cannot exercise Your right to increase coverage under this rider if You are already exercising Your right to inflation protection under another rider for the same period of time.

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, 333 S. Wabash Ave., Chicago, Illinois 60604.
GLTC-3-R04-XX-01

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INFLATION PROTECTION RIDER

LIFETIME COMPOUND AUTOMATIC BENEFIT INCREASE

What is the Lifetime Compound Automatic Benefit Increase?

This benefit automatically increases Your coverage each year.

By what amount will my coverage increase?

On each anniversary of this rider's effective date indicated below, all benefit amounts in effect on that anniversary and Your remaining Lifetime Maximum Benefit will increase by the percentage shown in the Schedule of Benefits.

What are the conditions of this benefit?

- (a) This benefit voids any other Inflation Protection Rider;
- (b) The benefit increase will be based on the benefits in effect on the prior anniversary.

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, 333 S. Wabash Ave., Chicago, Illinois 60604.
GLTC-3-R02-XX-01

Continental Casualty Company



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SHARED LIFETIME MAXIMUM RIDER

SHARED LIFETIME MAXIMUM BENEFIT

What is the Shared Lifetime Maximum Benefit?

If You and Your spouse are both covered under this Policy, this benefit provides one additional Lifetime Maximum Benefit. This additional Lifetime Maximum Benefit is to be shared by You and Your spouse once one or both of you have reached the original Lifetime Maximum as shown in the Schedule of Benefits.

What is the amount of the Shared Lifetime Maximum?

This amount will be an amount equal to the "Lifetime Maximum Benefit" as shown in Your Schedule of Benefits.

What are the conditions of this benefit?

- (a) You and Your spouse must both be covered under the Policy and have identical plans of coverage;
- (b) If either You or Your spouse is receiving claim benefits, the claiming spouse is entitled to all the benefits available under the Shared Lifetime Maximum once the original Lifetime Maximum Benefit is exhausted;
- (c) If both You and Your spouse are receiving claim benefits, We will pay benefits from the Shared Lifetime Maximum for both spouses until the Shared Lifetime Maximum is exhausted;
- (d) If You and Your spouse become divorced, or coverage ends for one of you, and neither of you are receiving claim benefits at the time of the divorce, each of you will receive an amount equal to one-half of the Shared Lifetime Maximum. This amount can be accessed when the original Lifetime Maximum Benefit is exhausted;
- (e) If You and Your spouse become divorced, or coverage ends for one of you, and one or both of you have an active claim at the time of the divorce, the Shared Lifetime Maximum will continue to be available to each of you until neither of you have received benefits for 180 consecutive days. After 180 days, each of you will receive an amount equal to one-half the remaining Shared Lifetime Maximum. This amount can be accessed when the original Lifetime Maximum Benefit is exhausted;
- (f) If You or Your spouse die, any remaining Shared Lifetime Maximum will be added to the Lifetime Maximum Benefit of the living spouse without a change in premium.

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, 333 S. Wabash Ave., Chicago, Illinois 60604.
GLTC-3-R15-XX-01

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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, 333 S. Wabash Ave., Chicago, Illinois 60604.

GLTC-3-R12-XX-01

Continental Casualty Company



Chairman of the Board