

Continental Casualty Company

For All the Commitments You Make®

CNA Plaza A Stock Company
Chicago, Illinois 60685

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

Holder: The University of Texas System
Policy Number: 0010025TQ(the "Policy")
Policy Effective Date: September 1, 2001

**THIS POLICY IS INTENDED TO BE A QUALIFIED LONG TERM CARE INSURANCE CONTRACT
AS DEFINED BY THE INTERNAL REVENUE CODE OF 1986, §7702B(b).**

The Policy is issued in consideration of the statements made in the Master Application, and 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 a Medicare Supplement policy. If the Insured is eligible for Medicare, the Medicare supplement Buyer's Guide is available from Us for review.
SPS1AA-42-TQ

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. Termination of the Policy will be the later of: (a) The effective date of non-renewal stated in the written notice; or (b) The end of the Period for Notice of Non-Renewal stated in the Schedule. This period starts on the date We receive the written notice from the Holder.

We guarantee to renew the Policy at the end of each renewal period, unless the Holder fails without good and sufficient cause to duly perform in good faith any obligation pertaining to the Policy. The 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. 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. 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. In the event the Policy is not renewed, each Insured may continue coverage as provided in the Continuation of Coverage Due to Termination provision.

All insurance periods start and end at 12:01 a.m., Standard Time, at the Holder's address stated in the Master Application.
SPS2BA-42

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

Chairman of the Board

Secretary

GROUP LONG TERM CARE INSURANCE POLICY

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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:

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

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

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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 for medical or nonmedical services provided to ill, disabled or infirm persons when received from a Home Health Care Provider at the Insured's Residence:

- (1) Homemaker, 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) Assistance with Activities of Daily Living;
- (4) Respite Care Services;
- (5) Hospice Care;
- (6) Case Management Services; or
- (7) Any other maintenance or personal care services that are Qualified Long Term Care Services, provided by a home health aide.

A Home Health Care Provider is an entity which:

- (1) Has a business which provides home health care service and;
- (2) Is licensed by the Texas Department of Health under Texas Civil Statutes, Article 4447u or
- (3) For residents outside of Texas, is certified or licensed by the state in which it is located as a provider of such care.

SGDH1BA-42-TQ

(b) Adult Day Health Care means a community based group program of health, social and related support services for Insureds living at home who can benefit from care in a group setting outside the home. 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.

SGDH2AA-42

(c) 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.

SGDH4AA

(d) Assisted Living Care means a living arrangement in a 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 providing this type of care must be certified or licensed by the state in which it is located.

SGDH3AA

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

SGD28AA-TQ

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

SGD2AA-TQ

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

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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.

SGD4AA

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

SGD24AA-TQ

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

SGD5AA-TQ

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

SGD6IA-TQ

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

SGD7AA

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

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-42-TQ

Schedule means the schedule of benefits.

SGD8AA

Waiting 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. Sufficient mobility to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, a wheelchair or other means.

SGDQ2BA-8-42

Severe Cognitive Impairment means a deterioration in the Insured's intellectual capacity which has been diagnosed by a Licensed Healthcare Practitioner and which requires Substantial Supervision of the Insured by another person because the Insured engages in behavior which poses a health or safety hazard to him or to others. Such diagnosis is measured by clinical evidence and standardized tests that reliably measures impairment in the following areas:

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

SGDQ3EA-42

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.

SGD32AA

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

Exclusions - We will not pay benefits for the following:

SGL2AA

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

SGL2AA-1

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

SGL2CA-2-TQ

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

SGL2AA-3

4. Treatment for neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder which is not of organic origin. Alzheimer's Disease and similar dementias; biologically-based brain disease/serious mental illness including schizophrenia; paranoid and other psychotic disorders; bipolar disorders (mixed, manic and depressive); major depressive disorders (single episode or recurrent) and schizo-effective disorders (bipolar or depressive) are covered, subject to the provisions of the Policy.

SGL2AA-4-42

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

SGL2DB-5

6. Long Term Care received outside the United States and its possessions.

SGL2AA-6

7. 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.

SGL2AA-7-TQ

Waiting Period - The Insured must complete the Waiting Period before the Long Term Care Benefit becomes payable. The Waiting Period starts on the date We receive written notice of claim at Our Home Office. For benefits to become payable after the Waiting Period, the Insured must have been certified as Chronically Ill during the entire Waiting 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 Waiting Period starting on the date the Disability began.
SGL3EB-TQ

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

WAIVER OF PREMIUM

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

ALTERNATE PLAN OF CARE BENEFIT

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

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

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

SGA1AB-TQ

INDIVIDUAL TERMINATIONS

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

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

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

SGS4AA

CONTINUATION OF COVERAGE DUE TO TERMINATION

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

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

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

- (b) Upon receipt of the Insured's remittance of the first quarterly premium for continuation coverage, We will verify that the Insured is eligible for continuation and provide ongoing billings. All future premiums under the continuation policy are due quarterly. The Insured must remit them directly to Us. We will consider requests for payment modes other than quarterly.
- (c) Coverage will be continued under the continuation policy with the same benefits and provisions as the Policy, such that the Insured is left in the same position as if coverage had not terminated.
- (d) The Insured's coverage under the continuation policy is effective as of the date coverage terminates under the Policy. The Insured will not be covered or receive benefits simultaneously under the Policy and the continuation policy.
- (e) There is no continuation of coverage if Extension of Benefits stops due to the Lifetime Maximum Benefit having been reached.

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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.

SGS6AA

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.

SGS7AA

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

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.

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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.

SGC1AA

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.

SGC2AA

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 reasonably possible, the claim is not affected if the proof is given to Us as soon as possible. Unless the Insured is legally incapacitated, written proof must be given within 1 year of the time it is otherwise due.

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.

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.

SGP1AA

Grace Period: We allow a grace period of 65 days for each premium due after the first premium. The Insured's coverage stays in force during the grace period. It terminates, subject to the Unintentional Lapse provision, unless non-payment is due to a clerical error made by Us or the Holder.

SGP2AA-42

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

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

BENEFIT

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

- (a) The conditions which must be met for the Long Term Care Benefit to become payable, stated in the Long Term Care Benefit provision, must also be met for benefits to become payable under this provision. However, there is no Waiting Period.
- (b) The Caregiver Training must be provided by a Home Health Care Provider, Nursing Home or hospital while the Insured is receiving Long Term Care or Informal Care. If the Insured is in a Nursing Home or in a hospital, the Caregiver Training Benefit will only be payable if the training will make it possible for the Insured to return to the Insured's Residence where he or she can be cared for by the Informal Caregiver.