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DEFINITIONS

The terms defined here are capitalized whenever they are used.

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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:

- (a) 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.
- (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 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;
- (g) has appropriate methods and procedures for recording, handling and administering drugs and biologicals, as needed; and
- (h) 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.

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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 Insureds living at home whose condition is such that they cannot be left alone. It does not include 24-hour care. The facility providing this type of care must meet the certification or licensing requirements, 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.

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- (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 residential alternative to Nursing Home Care 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.

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Disability means any disorder resulting in the Insured being Chronically III.

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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 III.

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.

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

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

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

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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. 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.

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

SGD6IA-TQ

Maintenance Services means any care which is received due to the Insured having a Disability. This may include homemaker services such as cooking, cleaning, laundering, organizing bills for payment and running errands.

SGD29AA-TQ

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

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Nursing Home means a place which:

- (a) Is licensed by the state in which it is located;
- (b) Provides Nursing Home 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.

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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 an RN, LVN or 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.

SGDN2AA

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 preventive, therapeutic, mitigating and rehabilitative services and Maintenance or Personal Care Services, which:

- 1. are required due to a Disability, and
- 2. are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

SGD27AA-TQ

Schedule means the schedule of benefits.

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Elimination Period means the number of consecutive calendar days, stated in the Schedule, which must pass before the Long Term Care Benefit becomes payable and before we start to waive premiums.

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ELIGIBILITY FOR THE PAYMENT OF BENEFITS

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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 an Activities of Daily Living Impairment 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-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.

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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.

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LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

Exclusions - We will not pay benefits for the following:

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(a) Loss due to or resulting from war or an act of war whether declared or undeclared.

SGL2AA-1

(b) 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 Elimination Period, subject to the provisions of the Policy.

SGL2CA-2-TQ-20

(c) Long Term Care which would be provided without charge in the absence of insurance.

SGL2AA-3

(d) 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

(e) Long Term Care received outside the United States and its possessions.

SGL2AA-6

(f) 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-TQ

Elimination Period - The Insured must complete the Elimination Period before the Long Term Care Benefit becomes payable. The Elimination Period starts on the date we receive written notice of claim at our Home Office. For benefits to become payable after the Elimination Period, the Insured must have been certified as Chronically Ill during the entire Elimination Period. If we receive proof that the Insured was Chronically Ill prior to the date we receive the written notice of claim, we will begin the Elimination Period starting on the date the Disability began.

SGL3EB-TQ-20

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.
SGNH1AB-TQ

INTERRUPTION IN CARE

If the Insured has completed the Elimination 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 for the same or for a related condition recurs, the Insured must complete the full Elimination Period before benefits again become payable and premiums are again waived for Long Term Care due to such condition.

SGNH2BA-20

WAIVER OF PREMIUM

We will waive premiums starting with the first premium due after the Insured completes the Elimination 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.

SGS3BA-20

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.

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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) We must receive the Insured's written election to continue coverage within 31 days after the date coverage under the Policy terminates, unless benefits are payable under the Extension of Benefits provision. In this case we must receive the written election no later than 31 days after the date extension of benefits stops. There is no continuation of coverage if extension of benefits stops due to the Lifetime Maximum Benefit having been reached.
- (b) The Insured must remit the first quarterly premium for the continued coverage with the election to continue coverage or, if a claim started before termination, when waiver of premium stops. 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.

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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 quarterly 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 quarterly. The Insured must remit them directly to us. We will consider requests for payment modes other than quarterly.

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 6 month period during which no benefits become payable due to the same or a related condition; or
- (b) The date the Lifetime Maximum Benefit is reached.

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REINSTATEMENT OF COVERAGE

If the Insured's coverage terminates for non-payment of premium and if the Insured has a diagnosed organic brain disease or is Chronically Ill 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-TQ

CLAIMS

Notice of Claim. Written notice must be given to us within 30 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 P.O. Box 946760, Maitland, FL 32794-6760.

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Claim Forms: After we receive the written notice of claim, we will furnish claim 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.

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Written Proof of Loss: Written proof of loss must be given to us within 90 days after the date of such loss. If this is not reasonable 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.

SGC3AA

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.

SGC6AA

Physical Examination and Assessment: At our expense, we may, as often as reasonably necessary while the claim is pending, have a physician examine the Insured or obtain an assessment of the Insured's impairment.

SGC7AA-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, 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.

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Grace Period: We allow a grace period of 31 days for each premium due after the first premium. The Insured's coverage stays in force during the grace period. It terminates at 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.

SGP2AA

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.

After the Insured's coverage has been in force for 2 years, only fraudulent misstatements of the Insured may be used to void the Insured's coverage. After the Insured's coverage has been in force for at least 6 months but less than 2 years, only misstatements of the Insured on the application and which pertains to the condition for which benefits are sought may void the Insured's coverage. If the Insured's coverage has been in force for less than 6 months, any misstatements of the Insured may be used to void the Insured's coverage in the event that we would not have issued coverage if the correct information was known.

After the Policy has been in force for 2 years, only fraudulent misstatements of the Holder may be used to void the Policy.
SGX2AC-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

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

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 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 Elimination 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.

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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

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

GUARANTEED BENEFIT INCREASE OPTION

On the third anniversary of the Policy Effective Date, as stated in the Schedule, 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.

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.

SGI1GB

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	No refund is
older		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.

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WORLD WIDE COVERAGE RIDER

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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